VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
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AGENCY OF HUMAN SERVICES

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 12, 2025

Martha Ilsley, Manager
The Village At White River Junction
101 Currier Street
White River Junction, VT 05001

Dear Ms. Ilsley:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 15, 2025**. 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 04/15/2025

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
R100	Initial Comments: On 4/15/25 the Division of Licensing and Protection conducted an investigation of one facility reported incident. The following regulatory deficiencies were identified:	R100	The Village at WRJ neither admits or denies the Deficiencies set forth in this Statement of Deficiencies. The facility alleges compliance with all deficiencies cited by the Division of Licensing and Protection by the alleged completion date.	
R144 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c.(1) Complete an assessment of the resident in accordance with section 5.7; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the Registered Nurse failed to complete Resident Assessments for 2 applicable residents (Resident #1 and Resident #2) in accordance with Section 5.7 of the Vermont Residential Care Home Regulations effective 10/3/2000. Findings include: The facility's Resident Change in Condition, Subcategory Assessment & Service Plan policy provided for review on request states, "When changes in condition or need are identified, a nurse/designee will initiate a change in condition HSE (Health Services Evaluation)." and "A change of condition HSE will also be initiated...per state guidelines." This policy does not indicate the Registered Nurse shall complete a Resident Assessment at any point in which there is a change in the resident's physical or mental condition. 1. Per record review, Resident #1 was admitted to the facility's Memory Care unit on 2/17/2025. An Admission Assessment dated 2/17/25	R144 R144	Resident # 1 has a completed Significant change assessment dated and signed by the RN on 4/22/25 and 5/2/25. on 5/2/25Resident #2 has a completed significant change assessment. An audit will be conducted of all resident assessments to ensure that all admission assessments have	

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Martha Illsley TITLE: Executive Director (X6) DATE: May 2, 2025

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R144	Continued From page 1 indicates a Registered Nurse completed this Resident Assessment; however, this Assessment is incomplete as it has not been signed and dated as completed by the applicable Registered Nurse in the designated areas of section N.1 of the Resident Assessment as required. Per review of this Resident Assessment, on admission to the home Resident #1 was never physically abusive. Per Staff interview on the afternoon of 4/15/25, Resident #1 has a history of biting and hitting staff since the Resident's admission to the home. Resident #1's Admission Assessment also indicates they exhibit socially inappropriate /disruptive behaviors less than daily; however, Resident #1's Service Plan indicates they exhibit socially inappropriate/disruptive behaviors "Frequently (up to 1x /day)". Per record review, Resident #1's Admission Agreement dated 2/17/25 is incomplete; and a Significant Change Assessment has not been completed by a Registered Nurse in response to significant changes in Resident #1's behaviors. 2. Per record review, Resident #2 was admitted to the facility's Memory Care unit on 8/1/24. A Resident Assessment dated 9/6/24 is identified as a re-assessment. This Resident Assessment indicates a Registered Nurse completed this Resident Assessment and documents a significant change in Resident #2's behavioral status. This Assessment is incomplete as it has not been signed and dated as completed by the applicable Registered Nurse in the designated areas of section N.1 of the Resident Assessment as required.	R144	been completed within 14 days of admission, consistant with the diagnosis and orders from the licensed health care provider, and that all residents have been reassessed annually and at any point in which there is a significant change in the residents physical, or mental condition. The a\ assessments will be completed by a Registered Nurse, and will be dated when completed. The results of this audit will be presented to the Quality Assurance Performance Improvement committee for further action and monitoring. This audit will be conducted monthly for 3 months and as needed. The Director of Health Services or RN designee will monitor R144 Plan of Correction accepted by Jo A Evans RN on 5/10/25	5/2/25

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R144	Continued From page 2 On the afternoon of 4/15/25 the Interim Director of Health Services and the Executive Director confirmed Resident Assessments on file for Resident #1 and Resident #2 were not completed in accordance with Section 5.7 of the Vermont Residential Care Home Regulations effective 10/3/2000.	R144		
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 R179	R179 – Staff have been re-educated regarding how to safely and effectively respond to a behavioral outburst or refusal of care, and have demonstrated competency using learned techniques such as redirection, validation, staff assistance, and or other creative re-direction techniques. Staff will receive the required training and demonstrate competency in the skills and techniques they are expected to perform prior to providing direct care.	

