

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

Lamela MCotaRN

Licensing Chief

Division of Licensing and Protection STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: C B. WING 0660 02/22/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **101 CURRIER STREET** THE VILLAGE AT WHITE RIVER JUNCTION WHITE RIVER JUNCTION, VT 05001 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) R100 R100 Initial Comments: See attached 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. R206 V. RESIDENT CARE AND HOME SERVICES R206 SS=H 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.

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Executive Director

Division of Licensing and Protection						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER	A. BUILDING: _		COMPLETED	
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NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
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(X4) ID	SUMMARYST	ATEMENT OF DEFICIENCIES	○ ID	PROVIDER'S PLAN OF CORRECTION	V (X5)	
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R206	Continued From page	e 1	R206			
			i			
	On 1/2/23 during the	11:00 PM to 7:00 AM shift	1			
		became agitated and	į	see attached		
		ssive behavior. During a	i i	Sel attached		
		hair to recliner by 2 QLS	200	2000		
		staff, Resident #1 grasped				
	, , ,	rist. After requesting the	!			
		staff member's arm/wrist,	į			
		slap Resident #1 in the				
	•	present at the time of the				
		LS #1's response was not	Î			
		d cost his/her job. QLS #1	Ĭ			
	responded by stating	"I don't give a XXXX".	!			
	Staff reported the inc	ident to the DOHS (Director	ŀ			
	of Health Services), a	and witness statements were				
	-	or requested the ALR's	Ì			
	_	y for the 1/2/23 incident. The	ĺ			
	_	s not found and on 2/22/23 a	Ì			
		and witness statements were				
	•	cutive Director for surveyor's				
		nined by both the Executive				
		he slap to Resident #1's arm				
		tion to be a defensive				
		n and not reportable". A	1			
		ver filed with APS regarding	1		5	
	this incident which re	quired a review for abuse.	ţ.		40	
	A second event eccu	rred between QLS #1 and				
		ne early morning of 2/11/23.				
		cident which occurred on				
	1/2/23, Resident #1 t					
		the early morning of 2/11/23.				
		0 AM, while sitting in his/her				
		non area of the Memory	ĵ			
		#1 awakened from a nap.				
		ed to get up from the	i			
		ained his/her walker and				
		te the resident around the	Ž			
9		equesting to use his/her	ì			

bathroom, 2 QLS staff members assisted

Division of	of Licensing and Protect	ction				
STATEMENT OF DEFICIENCIES (X1) PROVIDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING:		(X3) DATE SURVEY COMPLETED	
ANDPLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED	
		1	D. M/MC		С	
		0660	B. WING		02/22/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	E, ZIP CODE		
			RRIER STREET			
THE VILLAGE AT WHITE RIVER JUNCTION WHITE RIVER JUNCTION, VT 05001						
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL		
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			Ü	DEFICIENCY)	ļ	
R206	Continued From page	2	R206		9).54).	
	Resident #1 to his/he	r room Resident #1's			7	
		ccelerate and s/he became	31		Î	
	_	. Resident #1 hit 2 staff				
	members (QLS #1 &:				<u> </u>	
	attempting to leave hi			See attached		
(0	responded by punching			Sil mice,		
		reported when hit, Resident	4	_		
70	#1 groaned and bega	n to drop to his/her knees				
39	i	he floor. Once on the floor,			*	
	1	cking and QLS #1 kicked				
1		tnessing the assault, the			i	
	-	Memory Care Unit ordered	1			
	QLS #1 out of the res		2			
7.		leave Resident #1's room,			*	
		ave and began to verbally tating "I hope s/he falls and				
	bust his/her head ope				î	
		s to her/him" and continued				
		th profanity. The nurse				
	contacted the DOHS	•				
	seeking guidance in n	nanaging Resident #1. The			*	
		the DOHS to let Resident				
	#1 rest on the floor, p	rovide a pillow and blanket.				
	This was done and ev				É	
		I finally allowed staff to			E	
	assist the resident to I	bed where s/he fell asleep.				
	In addition, after the in	ncident on 2/11/23 at 10:23				
		ed an email from the nurse				
		e altercation on the Memory				
i		1:00 PM - 7:00 AM shift on				
3	_	email the nurse stated QLS				
		now to deal with (Resident				
		combative and verbally			7.7	
	,	#1) hits her/him in any way,				
		QLS #1) will give it back to				
	•	her/him to walk away to let				
	us deal with him/her (•				
	wouldn't and didn't liet	ten " The DOHS failed to	1			

