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

January 22, 2020

Ms. Jodi Egger, Manager
The Village At White River Junction
101 Currier Street
White River Junction, VT 05001

Dear Ms. Egger:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **December 12, 2019**. 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 12/12/2019

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 investigation of a complaint was conducted by the Division of Licensing and Protection on 12/11 through 12/12/19. The investigation identified that the facility is not in compliance with staffing ratio's that were agreed upon at the time the licensing agency approved the Special Care Unit. During the investigation it was identified that the Special Care Unit has a census of 19 residents and the staffing on the overnight shift is 1 nurse and 1 Quality Life Specialist (QLS), a care provider. The ratio agreed upon at the time of licensure was 1 staff member for every 8 residents. This staffing ratio was determined to represent a situation that required Immediate Corrective Action (ICA), due to the risk for the safety of residents residing on the Special Care Unit but also in the Assisted Living Residence. The Executive Director and the Director of Nurses were informed on 12/12/19 at approximately 4 PM, of the need for an ICA and the requirement for a written response prior to the surveyor leaving the facility on 12/12/19. The facility submitted an Immediate Corrective Action plan within 45 minutes of the request. The surveyor approved the plan. The findings are as follows:	R100	Please see attached plan of correction.	
R131 SS=K	V. RESIDENT CARE AND HOME SERVICES 5.6 Special Care Units 5.6.b A request for approval must include all of the following: (1) A statement outlining the philosophy, purpose and scope of services to be provided; (2) A definition of the categories of residents to	R131		

R131 - A901. POC's accepted 1/22/20 MBertrandRN/PMC

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R131	Continued From page 1 be served; (3) A description of the organizational structure of the unit consistent with the unit's philosophy, purpose and scope of services; (4) A description and identification of the physical environment; (5) The criteria for admission, continued stay and discharge; and (6) A description of unit staffing, to include: i. Staff qualifications; ii. Orientation; iii. In-service education and specialized training; and iv. Medical management and credentialing as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of staffing schedules, the facility has failed to ensure that the staffing ratio on the Special Care Unit meets the agreed upon staffing of 1 staff per 8 residents. This was agreed upon at the time the licensing agency granted and approved the licensure of the unit. The findings are as follows: During an investigation on 12/11-12/12/19, staffing schedules dating back to September 2019 identified that on the overnight shift, the special care unit is staffed with 1 nurse and 1 Quality Life Specialist (QLS), a care provider. There are 19 residents residing on the unit at present. This staffing ratio was determined to represent a situation that required Immediate Corrective Action (ICA), due to the risk for the safety of residents residing on the Special Care Unit but also in the Assisted Living Residence (ALR). Confirmation was made by a Licensed Practical	R131		

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R131	Continued From page 2 Nurse (LPN) on 12/11/19 at approximately 12 noon, that the facility is not adequately staffed. ["There are many residents on the Special Care Unit who require 2 assists for personal care primarily on the overnight shift. One resident requires 2 staff to change his/her bed. If one staff is in the Assisted Living Residence, then you can't do it"]. Interview with a QLS care provide on 12/12/19 at approximately 10:20 AM, confirms that Resident #4 requires frequent checks in the morning, after a recent fall. The resident does not know how to use his/ her pendant (a system used to call for help). Confirmation was made on 12/11/19 at 1:45 PM by the DNS in the presence of the ED, that the staffing is dictated by the corporate office. The overnight shift staff are expected to make rounds on the Special Care Unit and check, toilet and change residents in need. At the completion of the Special Care Unit rounds, one staff member will walk the halls in the ALR, ensuring that residents are in their rooms. Staff are not expected to enter resident rooms unless a concern is identified. Staff respond to pendant calls throughout the building as needed throughout the shifts. Per interview with the Executive Director (ED) and the Director of Nurses (DNS) 12/12/19 at approximately 4 PM, the Special Care Unit admission agreement identifies the staffing ratio of 1 staff per 8 residents. Both the ED and the DNS question the surveyor as to what document identifies the staffing requirement. Once shown, confirmation was made by the ED and the DNS at this time, that the overnight staffing includes 1 nurse and 1 care provider. They are expected to cover the entire building (Special Care Unit and ALR).	R131		

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R131	Continued From page 3 Currently there are 19 residents on the Special Care Unit and 10 residents in the ALR, (6 residents on the 3rd floor, 2 on the 4th floor and 2 on the 5th floor). The census has varied, on 10/13/19 the total census was 24 and on 11/1/19 at 22 residents and currently 29. The ED and the DNS were informed on 12/12/19 at approximately 4 PM, of the need for an ICA and the requirement for a written response prior to the surveyor leaving the facility on 12/12/19. The facility submitted an ICA plan within 45 minutes of the request. The surveyor approved the plan that identified that ["Effective immediately there will be 3 scheduled staff on the 11 PM to 7 AM shift. Adjustments will be made to maintain a 1:8 staff to resident ratio"].	R131		
R145 SS=E	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 observation, record review and staff interview the facility failed to provide instruction to all direct care staff regarding the health care needs for 2 applicable residents after falls that resulted in head injuries, (Resident #3 and	R145		

