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

March 13, 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 investigation survey conducted on **February 22, 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 02/22/2023

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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 complaint investigation of a facility self-report was conducted by the Division of Licensing and Protection on 2/21/23 and completed on 2/22/23. The following regulatory violations were identified.	R100	See attached	
R206 SS=H	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be contacted by calling toll-free 1-800-564-1612. Reports must be made to APS within 48 hours of learning of the suspected, reported or alleged incident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the ALR (Assisted Living Residence) failed to report suspected cases of abuse between a former employee and a resident within the required 48 hours after learning of the suspected abuse incidents. Findings include: Resident #1 who has a history of dementia and Traumatic Brain Injury, was admitted to the ALR Memory Care unit on 8/15/22. Since admission, Resident #1's behaviors have been challenging for staff. Per the resident's Service Plan interventions have been established to intervene prior to Resident #1's aggressive behavior from accelerating. Distractions such as music, dance, snacks & video of airplanes at times help in managing the Resident's behavior.	R206		

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R206	Continued From page 1 On 1/2/23 during the 11:00 PM to 7:00 AM shift Resident #1, age 83, became agitated and demonstrated aggressive behavior. During a transfer from wheelchair to recliner by 2 QLS (Quality Life Support) staff, Resident #1 grasped onto QLS #1's arm/wrist. After requesting the resident let go of the staff member's arm/wrist, QLS #1 proceeded to slap Resident #1 in the arm/wrist area. Staff present at the time of the incident cautioned QLS #1's response was not appropriate and could cost his/her job. QLS #1 responded by stating "I don't give a XXXX.....". Staff reported the incident to the DOHS (Director of Health Services), and witness statements were obtained. The surveyor requested the ALR's investigated summary for the 1/2/23 incident. The original summary was not found and on 2/22/23 a replicated summary and witness statements were submitted by the Executive Director for surveyor's review. It was determined by both the Executive Director and DOHS the slap to Resident #1's arm "...deemed the situation to be a defensive reaction with no harm and not reportable". A timely report was never filed with APS regarding this incident which required a review for abuse. A second event occurred between QLS #1 and Resident #1 during the early morning of 2/11/23. Subsequent to the incident which occurred on 1/2/23, Resident #1 became the target of additional abuse on the early morning of 2/11/23. At approximately 2:30 AM, while sitting in his/her wheelchair in a common area of the Memory Care Unit, Resident #1 awakened from a nap. The resident attempted to get up from the wheelchair, staff obtained his/her walker and attempted to ambulate the resident around the unit hallways. Upon requesting to use his/her bathroom, 2 QLS staff members assisted	R206	See attached	

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R206	Continued From page 2 Resident #1 to his/her room. Resident #1's behaviors began to accelerate and s/he became physically aggressive. Resident #1 hit 2 staff members (QLS #1 & #2) while s/he was attempting to leave his/her room. QLS #1 responded by punching Resident #1 in the abdomen. Witnesses reported when hit, Resident #1 groaned and began to drop to his/her knees and was assisted to the floor. Once on the floor, Resident #1 began kicking and QLS #1 kicked the resident back. Witnessing the assault, the nurse assigned to the Memory Care Unit ordered QLS #1 out of the resident's room. Despite repeated requests to leave Resident #1's room, QLS #1 refused to leave and began to verbally harass Resident #1 stating "I hope s/he falls and bust his/her head open"; "S/he deserves everything that comes to her/him" and continued verbally assaulting with profanity. The nurse contacted the DOHS at 3:14 AM on 2/11/23 seeking guidance in managing Resident #1. The nurse was advised by the DOHS to let Resident #1 rest on the floor, provide a pillow and blanket. This was done and eventually Resident #1 accepted a snack and finally allowed staff to assist the resident to bed where s/he fell asleep. In addition, after the incident on 2/11/23 at 10:23 AM the DOHS received an email from the nurse who had witnessed the altercation on the Memory Care Unit during the 11:00 PM - 7:00 AM shift on 2/10 - 2/11/23. In the email the nurse stated QLS #1 "...does not know how to deal with (Resident #1) when s/he's being combative and verbally abusive. If (Resident #1) hits her/him in any way, shape or form, s/he (QLS #1) will give it back to him/her....I kept telling her/him to walk away to let us deal with him/her (Resident #1) and s/he wouldn't and didn't listen...". The DOHS failed to follow-up with the night nurse or investigate	R206	See attached	

