



VERMONT

**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

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

Sarah Rowan, Manager

Lincoln House

120 Hill Street

Barre, VT 05641-3915

Dear Ms. Rowan:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 26, 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".

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: 0175	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/26/2025
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LINCOLN HOUSE

**120 HILL STREET
BARRE, VT 05641**

(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 8/26/25 the Division of Licensing and Protection conducted an unannounced on-site annual survey and an investigation of one complaint. There were no deficiencies related to the complaint. The following deficiencies were identified:	R100		
R159 SS=F	5.9.c (2) Nursing Services For each resident requiring a nursing overview, administration of medication, or nursing care, the registered nurse must: Develop a person-centered written plan of care within 14 days after admission, in accordance with the nursing process and professional standards of practice, for each resident that is based on abilities and needs as identified in the resident assessment. The resident, and if the resident chooses, resident representatives such as family or close supports, must be invited and allowed to participate in care planning meetings. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being, and must be revised as the resident's abilities and needs change This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure development of person-centered written plans of care which identify goals and interventions needed to assist the residents in maintaining independence and well-being. Findings include:	R159		

Division of Licensing and Protection

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

TITLE

(X6) DATE

Shawna RN

Executive Nurse Administrator

9/26/25

STATE FORM

6899

XBO011

If continuation sheet 1 of 13

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0175	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/26/2025
NAME OF PROVIDER OR SUPPLIER LINCOLN HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 120 HILL STREET BARRE, VT 05641		
(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
R159	Continued From page 1 The home's Service/Care Plan policy is consistent with this licensing rule. 1. Per record review, the care plans on file for residents of the home were observed to be developed in a standard format which lists resident needs without providing written descriptions of the steps to be taken to meet the resident's needs. Per record review, information in the home's Care Plans does not include goals and interventions to assist the resident in maintaining independence and well-being. 2. Per record review, the care plans on file for 3 out of 3 sampled residents did not address care and services necessary to maintain the residents well-being as follows: Resident #1 Care Plan does not address identified needs including but not limited to: a. Interventions related to multiple medical conditions requiring monitoring and management of symptoms b. Risk for elopement with recent attempted elopement on 7/18/25 c. Risk for falls due to unsteady gait Resident #2's Care Plan does not address identified needs related to Insomnia and Moderate to Severe Anxiety Resident #3's Care Plan does not address identified needs related to: a. The resident's recent decision to stop treatment for a terminal disease and subsequent admission to hospice b. Risk for falls related to abnormal gait c. Risk for pain and pain management related to multiple medical conditions	R159			

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0175	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/26/2025
NAME OF PROVIDER OR SUPPLIER LINCOLN HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 120 HILL STREET BARRE, VT 05641		
(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
R159	Continued From page 2 d. Diagnosis of Sleep Apnea e. Psychosocial needs related to diagnoses of Adjustment Disorder and Phobias These findings were confirmed by the Administrative Assistant at 5:13 PM on 8/26/25.	R159			
R206 SS=F	5.10.h (4) Medication Management Medications left after the death or discharge of a resident, or outdated medications, must be promptly disposed of in accordance with the home's policy and applicable standards of practice. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure outdated medications prescribed for 13 residents were promptly disposed upon expiration (Residents #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15 and #16). Findings include: Policies governing disposal of outdated medications have not been developed by the home. On the afternoon of 8/26/25, thirty- two expired medication cards belonging the following residents were observed to be stored in one of the home's medication carts including: 1. For Resident #4: a. 2 cards of Gabapentin 100 mg tabs expired on 4/30/25 and 1 card of Gabapentin 100 mg tabs expired on 3/19/25	R206			

