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

August 13, 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 **July 17, 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 07/17/2024

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 7/17/24 the Division of Licensing and Protection conducted an onsite unannounced investigation of one complaint. The following regulatory deficiencies were identified:	R100		
R128 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure the antipsychotic medication Risperidone was discontinued as ordered by the prescribing physician for one applicable resident (Resident #1). Findings include: The facility's Medication System policy and procedures effective 8/12/25 state, "Each MAR/MOR sheet shall list any/all medications order by the resident's physician in accordance with F.D.A. requirements. Designated staff will review all MAR's/MOR's monthly or as needed to ensure all order changes are reflected. A licensed pharmacist shall perform all label changes for community and/or individual resident, within 10 days of order change." Per record review, on 12/8/24 Resident #1's Physician discontinued his/her order for Risperidone 0.5 mg scheduled once daily at 4 PM. Per review of Resident #1's Medication	R128		

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R128	Continued From page 1 Administration Records (MARs), this order was not discontinued as ordered and administration of his/her scheduled dose of Risperidone continued until 6/12/24. During an interview commencing at 11:15 AM on 7/17/24, the facility's Interim Director of Health Services (DOHS) confirmed documentation of a Physician's order to discontinue Resident #1's scheduled dose of Risperidone is not on file in his/her resident record. The Interim DOHS stated the facility was not aware of this medication change until the prescribing physician discovered this medication error during a subsequent appointment in June of 2024. On the morning of 7/17/24 the Executive Director (ED) and Interim Director of Health Services confirmed Resident #1's Risperidone was not administered according to his/her Physician's orders.	R128		
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure the ensure completion of a resident assessment in response to a significant change	R136		

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R136	Continued From page 2 in physical condition for one applicable resident (Resident #1). Findings include: The facility's Quality of Life Assessment policy effective 1/21/15 states, "Residents shall be assessed prior to admission, on admission and on the required schedule as stated in the Community Residency Agreement with PRN (as needed) due to significant change of condition [sic]." Per record review, Resident #1 experienced a significant decline in his/her physical condition and was admitted into hospice care on 7/2/24. At 1:15 PM on 7/17/24 the Executive Director and Interim Director of Health Services confirmed a significant change assessment was not completed for Resident #1 in response to this change in condition.	R136		
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 based on individual abilities and needs which describes the	R145		

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R145	Continued From page 3	R145		

care and services required to maintain independence and well-being for one applicable resident (Resident #1). Findings include:

The facility's Policy and Procedures Manual states the policy for Care Plans-Service Plans effective 10/25/28 is "To develop a preliminary and comprehensive Care Plan /Service Plan for each resident that includes measurable goals and objectives, realistic approaches and interventions, timetables and evaluations to meet the resident needs as they age in place."

Per record review:

a. Resident #1 is diagnosed with Post Traumatic Seizures and is prescribed an antiseizure medication. S/he has an allergy to tree nuts and seeds; and is prescribed an Epipen in case of an anaphylactic reaction (life threatening allergic reaction).

b. Resident #1 requires a wheelchair and has limited ability to ambulate for brief periods of time with 1 staff assist and a second standby staff following with a wheelchair for safety. Resident #1 has a history of frequent falls including falls from his/her wheelchair. Per the Director of Health Services and the Executive Director ensuring placement of footrests on Resident #1's wheelchair when in use has been identified as an intervention for fall prevention, and Resident #1 is dependant on staff for placement of foot rests on his/her wheelchair.

c. Resident #1 has experienced significant decline in health and was admitted into hospice care on 7/2/24.

At 3:22 PM on 6/17/24 the Executive Director and

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R145	Continued From page 4 Interim Director of Health Services confirmed Resident #1's Plan of Care does not include care and services required to maintain his/her independence and well-being related to use of antiseizure medications and an Epipen, safe use of a wheelchair including placement of footrests on his/her wheelchair, and hospice care.	R145		
R179 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 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.	R179		

