VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
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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

May 29, 2026

Mary Belanger, Manager
St Joseph's Residential Care Home
243 North Prospect Street
Burlington, VT 05401-1609

Dear Ms. Belanger:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 27, 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
	0155	A. BUILDING: _____ B. WING _____	C 04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH'S RESIDENTIAL CARE HOME	243 NORTH PROSPECT STREET BURLINGTON, VT 05401

R360 and R232 Accepted
5-29-2026 Susan 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 27, 2026, the Division of Licensing and Protection conducted on unannouced on-site investigation of three facility reported incidents. The following regulatory deficiencies were identified:	R100		
R232 SS=C	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 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.	R232		

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Mary Abel Administrator 5.18.26

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R232	Continued From page 1 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: This REQUIREMENT is not met as evidenced by: Per staff interview and record review, there is a failure to ensure an alleged resident-to-resident abuse incident was reported to the Adult Protective Services (APS) and the Licensing Agency within 48 hours. Findings include: The facility's Abuse Prevention and Reporting policy is consistent with the licensing rules. Per record review, the Administrator was made aware on 12/05/2025 of an alleged incident of physical contact, inconsistent with appropriate resident interactions, that occurred on 12/05/2025. The incident summary indicated that a volunteer witnessed Resident #2 "nuzzling" their face into Resident #3's neck and rubbing Resident #3. The documentation noted this incident was reported to Adult Protective Services (APS) on 12/08/2025 and to the Licensing Agency on 12/10/2025, after the 48-hour time frame outlined in the licensing rules.	R232		

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R232	Continued From page 2 These findings were acknowledged by the Administrator of the facility on the afternoon of 4/27/2026.	R232		
R360 SS=H	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 observation, staff interviews and record review, the licensee failed to ensure that one applicable resident (Resident #1) was free from abuse by a staff member. Findings include: The licensee's policies and procedures are consistent with this licensing rule. Per record review of Resident #1's plan of care conducted on the morning of April 27, 2026, the Resident is identified as having cognitive and physical impairments, requires the use of a walker for ambulation, and ongoing assistance with activities of daily living, and demonstrates communication impairment, including difficulty with word finding. Resident #1 has been residing in this home for over six years. Per observation conducted on the morning of April 27, 2026, Resident #1 was noted to have difficulty transitioning between sitting and standing positions, demonstrated a forward-flexed posture and unsteady gate while ambulating with a walker, and, during interaction, exhibited pauses in speech with an inconsistent	R360		

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R360	Continued From page 3	R360		

ability to verbalize responses to questions.

Per record review conducted on the morning of April 27, 2026, of a documented incident report provided by the licensee, the report indicates that on March 9, 2026, Resident #1 informed a Healthcare Provider of sexual contact with a staff member employed by the home. The documentation further indicates that the Healthcare Provider notified the Director of Nursing, who subsequently reported the allegation to the Administrator on the same day.

Per record review conducted on April 27, 2026, of a documented clinical encounter completed by a Healthcare Provider, the report reflects that on March 9, 2026, between 2:00 and 3:02 PM, Resident #1 disclosed that a staff member requested a romantic relationship with them and provided the Resident with several days to consider or consent to the request. The documentation further indicates that the staff member administered medications but was not directly involved in the Resident's physical care. The report documents that, during the interaction, the Healthcare Provider asked the Resident if any sexual activity had occurred, to which Resident #1 responded affirmatively. The documentation indicates that the Resident clarified this response to mean intercourse and subsequently stated, "I want to stop."

Per record review conducted on the afternoon of April 27, 2026, of a separate incident report related to the same reported interaction, authored by the Administrator, documentation indicates that Resident #1 disclosed sexual contact with the staff member and reported that the interaction began the prior week during the evening, at which time the staff member requested a response

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regarding continued contact. The documentation further indicates that when asked whether the staff member had physically touched them, Resident #1 gestured toward their genital area and indicated affirmation. The incident report further documents that Resident #1 stated they had told the staff member "no"; however, the contact continued. Resident #1 reported that intercourse occurred on two occasions and indicated that the most recent incident occurred during the past weekend.

