



**Department of Disabilities, Aging and
Independent Living**
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
www.dlp.vermont.gov

[phone] 802-241-0344
[fax] 802-241-0343

AGENCY OF HUMAN SERVICES

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
<http://www.dail.vermont.gov>
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 11, 2025

Amy Croteau, Manager
The Residence At Shelburne Bay
185 Pine Haven Shore Road
Shelburne, VT 05482-7805

Dear Ms. Croteau:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 19, 2025**. 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,

A handwritten signature in black ink, appearing to read "Carolyn Scott", with a large, stylized loop at the end.

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: 0589	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/19/2025
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NAME OF PROVIDER OR SUPPLIER THE RESIDENCE AT SHELburne BAY	STREET ADDRESS, CITY, STATE, ZIP CODE 185 PINE HAVEN SHORE ROAD SHELburne, VT 05482
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(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: An unannounced onsite relicensure survey was conducted by the Division of Licensing and Protection on 2/19/25. Regulatory deficiencies were identified. Findings include:	R100		
R179 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there	R179		

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

93MS11

If continuation sheet 1 of 3

Key Crutcher Reflections Memory Care Director 4/1/25

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0589	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/19/2025
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R179	Continued From page 1 was a failure to ensure 3 out of 5 sampled staff completed (12) hours of required yearly trainings. Findings include: The home's policies and procedure for providing educations are consistent with regulatory requirement. Per review of staff training records, 3 out 5 staff failed to complete 12 hours of required annual trainings. Per interview on 2/19/25 at 12:20 PM, the Business Office Manager confirmed the staffing educations records, acknowledging 3 out of 5 staff had not completed all of the required annual.	R179		
R190 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the RCH failed to ensure staff records for abuse registry checks were completed on an annual basis. Per record review of staff abuse registry check records, 5/5 staff records did not include a completed annual abuse registry check. Per interview on 2/19/25 at 11:30 AM, the Business Office Director confirmed abuse registry checks were not completed on an annual basis.	R190		

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R190	Continued From page 2 They acknowledged the facility policy is not congruent to the updated requirements sent forth in the memorandum issued on 10/24/2022 and 5/1/23.	R190			

Deficiency Statement Plan of Correction (POC)

Survey Date:2/19/25

Facility Name: The Residence at Shelburne Bay West

POC date: 3/17/25

[illegible]