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R206	Continued From page 3 further with staff on the Memory Care Unit to learn what had happened during the early morning of 2/11/23. In addition, the employee was allowed to continue working on the Memory Care Unit on 2/14/23 (11:00 PM - 7:00 AM shift), still being made responsible for the provision of care for other vulnerable residents along with being in contact with Resident #1. It was not until 2/15/23 when a further discussion occurred between the DOHS and another staff nurse it was determined the QLS #1 should be interviewed. Upon interview with Administrative staff, QLS #1's employment was terminated. Per the ALR's Abuse Prevention Policy: VI "Internal Investigation of Abuse, Neglect, or Misappropriation Allegations and Response" states "2. Any incident or allegation involving abuse, neglect, or misappropriation will result in an abuse investigation". However, the facility failed to file a report with APS regarding either instance of abuse within the required 48 hours.	R206	See attached	
R207 SS=H	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.b The licensee and staff are required to report suspected or reported incidents of abuse, neglect or exploitation. It is not the licensee's or staff's responsibility to determine if the alleged incident did occur or not; that is the responsibility of the licensing agency. A home may, and should, conduct its own investigation. However, that must not delay reporting of the alleged or suspected incident to Adult Protective Services. This REQUIREMENT is not met as evidenced	R207		

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R207	Continued From page 4 by: Based on staff interview and record review, the ALR failed to identify, acknowledge and report to Adult Protective Services in a timely manner incidents of abuse which resulted between a vulnerable resident and an employee on 2 separate occasions. (Resident #1) Findings include: Resident #1 who has a history of dementia and Traumatic Brain Injury, was admitted to the ALR Memory Care unit on 8/15/22. Since admission, Resident #1's behaviors have been challenging for staff. Per the resident's Service Plan interventions have been established to intervene prior to Resident #1's aggressive behavior from accelerating. Distractions such as music, dance, snacks & video of airplanes at times help in managing the Resident's behavior. On 1/2/23 during the 11:00 PM to 7:00 AM shift Resident #1, age 83, became agitated and demonstrated aggressive behavior. During a transfer from wheelchair to recliner by 2 QLS staff, Resident #1 grasped onto QLS #1's arm/wrist. After requesting the resident let go of the staff member's arm/wrist, QLS #1 proceeded to slap Resident #1 in the arm/wrist area. Staff present at the time of the incident cautioned QLS #1 his/her response was not appropriate and could cost his/her job. QLS #1 responded by stating "I don't give a XXXX.....". Staff reported the incident to the DOHS (Director of Health Services), and witness statements were obtained. The surveyor requested the ALR's investigated summary for the 1/2/23 incident. The original summary was not found and on 2/22/23 a replicated summary and witness statements were submitted by the Executive Director for surveyor's review. It was determined by both the Executive	R207	See attached	

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R207	Continued From page 5 Director and DOHS the slap to Resident #1's arm "....deemed the situation to be a defensive reaction with no harm and not reportable". Despite the State APS (Adult Protective Services) Statute which states "...it is not the licensee's or staff responsibility to determine if the alleged incident did or did not occur", requiring the facility to file the report and allow APS to investigate to make a determination of alleged abuse. After the incident of 1/2/23, QLS #1 remained employed at the ALR with no evidence of additional monitoring of work performance or opportunities for improvement to include additional training. QLS#1 continued to be assigned to the vulnerable residents on the Memory Care Unit. At approximately 2:30 AM on 2/11/23, while sitting in his/her wheelchair in the common area on the Memory Care Unit, Resident #1 awakened from a nap. Resident #1 attempted to get up from the wheelchair, staff obtained his/her walker and had the resident ambulate around the unit hallways. Upon requesting to use that bathroom, 2 QLS staff members assisted Resident #1 to his/her room. Once in his/her room, Resident #1's behaviors began to accelerate and s/he became physically aggressive. Resident #1 hit 2 staff members (QLS #1 & #2) while attempting to leave his/her room. QLS #1 responded by punching Resident #1 in the abdomen. Witnesses reported when hit, Resident #1 groaned and began to drop to his/her knees and was assisted to the floor. Once on the floor, Resident #1 began kicking and QLS #1 kicked the resident. Witnessing the assault, the nurse assigned to the Memory Care Unit ordered QLS #1 out of the resident's room. Despite repeated requests to leave Resident #1's room, QLS #1 refused to leave and began to verbally harass Resident #1 stating "I hope s/he falls and	R207	See attached	

