VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
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AGENCY OF HUMAN SERVICES

Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

April 15, 2026

Lori Cannon, Manager
Barbara's 1840 House, Inc
Po Box 536
Wallingford, VT 05773

Dear Ms. Cannon:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 24, 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,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0613	A. BUILDING: _____ B. WING _____	C 02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARBARA'S 1840 HOUSE, INC	PO BOX 536 WALLINGFORD, VT 05773

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R100	Initial Comments On 2/24/2026 the Division of Licensing and Protection conducted an unannounced on-site annual survey and an investigation of 2 complaints. The following deficiencies were identified:	R100	Corrective Actions for all tags cited accepted by Jo A Evans RN on 4/15/2026 Please refer to the attached document to review all accepted corrective actions.	
R105 SS=C	5.2.a Uniform Consumer Disclosure-Admit Agreements The licensee upon initial licensure must state the services it can and will provide, the public programs or benefits that it accepts or delivers, the policies that affect a resident's ability to remain in the home, and any other relevant information. (1) The uniform consumer disclosure must be completed on a form provided by the licensing agency and must be kept on file by the licensee. (2) The uniform consumer disclosure must include a statement describing the daily, weekly or monthly rate to be charged, a description of the services that are covered in the rate and all other applicable financial issues. (3) The uniform consumer disclosure must include a statement that rates are subject to change, including rate changes due to increased care needs,and describe the situations in which the changes (s) could occur. (4) The uniform consumer disclosure must be provided; i. to residents prior to or at admission and at any time it is changed or is requested by the resident; and ii. to the public upon request (5) The availability of a uniform consumer disclosure must be noted prominently in all marketing brochures and written materials.	R105		

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R105	Continued From page 1	R105		

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review there is a failure to complete a Uniform Consumer Disclosure form and to provide this completed form to resident's during the admission process and as required. Findings include:

On the morning of 2/24/2026 the Manager of the home was requested to provide a copy of the home's completed Uniform Consumer Disclosure form for review. At 5:19 PM on 2/24/2026 the Manager confirmed the home had not completed this form.

R113 SS=C — 5.2.c (7) Uniform Consumer Disclosure- Admit Agreements

R113

In addition to general resident agreement requirements, agreements for all ACCS participants must include:

A home certified to provide assistive community care services (ACCS) must designate a staff person responsible for case management. Residents must be informed upon admission, and any time there is a change, of the name of the staff person responsible for case management.

This REQUIREMENT is not met as evidenced

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R113	Continued From page 2 by: Based on staff interview and record review there is a failure to designate a staff member to provide case management for a residents of the home receiving Assistive Community Care Services (ACCS) . Findings include: Per review, the home's Admission Agreement states case management is provided to residents of the home receiving Assistive Community Care Services; however the name of the staff person responsible for ACCS case management is not included in the home's Admission Agreement. At 11:04 AM on 2/24/2026 the Manager of the home confirmed a staff member has not been designated to serve as the case manager for residents of the home receiving Assistive Community Care Services.	R113		
R126 SS=D	5.3.b 3 Emergency Discharge or Transfer Requirements The home must issue a written notice of emergency discharge to the resident as soon as a determination has been made. The notice must include the notice requirements set forth in 5.3.a (2), above with the exception of 5.3.a (2) iii. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure the written notice of emergency discharge provided to one applicable resident (Resident #1) included notice requirements set forth in the Vermont Residential Care Home and Assisted Living Residences Licensing Rules effective April 1, 2026. Findings	R126		

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R126	Continued From page 3	R126		

include:

Per record review the home requested, and on 1/20/2026 was granted, a level of care variance allowing the home to admit Resident #1 based on a pre-admission assessment signed as completed by the Director of Nursing on 1/16/2026 and the home's attestation of ability to meet the needs of this Resident, which were determined to meet the criteria for nursing home level of care. Per staff interview and record review, Resident #1 was admitted to the home on 1/27/2026 with a diagnosis of Alzheimer's Dementia with Aggressive Behaviors. Per staff interview commencing at 2:37 PM on 2/24/2026, and record review, on 1/28/2026 the home initiated an emergency transfer of Resident #1 to a hospital emergency department in response to aggressive behaviors directed towards other residents and staff, incontinence with refusal to accept staff assistance with care, poor response to staff attempts to redirect, and administration of psychoactive PRN (as needed) medication with ineffective results.

