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

May 9, 2024

Jolynn Whitten, Manager
The Village At White River Junction
101 Currier Street
White River Junction, VT 05001

Dear Ms. Whitten:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 9, 2024.** 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.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

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 04/09/2024

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**

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R100	Initial Comments: On 4/9/24 the Division of Licensing and Protection conducted an unannounced on-site relicensure survey and investigation of one complaint. There were no regulatory deficiencies identified related to the complaint investigation. The following regulatory deficiencies were identified related to the relicensure survey:	R100	Corrective actions for all tags accepted by Jo A Evans RN on 5/8/24. Please see the attached document to review the corrective actions accepted for individual tags.	
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to develop a plan of care which describes the care and services necessary to maintain well-being for one applicable resident (Resident #1) . Findings include: The facility's policy entitled Care Plans-Service Plans states, "The Director of Health Services, the resident, resident's family per the resident's consent, and/or their legal representative will collaboratively work together to develop and maintain a written individualized care plan for those that required and receive care. The plan of care will depict the resident's assessed needs and choices and support their dignity, privacy,	R145		

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R145	Continued From page 1	R145		

individuality as well as independence."

Per record review Resident #1 has diagnoses including Parkinson's Disease, Diabetes Mellitus, and has an allergy to Bee Venom. Resident #1 is prescribed an Epipen due to risk for anaphylaxis, which is a severe allergic reaction that is a risk for an airway obstruction caused by swelling. S/he has multiple Cardiovascular conditions and has a recent history of a heart attack in January of 2024. S/he also has a recent history of a Gastrointestinal Bleed (GI Bleed) in March of 2024 attributed to an inflammatory bowel condition; and a risk for stomach ulcers and bleeding due to the concurrent use of Aspirin and Clopidogrel which are both antiplatelet medications (medications that interfere with blood clotting).

Per record review, Resident #1's Plan of Care does not address care and services necessary to maintain his/her well-being related to Parkinson's Disease; Diabetes Mellitus; Bee Venom allergy, risk for anaphylaxis and use of an Epipen; risk for a cardiovascular event;and risks for stomach ulcer and bleeding.

This finding was confirmed by the Director of Health Services at 3:11 PM on 4/9/24.

In conclusion this deficient practice is a risk for more than minimal harm for this resident resulting from unidentified residents needs and interventions.

R179 SS=F — V. RESIDENT CARE AND HOME SERVICES — R179

5.11 Staff Services

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R179	Continued From page 2 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure 5 out of 5 sampled staff completed the required yearly trainings. Findings include: The facility's Orientation and In-Service Employee policy states, "The community should develop and implement a new employee orientation, job specific orientation, and ongoing in-service education programs consistent with Federal and State Regulatory requirements." This policy	R179		

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R179	Continued From page 3 contains a list of required in-service trainings which is not consistent with all yearly trainings required by the licensing agency. Per review of staff training records provided for review on request on 4/9/24, 5 out of 5 sampled staff did not complete the required yearly trainings . This finding was confirmed by the Executive Director at 1:28 PM on 4/9/24. This deficient practice is a potential risk for more than minimal harm for all facility residents due to inadequate staff education and training to safely and effectively provide resident care.	R179		
R190 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to complete all required background checks for 1 out of 6 applicable staff. Findings include: The facility's Human Resources Manual includes a policy entitled Criminal Background Check: Monitoring, Evaluation, and Approval Process effective in 2018 which states, " The facility shall follow, at minimum, state mandated background check guidelines." Per review of the documentation of criminal background and abuse registry checks for a	R190		

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R190	Continued From page 4 sample of staff provided for review on request on 4/9/24, the required adult and child abuse registry checks were not completed as required for 1 out of 6 applicable staff. This finding was confirmed by the Executive Director at 2:40 PM on 4/9/24. In conclusion this deficient practice is a potential risk for more than minimal harm for all residents, as the requirement for criminal background and abuse checks is intended to ensure all residents are free from the risk of harm.	R190		
R247 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall be labeled, dated and held at proper temperatures: (1) At or below 40 degrees Fahrenheit. (2) At or above 140 degrees Fahrenheit when served or heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure all perishable foods and beverages were labeled and dated; and to ensure all perishable beverages are held at proper temperatures. Findings include: The facility's Food Safety policy states, "The community will comply with all Vermont regulations relating to food, food labeling, handling, and the prevention of food-borne illnesses.". This policy includes a procedure which states "All food will be labeled and dated	R247		

