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

June 26, 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 **June 6, 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

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
	0660	A. BUILDING: _____ B. WING _____	C 06/06/2023

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

(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: An unannounced on-site complaint investigation was conducted on 6/6/23 by the Division of Licensing and Protection. The investigation included 3 facility self- reports and 1 anonymous complaint. As a result of the investigation, regulatory findings were identified related to 2 of 3 facility self reports. Findings include:	R100		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, there was a failure by staff to follow the care plan developed to assist in the management of behaviors for 1 applicable resident. (Resident #1) Findings include: Per review of the facility service plan (care plan) last updated on 3/29/23 states in addressing Resident #1's "Aggressive behavior towards others" the goal would be to "Maintain a safe/secure, calm, routine, harmonious environment". Staff are directed: " to provide cues and reminders regarding orientation, staff to monitor to provide safety....and " Intercede at first sign of agitated behavior. Distract and remove	R145	See attached R145-Accepted by Carolyn Scott 6-23-23	

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R145	Continued From page 1 resident from immediate area". In addition, the Service Plan states: " Utilize female caregivers when resident is agitated state (exhibits aggression towards males). However, on 5/19/23 at approximately 6:30 PM a female RA (Resident Assistant) requested 2 male RAs to assist her with the provision of evening care and toileting for Resident #1. Shortly after approaching Resident #1 to assist with the transfer from his/her wheelchair to the toilet, the resident became combative, kicking and hitting. Instead of removing the resident from the bathroom; allowing him/her to calm down and be reapproached by staff at a later time, the RAs continued to remove the resident from the wheelchair while s/he continued to struggle defensively against the staff. Utilizing 2 male RAs was contraindicated especially when Resident #1 was experiencing increased anxiety and defensive bahaviors. As a result, staff reportedly demonstrated increased force during the transfer from Resident #1's wheelchair to toilet while attempting to avoid Resident #1's repeated hitting and kicking. The transfer and increased agitation experienced by Resident #1 was avoidable if staff followed the service plan to include re-approaching the resident after a period of time, utilizing different staff and avoiding confrontation when Resident #1's behavior's became combative and difficult to manage safely. The staff failed to maintain a safe/secure and calm environment for Resident #1. On the afternoon of 6/6/23, the Director of Health Care Services acknowledged staff failed to follow the service plan developed to manage Resident # 1's behaviors.	R145		
R190 SS=E	V. RESIDENT CARE AND HOME SERVICES	R190		

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R190	Continued From page 2 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to provide documentation of criminal record and adult abuse registry checks for one contracted staff who provided direct care services for residents and one full time staff. Findings include: On the afternoon of 6/6/23 the Director of Health Services confirmed the required criminal background and abuse registry checks for one contracted staff who provided direct care services for residents were not on file and available for review; and confirmed abuse registry checks had not been completed for one full time staff.	R190	See attached R190-Accepted by Carolyn Scott 6-23-23	
R200 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to follow the facility's written policies and procedures that require the licensing of the salon operator. Findings include:	R200	See attached R200-Accepted by Carolyn Scott 6-23-23	

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R200	Continued From page 3 The facility's Salon Services and Space Use Agreement states "2.5 Licenses and Certifications. Vendor will maintain in effect at all times all necessary licenses and certifications to carry on operations of the Salon at [the facility] ... Vendor shall provide [the facility] with evidence of such licenses or certifications prior to commencement of Services and thereafter, as required and requested by [the facility]." On the afternoon of 6/6/23 the Director of Health Services confirmed the facility's Salon Services and Space Use Agreement was in effect when contracted Staff #1 maintained operations and provided salon services at the facility; and confirmed Staff #1 did not have a valid Vermont Cosmetologist License as required by the facility and the State of Vermont.	R200		
R213 SS=G	VI. RESIDENTS' RIGHTS 6.1 Every resident shall be treated with consideration, respect and full recognition of the resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, staff failed to treat a resident with consideration, respect and full recognition of the resident's dignity, individuality and privacy. (Resident #1) Findings include: During the evening of 5/18/23 3 RAs attempted to	R213	See attached R213-Accepted by Carolyn Scott 6-23-23	

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R213	Continued From page 4 provide evening care and toileting to Resident #1. Although the resident's service plan states staff shall: "Maintain a safe/secure, calm, routine, harmonious environment". Staff are directed: " to provide cues and reminders regarding orientation, staff to monitor to provide safety....and "Intercede at first sign of agitated behavior. Distract and remove resident from immediate area". In addition, the service plan states: "Utilize female caregivers when resident is in agitated state (exhibits aggression towards males). However, 2 male RAs were requested to assist a female RA in providing evening care to Resident #1. When approached by the 3 RAs, Resident #1 became vocal, combative, hitting and kicking. Instead of removing the resident from the bathroom; redirecting later when Resident #1 became calm, the RAs continued to transfer the resident from his/her wheelchair to the toilet without acknowledging the resident's state of mind and resistance to hands on care. The resident remained agitated and reactive while being transferred and undressed in an undignified manner. Staff failed to respect Resident #1's needs and demonstrated a lack of recognition of the resident's right to be treated with consideration and in accordance with the behavioral service plan. The event was reported and administrative action was taken to include additional training and monitoring of staff interactions with residents residing on the Memory Care Unit. Refer to Tag: 145	R213		

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 6/30/2023.

Response to Survey ending June 6, 2023

Tag: R145 V. Resident Care and Home Services

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

   The facility will follow the care plan developed to assist in the management of behaviors for Resident #1.

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

   The facility will provide in-service training to all direct care staff about following care plan instructions.

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 care plan in-service training. The first audit will be completed by 6/30/2023.

4. **Plan of Correction completion date: 06/30/2023**

Tag: R190 V. Resident Care and Home Services

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

   The facility will ensure that criminal record and adult abuse registry checks are completed for all staff as well as for contractors who have regular interaction with residents.

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

   The facility will utilize a checklist to ensure that all criminal record and adult abuse registry checks are completed.

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

   The facility will conduct a facility-wide audit of all HR files to ensure all staff and contractors who have regular interaction with residents have criminal records and adult abuse registry check results on file.

4. **Plan of Correction completion date: 07/15/2023**

Tag: R200 V. Resident Care and Home Services

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

   The facility will follow the facility's written policies and procedures that require the licensing of the salon operator.

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

   The facility will confirm a valid salon operator's license prior to a salon operator performing services in the facility's salon.

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

   The facility will maintain a checklist for all salon operators which will include the need to confirm a valid salon operator's license.

4. **Plan of Correction completion date: 06/30/2023**

Tag: R213 VI. Resident's Rights

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

   The facility will treat every resident with consideration, respect, and full recognition of the resident's dignity, individuality, and privacy.

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

   The facility will provide in-service training to all direct care staff to about following care plan instructions to help ensure every resident is treated with consideration, respect, and full recognition of the resident's dignity, individuality, and privacy. The facility will provide education to all direct care staff that all refusals of care must be reported to the charge nurse on that shift.

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

   The facility will have all current direct care staff, and any direct care staff hired in the future, sign a policy that states that all refusals of care are to be reported to the charge nurse for the shift in which the refusal occurred.

4. **Plan of Corrections completion date: 06/30/2023**