Per staff interview and record review, on 1/28/2026 the home issued a written notice of emergency discharge to Resident #1's Guardian which stated, "EMERGENCY DISCHARGE 1/28/26 In accordance with Regulation 5.3b III. (sic) THERE ARE NO APPEAL RIGHTS UNDER EMERGENCY DISCHARGE."

Per review, licensing rule 5.3.b (3) states a written emergency discharge notice must include the notice requirements set forth in licensing rule 5.3.a (2) which states, "In the case of an involuntary discharge or transfer, the manager must ... ii. Include a statement in any legible font, size 18, that the resident has the right to appeal

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R126	Continued From page 4 the home's decision to transfer or discharge with the appropriate information regarding how to do so." Licensing rule 5.3.a (2) further states the manager must: "iv. Include the name, address and telephone number of the Office of the State Long Term Care Ombudsman." Per review, the written notice of emergency discharge provided to Resident #1's Guardian on 1/28/2026 does not include notification of the right to appeal the home's decision, and contact information for the Office of the State Long Term Care Ombudsman. During an interview conducted on the afternoon of 2/24/26 the Director of Nursing acknowledged the written notice of emergency discharge provided to Resident #1's Guardian on 1/28/2026 did not meet the licensing requirements.	R126		
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 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	R210		

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R210	Continued From page 5 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 there is a failure to ensure all staff complete the required training. Findings include: On the morning of 2/24/2026 the Manager was asked to provide documentation of trainings completed by 5 sampled staff. Per the documentation provided for review on 2/24/2026, all 5 sampled staff did not complete the trainings as required. Per interview with the Manager, as of 2/24/2026 the organization that manages the home had not implemented provision of the trainings added to the licensing rules effective 4/1/2025 for all of the home's staff. These findings were confirmed by the Manager of the home at 6:24 PM on 2/24/2026.	R210		
R211 SS=C	5.11.d Staff Services	R211		

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R211	Continued From page 6 All training to meet the requirements of 5.11.c must be documented. Training in direct care skills by a home ' s licensed nurse may meet this requirement, provided the nurse documents the content and amount of training. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to document staff completion of the required Resident Rights training. Findings include: During an interview conducted on the evening of 2/24/2026, Manager stated all staff employed at the home had completed yearly Resident Rights training as required. At 6:24 PM on 2/24/2026 the Manager confirmed completion of this training for all staff was not documented; and confirmed the form used by the home to document staff trainings does not include a designated space to document completion of this training.	R211		
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 there is a failure to ensure yearly background checks were completed as required for 1 out of 5 sampled staff. Findings include:	R225		

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R225	Continued From page 7 At 10:54 AM on 2/24/2026 the Manager was requested to provide documentation of criminal record and abuse registry checks completed for 5 sampled staff. Per review of the documentation provided, yearly background checks were not completed as required for 1 out of 5 sampled staff. This finding was confirmed by the Manager at 6:35 PM on 2/24/2026.	R225		
R358 SS=F	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 there is a failure to ensure resident's personal information remains private and inaccessible to individuals who are not directly involved in their care related to disposal of medication cards without removing labels with personal information. Findings include: During an observed med pass commencing at 12:08 PM on 2/24/2026 an empty medication card was observed to be discarded by Staff in an uncovered trash can beside the medication cart without removal of the label which included a resident's personal information.	R358		

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R358	Continued From page 8 During a review of the medication storage area at 1:47 PM, Staff confirmed the applicable medication card disposed of during the observed med pass remained in the trash can with the label attached to the card, and stated medication packaging is disposed of without removing the labels.	R358		
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 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 care in a safe, sanitary and homelike environment. Findings include: The following environmental concerns were observed during the survey conducted on 2/24/2026: 1. The shower pan (floor) of the first bathroom shower was observed to be chipping and covered with areas of discoloration. The Manager confirmed this finding at 1:37 PM on 2/24/2026. 2. The basement door was observed to be unlocked, leaving the basement accessible to residents of the home. The basement doorway opens to the landing of a stairway without	R403		

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R403	Continued From page 9	R403		

handrails that descends into the basement along a wall with damage including exposed wooden slats. Two nails were observed to be protruding from the area just above where the wall transitions to brick and stone construction and two of the stairs in the middle of the staircase were observed to be cracked, including one that with a deep crack along the entire width of the stair. The cement landing at the bottom of the staircase was observed with deep cracks, and piles of debris. At 1:52 PM on 2/24/2026 the Manager confirmed the basement door was unlocked, leaving a hazardous area accessible to residents of the home.

