VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
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AGENCY OF HUMAN SERVICES

Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

February 10, 2026

Stacey Bowen, Manager
St Joseph Kervick Residence Iii
131 Convent Avenue
Rutland, VT 05701

Dear Ms. Bowen:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 6, 2026.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0298	A. BUILDING: _____ B. WING _____	C 01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH KERVICK RESIDENCE III	131 CONVENT AVENUE RUTLAND, VT 05701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments On 1/6/26 the Division of Licensing and Protection conducted an unannoucne on-site investigation of one complaint. the following deficiencies were identified:	R100		
R153 SS=D	5.8.b Licensed Health Care Provider Services A resident has the right to refuse all medical care. In such cases, the home must assess its ability to properly care for the resident and document the refusal and the reasons for it in the resident's record. This REQUIREMENT is not met as evidenced by: Based on Staff interview and record review there is a failure to document one applicable resident's refusal of oral care (Resident #1). Findings include: Per record review Resident #1 was diagnosed multiple medical conditions impacting their ability to perform self-care. Per staff interviews and record review, Resident #1 required assistance with Activities of Daily Living including but not limited to Personal Hygiene and Oral Care. Resident #1's Care Plan indicated they required reminders and assistance with this care; and identified interventions with instructions to re-approach when care was refused, provide education about possible outcomes of refusing care, and document any refusals. The most recent Resident Assessment on file in Resident #1's record was signed by the Director of Nursing on 12/1/2025 and indicated Resident #1 resisted care daily and their	R153	R153 1. Assessed all residents for the potential for refusal of care. 2. Implemented training for nursing staff on the proper Documentation of Refusal of Care on 1/9/2026. 3. Staff meeting on 1/27/26 reviewed Documentation of Refusal of Care and discussed residents with potential for refusal of care. 4. 24-hour report reviewed daily for documentation by DON or designee. Documentation of Refusal of care annually. 5. Completed 1/27/2026. R153 Plan of Correction accepted by Jo A Evans RN on 2/10/26.	

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R153	Continued From page 1 resistance to care was not easily altered. This Resident Assessment form indicated Resident #1 had dentures which were cleaned daily by the Resident or staff. During interviews conducted on 1/6/26 Staff stated they observed Resident #1 to have poor oral hygiene, Resident #1 refused prompts and assistance with oral care, and Resident #1 would state they had already completed self-care tasks including oral care when they had not. Per record review, Progress Notes on file since March of 2025 do not include documentation of refusal of oral care and actions taken. Documentation of services provided to Resident #1 included staff instructions which stated "Resident requires reminders to perform oral care and perform personal hygiene". Staff were required to document this care twice daily. Per review of the record of services provided to Resident #1 between 12/24/25 - 1/2/26, multiple Direct Care Staff and the Director of Nursing signed documentation indicating they performed this task. Out of 19 documented occurrences of staff performing this care task during the 10 day period leading up to Resident #1's hospitalization, this service was documented as completed 18 times and documented as refused one time on 1/1/26. During an interview commencing at 4:43 PM on 1/6/26 the Director of Nursing confirmed the failure to document Resident #1 refusal of personal hygiene including oral care in Resident #1's record.	R153	R228 1. Documentation of death recorded in resident record, as well as notification of untimely death to licensing agency completed on 1/6/2026. 2. Policy and Procedure will be followed in the future, as they were in place. 3. Educated Designated (reporting) staff of Policy and procedures that include circumstances re: untimely death. 4. Designated reporting staff educated about the reporting of a resident's expiration outside of facility. 5. Completion 1/6/2026. R228 Plan of Correction accepted by Jo A Evans RN on 2/10/26.	
R228 SS=D	5.12.c (2) Records/Reports A home must file the following reports with the licensing agency:	R228		

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R228	Continued From page 2 Any untimely deaths or serious injury as a result of an accident or incident must be reported to the licensing agency and a record kept on file. i. In those deaths in which the law applies (such as an unexpected, untimely dearh, pursuant to 18 V.S.A. §5205 (a), the manager is responsible for immediately notifying the regional medical examiner. ii. In those deaths in which the medical examiner need not be notified, the manager must: (A) Follow the instructions of the deceased, legal representative, if any, next of kin, or other relative regarding funeral and other related arrangements. (B) In instances where the services of an undertaker are not immediately available, and the resident occupied a multi-bed room, the manager must arrange for the immediate removal of the body of the deceased resident to a separate unoccupied room. (C) Remove a deceased resident's body from the home within a reasonable amount of time, given the circumstances, but in any case, within the time required by the local town or municipal ordinance, if any. iii. When a resident dies unexpectedly or within two (2) weeks of a fall, injury or incident (such as choking, exposure, etc.), the licensee must send a report to the licensing agency with the following information: (A) Name of resident; (B) Circumstances of the death; and (C) Circumstances of any recent injuries, falls, or incidents.	R228		

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R228	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to report the untimely death of one applicable resident (Resident #1) to the licensing agency; and a failure to ensure a written record of the applicable resident's death is on file in the applicable resident's record. (Resident #1). Findings include: The home's Death of a Resident Policy effective 7/2018 states in the event of an unexpected death a report shall be sent to the licensing agency. 1. Per record review Resident #1 was diagnosed multiple medical conditions including Chronic Stage 4 Kidney Disease. A Progress Note written on the morning of 1/2/26 states the Director of Nursing was informed Resident #1 presented with changes from their baseline, was not feeling well and had not been getting out of bed. The Director of Nursing checked on the Resident, and found they were audibly wheezing, in a weakened state, and unable to stand. Resident #1 was transported via ambulance to the Emergency Department, admitted to the hospital for kidney failure and passed away in the hospital on 1/4/26. During an interview conducted at 4:43 PM on 1/6/25, the Director of Nursing confirmed Resident #1's untimely death had not been reported to the licensing agency as they were not aware the home was required to report Resident	R228		

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R228	Continued From page 4 #1's untimely death. 2. Per record review, a written report of Resident #1's death was not on file in the Resident's record. This finding was confirmed by the Director of Nursing at 6:00 PM on 1/6/25.	R228		