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 22, 2026

Lydia Raymond, Manager
The Residence At Quarry Hill
465 Quarry Hill Road
South Burlington, VT 05403

Dear Ms. Raymond:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 16, 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

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
	1012	A. BUILDING: _____ B. WING _____	C 03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE RESIDENCE AT QUARRY HILL	465 QUARRY HILL ROAD SOUTH BURLINGTON, VT 05403

(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 3/16/2026 the Division of Licensing and Protection conducted an unannounced on-site annual survey and an investigation of one facility reported incident. The following deficiencies were identified:	R100	Corrective actions for all tags, R194, R205, R210, R215, R358, R366, R381, R382, R388, R403, and R443, are accepted by Jo A Evans RN on 4/22/2026.	
R194 SS=F	5.10.d (3) Medication Management The registered nurse must accept responsibility for the proper administration of medications, and is responsible for: i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects; ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications; iii. Assessing the resident's condition and the need for any changes in medications; and iv. Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions regarding medication administration and documentation. v. Ensuring that all applicable staff are trained and delegated before the staff are permitted to administer any newly prescribed medication to any resident. This REQUIREMENT is not met as evidenced by: Based on staff interview there is a failure to ensure the Registered Nurse teaches designated staff the proper techniques for medication administration. Findings include:	R194	Please see the attached document to review all accepted corrections.	

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R194	Continued From page 1 1. The home's Vermont Med Tech Training packet states in order to be authorized to assist in administering medications a Med Tech must complete steps including, but not limited to, "physically and verbally demonstrate to the Nurse that you have the knowledge, skills and judgement required to read and follow medication orders the eMar [sic], and to administer the medications to the resident(s) you support. This is accomplished with 3 face-to-face supervised med passes ". The home's Staff Training policy states, " Medication Assistance Training. Staff members who assist with medications must be trained by the RN/Nurse/MT on medication assistance procedures, with the RN/Nurse delegating the responsibility for the administration of medications to designated staff members." At 1:50 PM on 3/16/26 the Executive Director confirmed the home's medication administration training process includes Med Tech trainees preparing and administering medications to residents of the home under the supervision and oversight of delegated Med Techs prior to the Registered Nurse delegating the trainee to perform the nursing task of administering specific medications to designated residents. 2. The home's Assisting with Routine Medications policy states,"Hand the medication cup to the resident. Be sure to observe the resident taking his/her medication. Do not leave the medication with the resident for him/her to take at a later time." Per record review, the Resident Assessment on file for Resident #1 signed by the Registered	R194		

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R194	Continued From page 2 Nurse on 12/4/2025 indicates this Resident has short term memory impairment, requires full caregiver assistance with medication administration, and is always complaint with taking their medications. Resident #2's record includes a Resident Assessment signed by the Registered Nurse on 12/4/2025 which indicates this Resident also requires full caregiver assistance with medication administration and is always compliant with taking their medications. Per staff interview and record review, Resident #1 and Resident #2 reside in different apartments in the home. Per interview with the Executive Director commencing at 3:48 PM on 3/16/2026, and per record review, on the evening of 1/5/2026 a Med Tech entered Resident #1's apartment where Resident #1 and Resident #2 were spending time together. The Med Tech brought 2 cups of medication to the apartment, including a cup of medications prepared for Resident #1 and a cup of medications prepared for Resident #2. The Med Tech left the cups containing medications prepared for both Residents in Resident #1's apartment, and exited without witnessing the Residents taking their medications. Resident #1 ingested the medications in both cups, which resulted in Resident #1 taking medications prescribed to Resident #2 to treat Atrial Fibrillation including 250 mg of Dofetilide (Antiarrhythmic medication) and 20 mg of Xarelto (Anticoagulant medication) in additional to their own scheduled medications. This medication error was discovered on the night of 1/5/2026 when Resident #2 requested their medications. In response to the error, Resident #1 was transported via ambulance to the emergency department where they were monitored for side effects of the accidental ingestion of prescribed	R194		