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0175	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/26/2025
NAME OF PROVIDER OR SUPPLIER LINCOLN HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 120 HILL STREET BARRE, VT 05641		
(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
R206	Continued From page 3 b. 2 cards of Stool softener with laxative 50 mg/ 8.6 mg tabs expired on 3/19/25 c. 1 card of Loperamide 2 mg caps expired on 3/4/25 d. 1 card of Mucus Relief 600 mg tabs expired on 8/4/24 2. For Resident #5: a. Loratadine 20 mg tabs expired on 3/31/25 b. Hydroxyzine HCl 10 mg tabs expired on 5/19/25 c. Metoprolol Tartrate 25 mg tabs expired on 8/11/25 3. For Resident #6: a. Meclizine 25 mg tabs expired on 4/1/25 b. Loratadine 10 mg tabs expired on 5/4/25 4. For Resident #7: a. Ondansetron 4 mg tabs expired on 2/6/25 and 4/9/25 b. Acetaminophen 325 mg expired 2/6/25 c. Stool Softener 100 mg tabs expired on 6/11/26 5. For Resident #8: a. Meclizine 25 mg tabs expired 7/9/25 b. Ibuprofen 600 mg tabs expired on 4/23/24 6. For Resident # 9: a. Hydroxyzine 25 mg tabs expired on 9/17/24 b. Naproxen 500 mg tabs expired on 6/13/25 c. Acetaminophen 500 mg tabs expired on 7/15/25 7. For Resident #10: a. Cyclobenzaprine 10 mg tabs expired on 2/11/25 b. Senna 8.6 mg tablets expired on 8/19/24 8. For Resident # 11:	R206		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0175	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/26/2025
NAME OF PROVIDER OR SUPPLIER LINCOLN HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 120 HILL STREET BARRE, VT 05641			
(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
R206	Continued From page 4 a. Senna 8.6 mg tabs expired 1/19/25 b. DSS 100 mg tabs expired on 10/9/24 9. For Resident #12: a. Colchicine 0.6 mg tabs expired on 7/7/25 b. Acetaminophen 500 mg tabs expired on 7/7/25 10. For resident #13: Ondansetron 4 mg tabs expired on 6/8/25 11. For Resident #14: Trazodone 50 mg tabs 8/4/25 12. For Resident #15: Cetirizine 10 mg tabs 3/9/25 13. For Resident #16: Cyclobenzaprine 5 mg tabs expired on 12/23/24 These findings were confirmed by Med Tech on duty at approximately 4:00 PM on 8/26/25 and acknowledged by the Executive Nurse Administrator following the review of the medication cart. Additionally topical medications including tubes of Antibiotic Ointment expired on 12/2020 and Hydrocortisone Cream expired on 5/2020 were observed to be stored in a First Aid Kit stored in an unlocked cabinet on the second floor of the home. This finding was confirmed by the Executive Nurse Administrator at 10:27 AM on 8/26/25.	R206			
R210 SS=F	5.11.c Staff Services The home must provide, or arrange for the provision of, at least twelve (12) hours of training upon hire and each year to each staff person	R210			

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0175	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/26/2025
NAME OF PROVIDER OR SUPPLIER LINCOLN HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 120 HILL STREET BARRE, VT 05641		
(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
R210	Continued From page 5 providing direct care to residents. The manager may give credit towards the required 12 hours of training upon hire, for any formal training received in the twelve months preceding the date of hire, provided the home maintains documentation of the training and ensures competency in the subject matter. 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, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; (7) General supervision and care of residents; (8) Communication strategies, person-centered care, challenging behaviors and understanding dementia; (9) Recognition of and sensitivity to different cultures, belief systems, abilities, gender identities, sexual orientation; and (10) Trauma-informed care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, 5 out of 5 sampled staff did not complete all required trainings. Findings include: The home's Annual Staff Training policy is	R210			

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0175	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/26/2025
NAME OF PROVIDER OR SUPPLIER LINCOLN HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 120 HILL STREET BARRE, VT 05641		
(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
R210	Continued From page 6 consistent with this licensing rule. During the survey and investigation conducted on 8/26/25 the Executive Nurse Administrator was requested to provide documentation of trainings completed by a sample of 5 staff. Per the documentation provided for review, 5 out of 5 sampled staff did not complete all required yearly trainings. This finding was confirmed by the Administrative Assistant at 4:22 PM on 8/26/25.	R210			
R223 SS=D	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:	R223			