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R179	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review Memory Care Staff failed to demonstrate competencies in the skills they are expected to perform related to an incident which resulted in a resident injury requiring medical care. Findings include: 1. Per record review, Resident #1 and Resident #2 reside in the facility's memory care unit. Both Residents are diagnosed with Dementia and demonstrate behavioral changes associated with cognitive decline. Per a facility incident report to the licensing agency, on the evening of 3/25/25 Resident #1 obtained a Staff walkie-talkie, refused to return the device, and was aggressive towards Staff. Resident #2 overheard the incident and responded by pushing Resident #1. Per the facility's report, Staff immediately redirected Resident #2 then calmed and reassured both residents. Resident #1 complained of shoulder pain immediately after the incident, then voiced no further complaints and there was no known bruising or evidence of injury after the incident. Per record review, on 3/27/25 Resident #1 was examined by their Primary Care Provider during a previously scheduled appointment and was referred to the hospital for an x-ray which determined Resident #1 had sustained a right clavicle fracture during the incident on 3/25/25. 2. Per staff interview and record review staff on duty in the Memory Care unit on the evening of 3/25/35 failed to demonstrate competency in skills required to safely and effectively respond during the incident involving Resident #1 and Resident #2. The facility's Behavioral Outbursts - Handling By	R179	LNA's and Quality of life Specialists have reviewed skills and demonstrated competency that is necessary to perform their duties.An audit has been conducted to ensure that existing staff have completed required training , including 12 hours per year for direct care staff. All newly hired staff will be required to complete all trainings and demonstrate competencies prior to providing direct care.The audits will be conducted on all new hires for 3 months	

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R179	Continued From page 4 Staff policy includes Procedure #1 which states, "Staff witnessing behavioral outbursts and/or refusal of care shall immediately take steps to diffuse the behavior using learned techniques such as redirection, validation, have another staff offer assistance, and or creative reality [sic]." On the afternoon of 4/15/25, a Licensed Practical Nurse (LPN) described the incident on the evening of 3/25/25, which occurred after Resident #1 obtained a walkie-talkie left unattended by staff. Per the LPN, after Resident #1 refused to give the walkie-talkie back the LPN and another Staff approached Resident #1 from both sides and attempted to grab the device from the Resident. Resident #1 yelled and started "flinging [their] arms around" in response to this intervention. Resident #2 has a history of physically aggressive and abusive behaviors towards Resident #1 including an incident on 2/23/25 during which Resident #2 pushed Resident #1 causing this resident to hit their head on the med cart as they fell. Resident #1 required medical evaluation of a large bump on the left side of their head sustained during this incident. On 4/15/25, the LPN on duty during the incident on the evening of 3/25/25 stated Resident #2 was seated nearby and responded to Resident #1 yelling and flinging their arms by pushing Resident #1 into a door frame. The physical impact of Resident #1 striking the door frame fractured this Resident's right clavicle. The LPN stated they responded by "grabbing" Resident #2 by the shirt and "pulling" this Resident away from the area, then assisting Resident #1 off the floor with another Staff by "scooping under [the Resident's] armpits and lifting them up. "	R179	and as needed and will be presented To the Quality Assurance/Quality Improvement committee for Further review and follow up. This will be monitored by the Director of Health Services and/or RN designee and the Human Resource Manager	5/2/25

