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

March 10, 2026

Vanessa Fortune, Manager
Converse Home
272 Church Street
Burlington, VT 05401-4695

Dear Ms. Fortune:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 29, 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
	1010	A. BUILDING: _____ B. WING _____	C 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONVERSE HOME	272 CHURCH STREET BURLINGTON, VT 05401

(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 1/29/2026 the Division of Licensing and Protection conducted an unannounced on-site investigation of 2 complaints and 2 facility reported incidents. The following deficiencies were identified:	R100	VF	
R223 SS=E	5.12.b (2) Records/Reports The home must keep and maintain the following records. A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; licensed health care provider ' s name, address and telephone number; instructions in case of resident ' s death; the resident ' s assessment(s); progress notes regarding any accident or incident and subsequent follow-up; progress notes regarding any illness or change in condition and subsequent related follow-up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident ' s advance directives, if any completed; and a copy of the document giving legal authority to another, if any. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to include documentation of incidents and changes in condition in the resident records of 4 applicable residents (Residents #1, #2, #3 and #4) as required. Findings include:	R223	VF	

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R223	Continued From page 1 1. Per staff interview and record review, Resident #1 and Resident #2 were involved in an incident of Resident-to- Resident verbal abuse on 1/3/2026. Per review, Progress Notes on file for Resident #1 and Resident #2 do not include a record of this incident and subsequent actions taken by staff. 2. Per record review, Resident #3 was admitted to the home while receiving hospice care. Per review of public records Resident #3 passed away on 12/15/2025. A Progress Note documenting Resident #3's death is not on file in this Resident's record. 3. Per review, four Orders - Administration Notes dated 1/7/2025 on file in Resident #4's record indicate this resident was "out of house for operation"; however, Resident #4's record does not include documentation pertinent information regarding the referenced "operation" including any applicable pre and post operative instructions, and the type of operation being performed. On the afternoon of 1/29/2026 the Executive Director acknowledged the finding of a failure to include required documentation in resident records.	R223	VF	
R232 SS=E	5.12.c (5) Records/Reports Any reports, allegations, or incidents of abuse, neglect, exploitation of residents or misappropriation of resident property must be reported to the licensing agency. i. The licensee and staff must report any case of	R232	VF	

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R232	Continued From page 2 suspected abuse, neglect or exploitation of a resident to Adult Protective Services (APS). A separate report must also be made to the licensing agency. APS may be contacted by calling toll-free 1-800-564-1612. The licensing agency may be contacted by calling toll-free 1-888-700-5330. The home must make the reports to APS and to the licensing agency immediately but not later than within 48 hours of learning of the suspected, reported or alleged incident. ii. In addition to filing the reports as described above, a home must conduct its own investigation and must take immediate steps to prevent further abuse, neglect or exploitation from occurring. The results of the home ' s investigation must be reported to the licensing agency within 5 business days from the date of the initial report of the allegation. The home's investigation and determination must not delay reporting of the alleged or suspected incident to Adult Protective Services and to the licensing agency. iii. Incidents involving resident-to-resident abuse must be reported to the licensing agency any time a resident alleges, or the licensee or staff observe or suspect, verbal, physical or mental abuse; sexual abuse, if an injury has resulted; or if there is a pattern of abusive behavior. (A) All resident-to-resident incidents, even minor ones, must be recorded in the resident ' s record. (B) The home must notify legal representatives and families (if permitted) about the incident(s) and must document the report and the plan the home developed to address the behaviors. the following reports with the licensing agency:	R232	VF	

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R232	Continued From page 3	R232	VF	

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review there is a failure to report an incident of resident-to-resident abuse to the licensing agency within 48 hours; and a failure to report an allegation of staff to resident abuse to the Adult Protective Services and the licensing agency. Findings include:

The home's Mandated Reporting policy effective 4/7/2025 includes a copy of this licensing rule and identifies all staff as mandatory reporters. This policy states if an incident is related to the home or one of its residents, "the Home will conduct its own investigation. However, APS and/or DAIL Survey and Certification, must still be contacted within a certain number of hours of the incident. [sic]"

1. Based on staff interview and record review the home failed to report an incident of resident-to-resident verbal abuse to the licensing agency within 48 hours as required.

