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

April 22, 2026

Danielle Nickerson, Manager
Woodstock Terrace
456 Woodstock Road
Woodstock, VT 05091-9759

Dear Ms. Nickerson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 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
	1005	A. BUILDING: _____ B. WING _____	C 04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODSTOCK TERRACE	456 WOODSTOCK ROAD WOODSTOCK, VT 05091

R191 Accepted April 22, 2026
Susan C Gregoire RN

(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 April 6, 2026, the Division of Licensing and Protection conducted an unannounced on-site investigation of one facility reported incident. The following deficiency was identified:	R100		
R191 SS=D	5.10.c Medication Management Staff must not administer any medication, prescription or over-the-counter medications for which there is not a written, signed order from a licensed health care provider and a supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the licensee failed to ensure that medications were administered only to the intended resident in accordance with a written, signed order from a licensed health care provider, resulting in the administration of medications prescribed for another resident to Resident #1. Findings include: The home's Medication Management Policy states that all medications will be provided as prescribed by the Resident's Licensed Practitioner and that all medications shall be administered in accordance with the written and signed orders of the Licensed Practitioner or other professionals with prescriptive powers. Per record review of a documented facility-reported incident conducted on April 6, 2026, Resident #1 received medications not prescribed on March 19, 2026. Documentation indicated that the Nurse administering medications "mixed up" the residents resulting in	R191		

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R191	Continued From page 1 the administration of incorrect medications to Resident #1. The medications administered included Atorvastatin 40 MG, Clonazepam 1 MG, Furosemide 10 MG, and Temazepam 30 MG. The report indicates the medications were administered at approximately 6:00 PM. Resident #1 subsequently exhibited symptoms including tiredness, lethargy, and unsteadiness. The error was identified at approximately 6:30 PM and the Resident was transferred via Emergency Medical Services (EMS) to the hospital for evaluation. Per record review of the licensee's medication error report conducted on the morning of April 6, 2026, a medication error occurred on March 19, 2026, at approximately 6 PM involving Clonazepam, Temazepam, Furosemide, and Atorvastatin. Documentation indicated errors of wrong medication, wrong resident, and wrong dose. The report further states that a Nurse administered medications to Resident #1 that were not prescribed for the Resident. Resident #1 subsequently exhibited symptoms including lethargy, increased confusion, and unsteadiness, and was sent to the emergency department for evaluation. Per staff interview conducted with the Executive Director on the morning of April 4, 2026, the Executive Director confirmed the medication administration error involving Resident #1.	R191		

Deficiency Statement Plan of Correction (POC)

Survey Date: April 6, 2026

Facility Name: Woodstock Terrace Assisted Living

Deficiency Tag	How the deficiency was corrected	How other potential residents identified, and corrective action taken	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R191 5.10.C Medication Management	Orientation for Agency and Temporary Care staff policy has been created. This includes a check list for agency staff to get a tour of units, resident overview, care plan documentation, key policies and safety, and memory care items. All agency staff passing meds must review the “7 rights of Medication delivery” and sign verifying they have received orientation to the unit and the 7 rights of medication delivery.	This will be in place for both AL and Memory Care the two units located at Woodstock Terrace, to ensure that agency staff are oriented to the unit on their first shift.	04/24/2026	The Health Services Director will verify that the orientation checklist and 7 rights of medication delivery are completed when an agency staff works on either unit the first day, they work. The Health Service Director will educate all staff, so they know where the forms are located and who is responsible for the orientation when an agency staff picks up a shift.	Health Service Director R191 Accepted April 22, 2026 Susan C Gregoire RN