



**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

November 20, 2025

Samantha Tracey, Manager
Historic Homes Of Runnemedede-Stoughton House
40 Maxwell Perkins Lane
Windsor, VT 05089-1206

Dear Ms. Tracey:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 29, 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 blue 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: 0161	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/29/2025
NAME OF PROVIDER OR SUPPLIER HISTORIC HOMES OF RUNNEMEDE-STOUGHTON HC		STREET ADDRESS, CITY, STATE, ZIP CODE 40 MAXWELL PERKINS LANE WINDSOR, VT 05089		
(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 on-site investigation of four facility reported incidents were conducted by the Division of Licensing and Protection on 10/29/25. The following regulatory violations were cited:	R100		
R360 SS=E	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 interview and record review, the facility failed to ensure that 1 resident [Resident #1] remained free from mental, verbal or physical abuse, neglect, and exploitation from another resident [Resident #2]. Findings include: Per review of the facility's Investigation Report, dated 5/30/25, "On May 25, 2025, at 2:10 PM, [Resident #1] activated their call-bell pendant to alert staff that fellow resident [Resident#2] had entered [Resident #1's] apartment uninvited. [Resident #1] reported that [Resident #2] exposed themselves and engaged in indecent behavior (self-pleasuring) in [Resident #1's] presence." Further record review revealed a second incident on 8/18/25. Per review of the facility's Investigation Report, dated 8/23/25, "On August 18, 2025, at 10:45 AM, [Resident #1] activated their call-bell pendant to alert staff that fellow resident [Resident #2] had entered their apartment uninvited. [Resident #1] reported that [Resident #2] exposed themselves	R360		

Division of Licensing and Protection

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

TITLE

(X6) DATE

STATE FORM

6899

G8CL11

If continuation sheet 1 of 7

Division of Licensing and Protection

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R360	Continued From page 1 and engaged in indecent behavior (self-pleasuring) in [Resident #1's] presence." Review of Resident #1's medical record revealed a third incident involving Resident #1 and Resident #2. Per review of the facility's Investigation Report, dated 9/3/25, "On August 29, 2025 [Resident #1] rang their call-bell pendant. When staff arrived at [Resident #1's] room, the apartment door was locked. Staff used their key to unlock the door and saw [Resident #2] self-pleasuring in [Resident #1's] apartment, in front of [Resident #1]." An Interview was conducted with Resident #1 on 10/29/25 at 12:50 PM. Resident #1 was able to recall the incidents involving Resident #2 and was able to state the other resident's name. Resident #1 reported the incidents "did not make me feel very good." The incidents were "annoying" and "kept on happening." Resident #1 further stated "it's good they [Resident #2] don't come around anymore." An interview was conducted with the facility's Administrator [ADM] and Director of Nursing [DON] on 10/29/25 at 1:40 PM. The ADM reported that Resident #2 had a history of sexual abuse and had "targeted" Resident #1. Both the ADM and DON confirmed sexual abuse occurred between Resident #1 and Resident #2.	R360			
R487 SS=E	13.4.g Resident Care and Services Care Plans. The licensee, the resident, and/or the resident 's legal representative must work together to develop and maintain a written resident care plan for those residents who require	R487			

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R487	Continued From page 2 or receive care. The care plan must describe the assessed needs and choices of the resident and must support the resident 's dignity, privacy, choice, individuality, and independence. The licensee must review the plan at least annually, and whenever the resident's condition or circumstances warrant a review, including whenever a resident ' s decision, behavior, or action places the resident or others at risk of harm or the resident is incapable of engaging in a negotiated risk agreement. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the Care Plan of 1 resident [Resident #2's] was reviewed and revised to prevent further incidents after evidence of behavior that placed other residents at risk of harm. Findings include: Per review of Resident #2's "Care Plan and Psychotropic Medication Need Form", dated 4/22/25, Resident #2 "has cognitive and learning deficits. Mood: anxious, socially inappropriate, agitated. Socially: can become verbally abusive. Receives antipsychotic medication for a diagnosis of a serious mental health disorder. Per review of the facility's Investigation Report, dated 5/30/25, "On May 25, 2025, at 2:10 PM, [Resident #1] activated their call-bell pendant to alert staff that fellow resident [Resident#2] had entered [Resident #1's] apartment uninvited. [Resident #1] reported that [Resident #2] exposed themselves and engaged in indecent behavior (self-pleasuring) in [Resident #1's] presence."	R487		

