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

July 15, 2026

Shannon Robtoy, Manager
Ethan Allen Residence
1200 North Avenue
Burlington, VT 05408-2777

Dear Ms. Robtoy:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 29, 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
	0128	A. BUILDING: _____ B. WING _____	C 06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ETHAN ALLEN RESIDENCE	1200 NORTH AVENUE BURLINGTON, VT 05408

R159 and R342 Accepted
7-15-26 Susan 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 June 29, 2026, the Division of Licensing and Protection conducted an unannounced on-site annual re-licensure survey and an investigation of one complaint. The following regulatory deficiencies were identified:	R100	★ Please see attached deficiency statement plan of correction form	
R159 SS=D	5.9.c (2) Nursing Services For each resident requiring a nursing overview, administration of medication, or nursing care, the registered nurse must: Develop a person-centered written plan of care within 14 days after admission, in accordance with the nursing process and professional standards of practice, for each resident that is based on abilities and needs as identified in the resident assessment. The resident, and if the resident chooses, resident representatives such as family or close supports, must be invited and allowed to participate in care planning meetings. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being, and must be revised as the resident?s abilities and needs change This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the home failed to develop an updated, person-centered plan of care for one applicable Resident (Resident #1), including individualized goals and interventions to support the Resident's incontinence needs. Findings include:	R159		

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R159	Continued From page 1 The home's "Resident Assessments and Care Plans" policy states that a plan of care must describe the care and service necessary to assist the resident to maintain independence and well-being and must be revised as the resident's abilities and needs change. Per observation conducted on the morning of June 29, 2026, a strong odor consistent with urine was present in the common hallway outside Resident #1's room and remained noticeable upon entering Resident #1's room. Per record review conducted on the morning of June 29, 2026, Resident #1's care plan identified the Resident as having physical and cognitive impairments, urinary incontinence, impaired judgment related to physical abilities, and a recurrent history of falls. The Resident's care plan identified that the Resident required staff assistance with toileting needs and incontinence care. However, it did not identify individualized interventions describing how staff were to provide that assistance. Specifically, the plan did not include interventions related to scheduled toileting, routine toileting checks, or monitoring associated with the Resident's urinary incontinence, nor did it include individualized interventions addressing the Resident's cognitive impairment, impaired judgment, and history of falls as they related to toileting and incontinence management. Additionally, the care plan did not include individualized environmental or housekeeping interventions to address the Resident's ongoing urinary incontinence to maintain a clean and sanitary living environment. Per staff interview conducted with the Manager on the morning of June 29, 2026, the Manager confirmed there was a urine odor in the common	R159		

Administrator 7/9/2026

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R159	Continued From page 2 hall area outside Resident #1's room. Per staff interview conducted with the Registered Nurse on the morning of June 29, 2026, the Registered Nurse acknowledged there was an odor in Resident #1's room consistent with the Resident's urinary incontinence. The Registered Nurse further acknowledged that Resident #1's care plan required revisions to include individualized interventions addressing the Resident's urinary incontinence and measures to maintain a clean and sanitary living environment.	R159		
R342 SS=F	5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy must be available at the home for review upon request by residents and their representatives, advocacy organizations and the licensing agency. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the licensee failed to develop written policies and procedures governing hospice-related services provided by the home. Findings include: Per observation conducted during the morning and afternoon of June 29, 2026, care staff were observed providing care to residents receiving hospice services, including assistance with activities of daily living, meal setup, assistance and observation during meal intake, and ongoing interaction with hospice residents and family members regarding resident care.	R342		

Administrator 7/9/2026

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R342	Continued From page 3 Per staff interview conducted with the Manager on the morning of June 29, 2026, the Manager stated that eight residents residing in the home were receiving hospice services and that two additional residents were scheduled to begin receiving hospice services. Per staff interview conducted with the Manager and the Registered Nurse on the afternoon of June 29, 2026, the licensee was requested to provide written policies, procedures and staff training governing hospice-related services provided within the home. The Manager and Registered Nurse acknowledged that the home had not developed written hospice policies or procedures and was unable to provide hospice training documentation upon request.	R342		

Sheena TG Administrator 7/9/2026

Deficiency Statement Plan of Correction (POC)

(Please use additional pages if needed)

DLP Use Only:

Survey Date: 6/29/2026

Facility Name: Ethan Allen Residence

Deficiency Tag:	R159
How the deficiency was corrected:	Resident #1's care plan will be reviewed and updated to match their clinical picture and encompass all aspects of services provided.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	The RN will review all resident's care plans to ensure they are up to date and encompass all aspects of services that are provided.
System changes to ensure compliance with the regulation:	Care plan policy reviewed and updated as well as education to nursing staff.
Date corrected:	8/8/26
Who will monitor to ensure compliance:	DON
DLP Use Only	R159 Accepted 7-15-26 Susan Gregoire RN

Deficiency Tag:	R342
How the deficiency was corrected:	New policy put in place to focus specifically on hospice services and in service for entire facility staff.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	Hospice specific policy was put into place along with in service and education to all staff.
System changes to ensure compliance with the regulation:	New policy put in place to focus specifically on hospice services and in service for entire facility staff. Hospice education to be provided to staff annually and as needed.
Date corrected:	8/8/26
Who will monitor to ensure compliance:	DON
DLP Use Only	R342 Accepted 7-15-26 Susan Gregoire RN