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R207	Continued From page 6 bust his/her head open"; "S/he deserves everything that comes to her/him" and continued verbally assaulting with profanity. The nurse contacted the DOHS at 3:14 AM on 2/11/23 seeking guidance in managing Resident #1. The nurse was advised by the DOHS to let Resident #1 rest on the floor, provide a pillow and blanket. This was done and eventually Resident #1 accepted a snack and finally allowed staff to assist the resident to bed where s/he fell asleep. After the event, the night nurse followed up with an email to the DOHS on 2/11/23 at 10:23 AM reporting concerns regarding QLS #1. In the email s/he stated: ".....s/he does not know how to deal with (Resident #1) when s/he's combative and verbally abusive. If (the resident) hits her/him in any way, shape, or form, s/he will give it back to him/her. Last night when (the resident) was acting out, I kept telling her/him (QLS #1) to walk away to let us deal with him/her and s/he wouldn't and didn't listen.....I think it would be best for her/him to stay in AL (Assisted Living) if possible for her/his safety and Resident #1". Despite the concerns expressed by phone and email by the nurse, the DOHS failed to investigate immediately the concerns expressed. As a result QLS #1 continued to be scheduled for work, assigned to the Memory Care Unit on the 11:00 PM to 7:00 AM on 2/14/23. It was not until 2/15/23 when the DOHS began to conduct an investigation, 4 days after the second abuse incident. The licensee and staff are required to report suspected or reported incidents of abuse, neglect or exploitation. It is not the licensee's or staff's responsibility to determine if the alleged incident did occur or not; that is the responsibility of the licensing agency. A facility may, and should, conduct its own investigation. However,	R207	See attached	

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R207	Continued From page 7 that must not delay reporting of the alleged or suspected incident to Adult Protective Services. The ALR had failed to report the first instance of abuse occurring on 2/1/23 and delayed investigating and reporting the second event which occurred on 2/11/23.	R207	See attached	
R213 SS=H	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, the ALR failed to ensure each resident was treated with consideration, respect and full recognition of of the resident's dignity and individuality for 1 applicable resident. (Resident #1) Findings include Resident #1 who has a history of dementia and Traumatic Brain Injury, was admitted to the ALR Memory Care unit on 8/15/22. Since admission, Resident #1's, age 83, behaviors have been challenging for staff. Per the resident's Service Plan interventions have been established to intervene prior to Resident #1's aggressive behavior from accelerating. Distractions such as music, dance, snacks & video of airplanes at times help in managing the Resident's behavior. On 1/2/23 during the 11:00 PM to 7:00 AM shift Resident #1 became agitated and demonstrated	R213		

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R213	Continued From page 8	R213	see attached	

aggressive behavior. During a transfer from wheelchair to recliner by 2 QLS, Resident #1 grasped onto QLS #1's arm/wrist. After requesting the resident let go of the staff member's arm/wrist, QLS #1 proceeded to slap Resident #1 in the arm/wrist area. Staff present at the time of the incident cautioned QLS #1 his/her response was not appropriate and could cost his/her job. QLS #1 responded by stating "I don't give a XXXX.....".

After the incident of 1/2/23, QLS #1 remained employed at the ALR with no evidence of additional monitoring of work performance or opportunities for improvement to include additional training. QLS#1 continued to be assigned to the vulnerable residents on the Memory Care Unit. At approximately 2:30 AM on 2/11/23, while sitting in his/her wheelchair in the common area on the Memory Care Unit, Resident #1 awakened from a nap. Resident #1 attempted to get up from the wheelchair, staff obtained his/her walker and had the resident ambulate around the unit hallways. Upon requesting to use that bathroom, 2 QLS staff members assisted Resident #1 to his/her room. Once in his/her room, Resident #1's behaviors began to accelerate and s/he became physically aggressive. Resident #1 hit 2 staff members (QLS #1 & #2) while attempting to leave his/her room. QLS #1 responded by punching Resident #1 in the abdomen. Witnesses reported when hit, Resident #1 groaned and began to drop to his/her knees and was assisted to the floor. Once on the floor, Resident #1 began kicking and QLS #1 kicked the resident. Witnessing the assault, the nurse assigned to the Memory Care Unit ordered QLS #1 out of the resident's room. Despite repeated requests to leave Resident #1's room, QLS #1 refused to leave and began to verbally