follow-up with the night nurse or investigate

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Division of Licensing and Protection						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION			
AND PLAN OF CORRECTION IDEN		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		0660	B. WING		C 02/22/2023	
NAME OF PE	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STAT	E, ZIP CODE		
THEVILLA	GE AT WHITE RIVER JU	UNCTION 101 CUR	RIER STREET			
I HE VILLA	GEAT WHITE RIVER JO	WHITE R	IVER JUNCTION,	, VT 05001		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION SHOULD	Ç y	
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	· · · · · · · · · · · · · · · · · · ·			DEFICIENCY)		
R206	Continued From page	e 3	R206			
	further with staff on th	ne Memory Care Unit to				
	learn what had happe					
	•	n addition, the employee was		a lleach ad		
		vorking on the Memory Care 0 PM - 7:00 AM shift), still		see attached		
		ble for the provision of care	1	-		
		esidents along with being in	·			
		t #1. It was not until 2/15/23	8			
		taff nurse it was determined	(ii)			
	the QLS #1 should be	e interviewed. Upon	Si Si			
		strative staff, QLS #1's				
	employment was tern	ninated.				
	Per the ALR's Abuse	Prevention Policy: VI				
		n of Abuse, Neglect, or	1			
		gations and Response"	1			
	-	nt or allegation involving sappropriation will result in				
	_	on". However, the facility				
	failed to file a report with APS regarding either instance of abuse within the required 48 hours.					
R207 SS=H	V. RESIDENT CARE	AND HOME SERVICES	R207			
	5.18 Reporting of Ab	ouse, Neglect or Exploitation		ů		
	5.18.b The licensee a	and staff are required to				
		eported incidents of abuse,	1			
14		n. It is not the licensee's or o determine if the alleged				
		not; that is the responsibility	1			
		cy. A home may, and should,	!			
		stigation. However, that must				
		f the alleged or suspected				
	incident to Adult Prote	ective Services.				
	This REQUIREMENT	T is not met as evidenced				

Division of Licensing and Protection (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 0660 02/22/2023 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **101 CURRIER STREET** THE VILLAGE AT WHITE RIVER JUNCTION WHITE RIVER JUNCTION, VT 05001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) R207 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 see attached 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

Division of Licensing and Protection						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
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THE VILLAGE AT WHITE RIVER JU	UNICTION 101 CURR	IER STREET				
THE VILLAGE AT WATER IVER 30	WHITE RIV	VER JUNCTION,	, VT 05001			
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	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD			
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R207 Continued From page	e 5	R207				
Director and DOHS th	he slap to Resident #1's arm					
"deemed the situat						
reaction with no harm						
	S (Adult Protective Services)					
·	"it is not the licensee's or		Can attached			
	determine if the alleged		Sce attached			
	t occur", requiring the facility		,			
	allow APS to investigate to					
make a determination	_					
	ror anagar anagar	1				
After the incident of 1	/2/23, QLS #1 remained	1				
employed at the ALR						
	of work performance or					
opportunities for impre						
additional training. QL	_S#1 continued to be					
assigned to the vulne	erable residents on the					
Memory Care Unit. At	t approximately 2:30 AM on	1				
2/11/23, while sitting i	in his/her wheelchair in the					
common area on the						
Resident #1 awakene	ed from a nap. Resident #1					
	rom the wheelchair, staff					
	er and had the resident					
ambulate around the						
_	t bathroom, 2 QLS staff					
	esident #1 to his/her room.					
	, Resident #1's behaviors					
_	and s/he became physically					
	#1 hit 2 staff members					
	attempting to leave his/her					
	nded by punching Resident			9		
	Vitnesses reported when hit,			$\tilde{\mu}$		
	and began to drop to his/her	1		E.:		
	ted to the floor. Once on the			0.3 4.5 4.7		
-	gan kicking and QLS #1			El .		
	Vitnessing the assault, the					
=	Memory Care Unit ordered			*		
	sident's room. Despite			57		
The state of the s	leave Resident #1's room,	i		E)		
	ave and began to verbally	i				
narass Resident #1 s	stating "I hope s/he falls and	}				

