VERMONT

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

Kathleen Michaels, Manager
Our Lady Of Providence
47 West Spring Street
Winooski, VT 05404-1397

Dear Ms. Michaels:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 22, 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
	0198	A. BUILDING: _____ B. WING _____	06/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PROVIDENCE	47 WEST SPRING STREET WINOOSKI, VT 05404

R105, R190, R381 & R403
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 22, 2026, the Division of Licensing and Protection conducted an unannounced on-site annual re-licensure survey. The following deficiencies were identified:	R100		
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		

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathleen Michaels
TITLE: Administrator
(X6) DATE: 7/9/2026

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R105	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the licensee failed to ensure a Uniform Consumer Disclosure was completed on the form provided by the licensing agency and maintained on file, as required by state licensing rules. Findings include: On the morning of June 22, 2026, the Manager was requested to provide a copy of the licensee's Uniform Consumer Disclosure for review. Per staff interview conducted with the Manager on the morning of June 22, 2026, the Manager stated the licensee had not completed the required Uniform Consumer Disclosure on the form provided by the licensing agency. The Manager acknowledged the required form had not been implemented and stated it would be incorporated into the licensee's admission process.	R105		
R190 SS=D	5.10.b Medication Management The manager of the home is responsible for ensuring that all medications are handled according to the home's policies and that designated staff are fully trained in the policies and procedures. This REQUIREMENT is not met as evidenced by:	R190		

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R190	Continued From page 2 Based on observation, staff interview, and record review, the Manager of the home failed to ensure medications were handled in accordance with the home's medication policies and procedures. Findings include: The home's "Bedside Medication Storage" policy states that medication stored at the bedside is reordered in the same manner as other medications and the nursing staff is responsible for proper rotation of bedside stock, reordering, and removal of expired medications. Additionally, the policy states that at least once during each shift the nursing staff checks for usage of the medications by the residents and all nurses and aides are required to report to the charged nurse on duty any medications found at the bedside not authorized for bedside storage. The home's "Labeling of Medications Reviewed from Pharmacy" policy states that medications are identified with the resident's name, apartment ID, the name of the drug, the strength of the drug, directions for administration of the drug, and time of day sticker. "Labeling of Stock Over the Counter Medication" policy states that each medication will have an expiration date on the container itself. The home policy includes a monthly check that consists of confirming the accuracy of each medication as compared to the most current physician's order, including the name, strength, dose, route, frequency, and time of administration. During a medication review conducted at approximately 1:54 PM on June 22, 2026, Resident #1 was confirmed to be self-administering medications and stated they did not use all the medications maintained in their private bathroom. Observation of Resident #1's medication cabinet in their private bathroom	R190		

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R190	Continued From page 3 revealed expired medications; multiple unlabeled and unidentifiable medication containers lacking identifying information, including the medication name, strength, dosage instructions, and administration directions; and an unused, expired, antibiotic. Observation of Resident #1's bathroom medication baskets revealed expired medications and unlabeled medications that Resident #1 stated were no longer in use, and medications for which no current written provider orders were available. Per interview conducted with the Health Services Director on the afternoon of June 22, 2026, the Health Services Director confirmed the observed findings in Resident #1's bathroom medication baskets and medication cabinet, confirm the medications maintained by Resident #1 had not been reviewed, and stated that a review of medications maintained by all residents who self-administer medications would be completed following the survey.	R190		
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	R381		

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R381	Continued From page 4 properly labeled and dated and stored in 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 June 22, 2026, multiple food items were observed to be unlabeled, undated, expired, or otherwise not maintained in a sanitary condition. Findings included, but were not limited to, multiple unlabeled food items, including potato salad, cookies, garlic, fruit, vegetables, and salad bar ingredients; expired yogurt stored in the refrigerator and available for resident use; and four 28-ounce cans of fire roasted peppers stored in the food storage area that exhibited compromised container integrity, with the cans ruptured. The effective cans also exhibited dents and did not have legible expiration dates. These food items were stored in common kitchen and food storage areas where food was maintained for resident use. These findings were acknowledged by the Manager on the afternoon of June 22, 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 5 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 safe storage of chemical agents in an area of the home accessible to residents with cognitive impairment. Findings include: The home's policy on the storage of chemical agents aligns with applicable state rules. During a tour of the home conducted on the morning of June 22, 2026, multiple hazardous chemical agents were observed stored in unsecured, unlocked locations throughout the home that were accessible to residents with cognitive impairments. Specifically, hazardous chemical agents were observed in an unlocked wooden cabinet located in the kitchen serving area, which was accessible through an unlocked door; an unlocked closet in the kitchen storage area, where cleaning products were stored near food preparation areas; the salon; an unlocked staff room; and on the counter in the nurse's station. The hazardous chemical agents observed included glass cleaner, floor finish, disinfecting bleach wipes, powdered abrasive cleanser, insect repellent, and stainless-steel cleaner. These hazardous chemical agents were accessible to vulnerable adults with cognitive impairments residing in the home. These findings were acknowledged by the home's Manager on the afternoon of June 22, 2026.	R403		

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Deficiency Statement Plan of Correction (POC)

(Please use additional pages if needed)

DLP Use Only:

Survey Date: 6/22/26

Facility Name: Our Lady of Providence

Deficiency Tag:	R105 Uniform Consumer Discloser – Admit agreement
How the deficiency was corrected:	Every new move in will be given a copy of Admit Agreement
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	Every time we admit a new resident we will give them a copy of this agreement and place a copy in their folder.
System changes to ensure compliance with the regulation:	We have corrected the new admitting policy to ensure that this form will be given to every new resident admitted.
Date corrected:	6/23/2026
Who will monitor to ensure compliance:	The Administrator will review to make sure that the agreement is correct. and given
DLP Use Only	R105 Accepted 7-15-26 Susan Gregoire RN

Deficiency Tag:	
How the deficiency was corrected:	
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	
System changes to ensure compliance with the regulation:	
Date corrected:	
Who will monitor to ensure compliance:	

Deficiency Statement Plan of Correction (POC)

(Please use additional pages if needed)

DLP Use Only:

Survey Date: 6.22.26

Facility Name: Our Lady of Providence

Deficiency Tag:	R190 SS=D
How the deficiency was corrected:	Immediately, Resident #1's bedside and bathroom medications were reviewed by nursing. Expired medications, unlabeled/unidentifiable medications, discontinued medications, and medications without current provider orders were removed and disposed. The resident's current medications were reconciled with active provider orders, and only properly labeled, authorized medications were returned for self-administration.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	Meeting with 5 residents who self admin held 6.24.26 to review current practice, survey results, and changes to be implemented. (with 6th resident on 7.6.26 when returned from personal leave) Medications and treatments in apartments reviewed with all self-administering residents 6.22.26-7.6.26 Medications and treatments not used, disposed with HD Pharmacy.6.22.26-7.6.26 Medication and treatments residents wish to continue but need orders – stored in locked nurse office closet and orders requested from PCP 6.24.26-currently pending Self-Administration Assessment annually and with significant changes, meeting with Point Click Care 7.7.26 and 7.8.26 to improve assessment. Licensed nursing staff and Medication Assistants were re-educated on the facility's policies regarding bedside medication storage, medication labeling, monthly medication reconciliation, removal of expired medications, and documentation requirements. The monthly self-administration medication audit process was reinforced, and a tracking tool was implemented to verify completion and Health Services Director oversight.
System changes to ensure compliance with the regulation:	Policy update – 1. Residents to sign agreement: 2. Annual self-administration assessment – Facility RN 3. Annual provider order (standing orders) to approve self-administration 4. Residents to keep medications and treatments in one secure location 5. Order Summary kept with medications and treatments 6. Resident to utilize MAR montly 7. Resident to review medications, treatments, and MAR with staff nurse once monthly during pharmacy monthly cycle change 8. Residents understand must have provider orders for all OTC, Medications, and treatments 9. If residents purchases OTC, will bring to OLP nurse for assistance receiving order. Will be stored in locked nurse closet until order received.
Date corrected:	6.22.26-currently pending. Will be finalized 7.31.26
Who will monitor to ensure compliance:	Staff Nurse, Director of Nursing, Care Home Manager
DLP Use Only	R190 Accepted 7-15-26 Susan Gregoire RN

Survey Date: 6/22/26

Facility Name: Our Lady of Providence

Deficiency Tag:	R 381 Food Safety and sanitation
How the deficiency was corrected:	All perishable food and drink have been properly labeled, dated and held at proper temperatures.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	We created labels for every item in the salad bar. Everything now that is not in its original container has a label stating what it is and when it was opened. All food not labelled will be disposed of. All food that is labelled and dated will be checked by staff daily. And removed if it has expired. When an order arrives either the Chef or the Sous Chef will check the cans to see if they have any dents. They will then be placed in a separate spot awaiting a return to the vendor.
System changes to ensure compliance with the regulation:	A notice was hung up to remind staff of the proper protocols. The Chef is holding weekly meetings to remind his staff to follow the policies daily
Date corrected:	6/23-6/25
Who will monitor to ensure compliance:	The Chef and the Sous Chef
DLP Use Only	R381 Accepted 7-15-26 Susan Gregoire RN

Deficiency Tag:	
How the deficiency was corrected:	
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	
System changes to ensure compliance with the regulation:	
Date corrected:	
Who will monitor to ensure compliance:	
DLP Use Only	

Survey Date: 6/22/26

Facility Name: Our Lady of Providence

Deficiency Tag:	R403 9.1c Environment
How the deficiency was corrected:	Unsecured chemicals in all departments were moved to various locked cabinets away from the immediate reach of residents.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	One cabinet that didn't have a lock was given one to ensure that everything is now locked up. Staff are instructed to keep everything locked up, unlocked while in use and then promptly locked back up again.
System changes to ensure compliance with the regulation:	Notices were put up and staff have been instructed of protocols
Date corrected:	6/23-6/25
Who will monitor to ensure compliance:	Director of Facilities and the Director of Dining Services.
DLP Use Only	R403 Accepted 7-15-26 Susan Gregoire RN

Deficiency Tag:	
How the deficiency was corrected:	
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	
System changes to ensure compliance with the regulation:	
Date corrected:	
Who will monitor to ensure compliance:	
DLP Use Only	