VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
www.dlp.vermont.gov

[phone] 802-241-0344
[fax] 802-241-0343

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

July 1, 2026

Cassandra Quesnel, Manager
Shard Villa
1177 Shard Villa Road
Salisbury, VT 05769-9588

Dear Ms. Quesnel:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **May 27, 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
	0152	A. BUILDING: _____ B. WING _____	C 05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARD VILLA	1177 SHARD VILLA ROAD SALISBURY, VT 05769

(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 5/27/2026 the Division of Licensing and Protection conducted an unannounced on-site investigation of one facility reported incident and one complaint. The following deficiencies were identified.	R100		
R181 SS=D	5.10.a (3) Medication Management Each home must have written policies and procedures describing the home's medication management practices. The policies must cover at least the following: (3) How Medications will be obtained for residents, including choices of pharmacies. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure policies were in place for obtaining resident medications from an "outside" pharmacy. Findings include: The facility's Policy and Procedure for Medication Storage and Waste require medications to be stored in locked compartments and that only authorized personnel shall have access to the keys. Per record review of Resident #1's progress notes, on 1/10/2026 the facility's Registered Nurse was made aware of a missing bottle of Gabapentin 300mg capsules prescribed to Resident #1. The total number of capsules missing is 84. Resident #1 receives their medications via a pharmacy other than the facility's "partnered pharmacy". The facility did not	R181		

Jessica Quesal, RN Director 6.30.26

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R181	Continued From page 1 have policies or procedures regarding the handling of medications received from outside pharmacies at the time of this incident. The facility has since created policies and procedures for the handling of these medications. The Registered Nurse/Interim Manager confirmed these findings on the afternoon of 5/27/2026.	R181		
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 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	R210		

Cassie Sweet, RN Director 6.30.26

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R210	Continued From page 2 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, the facility failed to ensure documentation of required staff training was available for 4 of 5 sampled staff. Findings include: The facility's policy regarding staff training is consistent with the licensing rules. On the morning of 5/27/2026, training documentation for 5 sampled staff was requested. Review of the provided documentation indicated that 4 direct care staff lacked evidence of completion of required training. These findings were acknowledged by the Interim Manager of the facility on the afternoon of 5/27/2026.	R210		

Cassie Quesnel, RN Director 6.30.26

Deficiency Statement Plan of Correction (POC)

(Please use additional pages if needed)

DLP Use Only:

Survey Date: May 27, 2026

Facility Name: Shard Villa

Deficiency Tag:	R181
How the deficiency was corrected:	A policy and procedure for receiving mail order medications was created and reviewed with all staff at staff meeting.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	An audit was completed of all resident charts to identify those that use an outside pharmacy rather than the facility pharmacy of choice
System changes to ensure compliance with the regulation:	The current P&P for receiving medications from outside pharmacy was amended June 18, 2026 to include a quarterly review to ensure compliance
Date corrected:	06/18/2026
Who will monitor to ensure compliance:	Executive Director
DLP Use Only	R181 - Accepted on 07/01/2026 by YA

Deficiency Tag:	R210
How the deficiency was corrected:	Direct care staff identified as incompliant have completed their education hours with the Registered Nurse
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	A review of all direct care staff was completed, all staff that had not completed the 12 hours of education were set to complete the required hours with the RN.
System changes to ensure compliance with the regulation:	All education hours were previously tracked and paper documented. Following audit and findings of missing education sign offs a spread sheet was created by RN to digitally track staffing completion. P&P for new employee orientation was amended to include scheduled education completion with RN prior to providing direct care on the floor.
Date corrected:	06/15/2026
Who will monitor to ensure compliance:	Registered Nurse
DLP Use Only	R210 - Accepted on 07/01/2026 by YA