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R179	Continued From page 5 During the interview on the afternoon of 4/15/25 the LPN did not recall specific trainings provided by the home related to techniques for the safe removal of a resident from a situation, the use of "hands on" interventions with a resident, and procedures for a resident lift assist. The LPN stated they had received yearly training related to de-escalation techniques; and confirmed the techniques utilized during this incident including staff approaching the Resident #1 from both sides in an attempt to grab the walkie-talkie, grabbing Resident #2 by the shirt and pulling this Resident away from the area, and scooping Resident #1 under their armpits and lifting the Resident are not techniques included in facility trainings. 3. Per Staff interview and record review the Memory Care Nursing staff failed to demonstrate competency in performing roles and responsibilities consistent with the Vermont State Board of Nursing Scope of Practice following the incident between Resident #1 and Resident #2 on 3/25/25. The home's Behavioral Outbursts - Handling By Staff policy states, "To ensure the safety and wellbeing of residents, staff must understand their role and responsibility when a resident experiences behavioral outbursts and or refusal of cares. [sic]". On 4/25/25, the LPN confirmed the Memory Care Director, who is a Registered Nurse, was contacted after Resident #1 was assisted off the floor, and confirmed Resident #1 was not assessed by a Registered Nurse to determine if the Resident was injured and in need of medical care following the incident on the evening of	R179	R 179 Staff are re-educated regarding Lifting techniques , and all newly hired staff will be educated regarding lifting techniques and will demonstrate competency prior to providing direct care. This education will be monitored by the Health Services Director or RN designee with the Human Resource Coordinator. Audits will be conducted of all new employees to ensure that their trainings are complete and the results of the audits will be reviewed by the Quality Assurance Performance Review committee for further action and review 5.2.25	

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R179	Continued From page 6 3/25/25. The LPN stated they attempted to assess Resident #1 after the incident, and 2 additional Staff on duty during this incident stated the LPN assessed Resident #1 on the evening of 3/25/25. During an interview commencing at 3:38 PM on 4/15/25, a Staff present during the incident stated the way Resident #1 was holding their arm and said "ow" when the nurse was trying to feel it they could tell Resident #1 was in pain. A note included in an Incident Report regarding this incident states Resident #1's Durable Power of Attorney was notified of the incident and "came in to assess [Resident #1's] need to go the ED." The facility's LPN Supervision policy states, "The Director of Health Services shall ensure any/all LPN staff nurse job duties are specific to the care and services that shall be provided to the resident and within their individual scope of practice and supervised by an RN [sic]." Performing a physical assessment of a resident is not within a Licensed Practical Nurse's scope of practice in the State of Vermont. The failure to ensure Resident #1 was assessed by a Registered Nurse following this incident, and the LPN's reported assessment of Resident #1 indicate the Memory Care Nursing Staff did not demonstrate understanding of the roles and responsibilities of a Registered Nurse and a Licensed Practical Nurse. The facility's LPN Job Description also indicates a lack of understanding of the role and responsibilities of a Licensed Practical Nurse in the State of Vermont. The facility's LPN Job Description identifies the task of completing assessments as delegated by the DOHS (Director of Health Services) in the Position Summary. The Essential Job Functions listed in	R179	R 179 The LPN Job Description has been revised to define the performing roles and responsibilities of the LPN consistent with the Vermont State Board of Nursing Scope of Practice. The revised job description has been Explained and reviewed with all currently employed LPNs. The Registered Nurse is on call and available to the LPN 24 hours a day, 7 days a week if not available within The facility. 5.2.25 R179 Plan of Correction accepted by Jo A Evans RN 5/10/25	

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R179	Continued From page 7 the facility's LPN Job Description include "Assess resident and notify attending physician and responsible party in the event of a change in the resident's condition" and "Assess and monitor complex resident health status and determine the appropriate nursing intervention." Additional Essential Job Functions identified in the facility's LPN Job Description which are not within a Licensed Practical Nurse's scope of practice in the State of Vermont include development of resident care plans and re-assessment of each resident. On the afternoon of 4/15/25 the Interim Director of Health Services confirmed Memory Care Staff failed to demonstrate competencies in the skills they are expected to perform during and following the incident involving Resident #1 and Resident #2 on 3/25/25. At 4:13 PM on 4/15/25 the Executive Director confirmed documentation of competencies in the skills facility staff are required to perform are not on file and available for review 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 is a failure to develop policies and procedures	R200	R 200 – The community has performed a review of all Policies and Procedures. A Policy has been developed for the facilities On-Call policy for Registered Nurses, Nursing Assessment, Incidents and Accidents, and response to such by the Registered Nurse,	