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R487	Continued From page 3 Review of "Resident Care Plan Updates" for Resident #2, dated 5/27/25, reveal, "Following an incident with [Resident #1], [Resident #2] was instructed to stop going into [Resident #1's] room and exposing themselves. [Resident #2] acknowledged their behavior and said they "won't do it again." Care Plan Interventions were: "Advised [Resident #2] of inappropriate behavior. Staff will monitor mood and behaviors as well as redirecting to other activities." On 7/3/25, an additional "Resident Care Plan Update" was added after a Mental Health Case worker had a lengthy conversation with Resident #2 regarding their recent behavior. Per record review: "Resident Care Plan Update-Interventions: told [Resident #2] they had to listen and obey the rules ...no exposing themselves". Per review of the facility's Investigation Report, dated 8/23/25, "On August 18, 2025, at 10:45 AM, [Resident #1] activated their call-bell pendant to alert staff that fellow resident [Resident #2] had entered their apartment uninvited. [Resident #1] reported that [Resident #2] exposed themselves and engaged in indecent behavior (self-pleasuring) in [Resident #1's] presence." Per record review, following this second incident, Resident #2's Care Plan was "updated" on 8/18/25. "Following another incident with [Resident #1]. [Resident #2] was again instructed to stop going into [Resident #1's] room ...[Resident #2] again acknowledges their behaviors ...and that they won't do it again." Per record review, there were no new Interventions added to prevent further incidents.	R487			

Division of Licensing and Protection

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R487	Continued From page 4 Interventions listed after this second incident repeat interventions that were ineffective after the first incident. Interventions listed are "advised [Resident #2] of the seriousness and potential consequences of their inappropriate behaviors. Staff will monitor their general mood and behaviors as well as redirect them to other activities." Review of Resident #1's medical record revealed a third incident involving Resident #2. Per review of the facility's Investigation Report, dated 9/3/25, "On August 29, 2025 [Resident #1] rang their call-bell pendant. When staff arrived at [Resident #1's] room, the apartment door was locked. Staff used their key to unlock the door and saw [Resident #2] self-pleasuring in [Resident #1's] apartment, in front of [Resident #1]." Per record review, "Resident Care Plan Updates" for Resident #2 after the third incident repeat identical interventions for a third time that had failed to prevent the incidents from occurring again. "Resident Care Plan Updates" dated 9/1/25 record "[Resident #2] had another incident with [Resident #1]. [Resident #2] was again instructed to stop immediately and leave the room ... and advised to stop going in anyone's room uninvited and exposing themselves and touching themselves inappropriately. [Resident #2] acknowledges their behaviors ... [Resident #2] was advised of the seriousness and consequences of their inappropriate behaviors ...". Interventions: "Staff will monitor [Resident #2's] general mood and behaviors as well as redirect them to other activities". Staff will continue hourly rounding until further notice. Further record review revealed after the third incident [Resident #2] " has been temporarily	R487			

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R487	Continued From page 5 moved to another building." An interview was conducted with the facility's Administrator [ADM] and Director of Nursing [DON] on 10/29/25 at 1:40 PM. The ADM reported that Resident #2 had a history of sexual abuse and had "targeted" Resident #1. Both the ADM and DON confirmed Resident #1 experienced sexual abuse by Resident #2. Both the ADM and DON confirmed initial interventions were not effective in stopping Resident #2 sexual abuse but were still repeated with continued failure. The ADM confirmed that new Care Plan interventions should have been attempted to prevent further incidents after the initial interventions failed but were not.	R487		
R494 SS=F	13.5.a Policies and Procedures Policies. In addition to those policies required under the Residential Care Home Licensing Rules, the licensee must establish policies and procedures regarding: (1) Unexplained absences of residents; (2) Behavioral symptoms of the residents, including but not limited to wandering, sexually inappropriate or socially disruptive behaviors, or resistance to care; (3) Managing residents with declining cognitive status, including incompetence, and setting forth when and how a legal guardian will be obtained; (4) Negotiated risk agreement process, including the identity of the responsible staff person; and (5) Use by the residents of the community kitchen, if applicable, as well as other common areas. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	R494		

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R494	Continued From page 6 failed to establish policies and procedures regarding behavioral symptoms of residents, including sexually inappropriate behaviors. Findings include: An on-site complaints investigation regarding 3 facility reported incidents related to sexually inappropriate behavior was conducted on 10/29/25. Regarding the facility's response to the allegations of sexual abuse, the facility was asked to supply their policy and procedure related to sexually inappropriate behaviors. Per interview with the facility's Administrator [ADM] on 10/29/25 at 1:40 PM the ADM reported that the facility had no policy or procedure developed for behavioral symptoms of residents, including sexually inappropriate behaviors.	R494			

Deficiency Statement Plan of Correction (POC)