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R179	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure all facility staff are competent in skills and techniques related to assisting residents with use of a wheelchair. Findings include: On the afternoon of 7/17/24 the Executive Director confirmed policies and procedures for ensuring staff are competent in the skills and techniques they are expected to perform while caring for residents had not been developed by the facility. Per record review Resident #1 has a history of resistance to care and a history of falls including falls from his/her wheelchair. On 5/28/24 Resident #1 was assisted in transfer to his/her wheelchair by 2 staff following an episode of resistance to care during which Resident #1. Once seated in his/her wheelchair one Staff attempted to wheel Resident #1 out of his/her apartment and into the hall. As Staff pushed the wheelchair into the hallway Resident #1 fell out of the chair and sustained a head injury requiring hospitalization. While the cause of Resident #1's fall is unknown, during an interview commencing at 11:15 AM on 7/17/24 the Executive Director and Interim Director of Health Services confirmed Resident #1's footrests were not placed on the wheelchair at the time of the incident and use of the wheelchair without footrests was identified as a potential contributing factor in his/her fall. Per record review, it was identifiified footrests were also not placed on Resident #1's wheelchair during an additional fall from his/her chair in July 2024. During the interview commencing at 11:15 AM on	R179		

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R179	Continued From page 6 7/17/24 the Executive Director and Interim Director of Health Services confirmed the facility does not provide training to ensure all direct care Staff are competent in the skills and techniques required for safe use of a wheelchair; and competencies in skills and techniques direct care Staff are required to perform are not documented prior to provision of resident care at the facility.	R179		
R200 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure development of policies and procedure governing all services provided by the home. Findings include: During the complaint investigation conducted on 7/17/24 the Executive Director was requested to provide policies and procedures governing safe use of a wheelchair and staff competencies in the skills and techniques direct care staff are required to perform. On the afternoon of 7/17/24 the Executive Director confirmed policies and procedures governing these areas of service provided by the home had not been developed by the facility.	R200		

Plan of Correction for 7/17/24 Survey

R128 Resident Care and Home Services 5.5.c

Completion Date 9/8/24

1. The MAR for Resident #1 has been reviewed and updated to reflect current medication orders.
2. For each physician appointment, the after care summary will be reviewed by the receiving nurse after being returned to the facility and orders will be updated in the EMR.
3. Education will be given to all licensed nursing staff on the process of communication and documentation for all physician appointments.
4. The Director of Health Services or designee will do a sample audit monthly from the residents who had physician appointments to ensure that the aftercare summary medication list is accurately reflected in the MAR. The audit results will be reported to QAPI for the next 6 months.

R128 Plan of Correction accepted by Jo A Evans RN on 8/13/24

R136 Resident Care and Home Services 5.7.

Completion Date 9/8/24

1. Resident #1's assessment has been updated to reflect admission to hospice services.
2. Director of Health Services or designee will review all residents currently on hospice services and update their assessments, if needed.
3. Residents will now be reassessed for a significant change in condition when admitted to hospice services. The Director of Health Services or designee has been educated on this requirement.
4. All new hospice admission assessments will be audited monthly by the Director of Health Services or designee and reported to QAPI for the next 6 months.

R136 Plan of Correction accepted by Jo A Evans RN on 8/13/24

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

Completion Date 9/8/24

1. Resident #1's care plan has been updated to include use of antiseizure medications and an EpiPen, and hospice care. Resident #1 has been supplied a Broda chair by hospice and footrests remain attached. This is reflected in the current care plan.
2. Education will continue to 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 will be provided to all newly hired nurses as well.
3. DOHS or designee will continue to audit a sample of current residents' care plans monthly to ensure individualized care needs are present.
4. Monthly audits will be reported to QAPI by the Director of Health Services or designee for the next 6 months.

R145 Plan of Correction accepted by Jo A Evans RN on 8/13/24

R179 Resident Care and Home Services 5.11.b

Completion Date 9/8/24

1. The Business Office Manager or designee will assign the "Adaptive Equipment- Use of Wheelchair" module in Relias to all direct care staff to be completed.
2. Competencies for all direct care staff on wheelchair use will be documented by the Director of Health Services or designee.
3. This process will be ongoing for all newly hired direct care staff.
4. Compliance on documented direct care staff competencies for wheelchair use will be reported monthly at QAPI by the Director of Health Services or designee for the next 6 months.

R179 Plan of Correction accepted by Jo A Evans RN on 8/13/24

R200 Resident Care and Home Services 5.15

Completion Date 9/8/24

1. A policy and procedure will be developed regarding safe use of a wheelchair, including staff competencies.
2. All direct care staff will review and sign off on a copy of the new policy and procedure.
3. The policy and procedure will be made available to all nursing and direct care staff on an ongoing basis.
4. The policy and procedure will be reviewed and approved at the next QAPI meeting following implementation.

R200 Plan of Correction accepted by Jo A Evans RN on 8/13/24