



**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

February 3, 2026

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 **January 13, 2026**. 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: 0161	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/13/2026
NAME OF PROVIDER OR SUPPLIER HISTORIC HOMES OF RUNNEMEDE-STOUGHTON HC		STREET ADDRESS, CITY, STATE, ZIP CODE 40 MAXWELL PERKINS LANE WINDSOR, VT 05089		R216, R358, R364, R372, R381, and R403 Accepted 2-2-26 Susan Canas Gregoire RN	
(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 January 13, 2026, the Division of Licensing and Protection conducted an unannounced on-site annual relicensure survey and an investigation of one complaint. The following deficiencies were identified:	R100			
R216 SS=F	5.11.e (5) Staff Services If a prospective or current employee's background check is returned with a criminal offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to public welfare, the facility must keep on file a written decision to hire that records the reason the facility has determined that the employee's prior criminal offense poses no foreseeable risk of abuse, neglect, or exploitation to residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the home failed to complete and maintain the required written determinations documenting the rationale for hiring employees with prior criminal offenses. Findings include: During the home's re-licensure survey conducted on January 13, 2026, the home was requested to provide current background check documentation for six staff members. The home reported that the background check process was managed by the organization's human resources department. Upon review of the submitted documentation on the morning of January 13, 2026, it was identified that one of the six staff members had a prior misdemeanor conviction for theft. When interviewed regarding this finding, the Manager	R216			

Division of Licensing and Protection

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

TITLE

(X6) DATE

STATE FORM

6899

WLEY11

continuation sheet 1 of 9

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R216	Continued From page 1 confirmed the conviction and further stated that they were not previously aware of the conviction. The manager additionally confirmed that no written determination addressing whether the individual posed a foreseeable risk of abuse, neglect, or exploitation to residents had been completed or maintained as required by State Rules. Per additional record review conducted on the afternoon of January 13, 2026, the home was requested to identify all current employees working in the home who had prior criminal convictions and to provide corresponding background check documentation for everyone. Documentation subsequently provided by the organization's human resources department identified a second staff member with a prior criminal conviction. During an interview on the afternoon of January 13, 2026, the Manager confirmed the existence of this second conviction and acknowledged that they had not been previously informed of it. The Manager further confirmed that no written determinations had been completed or maintained for either individual addressing whether their prior criminal offenses posed a foreseeable risk of abuse, neglect, or exploitation to residents as required by State Rules. Additionally, no documentation was maintained explaining the facility's rationale for hiring either individual. On the afternoon of January 13, 2026, the Manager confirmed these findings.	R216			
R358 SS=F	6.10 Resident's Rights The resident's right to privacy extends to all records and personal information. Personal	R358			

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R358	Continued From page 2 information about a resident must not be discussed with anyone not directly involved in the resident's care. Release of any record, excerpts from or information contained in such records are subject to the resident's written approval, except as requested by representatives of the licensing agency to carry out its responsibilities or as otherwise provided by law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure residents' right to privacy related to records, including private health information. Findings include: Per the home's Resident Rights Policy, which is posted on the wall in a common area of the home, residents' right to privacy extends to all records and personal information. Per observation conducted during the facility tour beginning at 8:34 AM on January 13, 2026, multiple forms of resident documentation were observed to be maintained in unsecured, paper-based formats, that were readily accessible in the main common area of the home at the main desk. This documentation included the end-of-shift report book, the activities of daily living documentation book, individual resident folders, resident behavioral reports, and paper medication administration records. In addition, the full resident paper charts were observed to be stored in unlocked drawers that were easily opened and unsecured. These records contained residents protected and individually identifiable health information	R358			

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R358	Continued From page 3 including, but not limited to, full legal names, resident photographs, room numbers, medical histories, diagnosis, behavioral support plans, cognitive status information, scheduled and past medical appointments, physician orders, prescribed medication names and dosages, scheduled administration times, insurance information, and staff signatures verifying medication administration. As a result of these observations, residents' protected and individually identified health information was readily accessible to residents, visitors, and other unauthorized individuals, constituting a failure to appropriately safeguard protected health information in accordance with State Rules. Per interview conducted on the afternoon of January 13, 2026, the Manager confirmed these findings. .	R358		
R364 SS=F	6.16 Resident's Rights Residents have the right to formulate advance directives, to have in place DNR and clinician-ordered life-sustaining treatment (COLST) documents, as provided by state law, and to have the home follow the residents' wishes. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the	R364		

