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
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Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

December 23, 2025

Katy Munzir, Manager
The Residence At Shelburne Bay
185 Pine Haven Shores Road
Shelburne, VT 05482-7805

Dear Ms. Munzir:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **November 12, 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
	1009	A. BUILDING: _____ B. WING _____	C 11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT SHELBURNE BAY	185 PINE HAVEN SHORES ROAD SHELBURNE, VT 05482

(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 11/12/25 the Division of Licensing and Protection conducted an unannounced on-site investigation of one facility reported incident and one anonymous complaint. The following deficiencies were identified:	R100		
R142 SS=D	5.5.d General Care A home must provide each resident with adequate supervision and must facilitate obtaining assistive devices sufficient to prevent accidents, and/or to mitigate risk of injury due to accidents. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review there is a failure to provide adequate supervision to mitigate the risk for injury for one applicable resident (Resident #2). Findings include: Per record review, Resident #1 has a history of behaviors including wandering and exit seeking, and is noted to have episodes of confusion. Per review of Progress Notes, at 7:00 AM on 10/26/25 Resident #2 "was found shaking the exit door trying to get out of the building." During an interview commencing at 11:54 AM on 11/12/25, the Executive Director stated at approximately 2:00 AM on 10/27/25 a Staff member found Resident #2 attempting to gain access to a back stairway. Per the Executive Director, Resident #2 did not get into the stairwell because they were likely unable to figure out how to open the stairway door. During this interview the Executive Director and Resident Care Director confirmed the Staff member's interaction with Resident #2 at 2:00 AM on 10/27/25 was the last time Resident	R142		

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R142	Continued From page 1 #2 was accounted for until approximately 5:30 AM on 10/27/25, when this Resident was found on the ground outside the home's dining room with wet clothing due to urinary incontinence. When this incident occurred, Resident #2 was awaiting availability of a bed in a Memory Care Special Care Unit due to cognitive decline. Per record review and the Resident Care Director's confirmation, Resident #2's body temperature was 91.5 degrees Fahrenheit when found on the morning of 10/27/25, which is indicative of hypothermia. The Resident Care Director stated that on arrival at the home on the morning this incident occurred they immediately knew Resident #2 had exited the home through a dining room window because the dining room was "freezing cold" from the windows being open. A Progress Note written by the Resident Care Director states, "Windows in dining room open and several screens pushed out and one cut." Per the Resident Care Director, the hospice team made the decision not to transport Resident #2 to the hospital for treatment of hypothermia, and the Resident's family was in agreement with this decision. Per review, Resident #2's record did not contain notes written by the hospice provider as required, and a packet of hospice documents the Resident Care Director stated was stored in their office did not include documentation regarding this incident other than a record of Resident #2's body temperature being greater than 98 degrees Fahrenheit at 9:39 AM on 10/27/25, four hours after Resident #2 was found. Per the Resident Care Director, Resident #2's vital signs including body temperature returned to within normal limits in response to actions taken at the home. During the interview commencing at 11:54 AM on 11/12/25 the Executive Director stated the	R142		

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R142	Continued From page 2 frequency of Resident safety checks conducted at the home is determined by a resident's individual needs, and stated safety checks are conducted for all resident of the home three times during the overnight shift. The Executive Director and Resident Care Director confirmed the frequency of safety checks conducted for Resident #2 was not increased from the standard 3 times nightly in response to this Resident's known history of wandering and exit seeking, and Staff's observation of these behaviors on the morning of 10/26/25 and at 2: 00 AM on 10/27/25. Per interview with the Executive Director and Resident Care Director, Incident Reports, and Staff's written statements, on the morning of 10/27/25, Resident #2 was observed during the 1:00 AM safety check, was observed attempting to exit via the stairwell at 2:00 AM and redirected by Staff, then during the 4:00 AM safety check it was discovered that Resident #2 was not in their apartment and their walker had been left in the 3rd floor Med Tech station. Upon this discovery, Staff responsible for resident care for the floor on which Resident #2 resided conducted a search for Resident #2, and at 5:00 AM additional Staff on duty in other areas of the home were notified and joined the search for Resident #2. At 12:08 PM on 11/12/25 the Executive Director confirmed the Staff on duty did not follow the home's Missing Resident policy and procedures which indicate the Executive Director is to be notified immediately when a resident is not located and determined to be missing. Per the Executive Director, this failure to notify delayed implementation of search procedures outlined in the home's Missing Resident policy. Per record review, the Resident Care Director was notified when Resident #2 was found. Per review of a statement written by the Staff	R142		