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R200	Continued From page 8 governing all areas of service provided by the home. Findings include: During the investigation conducted on 4/15/25 the Executive Director and Interim Director of Health Services were requested to provide copies of the facility's On-Call policy; Nursing Assessment policies and procedures; policies and procedures governing response to resident incidents and injuries by a Registered Nurse; and policies and procedures related to Staff competencies in the skills they are expected to perform. Per review of the policies and procedures provided by the Executive Director and Interim Director of Health Services, the requested policies and procedures were not on file and available for review. On the afternoon of 4/15/25 the Executive Director confirmed the requested policies and procedures listed above had not been developed by the facility.	R200	and for Staff competencies and Required Training. The Policies and Procedures will be reviewed at least annually and as needed. Staff will be educated when there Is a change in policy. All new Policies and Procedures will be reviewed by the Quality Assurance Performance Improvement Committee and recommendations by the committee will be reviewed and implemented as needed. This will be monitored by the Executive Director. R200 Plan of Correction accepted by Jo A Evans RN on 5/10/25.	5/2/25
R213 SS=E	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 there is a failure to treat 2 applicable resident's (Resident #1 and Resident #2) with respect for both residents' dignity, individual abilities, and needs related to interventions utilized by Memory	R213	R213-Staff have been re-educated regarding how to safely respond to a behavioral outburst or refusal of care, and have demonstrated competency using	

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R213	Continued From page 9 Care Staff during an incident of resident to resident abuse on 3/25/25. Findings include: The facility's Abuse Prevention Program policy states, "We have established policies and procedures that will provide personnel ... with the knowledge to further ensure each resident is treated with individual respect and dignity. " Per record review, Resident #1 and Resident #2 are residents of the facility's memory care unit. Both Residents are diagnosed with Dementia and demonstrate behavioral changes associated with cognitive decline. During an interview on the afternoon of 4/15/25, a Licensed Practical Nurse (LPN) described the incident on the evening of 3/25/25 which occurred after Resident #1 obtained a walkie-talkie left unattended by staff. The LPN stated when Resident #1 refused to give the walkie-talkie back, the LPN and another Staff on duty approached Resident #1 from both sides in an attempt to grab the device from the Resident. This intervention did not demonstrate respect for Resident #1's individual needs and abilities; and resulted in further escalation of Resident #1's behaviors during the incident as evidenced by Resident #1 yelling and flinging their arms towards Staff. Resident #2 has a history of physically aggressive and abusive behaviors towards Resident #1 including an incident on 2/23/25 during which Resident #2 pushed Resident #1 causing this resident to hit their head on the med cart as they fell. Per Staff interview and record review, Resident #2's incidents of physically abusive behaviors towards Resident #1 appear to be related to Resident attempting to protect Staff from Resident #1. Per interview with the LPN on duty during the incident on 3/25/25, Resident #2	R213	the techniques such as redirection, validation, obtaining staff assistance, and or other creative re-direction techniques. Staff have also been re-educated regarding Resident 's Rights. All newly hired employees will also be educated in the above prior to providing direct care The LPN involved in the incident has been re-educated and has demonstrated competency in this area. Staff have also been re-educated regarding abuse, abuse prevention, definition of abuse and reporting. The Responsible persons, (DPOAHC) have had meetings with The Executive Director regarding these Incidents and a plan approved by both DPOAHC is in place with the goal of preventing any further incidences between Resident #1 and resident # 2.	