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R145	Continued From page 4 #4). This was cited on the 06/18/19 survey. The findings include the following: 1. Resident #3 had a fall on 10/19/19. The resident was transferred to the emergency room and required stapling of a head laceration. Despite the fact that the care plan was modified on 11/08/19, there are no instructions reflecting the care needs of Resident #3, related to the monitoring of a head injury and the laceration. 2. Resident #4 had a fall on 11/11/19 and a 2nd on 11/29/19 that required a 4-day hospitalization. The resident returned to the facility on 12/03/19. The care plan was last modified on 11/29/19. The resident sustained a subdural hematoma, traumatic right orbital hematoma, a subarachnoid hemorrhage and a possible nondisplaced maxillary fracture. Discharge instructions from the acute setting identified that the resident required 24/7 hands on assistance, utilized upright chair position or chair when someone can stay with her in room, ambulate/transfer with one assist and a walker as the resident is high risk for falls and physical assist for activities of daily living (ADL'S) as needed. Other recommendations included to orient the resident via communication and staff to cue resident and to monitor and limit excessive noise. Medications were adjusted and physical therapy was ordered to increase strength, endurance, gait training, transfer and safety. Monitor pain and blood pressure and follow up as needed. The discharge instructions have not been included on the care plan. The Director of Nursing (DNS) was interviewed on 12/12/19 and would not confirm that the care plans for both residents does not reflect their current status and does not provide direct care	R145		

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R145	Continued From page 5 staff instructions on the management of head injuries.	R145		
R178 SS=K	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that there is sufficient staff to resident ratios of qualified personnel available to provide necessary care to maintain safe and healthy environment. This citation required immediate corrective action due to risk to resident safety. The findings include the following: Per review of incident logs dated 09/08 - 12/07/19 identifies that the facility has had 35 incidents of falls. 10 falls occurred on the overnight shift, one resident had 17 falls, 5 of the residents required emergency room treatment and/or admission and all of the incident falls occurred on the Special Care Unit. 7 of the 17 falls that involved Resident #5 were not assessed by a Registered Nurse (RN). 1. Per record review for Resident #1, fell on 10/13/19 (Sunday), was hospitalized and died on 10/17/19. Cause of death was complications of a hip fracture after an accident. There is no evidence that an RN assessment was conducted	R178		

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R178	Continued From page 6	R178		

prior to the resident being sent to the emergency room.

2. Per record review for Resident #3, fell on 10/19/19 at 5:45 PM that resulted in a head laceration that required stapling and returned to the facility.

3. Per record review, Resident #4, had two falls one on 11/11/19 at 7:15 AM and a 2nd on 11/29/19 at approximately 1:15 PM that resulted in hospitalization for 4 days. The resident sustained a subdural hematoma, traumatic right orbital hematoma, a subarachnoid hemorrhage and a possible nondisplaced maxillary fracture. Discharge instructions from the acute setting identified that the resident required 24/7 hands on assistance, utilized upright chair position or chair when someone can stay with his/her in room, ambulate/transfer with one assist and a walker as the resident is high risk for falls. Physical assist for activities of daily living (ADL'S) as needed. Other recommendations included to orient the resident via communication and staff to cue resident and to monitor and limit excessive noise. Medications were adjusted and physical therapy was ordered to increase strength, endurance, gait training, transfer and safety. Monitor pain and blood pressure and follow up as needed.

4. Per record review, Resident #5 has had 17 falls as follows:
- 09/08/19 (Sunday) at 8:15 AM, resulting in a finger laceration;
- 09/11/19 at 12 AM, resulted in a gluteal fold bruise and an abrasion of the spine and arm;
-09/30/19 at 8:30 AM, resulted in a hospital evaluation;
-10/02/19 at 5:45 PM, resulting in bleeding of the left arm, abrasion to the left elbow knee. There

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R178	Continued From page 7	R178		

is no evidence of an RN assessment;
-10/10/19 at 8:15 PM, resulting in hospital evaluation;
-10/20/19 (Sunday) at 7:30 PM, resulting in hospital evaluation;
-10/25/19 at 3:15 PM no resulting injuries. There is no evidence of an RN assessment;
-11/05/19 at 8 AM no resulting injuries;
-11/07/19 (Sunday) at 7:45 PM no resulting injuries. There is no evidence of an RN assessment;
-11/10/10 (Sunday) at 7:15 AM no resulting injuries;
-11/20/19 at 7:30 AM no resulting injuries;
-11/22/19 at 8:15 AM no resulting injuries. There is no evidence of an RN assessment;
-11/28/19 (Thanksgiving) at 7:45 AM no resulting injuries. There is no evidence of an RN assessment;
-12/06/19 at 8 PM no resulting injuries. There is no evidence of an RN assessment;
-12/07/19 at 7:15 PM no resulting injuries. There is no evidence of an RN assessment;.