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R194	Continued From page 3 medications belonging to Resident #2. During an interview commencing at 4:58 PM on 3/16/2026, Resident #1 confirmed the Med Tech placed 2 cups of medication on a table in their apartment and exited before they ingested the medications in both cups. During the interview commencing at 3:48 PM on 3/16/2026 the Executive Director confirmed that on the evening of 1/5/2026 a medication error occurred when a Med Tech left medications belonging to Resident #2 in Resident #1's apartment and exited the apartment without witnessing Resident #1 and Resident #2 taking their medications.	R194		
R205 SS=F	5.10.h (3) Medication Management Residents who are capable of self-administration may choose to store their own medications provided that either they or the home is able to provide the resident with a secure storage space to prevent unauthorized access to the resident's medications. Whether or not the home is able to provide such a secured space must be included in the uniform consumer disclosure and in the admission agreement and must be explained to the resident on or before admission. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, there is a failure to ensure secure storage of medications belonging to one applicable resident capable of self-administration (Resident #3). Findings include:	R205		

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R205	Continued From page 4 The home's Centrally Stored Medications policy includes a section entitled Self-Administered Medications which states, "If a resident is self-administering his/her medications, all of his/her medications (both prescription and over-the-counter) must be stored in a locked container or cabinet in his/her apartment." This policy further states, "If the resident has a private apartment and agrees to keep the door to the apartment kept locked when he/she is not in the apartment, a separate locking container is not needed The residence is home to multiple residents with cognitive impairment with varying ability to safely managing access to unsecured medications. At 9:57 AM on 3/16/2026 unsecured medication were observed in Resident #3's apartment including Voltaren Arthritis Pain Reliever 1% topical gel, Prevagen For Your Brain Regular Strength Nutritional Supplement, Extra Strength Beano, Coricidin HBP Softgels, Neosporin Ointment, Metamucil 4-in-1 Fiber, Nystatin Topical Powder, and Calmoseptine ointment. At 4:00 PM Resident #3's apartment was observed to be unlocked and unattended. These findings were confirmed by the Executive Director on the afternoon of 3/16/2026.	R205		
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,	R210		

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R210	Continued From page 5 provided the home maintains documentation of the training and ensures competency in the subject matter. The training must include, but is not limited to, the following: (1)Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; (7) General supervision and care of residents; (8)Communication strategies, person-centered care, challenging behaviors and understanding dementia; (9) Recognition of and sensitivity to different cultures, belief systems, abilities, gender identities, sexual orientation; and (10) Trauma-informed care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, all 5 sampled staff did not complete the required training. Findings include: The facility's procedure, verbalized by the Executive Director, is consistent with the licensing rules. Documentation of training completed by 5	R210		

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R210	Continued From page 6 sampled staff was requested at 12:38 PM on 3/16/2026. Per review of the documentation provided, the required annual trainings were not completed by 1 out of 5 sampled staff. This was confirmed by the Executive Director of the facility at 5:30 PM on 3/16/2026.	R210		
R215 SS=F	5.11.e (4) Staff Services All background checks must be rechecked based on facility policy. The policy must include, at a minimum an annual re-check of Vermont criminal and abuse registries, and an annual re-check of all jurisdictions if a staff member has worked or lived in another state since the initial background check was completed and/or does so on a regular basis, and at any time any employee or caregiver notifies the home of a conviction or substantiation. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, there is a failure to ensure that applicable criminal and abuse registry checks were completed as required for 2 out of 5 sampled staff. Findings include: The facility's background check procedures, as verbalized by the Executive Director, are consistent with the licensing rules. Documentation of criminal and abuse registry checks completed on 5 sampled staff was requested at 12:38 PM on 3/16/2026. Per review of the documentation provided, the required annual checks of applicable criminal and abuse	R215		