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0175	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/26/2025
NAME OF PROVIDER OR SUPPLIER LINCOLN HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 120 HILL STREET BARRE, VT 05641		
(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
R223	Continued From page 7 Based on staff interview and record review there is a failure to ensure written Progress Notes in resident records document changes in condition including accidents and incidents, and subsequent follow-up by the home for one applicable resident (Resident #1). Findings include: Policies and procedures governing documentation to be included in Resident's Progress Notes have not been developed by the home. Per record review Resident #1 was admitted to the home on 3/25/25. Per review of the Progress Notes on file in Resident #1's record, four notes have been written in Resident #1's record to include an admission note with vital signs taken on admission on 3/25/25, documentation of monthly foot care attendance on 3/26/25, a blood draw completed with delivery of samples to the hospital lab on 7/9/25, and an attempted elopement with subsequent urine collection and plan to drop off at the hospital lab documented on 7/18/25. Per interview with the Executive Nursing Administrator on the afternoon of 8/26/25, urinalysis of the sample taken to the lab on 7/18/25 indicated Resident #1 had a urinary tract infection. Per interview with the Executive Nursing Administrator, the home's nursing staff experienced significant difficulties when attempts were made to schedule an appointment with Resident #1's provider and obtain antibiotics for Resident #1, which led to a delay in treatment until 7/23/25. Per record review Progress Notes regarding communications with Resident #1's primary care	R223		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0175	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/26/2025
NAME OF PROVIDER OR SUPPLIER LINCOLN HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 120 HILL STREET BARRE, VT 05641		
(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
R223	Continued From page 8 providers office, actions taken to obtain appropriate medical care, and monitoring for changes Resident #1's condition while waiting for medial care were not documented in Resident #1's record. This finding was confirmed by the Executive Nursing Administrator at 12:44 PM on 8/26/25.	R223			
R225 SS=F	5.12. b (4) Records/Reports The home must keep and maintain the following records: The results of the criminal record and adult abuse registry checks for all staff: This REQUIREMENT is not met as evidenced by: Based on staff interview and record review all required criminal record and abuse registry checks were not completed for 5 out of 5 sampled staff. Findings include: Policies and procedures governing Staff Criminal Record and Abuse Registry checks have not been developed by the home. During the survey and investigation conducted on 8/26/25 the Executive Nurse Administrator was requested to provide documentation of criminal record and abuse registry checks on file and available for review for a sample of 5 staff. Per review of the documentation provided, all required background checks were not completed for 5 out of 5 sampled staff. This finding was confirmed by the Executive Nurse Administrator at 1:47 PM on 8/26/25.	R225			

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0175	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/26/2025
NAME OF PROVIDER OR SUPPLIER LINCOLN HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 120 HILL STREET BARRE, VT 05641		
(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	
R342 SS=F	5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy must be available at the home for review upon request by residents and their representatives, advocacy organizations and the licensing agency. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to develop policies and procedures governing all areas of service provided by the home. Findings include: During the survey on 8/26/25 the Executive Nurse Administrator and Administrative Assistant were requested to provide policies governing the following areas of service which had not been developed by the home:: a. Posted Documents required to be posted for review in the home b. Provision of Uniform Consumer Disclosure Forms to residents of the home c. Secure storage of chemicals d. Secure storage of medications e. Staff background checks f. Disposal of outdated medications g. Labeling and dating of perishable items h. Resident Progress Notes These findings were confirmed by the Administrative Assistant on the afternoon of 8/26/25.	R342			
R403 SS=F	9.1.c Environment	R403			

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0175	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/26/2025
NAME OF PROVIDER OR SUPPLIER LINCOLN HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 120 HILL STREET BARRE, VT 05641		
(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	
R403	Continued From page 10 The home must ensure that the resident environment remains as free of accident hazards as possible. Maintaining a safe environment must include the safe storage and clear labeling of chemical agents, which must include secure storage of such agents if the home has residents with cognitive impairment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure cleaning chemicals and other poisonous substances are securely stored in locked compartments to prevent unsupervised access by residents of the home with cognitive impairment. Findings include: Policies and procedures governing secure storage of chemicals have not been developed by the home. The home's Residents have varying abilities to safely manage access to cleaning chemicals and other hazardous substances. During a tour of the home commencing at 9:33 AM on 8/26/25, cleaning chemicals and other poisonous substances were observed to be stored in unlocked areas of the home leaving these items unsecured and accessible to residents. Policies and procedures governing safe secure storage of cleaning chemicals and other poisonous substances had not been developed by the home. Unsecured cleaning chemicals and other poisonous substances were observed to be accessible to residents included:	R403			