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R142	Continued From page 3	R142		

member who found Resident #2 on the morning of 10/27/25, Resident #2 was on the ground outside of the dining room calling out for help. This Staff stated when they went out the dining room door to assist Resident #2 they got locked outside and used a radio to call for assistance to get back in. During an interview commencing at 2:29 PM on 11/12/25, the Resident Care Director confirmed as a safety measure the home's exterior doors are locked after 8:00 PM to prevent entry. The Resident Care Director confirmed doorbells are installed on all exterior doors which, when pressed, alert an overnight Staff positioned at the front desk of the Residential Care Home managed by the same organization that is located across the parking lot from this Assisted Living Residence. Per the Resident Care Director, the front desk staff of the Residential Care Home has access to surveillance cameras and intercoms installed at the Assisted Living Residence, and can unlock the doors remotely. During the interview commencing at 2:29 PM on 11/12/25, the Resident Care Director confirmed the staffing pattern for home does not include a staff posted at the front desk during the overnight shift. Per observation, the pathway taken by Resident #2 when they eloped via a window in the dining room would have included a section of the main floor hallway and the entrance to the dining room, which are visible from the front desk of this residence. The use of a doorbell and intercom system for assistance to re-enter the home is dependent on a resident's ability to understand and remember this process, and their cognitive and physical ability to utilize this system. In addition to impaired cognitive function, factors which impacted Resident #2's ability to safely return to the home following their elopement included not the having access to their walker which was left in the 3rd floor Med Tech station,

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R142	Continued From page 4 and need for assistance standing up from the ground. Resident #2 was discharged from the home on the morning of 11/12/25, and was not available for interview during the investigation. At approximately 4:45 PM on 11/12/25 the Residential Care Director acknowledged the finding of inadequate supervision to mitigate the risk for injury for Resident #2 related to the incident of elopement that occurred on 10/27/25.	R142		
R401 SS=D	9.1.a Environment The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This includes outdoor areas that are used by residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure the living environment of one applicable resident (Resident #1) was routinely cleaned and maintained to ensure care in a safe, functional, sanitary, homelike and comfortable environment. Findings include: The home's Environment of Care and Safety policy states the organization that manages the home is committed to providing a safe, functional and healthful environment for residents. Per in interview with the current Executive Director commencing a 1:29 PM on 11/12/25 PM, the expectations for maintenance of residents' individual living environments include weekly cleaning provided by staff. The Executive Director stated if residents need additional support in this	R401		

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R401	Continued From page 5	R401		

area of service the resident needs to ask for it. Per review of Progress Notes and a Care Plan on file, Resident #1 was admitted to the home with a history of a traumatic brain injury and aphasia (difficulty speaking due to damage to the areas of the brain involved in language which impacts communication), and was noted to demonstrate cognitive decline likely resulting from brain injury and a potential combination of vascular and degenerative dementia.

During the interview conducted on the afternoon of 11/12/25, the current Executive Director confirmed there were ongoing housekeeping issues in Resident #1's apartment that started prior to their employment as the home's Executive Director. Per review of a request for a change of the home's manager on file with the licensing agency, the current Executive Director's management of the home was confirmed on 6/30/2025. The current Executive Director reported conditions in Resident#1's apartment had improved for a while; however, Resident #1 would often refuse cleaning by staff, and would not let the staff change waterproof pads protecting furniture and bedding or allow staff to clean the carpeting and other areas in the apartment.