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R215	Continued From page 7 registries were not completed by the facility for 2 out of 5 sampled staff. This finding was confirmed by the Executive Director of the facility at 5:30 PM on 3/16/2026.	R215		
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 staff interview and observation, there is a failure to ensure the right to privacy for all residents of the home related to the storage of personal health information. Findings include: During a tour of the facility commencing at 9:50 AM on 3/16/2026, personal health information was observed to be unprotected and accessible. The Therapy Services Office on the first floor was observed to be unlocked, and contained a white board with resident names and weights. Additionally, there were community health screening records visible in this office. The Therapy Services Office is located in an area of the facility that is open and accessible to residents and guests.	R358		

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R358	Continued From page 8 This was confirmed by the Executive Director of the home on the afternoon of 3/16/2026.	R358		
R366 SS=F	6.18 Resident's Rights The enumeration of residents ' rights will not be construed to limit, modify, abridge or reduce in any way any rights that a resident otherwise enjoys as a human being or citizen. A copy of the Residents Rights set forth in this section must be written in clear language, large print (font size 18), given to residents on admission, and posted conspicuously in a public place in the home. The home's grievance procedure and directions for contacting the Office of the Long-Term Care Ombudsman and Disability Rights Vermont also must be written in the same font size, provided to each resident, and posted in the same location as the statement of Residents ' Rights. This REQUIREMENT is not met as evidenced by: Based on staff interview and observation, there is a failure to ensure the facility's grievance procedure is posted in the same location as the statement of Residents Rights. Findings include: The facility's grievance procedure is consistent with the licensing rules. During the tour commencing at 9:50 AM on 3/16/2026, it was observed that the facility's grievance procedure is posted in a public place of the facility, but it was not posted alongside the Residents Rights.	R366		

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R366	Continued From page 9 This was acknowledged by the Executive Director at 5:30 PM on 3/16/2026.	R366		
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, there is a failure to ensure all food is free from spoilage, all opened goods are labeled with the date it was opened, and that cans with dents are rejected and kept separate until returned to the supplier. Findings include: 1. During a tour of the facility, commencing at 9:50 AM on 3/16/2026, there were eight #10 cans and two small cans observed to have dents stored in the pantry adjacent the kitchen. Additionally, multiple boxes of Farina, Cream of Wheat, and Matzos that were observed to be expired in this pantry. 2. Per observation, the following expired perishable foods were observed in Country Kitchen on the 4th floor of the facility: a. Cream of tartar expired 6/10/2025 b. Corn starch expired 9/05/2025 c. Goldfish crackers expired 12/07/2025	R381		

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R381	Continued From page 10 d. Marshmallow Fluff expired 7/07/2025 This was acknowledged by the Executive Director of the facility at 5:30 PM on 3/16/2026.	R381		
R382 SS=F	7.2.b Food Safety and Sanitation 7.2.b All perishable food and drink must be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. (3) Staff must monitor the temperature of temperature-controlled food storage areas. Staff must conduct regular temperature checks of prepared food to ensure proper food safety and must document the time and results of each check. The U.S. Department of Agriculture provides guidance for time and temperature curves to ensure prepared foods remain outside of the 'danger zone' for food safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure perishable items in the residences' main kitchen are labeled and dated and required. Findings include: During a tour of the residence commencing at 9:50 AM on 3/16/2026 opened perishable items were observed in the 3rd floor Bistro and 2nd floor main kitchen without the required labeling including: 1. In the main kitchen multiple unsealed plastic bags of frozen foods were observed in a small	R382		

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R382	Continued From page 11 reach in freezer without labels identifying the foods contained within them and the dates the bags were opened. 2. Opened undated perishable items observed in the main kitchen's walk-in freezer included: a. bag of falafel fritters b. an unsealed bag of tortellini without an identifying label indicating the type of filling in the pasta c. boxes containing unsealed bags of meatballs and chicken breast d. an unlabeled plastic bag containing what appeared to be chicken breast e. individually wrapped unlabeled foods that appeared to be red meat and vegetables bundled in plastic wrap f. an opened undated bag of shrimp. These findings were confirmed by the Restaurant Operations Director during the tour of the Main Kitchen conducted on the morning of 3/16/2026. 3. An unlabeled squeeze bottle containing a thickened fluid that appeared to be simple sugar syrup and opened bottles of bitters were observed in a rolling cart stored in the hallway adjacent to the Bistro Kitchen. 4. Open undated perishable items observed in the 4th floor Country Kitchen included dates, meringue powder mix, dried cranberries, vanilla ice cream, green beans, frozen berries, and frozen broccoli. There findings were acknowledged by the Executive Director on the afternoon of 3/16/2026.	R382		