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R247	Continued From page 5 upon receiving and rotated to ensure quality and freshness using the F.I.F.O. (First In First Out) method". The facility's policy does not identify a procedure for ensuring perishable foods and beverages are labeled and dated to ensure timely use or disposal. The facility's Food Safety policy also includes a procedure which states, "All perishable food and drink will be held at or below 40 degrees F or at or above 140 degrees F. 1. During a tour of the Main Kitchen and food storage areas on the first floor of the facility commencing at 9:53 AM on 4/9/24 the following improperly stored perishable foods and beverages were observed: a. Refrigerator "Prep Units" contained perishable items without identifying labels and dates the items were opened or prepared including 13 containers of prepared vegetables and cheese, some without lids; 2 bins of ham; an opened bag and uncovered tub of mesclun lettuce mix; and an uncovered container of what appeared to be feta cheese without an identiyfying label. There was a container of sliced deli turkey dated "4/3", which the Cook confirmed was to be discarded on 4/6/24 per the kitchen policy to discard all items prepared for the "line" (cooking stations) after 3 days and all other opened perishables after 7 days. b. Perishable items without the dates the items were opened or prepared stored on the shelf above the Prep Units included the following unlabeld and undated items: an unrefrigerated bin of cooked bacon; an uncovered bin of croutons; containers of peanut butter, honey, oats, Cream of Wheat, Demi-Glace sauce mix; 6	R247		

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R247	Continued From page 6 unrefrigerated bottles of hot sauce; and 3 unrefrigerated blocks of butter, one which was uncovered and exposed to open air. c. The Reach-In Freezer was observed with perishable food items stored in clear plastic bags, paper bags, and boxes which were all without identifying labels. Undated opened perishables stored in the freezer included bags of ravioli, egg rolls, veggie burgers, what appeared to be battered fish or chicken, and a box of sausage which were all left unsealed and exposed. d. Perishable items in the "Low Boy" refrigeration unit without the dates the items were opened or prepared included cartons of soy milk, low fat milk, half and half, and fruit juices; 6 containers of chopped fruit; a bottle of wine and 5 opened bottles of soda. e. The Walk-In Refrigerator was observed with unlabeled and undated perishable items including 2 trays of what appeared to be fruit cobbler; 2 uncovered and exposed trays of sliced bacon; containers of soup base; multiple condiments, sauces, and dressings of various sizes; a 5 gallon bucket of pickles; soy milk and buttermilk; whipped cream without a top; a bin of pickled vegetables; an unsealed bag of icing; mandarin oranges; ricotta cheese; and gallon of lemonade. Additionally, a gallon of lemonade labeled as prepared on "3/30" and a container of tea labeled as prepared on "3/29" were observed and confirmed by the Cook to have been stored beyond the kitchen's 7-day discard policy. Containers of Lemonade dated "4/2" and Tea dated "4/5" were observed in the Low Boy refrigerator located in the kitchen, indicating the lemonade and tea were not properly rotated. A plastic tub with an unidentified brown liquid	R247		

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R247	Continued From page 7 labeled with the date "4/1" which was stored in the walk-in. Packages of meat placed in the walk-in to thaw were observed without labels indicating the dates the items were placed in the refrigeration unit including sliced deli meat, a smoked buffet ham. Two large pieces of meat wrapped in plastic wrap were observed in the walk-in without identifying labels and the dates these items were opened or prepared. These findings were confirmed by the kitchen staff during the tour of the Main Kitchen and acknowledged by the Executive Director on the morning of 4/9/24. 2. During a tour of the Memory Care area of the facility commencing at 10:22 AM on 4/9/24 the following improperly stored perishable food items were observed: a. In the Refrigerator Unit perishable food items which were stacked in multiple layers. This method of storage is a risk for cross contamination and impedes the even circulation of cold air which can increase spoilage times. Perishable foods and drinks observed in the fridge without the dates the items were opened or prepared included whipped cream without a lid; jelly; a bottle of chocolate syrup; 3 cartons of juice and two gallons of a red beverage prepared by the home without identifying labels; a stack of 3 stainless steel trays of leftovers and 3 plastic tubs of leftovers without identifying labels and dates; dairy products including milk, yogurt, half and half, and an uncovered cup of what appeared to be milk or cream without an identifying label. b. The Freezer Unit In the Memory Care Center	R247		

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R247	Continued From page 8 Kitchenette contained undated waffles without the date the package was opened; and three 3 gallon containers of ice cream, some with the lids left partially open. Additionally an unclean and uncovered basin of ice was observed in the freezer with foreign matter in the ice and stains on the inner lip and walls of the container. The bucket of ice was stacked on top of a milk crate filled with frozen items. c. The Dry Storage area of the Memory Care area was observed with open undated perishable items including cereals, crackers, breads, peanut butter, sundae syrup, and an unrefrigerated uncovered plate with a block of "buttery blend". 3. The refrigerator in the activity area of the Memory Care area was observed to be unsanitary and unsafe for the residents of the Memory Care who have open access to the kitchen at all times. The residents in this area are diagnosed with cognitive impairments and have varying ability to safely manage access to the kitchen. There were 12 single serving beverages which were opened, undated, and without labels indicating who the partially consumed beverages belonged to, which is a risk for spread of infectious diseases and foodborne illness. There were 4 open cans with exposed sharp edges among the single serve beverages. The fridge also contained an undated take out container without an identifying label. Dried spills on the shelves of the door and main compartment of the fridge. The findings in the Memory Center were confirmed by the Memory Center Director during the tour, and acknowledged by the Executive Director on the morning of 4/9/24.	R247		