Resident #5 has had private care givers since admission 06/27/19 from 9 AM - 1 PM. None of the falls occurred while the private care giver was present. The incident reports reviewed confirm that 7 of the 17 falls that Resident #5 had were not assessed by an RN.

Professional reference:

In the Vermont State Board of Nursing document titled Determining Scope of Practice Position Statement and Decision Tree, approved November, 2009, the following is stated:
"LPN role in assessment, planning, and implementation of a strategy of care:
-LPNs may not independently assess the health

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R178	Continued From page 8 status of an individual or group and may not independently develop or modify the plan of care. LPNs may contribute to the assessment and nursing care planning processes; however, patient assessment and care plan development or revision remain the responsibility of the RN/APRN/licensed physician/licensed dentist. -LPNs may not modify a patient care protocol. If the situation and/or data collected by the LPN are not clearly consistent with a protocol, the LPN must consult with the supervising professional or authorized provider before taking action or making a recommendation to a patient."	R178		
R188 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(2) 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; physician'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; 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 record review and staff interviews, the	R188		

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R188	Continued From page 9 facility Registered Nurse failed to ensure that progress notes regarding any accident/incident and subsequent follow-up were recorded for 2 applicable residents sampled, (Resident #4 and #5). This was cited on the 06/18/19 survey. The findings include the following: 1. Resident #4 had a fall on 11/11/19 at 1:30 PM. There is no evidence in the progress notes identifying the fall occurred and/or subsequent follow up. There is an incident report contained in the Electronic Medical Record (EMR). 2. Resident #5 had falls dated 10/2, 10/10, 11/20, 11/22, and 11/30/19. There is no evidence in the progress notes identifying the fall occurred and/or subsequent follow up. There is an incident report contained in the EMR Confirmation was made by the Licensed Practical Nurse on 12/11/19 at approximately 12:10 PM, that there are no progress notes identifying the fall or subsequent follow up on the above resident's identified. Asked if there should be and s/he responded ["You would think so"]. Per review of the facility policy titled Documentation for Resident Medical Record, directs staff that Information that relates to any change of status outside of the normal range of acceptance shall be documented in the resident medical record/file. Interview with the Director of Nurses on 12/11/19 confirms that incident reports are present in the EMR.	R188		
R191 SS=G	V. RESIDENT CARE AND HOME SERVICES	R191		

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R191	Continued From page 10 5.12 Records/Reports 5.12.c A home must file the following reports with the licensing agency: 5.12.c.(1) When a fire occurs in the home, regardless of size or damage, the licensing agency and the Department of Labor and Industry must be notified within twenty-four (24) hours. A written report must be submitted to both departments within seventy-two (72) hours. A copy of the report shall be kept on file. 5.12.c.(2) A written report of any accident or illness shall be placed in the resident's record. Any untimely deaths shall be reported and a record kept on file. 5.12.c. (3) A report of any unexplained absence of a resident from a home for more than 12 hours shall be reported to the police, legal representative and family, if any. The incident shall be reported to the licensing agency within twenty-four (24) hours of disappearance followed by a written report within seventy-two (72) hours, a copy of which shall be maintained. 5.12.c.(4) A written report of any breakdown or cessation to the home's physical plant's major services (plumbing, heat, water supply, etc.) or supplied service, which disrupts the normal course of operation. The licensee shall notify the licensing agency immediately whenever such an incident occurs. A copy of the report shall be sent to the licensing agency within seventy-two (72) hours. 5.12.c. (5) A written report of any reports or	R191		

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R191	Continued From page 11 incidents of abuse, neglect or exploitation reported to the licensing agency. 5.12.c. (6) A written report of resident injury or death following the use of mechanical or chemical restraint. This REQUIREMENT is not met as evidenced by: Based interview and record review the facility failed to report an untimely death to the licensing agency for 1 of 2 sampled residents, (Resident #1) The death occurred 4 days after a fall. The findings include the following: Per record review Resident #1, was admitted to the facility 05/08/19. On Saturday 10/13/19 at 2:15 PM, a Quality of Life Specialist (QLS-care giver) was attempting to locate the resident. S/He was in the resident's room when s/he heard a thud as the resident fell to the floor in the bathroom. Per review of the nurses notes and the incident report, at the time of the fall the Licensed Practical Nurse (LPN) assessed Resident #1 and determined that s/he did suffer an abrasion to the hip and was limping noticeably but denied pain. Physician orders dated 08/02/19 directed staff to not attempt resuscitation, do not intubate and do not transfer to the hospital unless comfort needs cannot be met on-site. Per interview with the LPN on 12/11/19 at approximately 12:08 PM, confirmation is made that at 7:30 PM Resident #1 could barely walk and was complaining of severe back pain. The nurse then called emergency services and had the resident transferred to the hospital. The resident was diagnosed with a fractured hip. The	R191		

