



**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 27, 2026

Sarah Rowan, Manager
Lincoln House
120 Hill Street
Barre, VT 05641-3915

Dear Ms. Rowan:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 17, 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,

A handwritten signature in black ink, appearing to read "Carolyn Scott", written over a light blue horizontal line.

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: 0175	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/17/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LINCOLN HOUSE

120 HILL STREET
BARRE, VT 05641

(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 6/17/2026, the Division of Licensing and Protection conducted an unannounced on-site investigation of one complaint and an annual relicensure survey. The following regulatory deficiencies were identified:	R100		
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 staff interview and record review, the home failed to ensure the revision of a person-centered written plan of care for one applicable Resident (Resident #2) as the plan of care was not updated to reflect changes in the residents' behaviors and needs. Findings include:	R159		

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Executive Nurse Administrator

7/17/26

STATE FORM

6899

503C11

If continuation sheet 1 of 8

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0175	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 06/17/2026
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R159	Continued From page 1 The facility's 5.04 Service/Care Plan policy is consistent with this licensing rule. Per record review conducted on the afternoon of 6/17/2026, Resident #2's progress notes identify a change in behavior for Resident #2 on 2/01/2026. Resident #2's plan of care was not updated to include individualized interventions to address this need. Per staff interview with the Registered Nurse, conducted on the afternoon of 6/17/2026, the documented behavior exhibited by Resident #2 did not result in the completion of a significant change assessment. These findings were acknowledged by the Manager of the home on the afternoon of 6/17/2026.	R159			
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;	R210			

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R210	Continued From page 2 (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 5 out of 5 sampled staff did not complete the required annual trainings. Findings include: The facility's 4.04 Annual Staff Training policy is consistent with licensing rules. Documentation of training completed by 5 sample staff was requested the morning of 6/17/2026. Per review of the documentation provided, the required annual trainings were not completed by 5 out of 5 sampled staff. This was acknowledged by the Manager of the facility on the afternoon of 6/17/2026.	R210			
R215 SS=F	5.11.e (4) Staff Services	R215			

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R215	Continued From page 3 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 record and abuse registry checks were completed annually by the facility as required for 5 out of 5 sampled staff. Findings include: The facility's policy regarding employee background checks is consistent with the licensing rules. Documentation of criminal and abuse registry checks completed on 5 sampled staff was requested the morning of 6/17/2026. Per review of the documentation provided, the required annual checks of applicable criminal and abuse registries were not completed by the facility for 5 out of 5 sampled staff. This finding was confirmed by the Manager of the facility the afternoon of 6/17/2026.	R215			
R223 SS=D	5.12.b (2) Records/Reports The home must keep and maintain the following records.	R223			

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R223	Continued From page 4 A record for each resident which includes: resident's name; emergency notification numbers; name, address and telephone number of any legal representative or, if there is none, the next of kin; licensed health care provider ' s name, address and telephone number; instructions in case of resident ' s death; the resident ' s assessment(s); progress notes regarding any accident or incident and subsequent follow-up; progress notes regarding any illness or change in condition and subsequent related follow-up; list of allergies; a signed admission agreement; a recent photograph of the resident, unless the resident objects; a copy of the resident ' s advance directives, if any completed; and a copy of the document giving legal authority to another, if any. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure progress notes of an incident regarding 2 applicable residents were documented in 1 applicable resident's record. Findings include: A policy regarding documentation in resident records was not available for review upon request. Per record review of Residents #2 and #3's progress notes, an incident occurring on 2/01/2026 and involving Resident #3 was documented in Resident #2's notes. However, this incident was not documented in Resident #3's progress notes.	R223			

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R223	Continued From page 5 These findings were acknowledged by the Manager of the facility on the afternoon of 6/17/2026.	R223		
R385 SS=F	7.2.e Food Safety and Sanitation The use of outdated, unlabeled, or damaged canned goods is prohibited, and such goods must not be maintained on the premises. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, there is a failure to ensure all unlabeled and outdated goods are not maintained on the premises. Findings include: The facility's policy regarding labeling of opened food was not developed by the home. During a tour of the facility, commencing at approximately 9:20 AM on 6/17/2026, the goods observed to be opened and undated in the kitchen were a tub of chocolate ice cream, 2 tubs of vanilla ice cream, multiple bottles of soda, a package of blueberries, a package of strawberries, multiple bottles of salad dressing, and a container of marshmallow fluff. This finding was acknowledged by the Manager of the facility on the afternoon of 6/17/2026.	R385		
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	R403		

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R403	Continued From page 6 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 the secure storage of chemical agents and that the resident environment remains as free of accident hazards as possible. Findings include: Policies and procedures regarding chemical storage have not been developed by the facility. During a tour of the facility, commencing at 9:20 AM on 6/17/2026, the hazardous items observed to be unsecured and accessible to residents include, but are not limited to: 1. A can of Lysol spray in the bathroom of 1 applicable resident's room. 2. Multiple types of chemicals in the laundry room include stain removers, urine remover, a bottle of spray starch and bottles of laundry detergent. Per record review, there are residents with varying levels of cognitive impairment in the facility with access to these areas. These findings were confirmed by the Manager of the facility on the morning of 6/17/2026.	R403			
R430 SS=D	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 7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, there is a failure to ensure the hot water temperature does not exceed 120 degrees Fahrenheit in the bathroom of 1 applicable resident. Findings include: A policy regarding hot water temperature in resident areas was not developed by the facility. During the facility tour, commencing at approximately 9:20 AM on 6/17/2026, the water temperature in a Resident #1's bathroom was observed to be maintained at 121.6 degrees Fahrenheit. This was confirmed by the Manager of the facility the morning of 6/17/2026. Following adjustments made to the facility's water heater, the water temperatures were observed to be maintained at or below 120 degrees Fahrenheit at 2:30 PM on 6/17/2026.	R430		