Per record review conducted on the morning of April 27, 2026, of a handwritten statement dated March 10, 2026, signed by a Licensed Nurse, documentation indicates that at approximately 9:15 AM the Nurse entered Resident #1's room to administer morning medications. The documentation indicates that Resident #1 initiated a conversation regarding a staff member and described the individual using derogatory language. When asked what had occurred, Resident #1 responded that the staff member "did what men do." The documentation further indicates that during the interaction the Nurse used a gesture to clarify the Resident's statement by indicating the genital area and Resident #1 confirmed that the staff member had exposed an erection in the Resident's presence. The documentation indicates that Resident #1 did not provide additional detail regarding the circumstances of the event but reported having notified the Director of Nursing and expressed their desire to protect other residents.

Per record review of the licensee's incident report dated March 10, 2026, documentation by the Registered Nurse indicates that the Nurse checked in with Resident #1 to assess well-being. Resident #1 questioned whether the staff

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member [alleged perpetrator] would return and expressed concern that the individual might attempt to engage in further unwanted interaction. The documentation indicates that the Nurse informed Resident #1 that the staff member would not be returning and that the Resident was safe, and door codes at the facility had been changed. Resident #1 further expressed a desire to protect other residents. The documentation indicates that the nurse asked whether Resident #1would like a family member notified of the alleged incident, and Resident #1 agreed.

Per record review of the licensee's incident report dated March 11, 2026, documentation by the Registered Nurse indicates that, during an interview, Resident #1 was asked to describe the staff member referenced in the reported interaction. Resident #1 described the staff member as tall, reported that the individual was involved in medication administration, and indicated the presence of tattoos across multiple areas of the body while gesturing to the chest, stomach, thighs, and lower legs. Resident #1 also described the staff member as having "weird things" in the ears.

Per record review conducted on the afternoon of April 27, 2026, of hospital documentation dated March 23, 2026, including notes completed by a Forensic Nurse Examiner, documentation indicates that Resident #1 consented to a forensic medical examination. The documentation indicates that Resident #1 reported sexual assault by a staff member and penetration on two separate occasions, describing the encounters as extremely painful. The documentation further indicates that Resident #1 was unable to identify exact dates of the incidents but reported that they occurred shortly after their [the Resident's]

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R360	Continued From page 6 birthday. Resident #1 reported that force was used and denied injury to other areas of the body. Per Resident interview conducted on the afternoon of April 27, 2026, Resident #1 was asked whether they felt safe in the home and stated, "I look around all the time, I don't really feel safe." During the interview, Resident #1 was observed to be tearful and looked down the hallway while making this statement. Resident #1 further stated, "They're letting me change rooms. My room is too much. It brings back too many memories of that," referring to the reported interaction with a staff member. When asked about the reported interaction with the staff member, as referenced in the facility documentation, Resident #1 confirmed inappropriate interactions with the staff person. Resident #1 was observed to be tearful during this portion of the interview. On the afternoon of April 27, 2026, the Director of Nursing and the Administrator acknowledged these findings.	R360		

Deficiency Statement Plan of Correction (POC)

R360 and R232 Accepted
May 29, 2026 Susan Gregoire RN

Survey Date: 4/27/2026

Facility Name: St. Joseph Residential Care Home

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
R360	Staff member referenced in this deficiency was hired in October of 2025. Background checks were completed as required by the State of Vermont Residential Care regulations and facility protocol by Human Resource department before staff member came in for orientation. LPN license was verified to be in good standing during background check by Human Resources. Staff member completed all required mandatory in services on October 20th, 2025 before said staff member was allowed to interact or provide any care to our residents. Our inservice includes Abuse, neglect, and	All residents were interviewed to determine if they felt safe and if they had any concerns regarding their care and safety at St. Josephs. No other residents indicated that they felt unsafe. All were reminded that the Administrator and Director of Nursing are always available if they have any concerns.	6/1/2026 6/10/26	This plan of correction was written to follow state and federal guidelines. It is not an admission of noncompliance. However, it is the facility's commitment to demonstrate and maintain compliance St. Joseph Residential Care Home will conduct re-education in-service training for all staff to include: • Resident Rights • Abuse Neglect and Exploitation These are in addition to all state mandated in-services. Additional education on professional boundaries will be initiated for all staff members. Resident Rights, Abuse Neglect and Exploitation, and	Administrator Administrator

