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

October 3, 2025

Lydia Raymond, Manager
The Residence At Quarry Hill
465 Quarry Hill Road
South Burlington, VT 05403

Dear Ms. Raymond:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 25, 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,

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
	1012	A. BUILDING: _____ B. WING _____	C 08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT QUARRY HILL	465 QUARRY HILL ROAD SOUTH BURLINGTON, VT 05403

(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 8/25/25 the Division of Licensing and Protection conducted an unannounced on-site investigation of 2 complaints and one facility reported incident. The following regulatory deficiencies were identified:	R100		
R139 SS=G	5.5.a General Care Upon a resident's admission to a home, necessary services must be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. Based on the comprehensive assessment of the resident, the home must ensure that each resident receives treatment and care in accordance with professional standards of practice, the resident's comprehensive, person-centered care plan, and the resident's choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure necessary services to meet one applicable resident's nursing and medical needs were provided or arranged by the home (Resident #1). Findings include: Per record review, on 6/30/25 Resident #1 was admitted to the residence from a rehabilitation center where they received care and services following surgical repair of an ankle fracture sustained during a fall. While at the rehabilitation facility Resident #1 received services including physical and occupational therapy, and wore an orthopedic boot typically utilized for protection and support to facilitate the healing process. Per review of documents provided to the residence	R139		

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R139	Continued From page 1 during the admission process, a written prescriber's order from the discharging rehabilitation facility included a prescriber's order for the boot worn by Resident #1 after surgery which stated, " ...wear boot at night and during the day but can remove ad lib (as desired) or remove boot for physical therapy." The Resident's Personal History and Preference form completed during the admission process included Resident #1's Power of Attorney's statement that Resident #1 "is in 'Boot Phase' recovering from compound fracture of ankle... [Resident #1] needs regular PT/OT ". At 2:32 PM on 8/25/25 the Director of Health Services confirmed the residence was aware of Resident #1's need for physical therapy and occupational therapy and stated the discharging rehab facility sent the prescriber's orders required for these services to the wrong home health agency. Per record review, a Progress Note written on the day of admission indicated Resident #1's referral for physical and occupational therapy was sent to the wrong provider and the contracted in-house home health provider was notified of this issue. There is no documentation of further actions taken by the residence to ensure the home health care and services Resident #1 required were initiated. Initiation of Resident #1's home health services were delayed until 7/11/25. Per Progress Notes dated 7/11/25, when the Physical Therapist removed Resident #1's boot during their initial evaluation an open wound was discovered with the hardware utilized to perform the surgical repair of Resident #1's ankle fracture exposed, and it was noted that Resident #1 reported pain in the area. Resident #1 was transported to the Emergency Department and subsequently admitted to the hospital to treat the wound infection and a second surgical repair.	R139		

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R139	Continued From page 2 During an interview with the Director of Health Services and the Executive Director commencing at 9:54 AM on 8/25/25, the Director of Health Services stated skin assessments are routinely completed on a resident's first or second day at the home. There is no documentation of a Registered Nurse completing an assessment of Resident #1's skin including the surgical site beneath the orthopedic boot during the Resident's admission process. Per Staff interview and record review, on the early morning of Resident #1's second day at the residence (7/1/25) the Resident had an unwitnessed fall and was transported to the hospital where they were diagnosed with a subdural hematoma (brain bleed) and hospitalized. Resident #1 returned to the residence on the afternoon of 7/3/25. There is no documentation in Resident #1's resident record indicating a skin assessment was completed on return from the hospital. A time-line of included in the residence's internal investigation of Resident #1's stay at the home indicates that on 7/6/25 a Nurse attempted to perform a skin assessment for the Resident which was not completed due to Resident #1 demonstrating resistance to care. A Progress Note describing this attempt to assess and subsequent actions taken were not documented in Resident #1's Progress Notes. The initial Progress Note documenting the discovery of Resident #1's infected open wound is time stamped as written at 3:23 PM on 7/11/25. At 3:06 PM on 7/11/25 the Director of Health Services entered assessment data into Resident #1's admission assessment indicating this Resident had open lesions other than ulcers and a surgical wound site. Resident #1's required admission assessment form includes assessment findings entered by a Licensed	R139		

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R139	Continued From page 3 Practical Nurse on 7/3/25 indicating Resident #1 did not have skin conditions related to foot problems or require foot care. On the afternoon of 8/25/25 the Director of Health Services confirmed the residence's Nursing Staff did not remove Resident #1's boot to assess for skin integrity or signs and infection during Resident #1's stay at the residence.	R139		
R214 SS=D	5.11.e (3) Staff Services The home must require a resident as a condition of occupancy to conduct abuse registry (both adult and child) and criminal record checks for any privately hired personal care providers not employed by a licensed or certified agency. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to maintain the results of criminal record and abuse registry checks on file and available for review for an individual hired as a private duty support person to meet the personal care needs of one applicable resident (Resident #1). Findings include: The policies and procedure for Personal Care Services outlined in the residence's Resident Agreement are consistent with this licensing rule. On the afternoon of 8/25/25 the Executive Director was requested to provide documentation of criminal record and abuse registry checks maintained on file and available for review for a private duty personal care assistant hired to assist Resident #1 with their personal care needs.	R214		