Per review of the Monthly Tasks Logs on file between July 1, 2025 and Resident#1's discharge to a Memory Care Special Care Unit at another facility in November 2025, records indicate Resident #1 required full assist with housekeeping tasks twice daily. Refusal of housekeeping services documented by staff during this time period was limited to 2 refusals on 7/16/5. No refusal of housekeeping services was documented in August 2025, September 2025, October 2025, and the days in November

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R401	Continued From page 6 2025 during which Resident #1 resided at the home. Progress Notes on file during Resident #1's residence at the home include documentation of requests for a family member to provide supplies including waterproof pads, incontinence supplies and cleaning supplies; however there is no documentation of Resident #1 refusing housekeeping services during their residency. Additionally, Resident #1's Care Plan identified "Housework" as an area of focus with the goal "Provide housekeeping in order to ensure a clean living environment"; however, specific interventions to address and ensure a consistent response to resistance and refusal of housekeeping services were not identified in Resident #1's Care Plan. Per interview with the current Executive Director on the afternoon of 11/12/25, and per emails with Resident #1's family member provided by the current Executive Director for review, a communication dated 10/14/25 includes the current Executive Director's acknowledgement of environmental issues in Resident #1's apartment; a list of maintenance completed; a plan for ongoing monitoring; and an apology for the condition of Resident #1's apartment. Evidence of efforts to address this ongoing issue and ensure a safe, functional, sanitary, homelike and comfortable living environment in Resident #1's apartment prior this email, including the period of time prior to the current Executive Director's employment at the home, were not on file or provided for review. Environmental concerns related to housekeeping services were confirmed by the current Executive Director during the interview commencing at 1:29 PM on 11/24/25, and acknowledged by the Residential Care Director at approximately 4:45	R401		

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R401	Continued From page 7 PM on 11/12/25.	R401		
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 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 staff interview and record review there is a failure to ensure development of care plans which address the identified needs and behaviors of 2 applicable residents (Resident #1 and Resident #2). Findings include: The home's policy governing resident Care Plans indicates at minimum a resident's care plan shall include individualized including, but not limited to, "Identification of the resident's problems and needs: Resident goals and intervention plans". 1. Per record review, Resident #1 has a history of a traumatic brain injury and multiple medical conditions including and associated with	R487		

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R487	Continued From page 8	R487		

advanced cardiovascular, respiratory, and kidney disease processes. Resident #1 was admitted to Hospice Care on 10/20/25. Resident #1 has a history of impaired skin integrity including skin tears and wounds, and infections. Resident #1's medical diagnoses include Hyponatremia (abnormally low sodium levels in the bloodstream) which indicates need for nursing assessment and monitoring to ensure proper fluid and electrolyte levels are maintained; and anemia (abnormally low red blood cell levels), which is a risk for poor oxygenation, weakness and fatigue.

During an interview commencing at 1:29 PM on 11/11/25, the Executive Director stated Resident #1 required use of a wheelchair for safe mobility to get to the elevator used to access the dining room, common areas, facility exits, and while in the community. Per interview with the Executive Director on the afternoon of 11/11/25, and per record review, Resident #1 also has identified needs related to behaviors including refusal of care and resistance to care including wound care and bathing; and had demonstrated inability to independently maintain a safe, functional, sanitary and homelike environment in their own apartment.

Per record review, the Care Plan on file during Resident #1's residency at the home did not identify needs, goals and interventions related to their history of traumatic brain injury; complex medication needs related to cardiovascular, respiratory, and kidney disease; hospice care; monitoring for signs and symptoms of anemia and Hyponatremia; risk for wounds and infections; use of a wheelchair for mobility to ensure safe access to common areas of the home and outings in the community; specific instructions to ensure consistent staff response to

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R487	Continued From page 9	R487		

refusals and resistance to care; and interventions to ensure maintenance of a safe and sanitary living environment in Resident #1's apartment.