Division of Licensing and Protection

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY	
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THE VILL	AGE AT WHITE RIVER JU	INCTION	RIER STREET	NT 05004	
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11201			1 1201		5
	bust his/her head ope				
		s to her/him" and continued	1		
	,	th profanity. The nurse			
		at 3:14 AM on 2/11/23		a todad	
		nanaging Resident #1. The		See attached	Ł
		the DOHS to let Resident	1	0-0	
5		rovide a pillow and blanket.			
9	This was done and ev	I finally allowed staff to			
	, .	bed where s/he fell asleep.			
	assist the resident to	bed where sine reli asieep.			¥
	After the event the ni	ght nurse followed up with	1 1		1
		on 2/11/23 at 10:23 AM			į.
		garding QLS #1. In the			8 9 - 3
		.s/he does not know how to			(
	deal with (Resident #	1) when s/he's combative			
3	and verbally abusive.	•			Ĕ
"	her/him in any way, sl	nape, or form, s/he will give			
0	it back to him/her. Las	st night when (the resident)			
	was acting out, I kept	telling her/him (QLS #1) to	1 1		
		eal with him/her and s/he	1 1		
		tenI think it would be best			
	for her/him to stay in A				
	possible for her/his sa	afety and Resident #1".			\$55 ***
	Doonito the conserve	ownroaded by phone and			
		expressed by phone and e DOHS failed to investigate			
8	-	e DORS falled to investigate erns expressed. As a result			
		be scheduled for work,			
		ory Care Unit on the 11:00			
	<u> </u>	4/23. It was not until 2/15/23			16 17 18 18
	when the DOHS bega				
		after the second abuse			
	_	and staff are required to			
		eported incidents of abuse,			
		. It is not the licensee's or			
	-	determine if the alleged			
		not; that is the responsibility			
	of the licensing agenc				
	should, conduct its ow	vn investigation. However,			

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Division of Licensing and Protection							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECT	ION	IDENTIFICATION NUMBER:	A. BUILDING;		COMPLETED		
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		0660	B. WING		02/22/2023		
NAME OF PROVIDER OR	SUPPLIER	STREET AL	DDRESS, CITY, STATI	E ZIP CODE			
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THE VILLAGE AT WH	HITE RIVER JU	UNCTION	IVER JUNCTION,	VT 05001			
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R207 Continue	d From page	e 7	R207	-5-122-24-24-2-1-1-1-1-1-1-1-1-1-1-1-1-1-1	~		
that mus	t not delay re	eporting of the alleged or					
		Adult Protective Services.					
		led to report the first instance		see attached	l l		
		n 2/1/23 and delayed	1	Le analie	^\		
		orting the second event		9			
which oc	curred on 2/	11/23.					
R213 VI. RESI	DENTS' RIG	HTS	R213		Ş		
SS=H			1				
0.4 5							
		hall be treated with					
		ct and full recognition of the	1				
		ividuality, and privacy. A resident to waive the					
resident's	-	resident to waive the					
rooldone	o riginto.		3.				
This RF(THREMENT	「 is not met as evidenced	į				
by:	XOII\LIVILIVI	13 Hot met as evidenced	į				
	n staff intervi	ew and record review, the	İ				
		each resident was treated					
with cons	sideration, re	espect and full recognition of					
	-	ity and individuality for 1					
• • • • • • • • • • • • • • • • • • • •	e resident. (f	Resident #1) Findings	1				
include							
Resident	#1 who has	a history of dementia and					
		y, was admitted to the ALR					
		8/15/22. Since admission,					
		3, behaviors have been	1				
		Per the resident's Service					
_	_	ve been established to	j				
intervene	prior to Res	sident #1's aggressive	į				
		rating. Distractions such as					
		s & video of airplanes at					
times he	p in managir	ng the Resident's behavior.					
On 1/2/2	2 during the	11:00 DM to 7:00 AM chift	Ł				
		11:00 PM to 7:00 AM shift agitated and demonstrated					