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R213	Continued From page 10 was seated nearby when the Staff on duty attempted to grab the walkie-talkie from Resident #1 followed by Resident #1 yelling and flinging their arms towards Staff. Resident #2 responded by moving towards the incident and pushing Resident #1 into a door frame. The physical impact of Resident #1's body striking the door frame fractured this Resident's right clavicle. On the afternoon of 4/15/25, the LPN on duty stated they responded by grabbing Resident #2's shirt and pulling this Resident away from the area. The use of this physical intervention to remove Resident #2 from the incident did not demonstrate respect for Resident #2's individual needs and abilities; and was a risk for further escalation and harm during this incident. On the afternoon of 4/15/25 the Interim Director of Health Services and the Executive Director acknowledged there was a failure to treat Resident #1 and Resident #2 with respect for both residents' dignity, individual abilities, and needs which resulted from the interventions utilized by Memory Care Staff during an incident of resident to resident abuse on 3/25/25.	R213	Both residents physicians are actively involved as well and following. Resident care and approach by staff will be monitored to ensure that all residents will be free of mental, verbal, or physical abuse, neglect and exploitation, and that Their rights will be respected. The results of This monitoring will be reviewed by the Quality Assurance Performance Improvement Committee for further action and Review The Director of Health Services, or RN Designee, other Department Managers and The Executive Director will monitor.	
R224 SS=G	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 there is a failure to	R224	R213 Plan of Correction accepted by Jo A Evans RN on 5/10/25 5.2.25 R224 –Staff including the LPN involved have been re-educated in Resident's Rights, including the right to be free from mental, verbal, physical abuse, neglect and	

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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
R224	Continued From page 11 ensure one applicable resident (Resident #1) remained free of physical abuse by another resident (Resident #2). Findings include: The facility's Abuse Prevention Program policy and procedures states, "It is the policy of this community to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse...". Per record review, Resident #1 and Resident #2 reside in the facility's memory care unit. Both Residents are diagnosed with Dementia and demonstrate behavioral changes associated with cognitive decline. Per record review, Resident #2 has a history of physically aggressive and abusive behaviors towards Resident #1 including an incident on 2/23/25 during which Resident #2 pushed Resident #1 causing this resident to hit their head on the med cart as they fell. On 2/23/25 Resident #1 required medical evaluation of a large bump on the left side of their head sustained during this incident. Per record review, on the evening of 3/25/25 a second incident of physical abuse occurred when Resident #2 pushed Resident #1, causing an injury requiring medical attention. On the afternoon of 4/15/25, a Licensed Practical Nurse (LPN) described this second incident which occurred after Resident #1 obtained a walkie-talkie left unattended by Staff. Per the LPN, when Resident #1 refused to give the walkie-talkie back the LPN and another Staff approached Resident #1 from both sides and attempted to grab the device from the Resident. Resident #1 responded by yelling and "flinging [their] arms around". Per staff interview on	R224	exploitation and have demonstrated competency and understanding of these rights. Staff have also been re-educated regarding abuse, definition of abuse, reporting requirements and prevention and have demonstrated understanding and competency in abuse. Staff have Been educated in abuse prevention specific to Residents #1 and #2, ways to redirect, creative activities to prevent and avoid incidences involving resident #1 and #2. Family meetings were held with responsible parties (DPOAHC) and primary care physican for resident #1 and is being scheduled for Resident #2 with PCP and Gero psychiatrist for input regarding redirection and alternatives to attempt to avoid incidences between	

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 04/15/2025

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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R224	Continued From page 12 4/15/25, Resident #2 was seated nearby during this incident and responded to Resident #1 yelling and flinging their arms by pushing Resident #1 into a door frame. The physical impact of Resident #1's body striking the door frame fractured this Resident's right clavicle. On the afternoon of 4/15/25, the Executive Director and Interim Director of Health Services acknowledged Resident #1 was physically abused by Resident #2 on 2/23/25 and 3/25/25. This deficiency is cited at a harm level due to the injuries caused to Resident #1 by Resident #2.	R224	both residents. The Executive DIrector and Department Managers will monitor direct care and staff interactions with Residents to ensure that residents are free from abuse, and that they are treated with respect and dignity and that their rights are being respected. The results of this monitoring will be reported to the Quality Assurance/ Performance Improvement Committee for further action and review. R224 Plan of Correction accepted by Jo A Evans RN on 5/10/25.	5.2.25