VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
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

May 12, 2023

Ms. Nicole Fortier, Manager
The Village At White River Junction
101 Currier Street,
White River Junction, VT 05001

Dear Ms. Fortier:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 13, 2023.** 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.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0660	A. BUILDING: _____ B. WING _____	C 04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT WHITE RIVER JUNCTION	101 CURRIER STREET WHITE RIVER JUNCTION, VT 05001

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R100	Initial Comments: An unannounced on-site investigation of two facility reported incidents was conducted by the Division of Licensing and Protection on 4/13/2023. There were regulatory deficiencies identified as a result of the investigations which resulted in the need for Immediate Corrective Action to be taken by the facility. Findings include:	R100		
R132 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.5 Special Care Units 5.6.c A home that has received approval to operate a special care unit must comply with the specifications contained in the request for approval. The home will be surveyed to determine if the special care unit is providing the services, staffing, training and physical environment that was outlined in the request for approval. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review the facility failed to ensure that all staff received training that is specified in their special care unit approval request. Findings include: Per review of the facility Special Care Unit request for approval the staff orientation in-service education and training is specified as follows: "All staff shall complete the Heartfelt Connections Memory Care Program, a 14-hour training that focuses on the following topics: * Heartfelt Connections' Mission and Philosophy	R132	see attached	

Tags R132 to R266 Accepted on 5/12/2023 - S. Freeman/C. Scott

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R132	Continued From page 1 * Understanding Alzheimer's disease and related dementia (ADRD) * Characteristics of Alzheimer's Disease * Communication with Residents with ADRD * Maintaining an appropriate environment for Residents with ADRD * Behavior Management * Assistance with Activities of Daily Living (ADLs) for Resident with ADRD * Activities for Residents with ADRD * Stress Management for the caregiver * Other issues related to ADRD (issues of sexuality, resident abuse, restraints, advance directives, and end of life/palliative care/hospice. The community will provide ongoing in-service training consisting of at least 2 hours every quarter specific to Alzheimer's' Disease and related dementia. The topics to be addressed in the in-service training shall include the following and each topic shall be addressed at least once per year." Per interview with the Business Office Manager (BOM) and the Director of Health Services, Registered Nurse (DHS) on 4/13/23 at 1:40 PM, the facility currently uses ten Resident Care Aides (RCAs) and one Licensed Practical Nurse (LPN) from a local staffing agency. Both BOM and DHS confirmed that the agency staff do provide care to the Residents who reside in the Memory Care Unit. They also confirmed that the agency staff have not received the specific dementia trainings as stated in the Special Care Unit request for approval.	R132	see attached	
R179 SS=F	V. RESIDENT CARE AND HOME SERVICES	R179		

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R179	Continued From page 2 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. 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, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the Assisted Living Residence (ALR) failed to ensure all staff received the required 12 hours of training each year. Findings include: Per review of staff training records it was determined that 5 out of 5 staff providing direct care to residents did not have the 12 hours of required yearly training.	R179	see attached	

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R179	Continued From page 3 During interview on 4/13/23 at 1:40PM the Business Office Manager (BOM) confirmed the training did not meet the 12-hour yearly requirement for 5 out of 5 employees.	R179		
R208 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to develop and implement a plan to prevent and effectively manage specific resident behaviors and to ensure the safety of two Residents in the applicable sample (Resident #2 and Resident #3) after a resident-to-resident physical altercation. Findings include: Per record review a progress written on 4/12/23 at 11:49 AM documented the altercation that occured on 4/11/23 around 5: 30 PM where Resident #2 went into another resident's apartment and laid down to sleep. Resident #3 alerted staff Resident #2 was in another resident's bed. Quality of Life Specialist (QLS) proceeded to go and check and woke up	R208	see attached	

