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

September 11, 2026

Angela Zizza
Valley Terrace
2820 Christian Street
White River Junction, VT 05001-9822

Dear . Zizza:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 24, 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
	1004	A. BUILDING: _____ B. WING _____	C 08/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY TERRACE	2820 CHRISTIAN STREET WHITE RIVER JUNCTION, VT 05001

(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 8/24/2026 the Division of Licensing and Protection conducted an unannounced on-site investigation of one anonymous complaint and an annual survey. No deficiencies were found related to the on-site complaint investigation. The following deficiencies were identified:	R100		
R206 SS=F	5.10.h (4) Medication Management Medications left after the death or discharge of a resident, or outdated medications, must be promptly disposed of in accordance with the home's policy and applicable standards of practice. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, there is a failure to ensure prompt disposal of outdated medications for 4 applicable residents. Findings include: Per record review, the facility's Medication Management policy is consistent with the licensing rules. Per observation, the following outdated medications observed to be stored in the facility's medication carts include, but are not limited to: 1. Acetaminophen 325mg tablets: expired 07/21/2026, available for use for Resident #1. 2. Acetaminophen 325mg tablets: expired 6/30/2026, available for use for Resident #2. 3. Albuterol Sulfate inhaler: expired 05/2026, available for use for Resident #3. 4. Mupirocin 2% ointment: expired 07/2026, available for use for Resident #4.	R206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1004	A. BUILDING: _____ B. WING _____	C 08/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY TERRACE	2820 CHRISTIAN STREET WHITE RIVER JUNCTION, VT 05001

(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
R206	Continued From page 1 Per staff interview, these findings were confirmed by the Executive Director and Registered Nurse of the facility on the afternoon of 8/24/2026.	R206		
R356 SS=F	6.8 Resident's Rights A resident may complain or voice a grievance without interference, coercion or reprisal. Each home must establish a written grievance procedure for resolving residents ' concerns or complaints that is explained to residents at the time of admission. The grievance procedure must include at a minimum, time frames, a process for responding to residents in writing, and a method by which each resident filing a complaint will be made aware of the role and contact information of the Office of the Long-Term Care Ombudsman and Disability Rights Vermont as an alternative or in addition to the home's grievance mechanism. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, there is a failure to ensure the facility's grievance procedure includes time frames for the grievance process. Findings include: Per record review of the facility's Grievance Resolution policy, there were no time frames included as required per the licensing rules. Per staff interview, these findings were confirmed by the Executive Director on 8/24/2026 at approximately 3:45 PM.	R356		
R382 SS=F	7.2.b Food Safety and Sanitation	R382		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	1004	A. BUILDING: _____ B. WING _____	C 08/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY TERRACE	2820 CHRISTIAN STREET WHITE RIVER JUNCTION, VT 05001

(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
R382	Continued From page 2 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, record review, and staff interview, there is a failure to ensure all opened perishable goods are dated. Findings include: Per record review, the facility's Food Storage, Safety and Sanitation policy is consistent with the licensing rules. During a tour of the facility, commencing at approximately 9:45 AM on 8/24/2026, the opened goods were observed to be undated in the main kitchen include, but are not limited to: A bag of walnuts, a bottle of prune juice, a container of half & half, two containers of milk, a container of rolled oats and multiple bags of sliced bread. Per staff interview, these findings were acknowledged by the Executive Director of the facility on the afternoon of 8/24/2026.	R382		

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
	1004	A. BUILDING: _____ B. WING _____	C 08/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY TERRACE	2820 CHRISTIAN STREET WHITE RIVER JUNCTION, VT 05001

(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
R430 SS=F	9.6.d Plumbing Hot water temperatures must not exceed 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, there is a failure to ensure the hot water temperature does not exceed 120 degrees Fahrenheit in resident areas. Findings include: Per record review, the facility's Water Temperature Policy is consistent with the licensing rules. During the facility tour, commencing at approximately 9:45 AM on 8/24/2026, the water temperature in a shared bathroom of the first-floor special care unit, accessible to residents, was observed to be maintained at 127.4 degrees Fahrenheit. Per staff interview, this was confirmed by the Executive Director of the facility on the morning of 8/24/2026. Following adjustments made to the facility's water heater, the water temperatures were observed to be maintained at or below 120 degrees Fahrenheit at 3:04 PM on 8/24/2026.	R430		

Deficiency Statement Plan of Correction (POC)

(Please use additional pages if needed)