Per staff interview and record review, Resident #2 is living with memory impairment due to cognitive decline and is often forgetful. Per the facility's reporting to the licensing agency, Resident #1 does not believe Resident #2's forgetfulness is "genuine" and "gets very upset" with Resident #2. Per record review an incident of resident-to-resident verbal abuse occurred on 1/3/2026 when Resident #1 presented with agitation directed towards Resident #2 while both residents were seated at the same table during meal service in the home's dining room. During this incident, Resident #1 used a derogatory word

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R232	Continued From page 4 and profanity to call Resident #2 a name typically used as an insult. Per record review, this incident was witnessed by staff and other residents. This incident was reported to the Adult Protective Services on 1/5/2026; however, it was not reported to the licensing agency until 1/12/2026, nine days after the incident occurred. At 2:22 PM on 1/29/2026 the Executive Director confirmed Resident #1's verbal abuse of Resident #2 on 1/3/26 was not reported to the licensing agency within 48 hours as required. 2. Based on staff interview and record review the home failed to report an allegation of staff to resident abuse to the Adult Protective Services and the licensing agency. Per record review, Resident #3 was admitted to the home on hospice on 11/03/2025. During an interview commencing at 2:29 PM on 1/29/2026, the Executive Director stated the home was notified by the organization that provided hospice care for Resident #3 regarding an allegation suspected abuse involving the home's staff and Resident #3 which was reportedly observed on 11/25/2025. Per the Executive Director an internal investigation was conducted by the home following receipt of notification regarding the alleged mistreatment of Resident #3 by staff on 11/25/2025; however, the allegation of abuse was not reported to the Adult Protective Services (APS) and the licensing agency. During the interview conducted on the afternoon of 1/29/2026, the Executive Director confirmed the home did not report the allegation of staff-to-resident abuse on 11/25/2025 to the Adult Protective Services or the licensing agency.	R232	VF	

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R360 SS=D	6.12 Resident's Rights Residents must be free from mental, verbal or physical abuse, neglect, and exploitation. Residents must also be free from restraints and seclusion as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure one applicable resident (Resident #2) remained free of verbal abuse by another resident (Resident #1). Findings include: Per record review Resident #1's short term and long term memory are intact, they do not have difficult remembering, and they are able to make decisions independently. Per record review Resident #2's diagnoses include Alzheimer's Disease, and psychological conditions including Anxiety and Depression. Per review of information provided to the licensing agency, Resident #2 is very forgetful, and Resident #1 becomes very upset with Resident #2 because they do not believe Resident #2's forgetfulness is "genuine". Per staff interview and record review, while Resident #1 and #2 were seated at the same table during lunch service on 1/3/2026 Resident #1 expressed dislike for Resident #2 and stated Resident #2 was pretending to be forgetful. Resident #1 then engaged in name calling directed towards Resident #2 using profanity and a derogatory word in a loud voice in front of other residents and staff in the dining room. Per the Director of Nursing's follow-up summary of this incident, Resident #2 does not feel safe when they are spoken to in this way. During an interview	R360		

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R360	Continued From page 6 commencing at 3:38 PM on 1/29/2026, Resident #2 appeared to have some recollection of this incident when stating another resident had been mean and yelled at them; however, Resident #2 did not recall what the other Resident had said. The incident of resident-to-resident verbal abuse between Resident #1 and Resident #2 on 1/3/2026 was confirmed by Executive Director at 2:22 PM on 1/29/2026.	R360	VF	

Plan of Correction Response to Division of Licensing and Protection

Investigation 1/29/2026

Plan of Correction Response due 2/23/2026

Updated: 3/6/2026

R223

Action to correct deficiency:

Measure/Systemic Change to ensure no recurrence:

1. Resident 1 & 2-Converse Homes internal policy "Resident to Resident Incident of Harassment or Abuse" has been updated on 2/13/26 to include that an Incident Report will be documented triggering a Progress Note to be written by the Charge of Shift or Shift Supervisor in both residents Electronic Medical Record.
2. Resident 3- It is already part of our written procedure that a Progress Note be entered upon a resident's death.
3. Resident 4 record does not include documentation pertinent information regarding the referenced "operation" because the documenting caregiver incorrectly documented "operation" as the reason the resident did not have medications administered. The actual reason medication was not administered is because the resident was being evaluated in the Emergency Department at UVMC. The resident did not have an operation after the fall. Effective 2/23/26, the nursing department will document the status of a resident as they transition out of house.

Monitor:

1. The original Incident Report is given to the Executive Director. The Executive Director, or designee, will confirm all required information has been documented in the eMAR after each reported incident effective 2/13/26.
2. All the Shift Supervisors and Charge of Shifts will review the Pronouncement of Death procedure and initial their understanding of the process. If the resident was followed by Hospice services, the pronouncing Hospice clinician will document in the residents eMAR. A Progress Note will be created after each pronouncement with the following information:
    - Resident's name, DOB
    - Absence of BP, heat sounds and respirations
    - Date and time of death
    - Date and time of pronouncement
    - Name and relationship of those in attendance
    - Time and notification of attending provider
    - Disposition of residents' medications (per narcotic disposal policy)
    - Notification of funeral home and funeral arrangements if known
3. The Director of Nursing will document or follow up for the documentation of a resident going out of house to the emergency department. Documentation will include visit to

ED/admission/surgical intervention/rehabilitation/family meetings/discharge to home, etc., so there is clear communication on the progression of the resident effective 2/23/26.

Completion:

1. The Executive Director, or designee, will complete a final review to ensure the resident-to-resident incident is reported to APS and DAIL Survey and Certification within 48 hours of incident and a 5 day follow up investigation form will be completed and sent to Survey and Certification and is documented in the eMAR. This packet is then filed in a reporting binder in the Director of Administrations office effective 2/13/26.
2. The Director of Nursing will review the documentation after each resident death to ensure all the necessary information in documented in the EMAR effective 2/13/26.
3. All residents will have out of house communications documented in the eMAR effective 2/23/26.

R232

Action to correct deficiency:

Measure/Systemic Change to ensure no recurrence:

The Executive Director will re-educate and review the reporting process for a resident-to-resident incident with the leadership team. Each member of the leadership team is a department director. The Directors will be responsible for educating their teams on individual responsibility and procedure for incident reporting. The Mandated Reporting policy has been updated to include notifying the licensing agency and 5-day follow-up investigation for resident-to-resident incidents.

Monitor:

The Executive Director, or designee, will support leadership in the reeducation process for staff, ensure all policies and procedures updated are reviewed and acknowledged by staff, and each incident is reported, documented, and filed within the mandated time frame.

Completion:

Effective 2/13/26, the Executive Director or Director of Administration will complete a final review to ensure the resident-to-resident incident is reported to APS and DAIL Survey and Certification within 48 hours of incident and a 5 day follow up investigation form will be completed and sent to Survey and Certification and is documented in the eMAR. This packet is then filed in a reporting binder in the Director of Administrations office.

R360

Action to correct deficiency:

Measure/Systemic Change to ensure no recurrence:

Converse Home strives for each resident to live their life free of harassment of any kind. Effective 3/1/26 there will be continued education to all staff that any harassment or bullying that is

observed or reported is then documented with an Incident Report and given to the Executive Director. The Nurse Charge of Shift or Shift Supervisor will also be made aware, and a Progress Note will be documented in the residents and any other involved residents' chart.

Monitor:

The Executive Director, or designee, will confirm all required information has been documented in the eMAR after each reported incident.

Completion:

The Executive Director, or designee, will complete a final review to ensure the resident-to-resident incident is reported to APS and DAIL Survey and Certification within 48 hours of incident and a 5 day follow up investigation form will be completed and sent to Survey and Certification and is documented in the eMAR. This packet is then filed in a reporting binder in the Director of Administrations office.