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R208	Continued From page 4 Resident #2 and removed him/her from the room. As staff member was redirecting Resident #2 from the room and into his/her own room, Resident #3 began to accuse Resident #2 of knowing what s/he was doing in the other resident's room and proceeded to hit Resident #2 with open hand on his left shoulder with significant force. Per interview on 4/13/23 at 12:00 PM with a Licensed Practical Nurse (LPN), Resident #2 wanders often and can be found in other resident rooms, his/her demeanor is calm, approachable and accepts redirection agreeable. The LPN indicated Resident #3 has had an escalation in agressive type behaviors. The LPN also stated that after a resident-to-resident altercation the expectation is that "Alert" progress notes are written for a 72-hour period post occurrence. Further review of the record revealed that there was no follow-up documentation for Resident #2 and Resident #3 related to the altercation on 4/11/23 and, the plans of care were not updated to include interventions or a plan to address specific behaviors related to the altercation. Resident #3 care plan indicates that s/he requires supervision related to dementia, wandering, and a behavioral management program for combative behaviors with redirection. However, there is no documented behavioral management program or resident specific interventions to assist staff in management of behavioral expressions. During an interview on 4/13/23 at 1:30 PM the Director of Health Services (DHS) confirmed that the plans of care for Resident #2 and Resident #3 have not been updated to provide interventions or a plan to manage behaviors. The DHS also confirmed that the last progress notes	R208	see attached	

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R208	Continued From page 5 documented for Resident #2 and Resident #3 were on 4/12/23, the day after the occurrence, and no further "Alert" progress notes were documented.	R208		
R266 SS=K	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a safe secure environment to prevent Residents of the Memory Care Unit from exiting the building and leaving the grounds unsupervised, resulting in the need for immediate Corrective Action. Findings include: 1. Throughout observations on the Memory Care Unit on 4/13/23 between 12:0:05PM - 12:30PM there were 5 residents observed wandering throughout the unit. There are two exit doors that lead to stairwells, and at the bottom of the stairs there is a door that leads to the outside. The doors to both stairwells are locked and have a sign on them that reads "Emergency Exit Only. Push until alarm sounds. Door can be opened in 15 seconds." There is also a Velcro stop sign across the door. The Memory Care Unit elevator door has a keypad lock with a code that must be entered to open the door. However, the Memory Care Unit can be accessed from inside the elevator by pushing the button for the 2nd floor.	R266	see attached	

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R266	Continued From page 6 Per interview with a Licensed Practical Nurse (LPN) assigned to the Memory Care Unit on 4/13/23 at 12:20PM, the system that is in place to prevent Residents from exiting the building is not adequate. If staff are in a room taking care of a Resident, they can't hear the alarm when it sounds and would not know it was going off. There are at least four Residents on the unit that attempt to exit the unit by stairs or elevator. The LPN explained that there is a code for the elevator, but anyone can hit the button for the 2nd floor and the door will open. If a Resident is near the elevator and staff are not around, a Resident could get on the elevator and go. There is no type of alarm to alert staff that a Resident has gotten on the elevator. The LPN was asked to demonstrate the stairwell door alarms. The LPN pushed on the door release for a period of time and as the door opened an alarm went off. This surveyor walked down the hall and found that the alarm was not audible past the turn of the corner of the hall. The door on hall #1 was then opened by the LPN and the alarm sounded, two surveyors walked down the hall to determine how far the alarm was audible. As the corner going toward Hall #2 was turned the alarm could not be heard at all. No staff responded to either alarm. Per review of the Memory Care Residency Agreement Section 3.3.2. Exit Monitoring of the agreement reveals: "Doors exiting the Memory Care Neighborhood at the community will be monitored by a keypad monitoring system, per the Resident Guide." Per interview on 4/13/23 at 1:40PM with the Director of Health Services Registered Nurse (DHS) there are 26 Residents residing in the Memory Care Unit and there are five Residents	R266	see attached	