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R388	Continued From page 12	R388		
R388 SS=F	7.3.c Food Storage and Equipment All Food service equipment must be kept clean and maintained according to manufacturer's guidelines. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure food service equipment in the home's main kitchen is kept clean. Findings include: During a tour of the home's main kitchen commencing at 10:10 AM on 3/16/2026 kitchen equipment including the ice cream freezer, a reach in freezer, service carts, a hand washing sink, grills, ovens, the stovetop, a two basket fryer, the cutting board on top of a prep unit and a red fan circulating air in the food prep area were observed to be in need of cleaning. The Restaurant Operations Director confirmed these findings during the kitchen tour conducted on the morning of 3/16/2026. The cleaning procedures checklist provided for review on request for the home's policies and procedures governing cleaning and maintenance of kitchen equipment does not include procedures for cleaning and maintaining the kitchen equipment observed to be in need of cleaning during the kitchen tour conducted on the morning of 3/16/2026.	R388		
R403 SS=F	9.1.c Environment The home must ensure that the resident environment remains as free of accident hazards	R403		

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R403	Continued From page 13 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 staff interview and observation, there is a failure to ensure the resident environment remains as free of accidents and hazards as possible. Findings include: Policies and procedures governing this area of service were not provided for review upon request. During a tour of the facility, commencing at 9:50 AM on 3/16/2026, the following items were observed to be unsecured and pose a potential hazard to the facility's residents: a. A can of butane fuel and chef's knife in the Bistro Kitchen on the 2nd floor b. Knives in the Country Kitchen on the 4th floor c. A can of furniture polish in a shared bathroom on the 4th floor d. Unsecured chemicals in the Therapy Services office and the Bistro Kitchen e. Oxygen was observed to be in use on the 4th floor without appropriate signage on the door of the resident's room f. Cleaning chemicals including Windex and Clorox Disinfecting Cleaner were observed to be	R403		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1012	A. BUILDING: _____ B. WING _____	C 03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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R403	Continued From page 14 unsecured in Resident #3's apartment during the facility tour on 3/16/2026. This Resident's apartment door was observed to remain unlocked while Resident was not present in the apartment at 4:00 PM on 3/16/2026. There are residents with varying cognitive abilities in the home who have access to these areas. These findings were acknowledged by the Executive Director at 5:30 PM on 3/16/2026.	R403		
R443 SS=F	9.11.d Disaster and Emergency Preparedness There must be an operable telephone on each floor of the home, available to residents at all times. A list of emergency telephone numbers must be posted by each telephone. This REQUIREMENT is not met as evidenced by: Based on staff interview and observation, there is a failure to ensure an operable telephone with a list of emergency numbers were available to residents at all times on each floor of the facility. Findings include: The facility does not have a current policy or procedure governing resident access to telephones on each floor of the home at all times. During the facility tour, commencing at 9:50 AM on 3/16/2026, it was observed that the facility did not have an operable telephone, with a list of emergency phone numbers by each phone, on all floors of the residence. This was confirmed by the Executive Director at	R443		

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R443	Continued From page 15 5:30 PM on 3/16/2026.	R443		

Deficiency Statement Plan of Correction (POC)