3. The shared bathroom on the second floor of the home was observed with a buildup of dust on the sprinkler head and the pipes that supply water to the sprinkler. The exhaust fan on the ceiling of this bathroom was observed with an accumulation of dust blocking the air vents, and the ceiling light was observed with an unidentified black substance accumulating inside the cover of the light fixture. The trim around the bathroom floor was observed to be in need of cleaning, and with areas of chipped, cracked and peeling paint. The toilet plunger in this bathroom was observed to be placed directly on the floor without a container. These findings were confirmed by the Manager at 2:02 PM on 2/24/2026.

4. The track for the chair lift on the staircase in the main entryway of the home is installed so the chair rests directly in front of the bottom stair when not in use, and the seat of the chair lift was observed to not stay in a folded position when not in use. Due to the condition and position of the chair lift rails and seat, and the narrow width of the staircase, the area through which residents can enter and exit the bottom of the stairs is

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R403	Continued From page 10 limited and access to the stairs was observed to be obstructed. Staff and residents were observed navigating through the narrow passage at the bottom of the stairs by stepping around the seat which was obstructing access to the stairs. These findings were acknowledged by the Manager and Registered Nurse on the afternoon of 2/24/2026. The walls of the foyer in the main entryway of the home were observed to be in need of repair and painting, with unsanded and unpainted spackling spread across areas visible on the walls of the foyer and the wall along the stairway to the second floor of the home. The staircase was also observed to be in need of painting, with areas of paint chipped off of many of the stairs. At 2:16 PM on 2/24/2026 two pieces of wood approximately a half to three quarters of an inch thick were observed to be nailed to the flooring in the middle of the doorway between the foyer and the dining area of the home. The placement of these boards prevents a smooth transition in the flooring of the doorway between the dining room and the foyer, which the residents use to access the upstairs living area. This is a trip hazard and a risk for injuries. These findings were acknowledged by the Manager and Nurse during a tour of the foyer and upstairs of the home on the afternoon of 2/24/2026.	R403		
R430 SS=F	9.6.d Plumbing Hot water temperatures must not exceed 120 degrees Fahrenheit in resident areas.	R430		

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R430	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure water temperatures are maintained at or below 120 degrees Fahrenheit in areas of the home accessible to residents. Findings include: On 2/24/2026 water temperatures water temperatures were observed to be above 120 degrees Fahrenheit in the following areas of the home accessible to residents: 1. At 12:36 PM on 2/24/2026 the water from the kitchen sink was 121.1 degrees Fahrenheit as confirmed by the staff on duty. 2. At 1:36 PM on 2/24/2026 the water from the first floor bathroom sink was 123.3 degrees Fahrenheit as confirmed by the Manager. 3. At 1:58 PM on 2/24/2026 the water from the second floor bathroom sink was 121.1 degrees Fahrenheit as confirmed by the Manager.	R430		

Deficiency Statement Plan of Correction (POC)

Survey Date: 02/24/2026

Facility Name: Barbara's 1840 House Inc.