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R213	Continued From page 9 harass Resident #1 stating "I hope s/he falls and bust his/her head open"; "S/he deserves everything that comes to her/him" and continued verbally assaulting with profanity. In both instances, Resident #1 was not treated with respect and dignity, despite the challenging behaviors s/he can demonstrate. The resident was subjected to being hit, kicked and verbal insults by a former employee while living on the Memory Care Unit of the ALR.	R213	See attached	
R224 SS=H	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, there was a failure to protect the right to be free from verbal and physical abuse for 1 applicable resident. (Resident #1) Resident #1 who has a history of dementia and Traumatic Brain Injury, was admitted to the ALR Memory Care unit on 8/15/22. Since admission, Resident #1's behaviors have been challenging for staff. Per the resident's Service Plan interventions have been established to intervene prior to Resident #1's aggressive behavior from accelerating. Distractions such as music, dance, snacks & video of airplanes at times help in managing the Resident's behavior. On both	R224		

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R224	Continued From page 10 1/2/23 and 2/10/23 during the 11:00 PM to 7:00 AM shift on the Memory Care Unit, Resident #1 was subjected to both physical and verbal abuse by an employee. On 1/2/23 during the 11:00 PM to 7:00 AM shift Resident #1 became agitated and demonstrated aggressive behavior. During a transfer from wheelchair to recliner by 2 QLS staff members, Resident #1 grasped onto QLS #1's arm/wrist. After requesting the resident let go of the staff member's arm/wrist, QLS #1 proceeded to slap Resident #1 in the arm/wrist area. Staff present at the time of the incident cautioned QLS #1 his/her response was not appropriate and could cost his/her job. QLS #1 responded by stating "I don't give a XXXX.....". Staff reported the incident to the DOHS, and witness statements were obtained. The surveyor requested the ALR's investigated summary for the 1/2/23 incident. The original summary was not found and on 2/22/23 a replicated summary and witness statements were submitted by the Executive Director for surveyor's review. It was determined by both the Executive Director and DOHS the slap to Resident #1's arm "....deemed the situation to be a defensive reaction with no harm and not reportable". Subsequent to the incident which occurred on 1/2/23, Resident #1, age 83 became the target of additional abuse on the early morning of 2/11/23. At approximately 2:30 AM, while sitting in his/her wheelchair in a common area Resident #1 awakened from a nap. Resident #1 attempted to get up from the wheelchair, staff obtained his/her walker and attempted to ambulate the resident around the unit hallways. Upon requesting to use his/her bathroom, 2 QLS staff members assisted Resident #1 to his/her room. Resident #1's behaviors began to accelerate and s/he became	R224	See attached	

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R224	Continued From page 11 physically aggressive. Resident #1 hit 2 staff members (QLS #1 & #2) while s/he was attempting to leave his/her room. QLS #1 responded by punching Resident #1 in the stomach. Witnesses reported when hit, Resident #1 groaned and began to drop to his/her knees and was assisted to the floor. Once on the floor, Resident #1 began kicking and QLS #1 kicked the resident back. Witnessing the assault, the nurse assigned to the Memory Care Unit ordered QLS #1 out of the resident's room. Despite repeated requests to leave Resident #1's room, QLS #1 refused to leave and began to verbally harass Resident #1 stating "I hope s/he falls and bust his/her head open"; "S/he deserves everything that comes to her/him" and continued verbally assaulting with profanity. The resident remained on the floor for an extended period eventually accepted a snack and finally allowed staff to assist the resident to bed. There was a failure to protect Resident #1 and other residents from further abuse by continuing to schedule QLS #1 for the Memory Care Unit at the ALR. After the incident on 1/2/23 there was a lack of evidence for additional counseling, training or monitoring of this specific QLS's job performance not only with Resident #1 but all the vulnerable individuals who are residents residing on the Memory Care Unit. In addition, despite the notification of concerns related to QLS #1 expressed on 2/11/23 via email by the night Memory Care Unit nurse to the DOHS stating: "....s/he does not know how to deal with (Resident #1) when s/he's being combative and verbally abusive. If (Resident #1) hits her/him in anyway, shape or form, s/he will give it back to him/her(the resident). Last night when s/he was acting out, I kept telling her/him to walk away to let us deal with him/her s/he wouldn't and didn't listen..."	R224	See attached	