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R214	Continued From page 4 At 5:48 PM on 8/25/25 the Executive Director confirmed the required background checks requested were not on file and available for review.	R214		
R232 SS=D	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. iii. Incidents involving resident-to-resident abuse	R232		

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R232	Continued From page 5 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: Based on staff interviews and record review the facility failed to report to the Adult Protective Services and the licensing agency regarding an allegation of neglect communicated to the Executive Director by the Durable Power of Attorney for one applicable resident (Resident #1). Findings include: The facility's Abuse Policy states, "Any complaint of, observation of, or suspicion of resident abuse, mistreatment or neglect will be thoroughly investigated and reported.", and indicates reports are to be made to applicable state agencies according to state regulations. Per record review, Resident #1 was admitted to the residence on 6/30/25 from a rehabilitation center where they received care and services following surgical repair of an ankle fracture sustained during a fall. On 7/11/25 the removable boot worn by Resident #1 following surgery was removed for the first time since the Resident's admission to the home. When the boot was	R232		

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R232	Continued From page 6 removed on 7/11/25 it was discovered that Resident 1's surgical site was infected and the metal plate and screws utilized to surgically repair the fracture were exposed. Resident #1 was transported to the Emergency Department and subsequently admitted to the hospital for a revision of the surgical repair and treatment of the infection. Per record review, a letter dated 8/15/25 written by Resident #1's Power of Attorney and addressed to the residence's Executive Director expressed allegations of neglect on the part of the residence, which Resident #1's Power of Attorney described as harm resulting from the residence neglecting to address Resident #1's care needs. On the afternoon of 8/25/25 the Executive Director confirmed they had received the Power of Attorney's letter dated 8/15/25, and confirmed the residence did not report the allegation of neglect expressed in the letter to the licensing agency and the Adult Protective Services.	R232		
R349 SS=D	6.1 Resident's Rights Every resident must be treated with consideration, respect and full recognition of the resident ' s dignity, individuality, and privacy. Care provided to residents must be person-centered. A home may not ask a resident to waive the resident's rights. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure one applicable resident was treated with dignity and respect by a Staff	R349		

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R349	Continued From page 7 member employed by the residence (Resident #2). Findings include: Per record review, Resident #2's Care Plan identifies verbally inappropriate behaviors as an area of concern with identified goals including staff assisting Resident #2 in managing these behaviors and Resident #2 demonstrating verbally appropriate behaviors. The Care Plan instructs staff to redirect Resident #2 when demonstrating inappropriate behaviors, and to ensure there are two staff members present at all times when in Resident #2's room. Per record review and staff interviews, on 8/20/25 a staff member entered Resident #2's room without the required second staff member. Following this interaction Resident #2 reported to the Med Tech on duty that when they asked the Staff member for a cup of coffee the Staff member responded by yelling at them. Per interview with the Med Tech who received this information, Resident #2 expressed feeling afraid and asked if they should acquire a weapon for their safety because the Staff member had scared them. The Staff member who yelled at Resident #2 was placed on administrative leave pending an investigation of this incident. During the investigation process the applicable Staff member confirmed their behavior towards Resident #2 was inappropriate and unprofessional. At 12:31 PM on 8/25/25 the Executive Director reported the applicable Staff reported they "got frustrated" with Resident #2 and made reference to Resident #2's verbal behavior. Per record review, the applicable staff confirmed their behavior towards Resident #2 was unprofessional and inappropriate. On the afternoon of 8/25/25 the Executive Director confirmed the Staff member's mistreated of	R349		

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R349	Continued From page 8 Resident #2 and stated the Staff's employment was terminated following the investigation of this incident.	R349		

Deficiency Statement Plan of Correction (POC)