Survey Date: 10/28/2025

Facility Name: Historic Homes of Runnemedede – Stoughton House

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 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: R360 Based on interview and record review, the facility failed to ensure that 1 resident [Resident #1] remained free from mental, verbal or physical abuse, neglect, and exploitation from another resident [Resident #2]. Findings include: Per review of the facility's Investigation Report, dated 5/30/25, "On May 25, 2025, at 2:10 PM, [Resident #1] activated their call-bell pendant to alert staff that fellow resident [Resident#2] had entered [Resident #1's] apartment uninvited. [Resident #1] reported that [Resident #2] exposed themselves and engaged in indecent behavior (self-pleasuring) in [Resident #1's] presence." Further record review revealed a second incident on 8/18/25. Per review of the facility's Investigation Report, dated 8/23/25, "On August 18, 2025, at 10:45 AM, [Resident #1] activated	On 8/30/2025 Resident #2 was transferred from Stoughton House to another RCH on the Historic Homes of Runnemedede campus, to separate from Resident #1. Request will be made to Resident #2's PCP and Psychiatrist to undergo a comprehensive behavioral assessment conducted by a licensed psychologist or psychiatrist to evaluate the underlying causes of behavior. As part of the intake process, new residents will undergo a thorough review of their behavioral and medical history, including any incidents of inappropriate behavior, sexual misconduct, or violence in previous care settings, home	All residents have the potential to be harmed by failure to ensure residents remain free from mental, verbal or physical abuse, neglect, and exploitation. Each resident interviewed to assess feelings of safety within the facility. During interviews, residents educated on Resident Rights, including the right to be free from abuse, neglect, and exploitation, and provided with copy of Resident Rights. Residents educated of the procedure for reporting incidents of abuse, neglect, or exploitation. Any report of feeling unsafe in the facility or report of abuse, neglect, or exploitation during interviews to be	12/01/2025	Processes in place to increase behavioral review prior to resident admission. Process in place to check the National Sex Offender Public Website (NSOPW) and the Vermont Sex Offender Registry for residents prior to admission.	Nursing Leader to request and review behavioral assessment for Resident #2. Administrator to monitor checks of National Sex Offender Public Website (NSOPW) and the Vermont Sex Offender Registry of residents prior to admission to RCH. Nursing Leader to monitor assessment and review of behavioral and medical history, including any incidents of inappropriate behavior, sexual

their call-bell pendant to alert staff that fellow resident [Resident #2] had entered their apartment uninvited. [Resident #1] reported that [Resident #2] exposed themselves and engaged in indecent behavior (self-pleasuring) in [Resident #1's] presence." Review of Resident #1's medical record revealed a third incident involving Resident #1 and Resident #2. Per review of the facility's Investigation Report, dated 9/3/25, "On August 29, 2025 [Resident #1] rang their call-bell pendant. When staff arrived at [Resident #1's] room, the apartment door was locked. Staff used their key to unlock the door and saw [Resident #2] self-pleasuring in [Resident #1's] apartment, in front of [Resident #1]." An Interview was conducted with Resident #1 on 10/29/25 at 12:50 PM. Resident #1 was able to recall the incidents involving Resident #2 and was able to state the other resident's name. Resident #1 reported the incidents "did not make me feel very good." The incidents were "annoying" and "kept on happening." Resident #1 further stated "it's good they [Resident #2] don't come around anymore." An interview was conducted with the facility's Administrator [ADM] and Director of Nursing [DON] on 10/29/25 at 1:40 PM. The ADM reported that Resident #2 had a history of sexual abuse and had "targeted" Resident #1. Both the	environments, or during prior hospitalizations. Additionally, all new residents will be checked on the National Sex Offender Public Website (NSOPW) and the Vermont Sex Offender Registry.	reported and investigated.		R360 accepted by LTCM on 11-20-2025	misconduct, or violence in previous care settings, home environments, or during prior hospitalizations.
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ADM and DON confirmed sexual abuse occurred between Resident #1 and Resident #2.					
R487 13.4.g Resident Care and Services Care Plans. The licensee, the resident, and/or the resident 's legal representative must work together to develop and maintain a written resident care plan for those residents who require or receive care. The care plan must describe the assessed needs and choices of the resident and must support the resident 's dignity, privacy, choice, individuality, and independence. The licensee must review the plan at least annually, and whenever the resident's condition or circumstances warrant a review, including whenever a resident ' s decision, behavior, or action places the resident or others at risk of harm or the resident is incapable of engaging in a negotiated risk agreement. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the Care Plan of 1 resident [Resident #2's] was reviewed and revised to prevent further incidents after evidence of behavior that placed other residents at risk of harm. Findings include: Per review of Resident #2's "Care Plan and Psychotropic Medication Need Form", dated 4/22/25, Resident #2 "has cognitive and learning deficits. Mood: anxious, socially inappropriate, agitated. Socially: can	Facility will request a comprehensive behavioral assessment from Resident #2's PCP and psychiatrist. This assessment will aim to identify the underlying causes of Resident #2's behaviors and provide recommendations for appropriate strategies for behavior management. If the assessment is completed by the PCP and/or psychiatrist, the Care Plan will be updated based on the findings and recommendations from the PCP/psychiatrist. These updates will focus on adjusting interventions to better address Resident #2's specific needs and behaviors. However, if the assessment is not conducted, the facility will explore alternative avenues for further evaluation and will proceed with additional interventions as needed, based on the resident's current	All residents have the potential to be harmed by failure to implement interventions in the care plan after evidence of behavior. Facility will implement policy on care plan adjustment and intervention after evidence of behavior.	Resident #2's care plan to be updated by 12/01/2025, followed by additional updated in the event of behavioral assessment from PCP/Psychiatrist. Care Plan Policy implemented by 12/01/2025.	Process in place to implement policy on care plans for all residents. Process in place to review behavior of Resident #1 and implement behavioral interventions as needed.	Nursing leader to implement care plan changes and monitor on-going behavior of Resident #1. Administrator to implement policy on care plans. Nursing leader to adjust and develop care plans for all residents after evidence of behavior.