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R247	Continued From page 9 4. There was a failure to ensure all perishable beverages were stored and served at or below 40 degrees Fahrenheit in the Main Kitchen and in the Memory Care area kitchenette. During observation of the Memory Care area lunch service commencing at 11:55 AM on 4/9/24 the Orange Juice in the beverage dispenser was observed to be stored and served at 46 degrees Fahrenheit, and the Apple Juice was observed to be stored and served at 40.6 degrees Fahrenheit. During observation of the lunch service in the Main Kitchen and Dining Room commencing at 12:05 PM on 4/9/24 the Orange juice was observed to be stored and served at 41.4 degrees Fahrenheit. These findings were confirmed by the staff serving lunch in the Memory Care area and Main Dining area on 4/9/.24, and acknowledged by the Executive Director on the afternoon of 4/9/24. In conclusion, these deficient practices are a potential risk for more than minimal harm due to food borne illness for all facility residents.	R247		
R252 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Storage and Equipment 7.3.b Areas of the home used for storage of food, drink, equipment or utensils shall be constructed to be easily cleaned and shall be kept clean This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there	R252		

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R252	Continued From page 10	R252		

was a failure to ensure kitchen equipment and food storage areas in the main kitchen and memory care area are kept clean. Findings include:

The facility's Food Storage and Equipment policy includes a procedure which states," All areas of the home used for storage of food, drink, equipment or utensils shall be constructed to be easily cleaned and kept clean."

During the tour of the Main Kitchen commencing at 9:53 AM on 4/9/24 cooking equipment including the fryer and stovetop were observed to be unclean and poorly maintained. The stovetop had a thick crust of carbon on and around the burners, and there was a black greasy buildup along the back and sides near the burners. The oil in the fryer contained dark oil and there was a coating of food particles on the stainless steel around the oil basin. In the walk-in refrigerator the areas on the shelves had specks of dried on food, and the speed racks in the walk-in had stains and debris along the metal ledges where the baking sheets are placed. The kitchen flooring was in need of cleaning and the floor of the walk-in was observed to be in poor condition and in need of cleaning.

These findings were confirmed by kitchen staff during the tour of the main kitchen, and acknowledged by the Executive Director on the afternoon of 4/9/24.

During the tour of the Memory Center kitchen areas commencing at 10:22 AM on 4/9/24 the interior floor of the reach-in freezer in the kitchenette was observed with food debris and stains. There were dried flood spills and stains inside the microwave. In the activity area kitchen

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R252	Continued From page 11 the refrigerator was observed with dried food and beverage spills on the shelves and door; and a kitchenaid mixer stored above the fridge was covered what appeared to be dried on chocolate batter. These findings were acknowledged by the Memory Care Director and the Executive Director on 4/9/24. In conclusion, this deficient practice is a potential risk for more than minimal harm for all facility residents due to food borne illness resulting from food being stored and prepared in an unclean environment.	R252		
R258 SS=F	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.h All garbage shall be collected and stored to prevent the transmission of contagious diseases, creation of a nuisance, or the breeding of insects and rodents, and shall be disposed of at least weekly. Garbage or trash in the kitchen area must be placed in lined containers with covers. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure all garbage containers in the facility's kitchen areas are equipped with covers. Findings include: The facility's Food Storage and Equipment policy includes a procedure which states," Garbage or trash in the kitchen area must be placed in lined containers with covers."	R258		

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R258	Continued From page 12 During the tour of the Main Kitchen commencing at 9:53 AM and the Memory Care Center Kitchenette at 10:22 AM on 4/9/24 all garbage containers in these kitchen areas were observed to be without covers. At 10:20 AM the Chef confirmed there were no lids for all garbage cans in the Main Kitchen; an at 10:35 AM the Memory Care Director confirmed there were no lids for all garbage cans in the Memory Care Center. In conclusion this deficient practice is a potential risk for more than minimal harm due to the failure to prevent breeding of flies and infestation of rodents resulting from open and accessible rubbish.	R258		
R302 SS=F	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented.	R302		

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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
R302	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to conduct fire drills at least once in all quarters, and to conduct at least one drill at night during the previous year. Findings include: Per review of the fire drill records provided for review on request, there was a failure to conduct fire drills during the 3rd and 4th quarters, and to conduct at least one fire drill at night, during the previous year. These findings were confirmed by the Executive Director at 1:31 PM on 4/9/24. This deficient practice is a potential risk for more than minimal harm for all facility residents due to missed opportunities for staff and residents to practice the evacuation process and identify effective procedures for safe and timely evacuation.	R302		

Plan Of Correction

R145 Resident Care and Home Services 5.9.c(2)

Completion Date 6/6/24

Resident #1's care plan to be reviewed and updated to ensure individualized care needs are included.