Deficiency Statement Plan of Correction (POC)

(Please use additional pages if needed)

DLP Use Only:

Survey Date: 6/17/2026

Facility Name: Lincoln House

Deficiency Tag:	R159
How the deficiency was corrected:	A simple Care plan will be created within 24 hours after admission. A comprehensive care plan will be created within 14 days of admission.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	All care plans have been reviewed and updated. Care plan meetings have been held with each resident's families.
System changes to ensure compliance with the regulation:	As stated above, care plan meetings have been held with family, care plans have been reviewed and updated.
Date corrected:	Completed prior to survey
Who will monitor to ensure compliance:	Sarah Rowan RN
DLP Use Only	R159 Accepted 7/27/2026 by YA

Deficiency Tag:	R210
How the deficiency was corrected:	Staff received education and documentation will be completed in a more comprehensive manner.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	Documentation recording has been changed and will be more comprehensive moving forward
System changes to ensure compliance with the regulation:	Documentation recording has been updated to a more comprehensive system.
Date corrected:	6/18/26
Who will monitor to ensure compliance:	Sarah Rowan RN
DLP Use Only	R210 Accepted 7/27/2026 by YA

Survey Date: 6/17/26

Facility Name: Lincoln House

Deficiency Tag:	R210
How the deficiency was corrected:	Policy and procedures created for all deficiencies the same day they were identified (6/17)
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	Created policy and procedure for all deficiencies. Educated staff on Policy and Procedures at staff meeting 6/24/26.
System changes to ensure compliance with the regulation:	Policy and procedures created for all deficiencies the same day they were identified (6/17). Staff educated on policy and procedures.
Date corrected:	6/17/26
Who will monitor to ensure compliance:	Sarah Rowan RN
DLP Use Only	R210 Accepted 7/27/2026 by YA

Deficiency Tag:	R215
How the deficiency was corrected:	Policy and Procedures created for annual background checks on 6/17/26.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	Created Policy and Procedures on annual background checks. Educated staff on Policy and Procedures at staff meeting 6/24/26.
System changes to ensure compliance with the regulation:	Policy and Procedures created for annual background checks on 6/17/26.
Date corrected:	6/17/26
Who will monitor to ensure compliance:	Sarah Rowan RN
DLP Use Only	R215 Accepted 7/27/2026 by YA

Survey Date: 6/17/26

Facility Name: Lincoln House

Deficiency Tag:	R223
How the deficiency was corrected:	Policy and Procedure regarding documentation created on 6/17/26.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	Created policy and procedure on documentation on 6/17. Staff educated on policy at staff meeting on 6/24/26.
System changes to ensure compliance with the regulation:	Policy and Procedure regarding documentation created on 6/17/26. Staff educated on policy on 6/24.
Date corrected:	6/17
Who will monitor to ensure compliance:	Sarah Rowan RN
DLP Use Only	R223 Accepted 7/27/2026 by YA

Deficiency Tag:	R385
How the deficiency was corrected:	Policy and procedure regarding labeling of opened food created on 6/17.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	Created policy and procedure on labeling opened food on 6/17. Staff educated on policy and procedure.
System changes to ensure compliance with the regulation:	Policy and procedure regarding labeling of opened food created on 6/17. Staff educated on policy and procedure on 6/24.
Date corrected:	6/17
Who will monitor to ensure compliance:	Sarah Rowan RN
DLP Use Only	R385 Accepted 7/27/2026 by YA

Survey Date: 6/17/26

Facility Name: Lincoln House

Deficiency Tag:	R403
How the deficiency was corrected:	Policy and procedure created regarding chemical storage on 6/17.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	Created policy and procedure regarding chemical storage. Staff educated on policy and procedure on 6/24.
System changes to ensure compliance with the regulation:	Policy and procedure created regarding chemical storage on 6/17. Staff educated on policy and procedure 6/24.
Date corrected:	6/17
Who will monitor to ensure compliance:	Sarah Rowan RN
DLP Use Only	R403 Accepted 7/27/2026 by YA

Deficiency Tag:	R430
How the deficiency was corrected:	Policy and procedure created regarding hot water temperature in resident areas on 6/17
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	Created policy and procedure regarding hot water temperature. Staff educated on policy and procedure.
System changes to ensure compliance with the regulation:	Policy and procedure created regarding hot water temperature in resident areas. Staff educated on policy and procedure.
Date corrected:	6/17
Who will monitor to ensure compliance:	Sarah Rowan RN
DLP Use Only	R430 Accepted 7/27/2026 by YA