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R364	Continued From page 4 home failed to ensure that documentation was maintained indicating whether residents had completed, declined, or been offered the opportunity to complete Advanced Directives and COLST forms documenting residents' wishes related to end-of-life and life-sustaining treatment. Findings include: Per record review conducted on the morning of January 13, 2026, it was determined that eight of twenty-four resident charts did not contain documentation of an advanced directive, a clinician-ordered life-sustaining treatment (COLST) form or documentation indicating that the resident had been offered the opportunity to complete such forms and had declined. No documentation reflecting the residents' wishes regarding advanced care planning or end-of-life decision-making was present in these records. These findings were confirmed by the Manager on the afternoon of January 13, 2026. The Manager further stated that they intended to assign the Case Manager responsibility for offering residents the opportunity to complete advanced directives and COLST forms moving forward.	R364			
R372 SS=F	7.1.a (4) Menus and Nutritional Standards The current week's regular and therapeutic menu must be posted in a public place for residents and other interested parties. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the home failed to ensure that a weekly menu was	R372			

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R372	Continued From page 5 posted in a public location accessible to residents and other interested parties, as required by State Rules. Findings include: The home was unable to provide a policy or procedure addressing the posting of weekly menus as required by State Rules. Per observation, during a tour of the home conducted on the morning of January 13, 2026, no weekly menu was observed posted in any common or publicly accessible area of the home. Per a staff interview, conducted with the Manager on the morning of January 13, 2026, the Manager confirmed that there was no weekly menu posted at that time and stated that it was their intention to begin posting one in a common area.	R372			
R381 SS=F	7.2.a Food Safety and Sanitation Each home must procure food from sources that comply with all laws relating to food and food labeling. The home must ensure that all food is safe for human consumption, free of spoilage, filth or other contamination. All milk products served and used in food preparation must be pasteurized. Cans with dents, swelling or leaks must be rejected and kept separate until returned to the supplier. This STANDARD is not met as evidenced by: Based on observation and staff interview, the home failed to ensure that all perishable food was properly labeled, dated and stored in closed, sanitary packaging, and that dented cans were removed from food storage areas as required by State Rules. Findings include:	R381			

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R381	Continued From page 6 The home's policies and procedures governing labeling, perishable foods, and the handling of dented or damaged cans were found to be consistent with the applicable Licensing Rules for Residential Care Homes. During a tour of the home's kitchen and food storage areas conducted on the morning of January 13, 2026, multiple food items were observed to be unlabeled, undated, improperly stored, or otherwise not maintained in a sanitary or safe condition. Findings included several unlabeled food items, including three tubes of raw hamburger meat, two plastic bins of pasta, a plastic bin of rice, a container of wonton noodles, potato nuggets, and a frozen dinner removed from its original packaging. Additionally, multiple food items lacked preparation or discard dates, including a container of cornmeal, a container of flour, Swiss cheese wrapped in plastic wrap, and a tray of uncovered ice cream. A damaged spaghetti squash with visible mold growth was also observed. In addition, several dented canned or packaged items were present in storage, including a container of oatmeal that was open and dented, containers of breadcrumbs, and a large dented can of tomato paste. All these items were stored in a common kitchen storage area. These findings were confirmed by the Manager on the morning of January 13, 2026.	R381		
R403 SS=F	9.1.c Environment 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	R403		

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R403	Continued From page 7 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, the home failed to ensure the safe and secure storage of chemical agents. Findings include: The home's policies and procedures regarding maintaining a safe environment align with applicable State Rules. During a tour of the home conducted on the morning of January 13, 2026, unsecured chemical cleaning agents were observed on an unattended housekeeping cart that did not have a cover or a locked compartment. The cart was in a common hallway on the second floor. Visible and accessible items on the cart included Clorox Hydrogen Peroxide Cleaner and Lysol Power Cleaning Gel these chemical agents were observed at approximately 8:41 AM and again at approximately 9:53 AM, during which time the cart remained unattended and accessible to vulnerable residents of the home. Additionally, Clorox Hydrogen Peroxide Cleaner and Lysol Power Cleaning Gel were observed on the counter in an open bathroom on the second floor of the home. An unlocked propped open door to a room located behind the main desk in a first-floor common area was also observed. Under the sink in this room, chemical agents were present, including Resolve Carpet and Rug Cleaner and Clorox Hydrogen Peroxide. These chemical agents were unsecured and accessible to all residents, including vulnerable adults	R403		