DLP Use Only:
9-10-26- DLP accepts POC Tags 206, 356, 382, and 430-C. Scott LTCM

Survey Date: August 24, 2026

Facility Name: Valley Terrace Assisted Living Facility

Deficiency Tag:	R206 5.10.h (4) Medication Management
How the deficiency was corrected:	The expired medication was immediately removed from the medication cart, secured, and segregated from active medications. The medication was disposed of according to the facility's medication-disposal policy and applicable requirements, with disposal documented as required. The resident's medication supply was reviewed, and a replacement was obtained as needed to prevent an interruption in treatment.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	The Health Services Director or assigned nurse completed an audit of all medication carts, medication rooms, emergency medication supplies, and other medication-storage areas for expired, discontinued, damaged, or otherwise unusable medications. Any expired or discontinued medications found were immediately removed from active stock, secured for disposal, and documented.
System changes to ensure compliance with the regulation:	The Health Services Director reviewed medication-storage, expiration-date review, and medication-disposal procedures with all medication-trained staff. Medication-trained staff will check medications for expiration dates during each medication-cart audit and before administration. The Health Services Director or delegated medication staff will complete and document a weekly cart audit 1x per month then monthly for medication-storage audit, including medication-cart checks. Expired, discontinued, or damaged medications will be immediately removed from active stock, secured to prevent administration, and disposed of through the facility's approved process.
Date corrected:	August 24, 2026
Who will monitor to ensure compliance:	The Health Services Director or delegated medication staff will complete and document monthly medication-cart and medication-storage audits. The Executive Director will review audit documentation monthly and follow up on any identified concerns and will report to the QAPI on a quarterly basis.

9-10-26- DLP accepts POC Tag R206 - C. Scott LTCM

Survey Date: August 24, 2026

Facility Name: Valley Terrace Assisted Living Facility

Deficiency Tag:	R356 6.8 Resident's Rights
How the deficiency was corrected:	The Community revised its Grievance Resolution Policy to include clear time frames for acknowledging and responding to grievances in writing. The revised policy was posted in a conspicuous location accessible to residents, families, and visitors. A copy was also made available to residents upon request.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	The Executive Director reviewed all required resident-rights postings and policy documents to ensure the grievance procedure is posted, current, and includes: residents' right to file a grievance without interference, coercion, discrimination, or reprisal; the process for filing a grievance; response time frames; and contact information for the Vermont Long-Term Care Ombudsman, Disability Rights Vermont, and the Division of Licensing and Protection.
System changes to ensure compliance with the regulation:	The revised grievance policy provides that the Community will acknowledge receipt of a grievance within **two business days** and provide a written response within **ten business days**. If additional time is needed, the resident will receive written notice of the delay, the reason for the delay, and the anticipated response date. The grievance procedure will be explained to each resident at admission and will remain posted in a conspicuous location. The Executive Director will review postings and grievance-policy content quarterly and whenever regulations or contact information change.
Date corrected:	August 25, 2026
Who will monitor to ensure compliance:	The Executive Director will monitor compliance by reviewing the grievance log and written responses monthly and verifying required postings quarterly.
DLP Use Only	9-10-26- DLP accepts POC Tag R356 - C. Scott LTCM

Survey Date: August 24, 2026

Facility Name: Valley Terrace Assisted Living Facility

Deficiency Tag:	R382 7.2.b Food Safety and Sanitation
How the deficiency was corrected:	All refrigerated ready-to-eat food items that were not properly labeled were immediately discarded. Items with a known preparation or opening date were labeled with the appropriate discard date. Any item for which the preparation/opening date could not be verified was discarded.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	The Food Service Director or designee inspected all refrigerators, freezers, coolers, and food-preparation/storage areas for unlabeled or improperly labeled ready-to-eat food. Any additional unlabeled items were either correctly labeled, if the preparation/opening date could be confirmed, or discarded if the date could not be verified.
System changes to ensure compliance with the regulation:	The Food Service Director reviewed date-labeling procedures with all dietary staff. Refrigerated ready-to-eat, time/temperature control for safety (TCS) food held for more than 24 hours must be labeled with the preparation date, opening date, or discard date. Food must be used or discarded within seven days when held at 41°F or below, with the day of preparation or opening counted as Day 1. Dietary staff will check labels daily as part of opening and closing kitchen duties.
Date corrected:	August 24, 2026
Who will monitor to ensure compliance:	The Food Service Director or designee will conduct and document checks of refrigerated food labels **three times per week x's 2 months, then 3x's per month**.. The Executive Director will review the documentation weekly for four weeks and monthly thereafter.
DLP Use Only	9-10-26- DLP accepts POC Tag R382 - C. Scott LTCM

Survey Date: August 24, 2026

Facility Name: Valley Terrace Assisted Living Facility

Deficiency Tag:	R430 9.6.d Plumbing
How the deficiency was corrected:	Upon notification of the finding, the Maintenance Director immediately adjusted the hot-water system and/or thermostatic mixing valve(s). The affected fixture(s) were rechecked to confirm the temperature did not exceed 120°F and a safe water temperature was verified.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	The Maintenance Director completed a building-wide inspection of all and tested the temperatures of different areas in the building, Water temperatures were checked and documented at each location. Any fixture found to be above 120°F was adjusted, until compliant.
System changes to ensure compliance with the regulation:	The Maintenance Director will check and document hot-water temperatures at different locations throughout the building **three times per week x's 2 months, then 3x's per month**. The temperature log will include the date, location, temperature reading, corrective action taken, and the staff member completing the check. Water temperatures above 120°F will be reported immediately to the Executive Director and corrected promptly. The Executive Director will review completed temperature logs monthly. The logs will then be reported during the quarterly to QAPI meeting
Date corrected:	August 24, 2026
Who will monitor to ensure compliance:	The Maintenance Director will conduct and document temperature checks three times per month. The Executive Director will review the logs monthly and follow up on any readings outside the acceptable range.
DLP Use Only	9-10-26- DLP accepts POC Tag R430 - C. Scott LTCM