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R191	Continued From page 12 resident was admitted to the Jack Byrne Center for Palliative & Hospice Care where s/he died on 10/17/19, 4 days after the fall. Confirmation was made by the Executive Director and the Director of Nurses on 12/11/19 at approximately 9 AM that the death was not reported to licensing agency, for they agreed the death did not occur in the facility, therefore the regulation did not apply to The Village at White River Junction. However, they were aware that the resident died on 10/17/19 and had fallen in the facility on 10/13/19.	R191		
A 001	VI Initial Comments An unannounced on-site investigation of a complaint was conducted by the Division of Licensing and Protection on 12/11 through 12/12/19. The investigation identified that the facility is not in compliance with staffing ratios that were agreed upon at the time the licensing agency approved the Special Care Unit. During the investigation it was identified that the Special Care Unit has a census of 19 residents and the staffing on the overnight shirt is 1 nurse and 1 Quality Life Specialist (QLS), a care provider. The ratio agreed upon was 1 staff member for every 8 residents. This staffing ratio was determined to represent a situation that required Immediate Corrective Action (ICA), due to the risk for the safety of residents residing on the Special Care Unit but also in the Assisted Living Residence. The Executive Director and the Director of Nurses were informed on 12/12/19 at approximately 4 PM, of the need for an ICA and the requirement for a written response prior to the surveyor leaving the facility on 12/12/19. The facility submitted an Immediate Corrective Action	A 001		

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A 001	Continued From page 13 plan within 45 minutes of the request. The surveyor approved the plan. The findings are as follows:	A 001		
A 601 SS=K	VI Resident Care and Services 6.1 Eligibility The licensee may accept and retain any individual 18 years or older, including those whose needs meet the definition level of care if those needs can be met by the assisted living residence, with the following exceptions: 6.1.b The licensee shall not admit any individual who has the following equipment, treatment or care needs: ventilator, respirator, state III or IV decubitus ulcer, naso-harangeal, oral or trachial suctioning or two-person assistance to transfer from bed or chair to to ambulate. A current resident of the facility who develops a need for equipment, treatment or care as listed above in (b) or who develops a terminal illness may remain in the residence so long as the licensee can safely meet the residents needs and/or there resident's care needs are met by an appropriate licensed provider. This Statute is not met as evidenced by: Based on interview and record review the facility retained 2 applicable residents after one resident developed a head injury as a result of a fall and a 2nd resident has had 17 falls since 09/08/19. The facility did not initiated a service negotiation process to address an identified risk of further harm and to reach an agreed-upon plan of action, (Resident #4 and #5). The findings include the	A 601		

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A 601	Continued From page 14	A 601		

following:

1. Per record review, Resident #4, had two falls 1 on 11/11/19 at 7:15 AM and a 2nd on 11/29/19 at approximately 1 PM that resulted in hospitalization for 4 days. The resident sustained a subdural hematoma, traumatic right orbital hematoma, a subarachnoid hemorrhage and a possible nondisplaced maxillary fracture. Discharge instructions from the acute setting identified that the resident required 24/7 hands on assistance, utilized upright chair position or chair when someone can stay with his/her in room, ambulate/transfer with one assist and a walker as the resident is high risk for falls. Physical assist for activities of daily living (ADL'S) as needed. Other recommendations included to orient the resident via communication, staff to cue resident, monitor, and limit excessive noise. Medications were adjusted and physical therapy was ordered to increase strength, endurance, gait training, transfer and safety. Monitor pain and blood pressure and follow up as needed.

2. Per record review Resident #5 who was admitted 06/27/19, has had 17 falls in less then 6 months. 3 of the falls resulted in emergency transfer. The resident has had a 1:1 care giver from 9 AM - 1 PM, since admission. Incident reports identify that none of the falls occurred while the care giver was present.

Confirmation was made by the Executive Director and the Director of Nurses (DNS) on 12/11/19 at approximately 1:45 PM they have not conducted any negotiated risks. The DNS when asked about negotiated risks commented ["I know we have a form"].