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R266	Continued From page 7 who are at risk for elopement. The DHS also demonstrated how the door to the stairwell on the Memory Care Unit alarms to a phone system called Ciscor. All staff are to have a Ciscor on them while on duty. The DHS confirmed that the elevator did not have a secure system for preventing a Resident from getting on it if the door should open to the unit. S/he stated that s/he has asked for a keypad on the inside of the elevators to prevent the 2nd floor door from opening without a code. This has not been done and s/he is not aware if it can be. However the elevator door that opens to the kitchen area does have a key code to prevent people from accessing that area. 2. Per record review Resident #1 was admitted to the Memory Care Unit on 10/20/2022 with a diagnosis of Alzheimer's Dementia. Since admission the Resident has exhibited behaviors such as agitation, yelling, swearing, and exit seeking. Section F.2. Mood & Behavior of the Resident's Vermont State Assessment completed on 1/24/2023 reflects that the Resident wandered (moved with no rational purpose, seemingly oblivious to needs or safety) daily. Per assessment this behavior was easily altered. The comment section of F.2. states "wandering daily and nightly." Review of the Resident's care plan reflects that the Resident is at risk for wandering and elopement stating, "Wandering/Elopement Risk: Goal: Monitor Resident for wandering and/or elopement." The rationale states "Wanders mostly inside." The care plan also reflects "Wandering Minimal staff to document changes or increased wandering." The Resident's wandering tendency is described as "Wanders mostly inside." The care plan description reflects that the "resident has current or history of wandering within the residence or facility and may	R266	see attached	

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R266	Continued From page 8 wander outside, but does not jeopardize health or safety" (of self or others). On 3/19/23 Resident #1 exited the building unsupervised and unattended. S/he was found alone approximately 700 ft from the facility in a parking lot. A progress note written on 3/19/2023 at 9:38 PM states "Stairwell door alarm went off. When search was done of residents, resident was found missing. QLS [Quality of Life Specialist], [name omitted] was searching outside and found resident walking in the VFW [Veterans' of Foreign War] parking lot. Resident easily redirected and returned to floor with QLS. No injuries noted." On 4/12/23 s/he was found approximately 150 feet off property where s/he had fallen hitting her/his head on the ground prior to being located, resulting in the need for evaluation at the hospital. A progress note written on 4/12/2023 at 7:49 AM states "At 6:18 QLS [name omitted] called on radio, the alarm for the stairwell door next to the Sunflower room was alarming. Staff immediately began searching. QLS [name omitted] was outside on Gates Street walking toward the church, when [s/he] heard the resident fall. The resident was on the sidewalk on North Main Street next to the Marsicovetere & Levine Law Office, lying on [her/his] back trying to sit up, yelling "My Head". Police were passing by and stopped to assist. Resident had positive ROM [range of motion] for extremities, initial c/o [complaint of] left side lower back pain. C/O head pain. When resident sat up, [s/he] c/o dizziness. When [s/he] stood, [s/he] c/o dizziness. There is a contusion approximately 3cm x 6cm oblong shaped at the Ocipital Lobe. Resident was assisted to a sitting position on the front steps of the building. Rescue called..." The Resident	R266	see attached	

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R266	Continued From page 9 returned to the facility after being evaluated at the hospital with no major injury. Per interview on 4/13/2023 at 3:08 PM with a PCA who was on duty and joined in the search for the Resident, s/he was helping another caregiver in a resident's room when a staff member on another unit came over the walkie talkie and stated that a door had alarmed. S/he stated that they had not heard the door alarm and the Ciscor system did not alert them either. The PCA stated that the door alarm should be louder so staff could hear it if they are in taking care of other Residents. Per interview with the BOM and the DHS on 4/13/2023 at 4:30PM the DHS again confirmed that the Memory Care Unit is not secure in that it does allow for Residents to exit without supervision. Both BOM and DHS stated that they had not been made aware that anyone's Ciscor did not go off when the incident happened. However, there has never been an issue with them. They have been looking for alternative systems but have not had success in implementing one that prevents unplanned exit of Residents with dementia that wander and are at risk for elopement.	R266	see attached	

Plan of Correction Outline

Preparation and execution of this plan of correction in no way constitutes an admission or argument by The Village at White River Junction of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. The Village at White River Junction reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts, and conclusions that form the basis of the deficiency. This plan of correction serves as the allegation of compliance by 5/31/2023.