	exploitation, mandatory reporting. Staff member oriented with supervision from nursing staff from 10/21/25- 11/3/25. Staff member was appropriate to start work off orientation on 11/4/25. As of start of orientation staff member was informed and aware of who to call with any issues, the DON, and if DON was not available to call the On Call nurse, or Administrator. Phone numbers provided to staff member. On 3/9/26 DON was informed of an inappropriate sexual encounter by the staff member and a resident. This was reported to DON by resident's therapist after resident disclosed it to therapist. This was reported to Administrator by the DON, and staff member was put on paid		5/27/2026	Professional Boundaries will be reviewed with new hires at 30 and 90 days of employment and documented.	Department Managers

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	administrative leave effective immediately of finding out about incident on 3/10/26. The accused staff member was not on the schedule for that particular day 3/9/26 and never returned to the building, during or after the investigation. On 3/11/26 HR met with the accused staff member for an investigative interview. On 3/16/26 staff member was terminated. Safety of the resident was maintained throughout the investigation. Resident was checked on daily by DON or on duty LPN. The accused staff member never came back to the facility. Resident was provided with appointments to PCP, and Emergency department. Resident was provided with extra therapy services from [redacted] therapist throughout				

Pronouns redacted by DLP 5-27-26

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	the first few weeks of reporting this allegation. Resident's therapist provided in house visits to resident on the premises and continues to treat they/them. Resident was provided with a room change on 4/30/26 as per the residents request.				
R232	Timeline of deficiency Friday 12/5/2025 6:00pm Volunteer AM called administrator to discuss a concern that resident expressed regarding behaviors by Resident 3 towards two female residents. Administrator requested a written statement for volunteer within 24 hours 12/7/2025 7:40pm	The late report did not have an impact on other residents.	12/7/2025	Staff will report all incidents of abuse, neglect and exploitation to APS and DAIL prior to an internal investigation.	Administrator and Director of Nursing

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	Formal statement emailed/received from volunteer. 12/8/2025 10;22am Incident reported to APS 12/8/2025 Interviewed residents Indicated that they/them and resident 3 are friends and it was all done in a friendly way. Asked is resident felt unsafe around resident 2 and stated "NO"! Asked if they/them would be comfortable telling me if they/them ever felt unsafe, they/them stated "of course"! Interviewed resident 2-Stated that it was all done with humor. They joke around a lot and people don't understand their humor. Asked if they/them felt unsafe around resident 3. and they/them stated "No, we joke around"! Was asked if they/them would tell me if they/them felt unsafe and they/them stated "yes". Conversation with resident 2.- Told they/them of the complaints and concerns that were brought to my				

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	attention. (rubbing resident 1 shoulders, sarcastic humor) Resident 2 was directed to not touch other residents and respect personal space of other residents. They/them needs to maintain civil conversations with all residents in dining room and other public spaces. They/them stated that "[redacted] understands and will behave" 12/9/25 Checked in with residents 3 and another resident, both stated that things are fine and they are all friends. 12/10/2025 Emailed report to DAIL. Checked in with residents 3 and another resident, both stated that they are fine and comfortable with Resident 2 12/11/2025 Administrator checked in on residents 3 and another resident. Resident indicated that everything is fine . 12/12/2025 Administrator checked to see how residents 3 and another resident were feeling				

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	regarding allegations. Residents did not want to be asked about it again. "Everything is fine" They/them stated everything was fine, they/them and resident #2 are friends and they joke around a lot.				

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