



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

December 9, 2022

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 **May 19, 2022**. 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,

A handwritten signature in cursive script that reads "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: 0660	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/19/2022	
NAME OF PROVIDER OR SUPPLIER THE VILLAGE AT WHITE RIVER JUNCTION		STREET ADDRESS, CITY, STATE, ZIP CODE 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 and facility self-report investigation was conducted on 5/17/22 and completed on 5/19/2022 by the Division of Licensing and Protection. Findings identified are associated with the facility self-report.	R100	see attached	
R208 SS=G	<p>V. RESIDENT CARE AND HOME SERVICES</p> <p>5.18 Reporting of Abuse, Neglect or Exploitation</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to report to the Licensing Agency when a pattern of abusive behavior involving 2 applicable residents had occurred over a period of 11 months. (Resident #1 & Resident #2) Findings include:</p> <p>Per record review Resident #1 was subjected to physical and verbal assaults from his/her spouse while a resident of the Assisted Living Residence (ALR). Over the course of 11 months, while experiencing a decline in health, Resident #1 became weaker and demonstrated a decreased ability in mobility, appetite, and personal</p>	R208		

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Executive Director

06/09/2022

R208 POC accepted 12/2/22 F. McIntosh RN/MLC

Division of Licensing and Protection

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R208	Continued From page 1 interactions. Resident #1 shared a suite with his/her spouse (Resident #2). At times Resident #2 would attempt to provide or assist with the care of their spouse while expressing frustration and anger when Resident #1 would not comply or respond to interactions in a manner that was considered acceptable by Resident #2. On 7/29/21 during a meal in the dinning room, Resident #2 was observed per progress note ".....very agitated...yelling for him/her to drink water...". When Resident #1 did not comply Resident #2 "....turned her/him around in the chair to face the window. Stated that s/he better be careful when they get to their room..." The pattern continued when staff witnessed on 8/23/21 while on the facility elevator, Resident #2 punched his/her spouse in the upper chest with a closed fist. On 12/16/21 it was reported by dinning room staff Resident #2 was observed verbally and physically assaulting his/her spouse with a closed hand to Resident #1's face. While on Hospice services and bed bound, Resident #1 was again assaulted by his/her spouse. Per progress note dated 2/21/22 at 12:55 AM "...staff reported to nurse that they saw (spouse) hovering over the resident as they entered the room...." Resident #1 stated "s/he hit me...". Observations made by the facility nurse on 2/21/22 documents via progress note ".....saw a hand print on the upper thigh of the resident..." When confronted by facility staff regarding the mistreatment observed, Resident #2 would repeatedly deny any assaults occurred. Although the facility had made reports to Adult Protective Services (APS) they failed to report to the licensing agency when assaults became a pattern, as required. Per telephone interview on the afternoon of 5/19/22, the ALR Administrator confirmed, although staff failed to report the pattern of abuse, the policy and procedure is to	R208			

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R208	Continued From page 2 file a Facility Report with the licensing agency.	R208		

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 6/9/2022.

Response to Survey ending May 19, 2022

Tag: R208 V. Resident Care and Home Services

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

The facility will report to both APS and the Licensing Agency when a pattern of abusive behavior involving residents occurs.

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

The facility will provide reporting instructions to all applicable staff, including DOHS, Business Manager, and nurses.

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

The Director of Health Services will alert the Executive Director of all APS reports. The Executive Director will confirm that those reports are also reported to the Licensing Agency.

4. **Plan of Correction completion date: 06-03-2022**