Response to Survey ending April 13, 2023

Tag: R132 V. Resident Care and Home Services

1. **The corrective actions to be accomplished to correct the deficient practice.**

   The facility will provide HeartFelt Connections Memory Care Program training to direct care staff. The facility will provide ongoing in-service training consisting of 2 hours every quarter specific to Alzheimer's Disease and related dementia to direct care staff.

2. **The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**

   The facility provided HeartFelt Connections training to direct care staff on 4/27/2023 and 4/28/2023. Another training session is scheduled for 5/18/2023 and 5/19/2023. HeartFelt Connections training is scheduled quarterly so that all direct care staff will attend within 90 days of hire.

3. **The facility will monitor the corrective action by implementing the following measures.**

   The facility will perform a quarterly audit of direct care staff training to ensure that all direct care staff have received HeartFelt Connections training. The first audit will be completed by 5/31/2023.

4. **Plan of Correction completion date: 05/31/2023**

Tag: R179 V. Resident Care and Home Services

1. **The corrective actions to be accomplished to correct the deficient practice.**

   The facility will ensure that staff who provide direct care to residents complete 12 hours of training each year. The training will include resident rights; fire safety and emergency evacuation; resident emergency response procedures; policies and procedures regarding mandatory reports of abuse, neglect and exploitation; respectful and effective interaction with residents; infection control measures; general supervision and care of residents.

2. **The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**

The facility will schedule all direct care staff to 2 shifts per year during which direct care staff will complete their required training.

3. **The facility will monitor the corrective action by implementing the following measures.**

   The facility will conduct a facility-wide audit of all direct care mandatory training to ensure compliance. This audit will be completed by 5/31/2023. Thereafter, the ED or designee will utilize an audit tool for required training. This audit will be completed quarterly for a year.

4. **Plan of Correction completion date: 05/31/2023**

Tag: R208 V. Resident Care and Home Services

1. **The corrective actions to be accomplished to correct the deficient practice.**

   The facility will record each instance of resident-to-resident abuse in the resident's record. Families or legal representatives will be notified, and a plan will be developed to manage the behaviors.

2. **The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**

   Care plans for residents #2 and #3 were updated to include a plan to manage behaviors. The facility will provide in-service training to all nurses regarding required documentation and notification of resident-to-resident abuse. The facility provided a sign for resident #2 to direct him to his own apartment.

3. **The facility will monitor the corrective action by implementing the following measures.**

   The facility will conduct an audit of nurse training regarding required documentation and notification of resident-to-resident abuse. The facility will address behavior management plans in monthly quality assurance meetings.

4. **Plan of Correction completion date: 05/15/2023**

Tag: R266 IX. Physical Plant

1. **The corrective actions to be accomplished to correct the deficient practice.**

   The facility will ensure a safe secure environment to prevent residents of the Memory Care Unit from exiting the building and leaving the grounds unsupervised.

2. **The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**

   The facility immediately put into place a hall monitor program to watch the elevators and the exit door on Memory Care. The facility then acquired a permit from the state Division of Fire Safety to lock both exit doors on Memory Care. Locking of the doors was completed on

5/2/2023. The facility is pursuing available options to restrict Memory Care resident access to the elevators. The facility will provide education to direct care staff regarding functionality and use of the Ciscor alarm system. All current direct care staff will receive education by 5/15/2023 and the training will be provided during new hire orientation starting immediately.

3. **The facility will monitor the corrective action by implementing the following measures.**

   The facility will monitor the hall monitor program by daily log. The facility will perform an audit of the in-service training by 5/15/2023. The facility will include Ciscor training on the new hire checklist.

4. **Plan of Corrections completion date: 05/15/2023**