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R403	Continued From page 8 residing in the home. These findings were acknowledged by the Manager on the afternoon of January 13, 2026.	R403			

Deficiency Statement Plan of Correction (POC)

Survey Date: 01/13/2026

Facility Name: Historic Homes of Runnemede – 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
R216: 5.11.e (5) Staff Services If a prospective or current employee's background check is returned with a criminal offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to public welfare, the facility must keep on file a written decision to hire that records the reason the facility has determined that the employee's prior criminal offense poses no foreseeable risk of abuse, neglect, or exploitation to residents. This REQUIREMENT is not met as evidenced by: R216 Based on staff interview and record review, the home failed to complete and maintain the required written determinations documenting the rationale for hiring employees with prior criminal offenses. Findings include: During the home's re-licensure survey conducted on January 13, 2026, the home was requested to provide current background check documentation for six staff members. The home reported that the background check process was managed by the organization's human resources department. Upon review of the submitted documentation on the morning of January 13, 2026, it was identified that one of the six staff members had a prior	Manager will review all current employee background checks and implement written documentation in each employee file for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to public welfare.	All residents of the home have potential to be harmed due to this deficiency, Manager will review all current employee background checks and implement written documentation in each employee file for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to public welfare.	02/06/2026	Human Resources will continue to manage the background check process for all new-hire candidates and annual/as-needed background checks. Once reviewed by Human Resources and Risk Management, information will be shared with Manager. Manager will review all new hire and annual background checks, and provide written documentation in each employee file for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to public welfare.	Human Resources and Manager

R216 Accepted 2-2-26
Susan Canas Gregoire RN

misdemeanor conviction for theft. When interviewed regarding this finding, the Manager confirmed the conviction and further stated that they were not previously aware of the conviction. The manager additionally confirmed that no written determination addressing whether the individual posed a foreseeable risk of abuse, neglect, or exploitation to residents had been completed or maintained as required by State Rules. Per additional record review conducted on the afternoon of January 13, 2026, the home was requested to identify all current employees working in the home who had prior criminal convictions and to provide corresponding background check documentation for everyone. Documentation subsequently provided by the organization's human resources department identified a second staff member with a prior criminal conviction. During an interview on the afternoon of January 13, 2026, the Manager confirmed the existence of this second conviction and acknowledged that they had not been previously informed of it. The Manager further confirmed that no written determinations had been completed or maintained for either individual addressing whether their prior criminal offenses posed a foreseeable risk of abuse, neglect, or exploitation to residents as required by State Rules. Additionally, no documentation was maintained explaining the facility's rationale for hiring either individual. On the afternoon of January 13, 2026, the Manager confirmed these findings.