2. Per record review, on 9/27/25 Resident #2 moved to this Assisted Living Residence from the Residential Care Home owned by the same organization located on the same campus. Resident #2 was discharged to another facility on 11/11/25 due to cognitive decline indicative of need for care in a Memory Care Special Care Unit. Per review of Assessments, Progress Notes, Incident Reports and Medication Orders, the Care Plan on file and in use during Resident #2's residence at this Assisted Living Residence did not describe goals and interventions related to identified needs for this Resident including:

a. Cognitive decline and periods of confusion indicating a need for Memory Care

b. Admission to hospice care on 10/22/25

c. Incidents of searching for and obtaining sharp knives with demonstrated inability to safely manage access to sharp objects

d. Sensory Impairment including visual impairment resulting from Absolute Glaucoma (end stage Glaucoma) and Hearing loss with documentation of refusing to wear a hearing aid

e. Decreased appetite and weight loss

f. Medication refusals and resistance to care

g. Use of medications including prescribed orders for 4 anti-psychotic medications indicating the

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R487	Continued From page 10 need for monitoring for side effects of antipsychotic medications including the risk for Serotonin Syndrome (symptoms of a potentially fatal drug toxicity resulting from excessive serotonin activity associated with use of medications that increase serotonin levels in the brain). All 4 antipsychotic medications prescribed to Resident #2 can cause Serotonin Syndrome, particularly when used in combination. The Resident Care Director confirmed the Care Plans on file do not address identified needs for Resident #1 and Resident #2 during resident record reviews conducted on 11/12//25 and during the investigation exit conference at approximately 4:45 PM on 11/12/25.	R487		

Deficiency Statement Plan of Correction (POC)

Survey Date: 11/12/25

Facility Name: The Residence at Shelburne Bay Katy Munsie

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
R142 SS=D Plan of Correction accepted by Jo A Evans on 12/23/25	Training was provided to night shift associates regarding residents who may be exhibiting signs of exiting seeking should be handled by placing a 1x1 to ensure safety. Resident #2 was discharged from the community to a secure memory care community on 11/12/25.	No other incidents have occurred	11/6/25	Training conducted to all associates regarding elopement and elopement procedure. Elopement drill conducted on 12/9/25. Residents who are exhibiting exit seeking behavior are scheduled with a 1x1 while seeking alternate placement at a secure environment. All incidents will be reviewed by interdisciplinary safety committee to identify trends and address issues.	Resident Care Director Overseen by: Executive Director
R401 SS=D Plan of Correction accepted by Jo A Evans on 12/23/25	Training completed with housekeeping and nursing associates to alert management of any refusals for housekeeping services. Training for housekeeping on checklists to ensure proper cleaning done weekly to resident apartments. Education for care associates cleaning tasks and importance of refusals to be noted.	Leadership educated on importance of reminding all associates to report any concerns regarding lack of housekeeping in resident apartments.	12/12/25	Training for all associates to understand the importance of housekeeping to be kept up on in resident apartments. Alerting management of refusals and a care plan to ensure cleanliness is completed. Nursing and Maintenance to meet weekly to discuss any refusals and/or assistance needed to ensure all resident apartments are tended to. Maintenance and ED will look for trends and identify areas for improvement.	Resident Care Director Maintenance Director Overseen by: Executive Director

R487 SS=E Plan of Correction accepted by Jo A Evans on 12/23/25	Both residents noted have been discharged from the community and therefore, their care plans were not updated to reflect needed changes.	Nursing department to do an audit of all care plans to determine the need for adjustments for needs and behaviors.	01/05/25 Audit complete	Nursing staff were educated by Regional RN regarding care plans and the need for accurate updates as needed (ex: hospice, wound care, medication, diagnosis). Relias training completed regarding care plans. Care plan audits of 10% will be done each QA meeting and the findings discussed quarterly at QA meeting.	Resident Care Director Overseen by: Executive Director