DOHS or designee will audit all current residents' care plans to ensure individualized care needs are present.

Education will be provided to all current licensed nursing staff regarding the care planning process that is based on abilities and the needs of a resident as identified in the resident assessment and that the plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being. Education to all new hire nurses will be done as part of the new hire training process.

Care Plans will be audited on a monthly basis for the next 6 months by the DOHS or designee to ensure appropriate changes were made to accurately reflect the individualized needs of each resident.

To be presented and discussed at QAPI quarterly for the next 12 months by the DOHS or designee and then reassessed to determine need for ongoing monitoring beyond standard DOHS oversight.

R145 Plan of Correction accepted by Jo A Evans RN on 5/8/24

R179 Resident Care and Home Services 5.11.b

Completion Date 6/6/24

Business Office Manager or designee will complete a manual file audit of all current staff education.

All current staff who have not completed mandatory training will be given until 6/6/24 to complete the training. All newly hired staff will complete the required mandatory training before working with residents.

Staff education documentation will be audited monthly for 6 months by the BOM or designee for compliance.

To be presented and discussed at QAPI quarterly for the next 12 months by the BOM or designee and then reassessed to determine need for ongoing monitoring beyond standard BOM oversight.

R179 Plan of Correction accepted by Jo A Evans RN on 5/8/24

R190 Resident Care and Home Services 5.12.b.(4)

Completion Date 6/6/24

Business Office Manager or designee will complete a manual file audit of all current staff background check documentation.

All current staff will have the required background check documentation placed in their employee files. All new hires will have the required background check documentation on file prior to start date.

Background check documentation will be audited monthly for 6 months by the BOM or designee for compliance.

To be presented and discussed at QAPI quarterly for the next 12 months by the BOM or designee and then reassessed to determine need for ongoing monitoring beyond standard BOM oversight.

R190 Plan of Correction accepted by Jo A Evans RN on 5/8/24

R247 Nutrition and Food Services 7.2.b

Completion Date 6/6/24

All noted deficient products were removed from both kitchen areas.

Kitchen staff will be trained on proper labeling, dating, and holding temperatures for all food and beverages.

The Culinary Director or designee will audit both kitchens, including all prep units, refrigerators, freezers, dry storage, and juice machines on a weekly basis to ensure continued compliance.

To be presented and discussed at QAPI quarterly for the next 12 months by the Culinary Director or designee and then reassessed to determine need for ongoing monitoring beyond standard Culinary Director oversight.

R247 Plan of Correcton accepted by Jo A Evans RN on 5/8/24

R252 Nutrition and Food Services 7.2 and 7.3.b.

Completion Date 6/6/24

Both kitchen areas were thoroughly cleaned to address all noted deficient practices.

Kitchen staff will be trained on proper cleaning practices to meet regulations.

The Culinary Director or designee will audit the equipment in these two areas on a weekly basis to ensure continued compliance.

To be presented and discussed at QAPI quarterly for the next 12 months by the Culinary Director or designee and then reassessed to determine need for ongoing monitoring beyond standard Culinary Director oversight.

R252 Plan of Correction accepted by Jo A Evans RN on 5/8/24

R258 Nutrition and Food Services 7.3.h

Completion Date 6/6/24

New garbage containers and covers were purchased on 4/9/24 and put in place on 4/22/24 for both the main kitchen and Memory Care kitchenette.

Kitchen staff will be trained on proper practice for covering all garbage containers in both locations.

The Culinary Director or designee will audit these containers on a weekly basis to ensure continued compliance.

To be presented and discussed at QAPI quarterly for the next 12 months by the Culinary Director or designee and then reassessed to determine need for ongoing monitoring beyond standard Culinary Director oversight.

R258 Plan of Correction accepted by Jo A Evans RN on 5/8/24

<u>R302 Physical Plant 9.11.c</u>

<u>Completion Date 6/6/24</u>

Fire drills are now being completed on a quarterly basis on rotating shifts. For 2024, documented fire drills have been completed for the first and second quarters.

The community's fire plan has been updated in conjunction with the Fire Marshal from the Hartford Fire Department. Staff have been provided with a copy of this plan and educated at All Staff Meetings. Agency staff have also signed off on the updated fire plan.

Fire drill documentation will be presented and discussed at QAPI quarterly for the next 12 months by the Director of Plant Operations or designee and then re-assessed to determine need for ongoing monitoring beyond standard DPO oversight.

R302 Plan of Correction accepted by Jo A Evans RN on 5/8/24