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R358: 6.10 Resident's Rights The resident's right to privacy extends to all records and personal information. Personal information about a resident must not be discussed with anyone not directly involved in the resident's care. Release of any record, excerpts from or information contained in such records are subject to the resident's written approval, except as requested by representatives of the licensing agency to carry out its responsibilities or as otherwise provided by law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure residents' right to privacy related to records, including private health information. Findings include: Per the home's Resident Rights Policy, which is posted on the wall in a common area of the home, residents' right to privacy extends to all records and personal information. Per observation conducted during the facility tour beginning at 8:34 AM on January 13, 2026, multiple forms of resident documentation were observed to be maintained in unsecured, paper-based formats, that were readily accessible in the main common area of the home at the main desk. This documentation included the end-of-shift report book, the activities of daily living documentation book, individual resident folders, resident behavioral reports, and paper medication administration records. In addition, the full resident paper charts were observed to be stored in unlocked drawers that were easily opened and unsecured. These records contained residents protected and individually identifiable health information	All resident information was removed from this identified area, and open drawers containing resident information were locked. All staff to be re-educated on Resident Rights; including residents' right to privacy related to records, including private health information. Staff to be educated on locking drawers containing resident information. Monthly audits of public areas will be completed and documented to ensure all resident private health information is protected, until stabilization of	All residents of the home have potential to be harmed due to this deficiency. Resident information was removed from open areas, all staff to be re-educated, and monthly audits will be completed & documented.	All resident information was removed from this area on 01/13/2026 Staff education to be completed by 02/05/2026 Monthly Audits began 01/14/2026	Monthly audits of public areas will be completed and documented to ensure all resident private health information is protected, until stabilization of process is demonstrated. R358 Accepted 2-2-26 Susan Canas Gregoire RN	Manager to oversee staff education HHR Nursing Leader and Manager to complete and document monthly audits of common areas for resident information.
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including, but not limited to, full legal names, resident photographs, room numbers, medical histories, diagnosis, behavioral support plans, cognitive status information, scheduled and past medical appointments, physician orders, prescribed medication names and dosages, scheduled administration times, insurance information, and staff signatures verifying medication administration. As a result of these observations, residents protected and individually identified health information was readily accessible to residents, visitors, and other unauthorized individuals, constituting a failure to appropriately safeguard protected health information in accordance with State Rules. Per interview conducted on the afternoon of January 13, 2026, the Manager confirmed these findings.	process is demonstrated.				
R364: 6.16 Resident's Rights Residents have the right to formulate advance directives, to have in place DNR and clinician-ordered life-sustaining treatment (COLST) documents, as provided by state law, and to have the home follow the residents' wishes. This REQUIREMENT is not met as evidenced by: R364 Based on staff interview and record review, the home failed to ensure that documentation was maintained indicating whether residents had completed, declined, or been offered the opportunity to complete Advanced Directives and COLST forms documenting residents' wishes related to end-of-life and life-sustaining treatment. Findings include: Per record review conducted on the morning of January 13, 2026, it was determined	Audit of all resident charts completed, and identification of missing DNR and clinician-ordered life-sustaining treatment (COLST) documents. Documentation form created and implemented will all residents of the home acknowledging	All residents of home have the potential to be harmed by missing DNR and COLST information. Documentation audited and completed with residents.	Audit of all resident charts completed 01/22/2026 Documentation form and education completed by 02/20/2026	On admission, all residents will complete documentation form regarding DNR/COLST documents	HHR RN Case Manager and HHR Nursing Leader

that eight of twenty-four resident charts did not contain documentation of an advanced directive, a clinician-ordered life-sustaining treatment (COLST) form or documentation indicating that the resident had been offered the opportunity to complete such forms and had declined. No documentation reflecting the residents' wishes regarding advanced care planning or end-of-life decision-making was present in these records. These findings were confirmed by the Manager on the afternoon of January 13, 2026. The Manager further stated that they intended to assign the Case Manager responsibility for offering residents the opportunity to complete advanced directives and COLST forms moving forward.	education on Advanced Directives/DNR/ COLST, and indicating their wishes to complete or not complete a COLST and/or DNR. COLST and DNR documents not on file obtained and stored in resident chart if resident wishes to do so.			R364 Accepted 2-2-26 Susan Canas Gregoire RN	
R372: 7.1.a (4) Menus and Nutritional Standards The current week's regular and therapeutic menu must be posted in a public place for residents and other interested parties. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the home failed to ensure that a weekly menu was posted in a public location accessible to residents and other interested parties, as required by State Rules. Findings include: The home was unable to provide a policy or procedure addressing the posting of weekly menus as required by State Rules. Per observation, during a tour of the home conducted on the morning of January 13, 2026, no weekly menu was observed posted in any common or publicly accessible area of the home. Per a staff interview, conducted with the Manager on the morning of January 13, 2026, the	Resident menu posted in common area, including alternative menu. Policy and procedure to be developed for the posting of weekly menus.	All residents have the potential to be harmed from failure to post weekly menus, and lack of policy. Weekly menus including alternative options will be posted in common areas, and policy developed and implemented.	Menus posted in common areas on 01/13/2026 Policy in place by 02/06/2026	Policy developed for weekly menu posting. Menus posted in common areas. R372 Accepted 2-2-26 Susan Canas Gregoire RN	Kitchen Manager and Manager