Facility policy titled MANAGED NEGOTIATED

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A 601	Continued From page 15 RISK AGREEMENT, that whenever the community determines that a resident's decision, behavior or action places the resident or others at risk of harm, the community designee shall initiate a service negotiator process to address the identified risk and to reach a mutually agreed upon plan of action.	A 601		
A 607 SS=E	VI Resident Care and Services 6.7 Care Plans The licensee, the resident and/or the resident's legal representative shall work together to develop and maintain a written resident care plan for those residents who require or receive care. The care plan shall describe the assessed needs and choices of the resident and shall support the resident's dignity, privacy, choice, individuality, and independence. The licensee shall review the plan at least annually, and whenever the resident's condition or circumstances warrant a review, including whenever a resident's decision, behavior or action places the resident or others at risk of harm or the resident is incapable of engaging in a negotiated risk agreement. This Statute is not met as evidenced by: Based on observation, record review and staff interview the facility failed to update care plans and provide instruction to all direct care staff regarding the health care needs for 2 applicable residents after falls that resulted in head injuries, (Resident #3 and #4). The findings include the following: 1. Resident #3 had a fall on 10/19/19. The resident was transferred to the emergency room	A 607		

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A 607	Continued From page 16	A 607		

and required stapling of a head laceration. Despite the fact that the care plan was modified on 11/08/19, there are no instructions to the direct care staff, reflecting the care needs of Resident #3, related to the monitoring of a head injury and the laceration.

2. Resident #4 had a fall on 11/11/19 and a 2nd on 11/29/19 that required a 4-day hospitalization. The resident returned to the facility on 12/03/19. The care plan was last modified on 11/29/19. The resident sustained a subdural hematoma, traumatic right orbital hematoma, a subarachnoid hemorrhage and a possible nondisplaced maxillary fracture. Discharge instructions from the acute setting identified that the resident required 24/7 hands on assistance, utilized upright chair position or chair when someone can stay with her in room, ambulate/transfer with one assist and a walker as the resident is high risk for falls and physical assist for activities of daily living (ADL'S) as needed. Other recommendations included to orient the resident via communication and staff to cue resident and to monitor and limit excessive noise. Medications were adjusted and physical therapy was ordered to increase strength, endurance, gait training, transfer and safety. Monitor pain and blood pressure and follow up as needed.
The discharge instruction have not been included on the care plan.

The Director of Nursing (DNS) was interviewed on 12/12/19 and would not confirm that the care plans for both residents do not reflect their current status and do not provide direct staff on the management of head injuries.

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A 609	Continued From page 17	A 609		
A 609 SS=E	VI Resident Care and Services 6.9 Services The licensee shall have the capacity to provide the following services: (a) A daily program of activities and socialization opportunities, including periodic access to community resources; and (b) Social services, which shall include information referral and coordination with other appropriate community programs and resources such as hospice, home health, transportation and other services necessary to support the resident who is aging in place. This Statute is not met as evidenced by: Based on interview with facility staff and the Executive Director (ED), the facility failed to ensure that there is a daily program of activities for both the Special Care Unit and the Assisted Living Residence. The findings include the following: Per observation by the surveyor on 12/11/19 at approximately 4 PM, residents are sitting in the activity room on the Special Care Unit with no activity program in place. Five residents are sitting in a line, 1 resident is reading the newspaper, 2 are resting with their eyes closed and the other 2 are not engaged just sitting unoccupied. 1 Resident is sitting at a table with gloves on and coloring supplies are in place but s/he not actively participating. A Quality of Life Specialist (QLS-care provider) is in the room and s/he is coloring on a sheet of paper that has resident's names and room numbers listed. The QLS staff member is approached and confirms they are coloring.	A 609		

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A 609	Continued From page 18 Per observation on 12/12/19 between 9:15 AM-11:15 AM, the activity room has few residents present. However, residents enter and exit over the next 2 hours. QLS staff are in and out of the room as well. There are no activity programs occurring, residents are assisted as needed and some conversation occurs. A QLS provider put classical music on for listening. A Licensed Practical Nurse and the Director of Nursing are both present in the room at the conclusion of the observation. Confirmation is made by the QLS employee via interview on 12/12/19 at approximately 10:20 AM, that there is no Activity Director currently and there has not been one for some time. QLS staff are expected to keep the residents busy. There is also a new QLS staff member who is sitting at a table observing. S/he is quick to correct residents who attempt to stand independently. Confirmation is made by the ED that there has not been an Activity Director since mid-September 2019. The new Director will begin 12/30/19 and that staff and volunteers are expected to provide ongoing activity programs. The Activity Programs for the month of December, are not posted on the Special Care Unit. A calendar of events is retrieved from the lobby. The calendar does not include specialized programs for the population on the Special Care Unit as identified at the time the unit was approved for licensure.	A 609		
A 901 SS=E	IX Negotiated Risk 9.1 Whenever the licensee determines that a	A 901		

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A 901	Continued From page 19	A 901		

resident's decision, behavior or action places the resident or others at risk of harm, the licensee shall initiate a service negotiation process to address the identified risk and to reach a mutually agreed-upon plan of action.