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
R105 5.2.a	Uniform Disclosure statement has been completed and is on file at the home.	Uniform Disclosure form is on file at the home and is available for review upon request	4/10/2026	A copy of the required Uniform Disclosure form is on file at the home and is available for review upon request	Manager and Nursing Director R105 accepted by Jo A Evans RN on 4/15/2026
R113 5.2.c (7)	Manager is aware that services listed, including case management are overseen (managed) by Nursing Director.	We will add signature line to Admissions Agreement with Nursing Director's name listed.	4/16/2026	Above is reviewed prior to admission with resident and/or guardian.	Nursing Director will be responsible for above R113 accepted by Jo A Evans RN on 4/15/2026
R126 5.3.b 3	1/28/26 – Emergency Discharge Letter was issued to guardian, however Ombudsman name and contact information and appeal rights were listed in the Admission Agreement, but were not listed on the discharge letter	Phone number for Ombudsman is in the Admissions Agreement and will be added to discharge letters	2/24/2026	We will include the Ombudsman name and contact information and appeal rights in future discharge notices.	Nursing Director will be responsible for ensuring above is complete per regulation R126 accepted by Jo A Evans RN on 4/15/2026
R210 5.11.c	We are adding training for #9-Recognition of Sensitivity & #10-Trauma-informed care to new hire and yearly staff in-services	Nursing Director will gather materials, develop in-service programs for #9-Recognition of Sensitivity & #10-Trauma-informed care and review with all staff. And will review all required trainings are completed and signed off in the training binder.	4/16/26	Manager and Nursing Director will be responsible for #9-Recognition of Sensitivity & #10-Trauma-informed care and all required in-service trainings being completed by staff upon hire and yearly thereafter.	Manager and Nursing Director will be responsible R210 accepted by Jo A Evans RN on 4/15/2026

R211 5.11.d	We had 2 different sign off sheets – The one presented to surveyor, in error, did not list Residents Rights for signature.	We are now using one form that includes a sign off for Residents Rights Inservice.	2/26/26	Manager and Nursing Director will ensure above is completed at each Residents Rights Inservice.	Manager and Nursing Director R211 accepted by Jo A Evans RN on 4/15/2026
R225 5.12.b (4)	As of 12/22/25 All employees had Abuse Registry, VT Criminal Convictions and AHS Adult/Child registry completed. As of 2024, all employees except [redacted] who started and had all background checks completed 10/16/25, had National Background checks completed. As of date of survey, Manager [redacted] who lives in New York State did not have yearly National Background completed. This was submitted and returned on 3/17/26.	Background check are completed upon hire and re-checked on a yearly basis by our Main Office. National Background checks are re-checked yearly for out of state employees Initials redacted by DLP 4-13-2026	3/17/26	Background check are completed upon hire and re-checked on a yearly basis by our Main Office. National Background checks are re-checked yearly for out of state employees	Nursing Director, Manager will review for current records yearly. R225 accepted by Jo A Evans RN on 4/15/2026
R358 6.10	Nursing Director reviewed HIPAA and policy for disposal of personal information with all staff.	A new shredder was purchased.	3/1/26	Manager will check daily when on site for proper disposal of all personal information, medication cards, etc.	Manager R358 accepted by Jo A Evans RN on 4/15/2026
R403 9.1.c	1) Licensee will review options with Maintenance Staff and decide on whether to replace floor or deep clean and repair	All areas noted by surveyor have been corrected by the Maintenance man	4/11/26	Manager will report any needs to the Licensee and Maintenance man for repairs as they occur.	Manager

R403 9.1.c cont.	2) Has a lock on it as of 2/25/26. Maintenance is installing new handrail, correcting brick and cement areas and debris will be removed		5/1/26		Manager will supervise and report to Program Director along with Maintenance Staff
R403 9.1.c cont.	3) Dust was removed on 2/24/26		2/24/26	Manager will check weekly and make sure area free of dust. Staff was made aware and it is daily task list.	Manager
R403 9.1.c cont.	4) Seat to stair chair is being checked by maintenance and will be corrected to be lifted up in fixed position when not in use to allow easy access to stairs.		5/1/26	Manager is supervising completion	Manager
R403 9.1.c cont.	5) Walls are being patched and painted		3/20/26	Manager is supervising completion	Manager
R403 9.1.c cont.	6) On 2/25/26 transition molding was put between foyer and dining area.		2/25/26	Manager checking to make sure transition stays in place	Manager R403 accepted by Jo A Evans RN on 4/15/2026
R430 9.6.d	Water checking policy was reviewed with all staff.	Overnight staff will check all water temperatures by 7am daily and report to maintenance if too cold or too hot. On 2/24/26 Maintenance corrected temperatures to be between 110 degrees F and 120 degrees F	2/25/26	Manager will check on temperature documentation daily and report to maintenance if correction is needed.	Manager R430 accepted by Jo A Evans RN on 4/15/2026

Corrective Actions for all tags cited accepted by Jo A Evans RN on 4/15/2026