Manager confirmed that there was no weekly menu posted at that time and stated that it was their intention to begin posting one in a common area.					
R381: 7.2.a Food Safety and Sanitation Each home must procure food from sources that comply with all laws relating to food and food labeling. The home must ensure that all food is safe for human consumption, free of spoilage, filth or other contamination. All milk products served and used in food preparation must be pasteurized. Cans with dents, swelling or leaks must be rejected and kept separate until returned to the supplier. This STANDARD is not met as evidenced by: R381 Based on observation and staff interview, the home failed to ensure that all perishable food was properly labeled, dated and stored in closed, sanitary packaging, and that dented cans were removed from food storage areas as required by State Rules. Findings include: The home's policies and procedures governing labeling, perishable foods, and the handling of dented or damaged cans were found to be consistent with the applicable Licensing Rules for Residential Care Homes. During a tour of the home's kitchen and food storage areas conducted on the morning of January 13, 2026, multiple food items were observed to be unlabeled, undated, improperly stored, or otherwise not maintained in a sanitary or safe condition. Findings included several unlabeled food items, including three tubes of raw hamburger meat, two plastic bins of pasta, a plastic bin of rice, a container of wonton noodles, potato nuggets, and a frozen dinner removed	All food will be labeled, dated, and stored in a safe and sanitary manner; weekly audits will be completed & documented, until stabilization of process is demonstrated. All dented containers and cans removed from dry storage, weekly audits will be completed and documented. All Kitchen staff re-educated on food safety and storage standards.	All residents of the home have potential to be harmed due to this deficiency. All food will be labeled, dated and stored in a safe and sanitary manner; weekly audits will be completed & documented. All staff re-educated on food safety and storage standards.	All food labeled, dated, and stored in a safe and sanitary manner 1/14/2026 Weekly audits completed and documented starting 01/16/2026 Staff education completed by 02/06/2026	Weekly audit of dry storage, refrigerator and freezer to ensure all food is labeled, dated, and stored in safe and sanitary manner. Weekly audit of cans and containers, to ensure no dents or defective containers, until stabilization of process is demonstrated.	Kitchen Manager and Manager

from its original packaging. Additionally, multiple food items lacked preparation or discard dates, including a container of cornmeal, a container of flour, Swiss cheese wrapped in plastic wrap, and a tray of uncovered ice cream. A damaged spaghetti squash with visible mold growth was also observed. In addition, several dented canned or packaged items were present in storage, including a container of oatmeal that was open and dented, containers of breadcrumbs, and a large dented can of tomato paste. All these items were stored in a common kitchen storage area. These findings were confirmed by the Manager on the morning of January 13, 2026.				R381 Accepted 2-2-26 Susan Canas Gregoire RN	
R403: 9.1.c Environment 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, the home failed to ensure the safe and secure storage of chemical agents. Findings include: The home's policies and procedures regarding maintaining a safe environment align with applicable State Rules. During a tour of the home conducted on the morning of January 13, 2026, unsecured chemical cleaning agents were observed on an unattended housekeeping cart that did not have a cover or a locked compartment. The cart was in a common hallway on the second	Housekeeping carts with locked compartment implemented. Locks installed on all chemical storage closets and staff bathroom. Re-education for all staff on proper storage of cleaning chemicals. Weekly audits of chemical closets and housekeeping carts, until	All residents of the home have the potential to be harmed from chemical agents that are not stored in a safe and secure manner. Housekeeping carts with locked compartments implemented, locks installed on all chemical storage closets and staff bathroom, re-education for all staff on proper storage.	Housekeeping carts with locked compartment implemented 01/20/2026 Locks installed on all chemical storage closets and staff bathroom 01/19/2026 Re-education for all staff completed by 02/06/2026	Manager to complete and document weekly audits of chemical closets and housekeeping carts to ensure all chemicals are stored in a safe and secure manner, until stabilization of process is demonstrated.	Manager

floor. Visible and accessible items on the cart included Clorox Hydrogen Peroxide Cleaner and Lysol Power Cleaning Gel these chemical agents were observed at approximately 8:41 AM and again at approximately 9:53 AM, during which time the cart remained unattended and accessible to vulnerable residents of the home. Additionally, Clorox Hydrogen Peroxide Cleaner and Lysol Power Cleaning Gel were observed on the counter in an open bathroom on the second floor of the home. An unlocked propped open door to a room located behind the main desk in a first-floor common area was also observed. Under the sink in this room, chemical agents were present, including Resolve Carpet and Rug Cleaner and Clorox Hydrogen Peroxide. These chemical agents were unsecured and accessible to all residents, including vulnerable adults residing in the home. These findings were acknowledged by the Manager on the afternoon of January 13, 2026.	stabilization of process is demonstrated.			R403 Accepted 2-2-26 Susan Canas Gregoire RN	
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