become verbally abusive. Receives antipsychotic medication for a diagnosis of a serious mental health disorder. Per review of the facility's Investigation Report, dated 5/30/25, "On May 25, 2025, at 2:10 PM, [Resident #1] activated their call-bell pendant to alert staff that fellow resident [Resident#2] had entered [Resident #1's] apartment uninvited. [Resident #1] reported that [Resident #2] exposed themselves and engaged in indecent behavior (self-pleasuring) in [Resident #1's] presence." or receive care. The care plan must describe the assessed needs and choices of the resident and must support the resident 's dignity, privacy, choice, individuality, and independence. The licensee must review the plan at least annually, and whenever the resident's condition or circumstances warrant a review, including whenever a resident ' s decision, behavior, or action places the resident or others at risk of harm or the resident is incapable of engaging in a negotiated risk agreement. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the Care Plan of 1 resident [Resident #2's] was reviewed and revised to prevent further incidents after evidence of behavior that placed other residents at risk of harm. Findings include: Per review of Resident #2's "Care Plan and Psychotropic Medication Need	condition and circumstances. Facility will implement policy on care plan adjustment and intervention after evidence of behavior.			R487 accepted by LTCM on 11-20-2025	
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#1. Both the ADM and DON confirmed Resident #1 experienced sexual abuse by Resident #2. Both the ADM and DON confirmed initial interventions were not effective in stopping Resident #2 sexual abuse but were still repeated with continued failure. The ADM confirmed that new Care Plan interventions should have been attempted to prevent further incidents after the initial interventions failed but were not.					
R494 13.5.a Policies and Procedures Policies. In addition to those policies required under the Residential Care Home Licensing Rules, the licensee must establish policies and procedures regarding: (1) Unexplained absences of residents; (2) Behavioral symptoms of the residents, including but not limited to wandering, sexually inappropriate or socially disruptive behaviors, or resistance to care; (3) Managing residents with declining cognitive status, including incompetence, and setting forth when and how a legal guardian will be obtained; (4) Negotiated risk agreement process, including the identity of the responsible staff person; and (5) Use by the residents of the community kitchen, if applicable, as well as other common areas. This REQUIREMENT is not met as evidenced by: R494 Based on interview and record review, the facility failed to establish policies and	Facility will implement policies and procedures relating to behavioral symptoms of residents, including sexually inappropriate behaviors.	All residents have the potential to be harmed by failure to implement policy and procedure relating to behavioral symptoms of residents, including sexually inappropriate behaviors. Facility will implement policies and procedures relating to behavioral symptoms of residents, including sexually inappropriate behaviors.	12/15/2025	Process in place to implement new policies and procedures. R494 accepted by LTCM on 11-20-2025	Administrator to implement policy and procedures relating to behavioral symptoms of residents, including sexually inappropriate behaviors.

procedures regarding behavioral symptoms of residents, including sexually inappropriate behaviors. Findings include: An on-site complaints investigation regarding 3 facility reported incidents related to sexually inappropriate behavior was conducted on 10/29/25. Regarding the facility's response to the allegations of sexual abuse, the facility was asked to supply their policy and procedure related to sexually inappropriate behaviors. Per interview with the facility's Administrator [ADM] on 10/29/25 at 1:40 PM the ADM reported that the facility had no policy or procedure developed for behavioral symptoms of residents, including sexually inappropriate behaviors.					
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