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 02/22/2023

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
R224	Continued From page 12 Although a previous incident existed without corrective action and a second abusive event had resulted related to QLS #1, the employee was not removed from the staff schedule and returned to work on 2/14/23, assigned again on nights to the Memory Care Unit. It was not until 2/15/23 when the Administration confronted the employee regarding allegations of abuse, that the employee was terminated. Prior to the employee's termination, Resident #1 was not free from verbal and physical abuse as evidenced by the 2 incidents as above mentioned.	R224	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 4/15/2023.

Response to Survey ending February 22, 2023

Tag: R206 V. Resident Care and Home Services

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

   The facility will report to APS within 48 hours any case of suspected abuse, neglect, or exploitation.

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

   The facility will provide abuse reporting instructions to all staff.

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 suspected abuse, neglect, or exploitation. The Executive Director will confirm that appropriate reports are made to APS within 48 hours.

4. **Plan of Correction completion date: 03-17-2023**

Tag R206 POC accepted on 3/10/23 by M. McIntosh/P. Cota

Tag: R207 V. Resident Care and Home Services

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

   The facility will report to APS within 48 hours any case of suspected abuse, neglect, or exploitation, regardless of the results of any internal investigation.

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

   The facility will provide abuse reporting instructions to all staff. The DOHS and ED will ensure that any case of suspected abuse, neglect or exploitation is reported, regardless of the results of any internal investigation.

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 suspected abuse, neglect, or exploitation. The Executive Director will confirm that appropriate reports are made to APS within 48 hours.

4. **Plan of Correction completion date: 03-17-2023**

Tag R207 POC accepted on 3/10/23 by M. McIntosh/P. Cota

Tag: R213 VI. Residents' Rights

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

   The facility will investigate each instance of a violation of residents' rights or suspected abuse, neglect, or exploitation by staff and determine whether that staff member requires additional monitoring of work performance, opportunities for improvement to include additional training, or termination of employment. A suspected staff member will be placed on leave pending the results of investigation. In this case the employment was terminated the same day the suspected abuse was reported to APS.

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

   The facility will conduct an internal investigation for each case of a violation of residents' rights or suspected abuse, neglect, or exploitation by staff to determine the extent to which the staff member requires additional monitoring of work performance or opportunities for improvement to include additional training. A suspected staff member will be placed on leave pending the results of investigation. The facility will perform additional training of staff regarding Residents' Rights.

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

   The Business Office Manager will ensure that all new staff have documented training of Residents' Rights during orientation. The Business Office Manager, DOHS, and ED will ensure that all current staff have documented training of Residents' Rights. The Business Office Manager will perform a quarterly audit to ensure that all staff have documented Residents' Rights training. The first audit will be completed by 4/15/2023.

4. **Plan of Correction completion date: 04-15-2023**

Tag R213 POC accepted on 3/10/23 by M. McIntosh/P. Cota

Tag: R224 VI. Residents' Rights

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

   The facility terminated the employment of the abuser in order to ensure the resident in question will be free from verbal and physical abuse.

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

   The facility will conduct an internal investigation for each case of a violation of residents' rights or suspected abuse, neglect, or exploitation by staff to determine the extent to which the staff member requires additional monitoring of work performance or opportunities for improvement to include additional training. A suspected staff member will be placed on leave pending the

results of investigation. The facility will perform additional training of staff regarding Residents' Rights.

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

   The Business Office Manager will ensure that all new staff have documented training of Residents' Rights during orientation. The Business Office Manager, DOHS, and ED will ensure that all current staff have documented training of Residents' Rights. The Business Office Manager will perform a quarterly audit to ensure that all staff have documented Residents' Rights training. The first audit will be completed by 4/15/2023.

4. **Plan of Corrections completion date: 04/15/2023**

Tag R224 POC accepted on 3/10/23 by M. McIntosh/P. Cota