Division of Licensing and Protection

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		TE SURVEY MPLETED
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			B M/INIO			С
		0660	B. WING	-		2/22/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	E, ZIP CODE		
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THE VILL	AGE AT WHITE RIVER J	LINCTION	RIVER JUNCTION,	VT 05001		
(X4) ID	SUMMARYST	ATEMENT OF DEFICIENCIES	ID .	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX	(EACH DEFICIENC	YMUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT	ION SHOULD BE	COMPLETE
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R213	Continued From page	e 8	R213			
	aggressive hehavior	During a transfer from				
		by 2 QLS, Resident #1				
	grasped onto QLS #1			- 11		1
	requesting the reside			see attac	NLO1	X.
		QLS #1 proceeded to slap		DOC 00.60		
	i e	m/wrist area. Staff present at	1			
	the time of the incider	nt cautioned QLS #1 his/her				Ī
		propriate and could cost				
		esponded by stating "I don't				
	give a XXXX".					7
		10/100 01 0 //4				İ
	l .	/2/23, QLS #1 remained				
	employed at the ALR					
	opportunities for impr	of work performance or				1
	additional training, Ql		1			
		rable residents on the				*.
		t approximately 2:30 AM on	1			
	· -	n his/her wheelchair in the				
	common area on the		i I			8
		ed from a nap. Resident #1				
	l .	om the wheelchair, staff				5
		er and had the resident				
	ambulate around the	, ,				
		t bathroom, 2 QLS staff				
		esident #1 to his/her room.				
		Resident #1's behaviors				
		and s/he became physically				
		#1 hit 2 staff members				
		attempting to leave his/her				0
		ided by punching Resident				3
		Vitnesses reported when hit, and began to drop to his/her				
	_	ed to the floor. Once on the				
		gan kicking and QLS #1				
		Vitnessing the assault, the				
		Memory Care Unit ordered				
	QLS #1 out of the res	· ·				
		leave Resident #1's room,				

QLS #1 refused to leave and began to verbally

Division of Licensing and Protection							
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBERS		A. BUILDING;		COMPLETED			
		1					
			B. WING	C			
		0660	B. WING		02/22/2023		
NAME OF PR	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE			
			RIER STREET				
THE VILLA	GE AT WHITE RIVER JU	UNCTION		VT 05004			
		AAULE L	RIVER JUNCTION,	V1 05001			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	, , ,		
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR			
1710			5	DEFICIENCY)			
		19-5MH			-		
R213	Continued From page	e 9	R213				
	harace Recident #1 c	stating "I hope s/he falls and					
	bust his/her head ope						
		s to her/him" and continued		see attached	2		
	verbally assaulting wi		1	see mound	1		
	verbally assaulting wi	itti piolariity.		8 - 1	'		
	In both instances Do	esident #1 was not treated	i i				
		sident #1 was not treated ity, despite the challenging					
		emonstrate. The resident					
		ng hit, kicked and verbal					
		mployee while living on the					
	Memory Care Unit of	the ALK.					
	VI. RESIDENTS' RIG	SHTS	R224				
\$S=H							
		shall be free from mental,					
	verbal or physical abo		¥5				
	•	ts shall also be free from	17				
	restraints as describe	ed in Section 5.14.	1				
			i				
	This REQUIREMENT	Γ is not met as evidenced	\$1 \$2				
	by:						
	Based on staff intervi	ew and record review, there					
	was a failure to prote	ct the right to be free from	- E				
	verbal and physical a	buse for 1 applicable					
	resident. (Resident #	1)	i				
	Resident #1 who has	a history of dementia and					
	Traumatic Brain Injur	y, was admitted to the ALR					
	Memory Care unit on	8/15/22. Since admission,					
	Resident #1's behavi	ors have been challenging					
	for staff. Per the resid	dent's Service Plan	1				
	interventions have be	een established to intervene					
	prior to Resident #1's	aggressive behavior from					
		tions such as music, dance,					
		planes at times help in	2				
		ent's behavior. On both					

H9L611

Division of Licensing and Protection STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 0660 02/22/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **101 CURRIER STREET** THE VILLAGE AT WHITE RIVER JUNCTION WHITE RIVER JUNCTION, VT 05001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) R224 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 See attached 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

Division of Licensing and Protection

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Division of Licensing and Protection						
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE O	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION	DENTIFICATION NOWDER;	A. BUILDING:		COMPLETED		
	2000	B. WING		C		
V Grane.	0660	D. HING		02/22/2023		
NAME OF PROVIDER OR SUPPLIER		DRESS, CITY, STATI	E, ZIP CODE			
THE VILLAGE AT WHITE RIVER J	UNCTION	RIER STREET VER JUNCTION,	VT 05001			
(· · ·) · –	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD			
	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR			
***		1	DEFICIENCY)	**-		
R224 Continued From page	e 12	R224				
	incident existed without a second abusive event had					
	LS #1, the employee was not		Con attached			
removed from the sta	aff schedule and returned to	i	Sce attached			
	igned again on nights to the	İ				
	was not until 2/15/23 when infronted the employee					
	of abuse, that the employee					
was terminated. Prior		Ì				
termination, Resident and physical abuse a	t #1 was not free from verbal	Ì				
incidents as above m						
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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