This Statute is not met as evidenced by:
Based on administrative interviews, the facility failed to initiate a service negotiation process to address identified risk for 2 applicable residents sampled, (Residents #4, and #5). The findings include the following:

1. Resident #4 had a fall on 11/11/19 and a 2nd fall on 11/29/19. The second fall required a 4-day hospitalization. The resident returned to the facility on 12/03/19. The resident sustained a subdural hematoma, traumatic right orbital hematoma, a subarachnoid hemorrhage and a possible nondisplaced maxillary fracture. Discharge instructions from the acute setting identified that the resident required 24/7 hands on assistance, utilized upright chair position or chair when someone can stay with her in room, ambulate/transfer with one assist and a walker as the resident is high risk for falls and physical assist for activities of daily living (ADL'S) as needed. Other recommendations included to orient the resident via communication, staff to cue resident, to monitor and limit excessive noise. Medications were adjusted and physical therapy was ordered to increase strength, endurance, gait training, transfer and safety. Monitor pain and blood pressure and follow up as needed.

2. Resident #5, who was admitted on 06/27/19, with diagnosis to include but not limited to, Hypertension, Cerebral Infarction, Dementia and Peripheral Vascular Disease. The resident has had 1:1 (private care giver), since admission from

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A 901	Continued From page 20 9 AM - 1 PM. Incident reports reviewed dated 09/08 - 12/7/19 identify 17 falls during that time frame. 6 of the falls occurred on the day shift, 10 falls on the evening shift and 1 on the overnight shift. None of the falls occurred during the time the private care giver was present. 3 of the falls resulted in an emergency transfer. Confirmation was made by both the Executive Director and the Director of Nurses on 12/11/19 at approximately 1:45 PM, that they have not initiated any negotiated risks. The facility policy titled Managed Negotiated Risk Agreement identifies, at the time it is determined the resident's decision, behavior or action places the resident or others at risk of harm, the community designee shall initiate a service negotiation process to address the identified risk and to reach a mutual agreed-upon plan of action.	A 901		

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 1.8.20.

Response to Survey ending 12-12-19

Tag: R131 V. Resident Care and Home Services

1. **The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**
   Memory Care residents may have been put at risk for limited care and compromised safety, with alleged staffing of less than 1:8 staff to resident ratio.

2. **The facility will identify other residents that may potentially be affected by the deficient practice.**
   Identification of at-risk residents will be accomplished, on a daily basis, by comparing the number of staff scheduled on duty vs. resident census and their level acuity.

3. **The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**
   Effective immediately, there will be 3 scheduled staff on the 11:00 p.m. to 7:00 a.m. shift. This scheduling pattern will remain in effect, until there is an increase or decrease in resident census. Adjustments will be made to maintain a 1:8 staff to resident ratio. Acuity of each resident will be taken into consideration when evaluating staffing ratios.

4. **The facility will monitor the corrective action by implementing the following measures.**
   On a weekly basis the Director of Health Services or designee will review the schedule and resident census and assess level of compliance.

5. **Plan of Correction completion date. 12-12-19**

Tag: R145 V. Resident Care and Home Services

1. **The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**
   Development of care plans. Residents #3 and #4, Care Plans have been reviewed and updated to reflect their current status.

2. **The facility will identify other residents that may potentially be affected by the deficient practice.**
   To identify any other residents at risk by the deficient practice, the Director of Health Services or designee shall review current residents and ensure that their Care Plans reflect the care and services necessary to assist the resident to maintain independence and well-being.

3. **The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**
   To prevent reoccurrence of the deficient practice, the Director of Health Services or designee shall review care plans per the community policy, admission, change of condition and quarterly to ensure the care plan reflects the current care needed to provide instruction to staff regarding the residents healthcare needs.

4. **The facility will monitor the corrective action by implementing the following measures.**
   The facility will monitor the corrective action by utilizing an audit tool for care plan updates. This audit will be completed weekly for 4 weeks, monthly for 3 months and reviewed monthly by the QAPI team to ensure completion and effectiveness.

5. **Plan of Correction completion date. 1-7-20**

Tag: R178 V. Resident Care and Home Services

1. **The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**
   There shall be sufficient staff of qualified personnel available to provide necessary care, to maintain a safe environment.

2. **The facility will identify other residents that may potentially be affected by the deficient practice.**
   The Director of Health Services and/or designee shall review those residents with potential for falls.

3. **The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**
   Residents shall receive adequate supervision and assistance to prevent accidents. The falls policy and procedures includes assessment, planning, intervention and evaluation. The fall assessment will be completed at move in, change of condition and semiannually. The post fall reporting guides the investigation of the fall, prompts physician notification, documentation and interventions to prevent another fall. Mandatory education was held with the nursing staff on 1/16/20 and included a review of the fall management program, definition of a fall, intrinsic and extrinsic risk factors to assess, how to do a thorough fall risk assessment, interventions for risk factors identified and re-education on answering the call lights, shifting our focus to a proactive approach to prevent falls and related injury from occurring. Managers and nurses will monitor for fall interventions during daily rounds. A weekly risk meeting shall be held to review residents at risk for falls and discuss their care and update their care plans.