Survey Date: 3/16/26

Facility Name: The Residence at Quarry Hill

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
R194	The medication error involving resident #1 and resident #2 was immediately addressed. Resident #1 was assessed, the physician and family were notified, and the resident was transported to the emergency department for evaluation. Resident #2 received medications per the physician's direction. Staff involved were immediately re-educated on proper medication administration practices, including not leaving medications unattended and ensuring direct observation of ingestion.	An audit of all residents receiving medication assistance was completed. Re- education on proper medication administration was completed for the 6 rights of entry to ensure compliance with policy. No additional concerns were identified.	3/20/26	All medication technician associates were retrained on the 6 rights of medication administration and required to complete competency validation before resuming independent medication administration. Policy was reinforced, requiring associates to administer medications to one resident at a time and remain with the resident until ingestion is confirmed. Med Tech trainees are no longer permitted to administer medications independently until the Registered Nurse delegation is complete.	The Registered Nurse and Executive Director will complete a random medication pass observation to ensure compliance.
R205	Resident #3's medications were immediately secured in a locked container. The RN reassessed the resident's ability to safely self-administer medications and updated the care plan accordingly. the care plan accordingly.	An audit of all residents approved self-administration was completed to ensure medications are stored securely. Any unsecured medications identified were immediately secured.	3/20/26 and 4/2/26	Policy requires all self-administered medications to be stored in a locked container or secure environment. Associates were re-educated on monitoring requirements and documentation of resident self-administration assessments.	Registered Nurse/ designee

R210	The identified associate, who had not completed the required annual training, was scheduled to complete it.	An audit was completed to ensure all associates completed their required annual training. No additional concerns were identified.	3/20/26	A weekly tracking system was implemented to monitor associate training requirements and due dates. The leadership team will receive monthly reports to ensure compliance.	Business Office Director/ designee
R215	Background and abuse registry checks for the identified associate were completed.	An audit of all associates files was conducted to ensure all required background and registry checks were completed. Any missing documentation was obtained.	4/2/26	A tracking system was implemented to ensure that annual background and registry checks are completed timely.	Business Office Director/ designee
R358	The Therapy office was secured. All visible protected health information was removed or secured to prevent public access.	A community-wide audit was conducted to identify any areas where protected health information may be accessible. No additional concerns were identified.	3/17/26	Associates were re-educated on HIPAA and resident privacy requirements. Policies were reinforced regarding securing offices and protected health information at all times.	Registered Nurse, Executive Director/ designee, through routine environmental rounds.
R366	The grievance procedure was immediately posted alongside the Resident Rights in a visible public area.	All required postings throughout the community were reviewed to ensure compliance.	3/17/26	Leadership was educated on posting requirements to ensure all required postings remain in place and visible.	Executive Director/ designee through environmental rounds.
R381	All expired food items and dented cans were immediately removed and discarded. A full inspection of all food storage areas was completed.	An audit of all food storage areas was conducted. Any expired or compromised items were removed immediately.	3/16/26	Policies were reinforced, requiring routine inspection of food items and proper storage. Culinary associates were re-educated on food safety standards.	Restaurant Operations Director/ designee

R382	All unlabeled and undated food items were immediately discarded or properly labeled and dated.	A full audit of the kitchen and storage areas was completed. All food items were reviewed for proper labeling.	3/16/26	Policy reinforced requiring all food items to be labeled and dated upon opening. Associates were re-educated on food labeling requirements.	Restaurant Operations Director/ designee
R388	All kitchen equipment was cleaned and sanitized immediately. A deep cleaning of the kitchen was completed.	All kitchen equipment and prep areas were audited for cleanliness and corrected as needed.	3/16/26	A detailed cleaning schedule was implemented for all equipment. Associates were re-educated on cleaning procedures.	Restaurant Operations Director
R403	All hazardous items were immediately secured. Oxygen signage was posted, and safety concerns were corrected.	A community-wide environmental safety audit was conducted. All identified hazards were corrected immediately.	3/17/26	Weekly environmental safety checks were implemented. Associates were re-educated on hazard prevention and safety protocols.	Resident Care Director/ Executive Director/ designee
R443	Operable telephones with posted emergency numbers were placed on each floor.	A community-wide check confirmed all required phones were in place and operational.	3/18/26	Routine checks added to maintenance responsibilities.	Maintenance Director/ designee

Corrective actions for all tags, R194, R205, R210, R215, R358, R366, R381, R382, R388, R403, and R443, are accepted by Jo A Evans RN on 4/22/2026.