Survey Date:8/25/25

Facility Name: The Residence at Quarry Hill

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
R139	The Residence Care Director (RCD) immediately reviewed the resident's clinical record and confirmed that attempts to initiate PT services were made on 6/30/25 and 7/1/25. The resident's prescriber and discharging facility were contacted for orders, and referral requests were placed with the contracted PT/OT provider. PT services were coordinated, and the resident's care plan was updated to reflect the current status and start date of 7/11/25.	A review of all residents admitted within the past 30 days was conducted to confirm timely PT/OT/ medical and nursing services. No other residents were identified as being without appropriate medical and nursing services. Any resident who has a therapy referral will have their orders verified and confirmed by the RCD or designee within three business days of request.	10/3/25	The RCD has re-educated the nursing team on the process of initiating PT/OT referrals, including direct communication with the in-house provider home office, and requesting orders from the discharging facility/prescriber at the time of admission. If no response is received, a follow-up attempt will occur within three business days, and this follow-up will be documented in the resident's chart. A checklist has been implemented for admissions to verify that all required medical and nursing services (medication, physician orders, treatments, and therapy needs) are in place before or on the day of move-in. The Residence will adhere to Vermont ALR regulation 5.5(a), which requires that upon a residents admission to the home, necessary services will be put in place to meet the residents care needs. An	RCD and ED are responsible for ongoing monitoring.

	R139 approved by LTCM 10/3/25			interview and assessment will be conducted with the resident on the day of move-in to ensure that all care needs are being met and reflected in the care plan, thereby preventing the recurrence of deficient practice. Daily nursing and care team huddles have been implemented to discuss resident care needs and observed changes. The RCD or assigned designee will audit all medical and nursing needs on a weekly basis to ensure timeliness and compliance. The ED and RCD will conduct audits of all new admissions within 48 hours of admission.	
R214	On 9/16/25, the Executive Director immediately requested hard copies of background checks for all contracted personal care providers currently working with residents. Copies have been obtained and placed in the administrative file for verification and compliance.	A review was conducted of all residents currently utilizing family-contracted personal care providers to ensure that background checks are on file. No other residents were identified as having providers without proper documentation. Should a family request to bring in a contracted	9/16/25	The Executive Director has implemented a system to maintain a separate, centralized file of all contracted personal care provider background checks for easy reference and compliance. Families will be re-educated on the requirement to provide background checks before the start of contracted personal care services.	ED and BOD

	Any missing documentation was followed up on promptly with the families and providers to ensure completeness. R214 approved by LTCM 10/3/25	provider in the future, the Executive Director or designee will verify that a background check is obtained and filed prior to the provider beginning work in the community.		The Executive Director or assigned designee will audit contracted personal care provider files quarterly to ensure ongoing compliance. These system changes will ensure that all contracted providers' background checks are consistently on file, preventing recurrence of this deficiency.	
R232	The Executive Director (ED) and Residence Care Director (RCD) did not report the allegation of neglect directly to the state, as they were made aware that a report had already been submitted and were provided a copy of the report that was sent to the state. Once the deficiency was identified, the ED and RCD reviewed the incident and verified the reporting requirements. Staff were counseled on the importance of ensuring that all allegations of abuse, neglect, or exploitation are reported directly by the ED or RCD to the state survey agency	A review of all incident reports from the past 90 days was completed to verify that allegations of abuse, neglect, or exploitation were reported in accordance with state requirements. No other unreported incidents were identified. All residents were monitored to ensure no other allegations or concerns had gone unaddressed, and no adverse outcomes were identified.	9/22/25	The Executive Director and Residence Care Director re-educated all staff on mandatory reporting procedures, including immediate notification to the ED or RCD and direct reporting to the state survey agency upon any allegation of abuse, neglect, or exploitation. A written quick-reference guide outlining the reporting process has been distributed to all department leaders. The Executive Director and RCD will audit incident reports monthly to ensure timely reporting has occurred. Going forward, the ED or RCD will make the report directly to the state survey agency within required timeframes (immediately, but no later than 24 hours), regardless of	ED, RCD and Department Leaders

	without relying on outside confirmation. R232 approved by LTCM 10/3/25			whether another party indicates a report has been filed. These measures will ensure full compliance with state reporting regulations and prevent recurrence of this deficiency.	
R349	During an internal investigation, it was confirmed that a staff member verbally abused a resident. The incident was reported immediately to the state survey agency. The staff member involved was suspended pending investigation and was subsequently terminated following the completion of the investigation. The resident involved received appropriate support and monitoring to ensure safety and well-being. R349 approved by LTCM 10/3/25	A review of all residents under the care of the staff member was completed to ensure no additional residents were affected. No other residents were identified as having experienced verbal abuse from this staff member. Residents were monitored for any changes in mood or behavior, and no ongoing issues were identified.	8/20/25	All current and new staff are in-serviced on the community's abuse prevention policy, including definitions of abuse, procedures for reporting, and consequences for violations. The abuse prevention training is completed upon hire and annually for all staff. Leadership reinforces expectations for professional behavior and immediate reporting of any abuse or suspected abuse. The Executive Director or designee will review compliance with abuse training annually and maintain documentation to ensure all staff are trained. These measures will prevent the recurrence of abuse and ensure ongoing compliance with state regulations.	ED, RCD and Department Leaders