   Should an LPN determine the need for immediate interventions of a resident, in the physical absence of a facility RN, the LPN shall contact the residents Licensed Practitioner. If the resident's Licensed Practitioner is non-responsive within an acceptable timeframe, a facility RN will be notified for direction on how to treat the resident. The LPN will make the calls with all pertinent information: e.g., level of pain, signs of injury, vital signs and any other information that could signify injury. Either the Licensed Practitioner or the RN will advise the LPN on the appropriate action to take. This consultation will be documented within the incident report and progress notes to ensure proper follow up. The RN of the community shall review and sign off on all incident reports. Nursing staff shall be in-serviced on determining the need for immediate care protocol.

4. **The facility will monitor the corrective action by implementing the following measures.**
   The facility will monitor the corrective action: An audit tool shall be implemented that will be used by the Director of Health Services and/ or Designee to ensure the risk meetings are occurring and that when additional

interventions are needed they are added to the residents care plan. Audit results will be reviewed by the Quality Assurance Committee monthly for 3 months and then randomly if 100% compliance is obtained.

The Director of Health Services or designee shall review progress notes, and incidents reports to ensure proper follow up. This audit will be completed weekly for 4 weeks, monthly for 3 months and reviewed monthly by the QAPI team to ensure completion and effectiveness.

5. **Plan of Correction completion date. 1-7-20**

Tag: R188 V. Resident Care and Home Services

1. **The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**
   Resident Records. A record for each resident which includes progress notes regarding any accident or incident and subsequent follow up shall be included in the resident record.

2. **The facility will identify other residents that may potentially be affected by the deficient practice.**
   All care plans have been reviewed and updated by the Director of Health Services.

3. **The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**
   To prevent reoccurrence of the deficient practice, residents that have accidents or incidents, as per Life Care Services' policy, the completion of an Occurrence Note: i.e., Progress Note will be maintained in the resident record. This note will address the incident, immediate care, any discharge instructions if the resident needed emergency intervention, or hospital discharge instructions and any applicable follow up care. Nursing staff shall be in-serviced on completion of occurrence notes and corresponding progress notes.

4. **The facility will monitor the corrective action by implementing the following measures.**
   The facility will monitor the corrective action: Director of Health Services or designee shall review incident reports weekly for 4 weeks, monthly for 3 months and reviewed monthly by the QAPI team to ensure completion of follow up notes and effectiveness.

5. **Plan of Correction completion date. 1-7-20**

Tag: R191 Resident Care and Home Services

1. **The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**
   Reporting of Untimely Deaths. Untimely deaths shall be reported to the agency and kept on file in the resident record. Resident # 1 record was updated to reflect his date of death.

2. **The facility will identify other residents that may potentially be affected by the deficient practice.**
   No other reportable events at this time.

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

To ensure that the facility continues to stay in compliance with appropriate reporting of untimely death, the Director of Health Services or designee shall review known death of resident and report to agency if considered untimely.

4. **The facility will monitor the corrective action by implementing the following measures.**
Director of Health Services shall review progress notes and records of residents out of the community, weekly for 4 weeks, monthly for 3 months and reviewed monthly by the QAPI team to ensure compliance with the regulation.

5. **Plan of Correction completion date. 1-7-20**

Tag: A601 VI. Resident Care and Home Services

1. **The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**
Negotiated Risk to address an identified risk of further harm, as it relates to falls and/ or changes in care needs. Residents #4 and #5's responsible persons will be requested to complete a Negotiated Risk form, as it relates to risk for future falls.

2. **The facility will identify other residents that may potentially be affected by the deficient practice.**
Director of Health Services will review all current residents that have had falls and/ or changes in in care needs within the past 90 days.

3. **The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**
To prevent reoccurrence of the deficient practice: Whenever the community determines that a resident's decision, medical condition, behavior or action places the resident or others at risk of harm, the community designee shall initiate a service negotiation process to address the identified risk and to reach a mutually agreed-upon plan of action. The community shall initiate the negotiated risk process by notifying the resident and, if applicable, the legal representative, verbally and in writing (NURS0051F). The community shall also give notice to the resident and legal representative that the State Long Term Care Ombudsman is available to assist in the process. If the community and the resident reach agreement, the mutually agreed upon plan shall be in writing.
a. The written plan shall be dated and signed by both parties to the negotiation;
b. Each party to the negotiation shall receive a copy of the written plan; and
c. A copy of the plan shall be attached to and incorporated into the resident's care and service plan.
d. If the community and the resident are not able to reach agreement, the community shall notify the State Long Term Care Ombudsman if the failure to reach agreement results in a notice of discharge.
e. Negotiated risk discussions and the plan shall be resident specific.