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0175	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/26/2025
NAME OF PROVIDER OR SUPPLIER LINCOLN HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 120 HILL STREET BARRE, VT 05641		
(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
R403	Continued From page 11 1. The door between the kitchen and dining room was observed to be propped open allowing unsupervised access to cleaning products stored in a small office area just inside the door way including a cans of urethane and butane lighter fluid. Disinfectant wipes and sprays were also observed to be unsecured and accessible in this area of the home. A staff member working in the dishwashing area of the kitchen was unable to see the area where the unsecured chemicals were stored. 2. An open laundry room in the basement was confirmed by the Activities Director/Kitchen Manager and a Med Tech to routinely have the door propped open allowing access to cleaning chemicals stored in this room. Laundry products, bottles of hydrogen peroxide, disinfectants, stain remover, bleach, and odor eliminating products were observed to be stored in this room at 9:50 AM. When this room was rechecked at 2:44 PM the door remained open without staff present in the area. 3. Resident rooms were observed with unsecured cleaning products accessible to residents including disinfectant sprays and wipes, stain remover, and spray cans of air freshener. These findings were confirmed by the Executive Nurse Administrator on the morning of 8/26/25. The Laundry Room recheck at 2:44 was confirmed by Staff on duty in the basement.	R403		
R999 SS=F	Miscellaneous This REQUIREMENT is not met as evidenced by:	R999		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0175	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/26/2025
NAME OF PROVIDER OR SUPPLIER LINCOLN HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 120 HILL STREET BARRE, VT 05641		
(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	
R999	Continued From page 12 1.8 License Required The terms residential care home, assisted living, or assisted living residence or words to that effect may not be used by any facility in its title, brochure, admission agreement, or other written or promotional materials unless the facility has a valid license to operate as a residential care home or assisted living residence issued by the Department of Disabilities, Aging and Independent Living. Based on observation, staff interview and record review this licensing requirement is NOT MET as evidenced by misrepresentation of the Residential Care Home as an "Assisted Living Residence" in written materials including the home's policies and procedures manual. Findings include: Per record review, the home's is licensed to operate as a Residential Care Home by the Vermont Division of Licensing and Protection. On the morning of 8/26/25 the policies and procedures manual stored in the common area outside the main office of the home was observed with a title that reads, "Assisted Living Policy and Procedure Manual". The top right hand corner of the policies and procedures manual index reads, "Assisted Living Provider Resource" and the policies and procedures contained within the manual are printed on paper which has headers that read, "Assisted Living Policy and Procedure Manual" and footers with a copyright symbol followed by, "American Health Care Association & National Center for Assisted Living". At 10:58 AM on 8/26/25 the Executive Nurse Administrator confirmed these findings.	R999			

Deficiency Statement Plan of Correction (POC)

Survey Date: 8/26/2025

Facility Name: Lincoln House

S. Rowan RN 9/26/25

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
R159 Plan of Correction accepted by Jo A Evans on 10/2/25	Care plans will be more resident specific and detail more specific diagnosis and the related care needs.	Each resident that lives at Lincoln House will have their care plan reviewed and corrected to reflect their specific needs.	10/31/25	Each care plan will be completed by this RN specific to the regulations and care needs of the resident within 14 days of admission.	Sarah Rowan, RN
R206 Plan of Correction accepted by Jo A Evans on 10/2/25	All outdated medication was disposed of and re-ordered as needed. Outdated medication found in an old first aid kit on the second floor was disposed of.	Pharmacy was contacted to ensure that a good process is in place for cycle turn over and the return of unused cards of PRN medication. Full turn over of all cards will happen with the monthly cycle and at that time PRN medications will be inspected and returned and reorder if out of date.	Completed the day after survey.	Full turn over of all cards will happen with the monthly cycle and at that time PRN medications will be inspected and returned and reorder if out of date.	Sarah Rowan, RN
R210 Plan of Correction accepted by Jo A Evans on 10/2/25	Materials for all of the education modules will be obtained. DEI will be completed at next staff meeting.	No resident should be affected by this deficiency.	9/30/25	All materials for required education modules will be developed and the education will be conducted 1 per month at staff meeting.	Sarah Rowan, RN
R223 Plan of Correction accepted by Jo A Evans on 10/2/25	Documentation policy and procedure will be developed. Staff will be trained at next meeting around documentation and this RN will follow up with incidents and document as well.	Resident's changes will be documented accordingly as needed.	Immediate action taken with more thorough documentation. 10/31/25	Documentation education will be provided annually and reviewed periodically to ensure proper follow up.	Sarah Rowan, RN

			for policy and procedure development.		
R225 Plan of Correction accepted by Jo A Evans on 10/2/25	ADP hired to conduct national background checks.		completed	Background checks will be run through the state as we have been and ADP will complete national background check	Sarah Rowan, RN
R342 Plan of Correction accepted by Jo A Evans on 10/2/25	Policy and procedure will be created and posted on Grievance policy. Policy and procedure with also be developed for the following: Provision of uniform disclosure, storage of chemicals and medication, staff background checks, disposal of outdated medication, labeling and dating of perishable items, resident progress notes.	Any resident that is interested in the manual and/or grievance policy will have access as it will be publicly posted and accessible.	10/31/25	Appropriate policies and procedures will be put into place and will be accessible to both staff and residents	Sarah Rowan, RN
R403 Plan of Correction accepted by Jo A Evans on 10/2/25	The kitchen door will be closed at all times other than during service of meals. Chemicals will be kept in a location away from food and not accessible to residents. The door to the laundry room will be closed and locked. Residents will be provided with a lock box for chemicals in their rooms.	Residents will be informed that they will have to keep chemicals under lock. Residents will not have access to chemicals because they will be kept secure within the house.	10/31/25	All chemicals will be secured safely with lock box and or locking door.	Sarah Rowan, RN

[illegible]