4. **The facility will monitor the corrective action by implementing the following measures.**
The Director of Health Services or designee of the facility will monitor the corrective action by utilizing an audit tool tracking all resident falls and changes in care needs. This audit will be completed weekly for 4 weeks, monthly for 3 months and reviewed monthly by the QAPI team to ensure completion and effectiveness.

5. **Plan of Correction completion date. Completion of the immediate action of putting the negotiated risk for resident #4 and #5 will be completed by 1-15- 2020.**

Tag: A607 VI. Resident Care and Services

1. **The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**
   As it relates to Falls Care Plan that do not reflect a resident's current status after a fall. To immediately address the two residents at risk, residents #3 and #4, their Falls Care Plans have been reviewed and updated accordingly to reflect their current status.

2. **The facility will identify other residents that may potentially be affected by the deficient practice.**
   Director of Health Services or designee shall review shall review careplans and make any necessary changes to reflect current needs and update direct care staff taking care of the resident, discussing, needs, goals, and interventions.

3. **The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**
   To prevent a reoccurrence of the deficient practice, The Director of Health Services or designee shall develop a comprehensive Care Plan/Service Plan for each resident that includes measurable goals and objectives, realistic approaches and
   interventions, timetables and evaluations to meet the resident needs as they age in
   place. The care plan will depict the resident's assessed needs and choices and support their
   dignity, privacy, individuality as well as independence. Care Plans/Service Plans are tools for accountability. It is to determine, among other things the resident's abilities and needs, making and initiating plans, assigning others to implement it and evaluating the extent to which the plan was effective in accentuating the strengths and resolving the needs of the resident as identified.

4. **The facility will monitor the corrective action by implementing the following measures.**
   Director of Health Services or designee shall review care for residents that have a fall. This review shall be completed weekly for 4 weeks, monthly for 3 months and reviewed monthly by the QAPI team to ensure completion and effectiveness.

5. **Plan of Correction completion date. 1-31-20**

Tag: A609 VI. Resident Care and Services

1. **The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**
   A new Life Enrichment Director started on 12-31-19 and shall provide a daily program of activities for both the assisted living and memory care residents.

2. **The facility will identify other residents that may potentially be affected by the deficient practice.**
   Review of activity engagement will be assessed for all residents by new Director of Life Enrichment or designee.

3. **The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**
   To prevent this deficient practice from reoccurring, there shall be a daily program of activities for both memory care and assisted living residents by the Director of Life Enrichment or designee.

4. **The facility will monitor the corrective action by implementing the following measures.**
   The facility will monitor the corrective action by: Executive Director or designee shall review the daily activity calendar weekly for 4 weeks and monthly by the QAPI team to ensure compliance and effectiveness.

5. **Plan of Correction completion date. 1-17-20**

Tag: A901 IX Negotiated Risk

1. **The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**
   Negotiated Risk to address an identified risk of further harm, as it relates to falls and/ or changes in care needs. Residents #4 and #5's responsible persons will be requested to complete a Negotiated Risk form, as it relates to risk for future falls.

2. **The facility will identify other residents that may potentially be affected by the deficient practice.**
   Director of Health Services will review all current residents that have had falls and/ or changes in care needs within the past 90 days.

3. **The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**
   To prevent reoccurrence of the deficient practice: Whenever the community determines that a resident's decision, medical condition, behavior or action places the resident or others at risk of harm, the community designee shall initiate a service negotiation process to address the identified risk and to reach a mutually agreed-upon plan of action. The community shall initiate the negotiated risk process by notifying the resident and, if applicable, the legal representative, verbally and in writing (NURS0051F). The community shall also give notice to the resident and legal representative that the State Long Term Care Ombudsman is available to assist in the process. If the community and the resident reach agreement, the mutually agreed upon plan shall be in writing.
   a. The written plan shall be dated and signed by both parties to the negotiation;
   b. Each party to the negotiation shall receive a copy of the written plan; and
   c. A copy of the plan shall be attached to and incorporated into the resident's care and service plan.
   d. If the community and the resident are not able to reach agreement, the community shall notify the State Long Term Care Ombudsman if the failure to reach agreement results in a notice of discharge.
   e. Negotiated risk discussions and the plan shall be resident specific. To prevent reoccurrence of the deficient practice, any resident that has a fall will be presented with a Negotiated Risk Agreement. In the event the resident is unable to sign on their own behalf their responsible party will be contacted to do so.

4. **The facility will monitor the corrective action by implementing the following measures.**
   The Director of Health Services or designee of the facility will monitor the corrective action by utilizing an audit tool tracking all resident falls and changes in care needs. This audit will be completed weekly for 4 weeks, monthly for 3 months and reviewed monthly by the QAPI team to ensure completion and effectiveness.

5. **Plan of Correction completion date. 1-15-20**