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
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Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

June 5, 2025

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

Dear Ms. Ilsley:

On May 20, 2025, we conducted a revisit to the survey of April 15, 2025 to verify that your facility had achieved substantial compliance. Based on our revisit, we found that your facility has corrected all violations cited at the time of this survey.

If you have any questions regarding this report, please feel free to contact this office at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, M.S.
State long Term Care Manager

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 _____	R-C 05/20/2025

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 5/20/25 the Division of Licensing and Protection conducted an unannounced on-site follow up survey to determine if the home was back in compliance with the Vermont Residential Care Home and Assisted Living Residence Licensing Rules subsequent to the findings of an investigation of one facility reported incident conducted on 4/15/25. The home was determined to not be back in compliance with the applicable licensing rules. Findings include:	{R100}	The Village at WRJ neither admits or denies the Deficiencies set forth in this Statement of Deficiencies. The facility alleges compliance with the deficiency cited by the Division of Licensing and Protection by the alleged completion date.	
{R224} SS=E	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure 3 applicable residents (Residents #1, #4, and #5) remained free of abuse by other residents of the home. The home's policies and procedures governing residents' right to be free of abuse are consistent with this licensing rule. Per record review the following incidents of resident-to-resident abuse occurred at the home: 1. Per record review Resident #1's diagnoses include Dementia and Age-Related Cognitive Decline. Resident #1 is prescribed the anti-coagulant medication Eliquis twice daily and	{R224}	R224 – All residents shall be free from mental, verbal or physical abuse, neglect, and exploitation, and shall also be free from restraints. Staff were re-educated about abuse, abuse prevention, reporting abuse, definition of abuse, communicating with residents with dementia related	

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{R224}	Continued From page 1 is at risk for bleeding. Resident #1's Service Plan identifies occasional behavior issues including aggressive behaviors towards others with a goal of maintaining a safe environment. Per record review Resident #2's diagnoses include Dementia, Metabolic Encephalopathy (altered brain chemistry that causes physical and /or mental changes), and a Mood Disorder due to a known physical condition. Resident #2's Service Plan identifies frequent poor judgement issues as an area of concern which requires protection and supervision due to unsafe and inappropriate decisions. Per staff interview and record review, at approximately 8:00 AM on 5/5/25 Resident #1 and Resident #2 were seated at the same table in the dining room when they began to engage in a verbal altercation. Per record review, Staff on duty in the dining room and kitchen area heard both Residents interacting with raised voices; however Staff were not located close enough to the Residents to hear their conversation. Before the Staff could reach the table where the Residents were seated to intervene, Resident #2 punched Resident #1 in the nose with a closed fist. Per Staff's written statements regarding this incident Resident #1 was noted to have continued eating breakfast after the residents were separated, and Resident #2 was removed from the dining room. Per Review of Progress Notes posted on the morning of 5/5/25 Resident #2 was observed to be crying, yelling, and "very emotional on approach" immediately following this incident; and stated they punched the other resident because they were frustrated and they were being yelled at by Resident #1. At 10:14 AM on 5/5/25, Resident	{R224}	illnesses, memory impairment, how to de-escalate a situation with a resident with memory impairment or dementia related illness. 5/28/25 R224 – All new employees are educated on Resident Rights, Abuse, Abuse Prevention, communication with residents with Dementia, memory impairment and dementia related illnesses, and how to de-escalate a situation with a resident with escalating behaviors. employees are also re-educated on the above annually. The Executive Director, Director Of Health Services and Human Resource Manager to monitor.	

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{R224}	Continued From page 2 #2 was noted to have no apparent injuries on assessment by the Memory Care Director who is a Registered Nurse. Per Progress Note written by the Memory Care Director at 8:58 AM on 5/5/25, Resident #1 did not appear to recall the incident approximately one hour later and replied "No, why?" when asked if their nose hurt. Per the Memory Care Director's written statement regarding the incident dated 5/5/25, Resident #1 was noted to have "reported no pain when asked, but grimaced and pulled away" when the Memory Care Director tried to assess the Resident's nose. This incident is cited as harm level resident-to-resident abuse due to signs and symptoms of pain displayed by Resident #1 following this incident. 2. On 5/9/25 and 5/10/25 two additional incidents of resident-to-resident abuse occurred on the Memory Care floor of the home, during which Resident #3 displayed physically aggressive and abusive behaviors directed towards Residents #4 and #5. All three Residents are diagnosed with Dementia and demonstrate behavioral changes associated with cognitive decline. Resident #3's diagnoses include Unspecified Dementia with agitation and Anxiety Disorder. Resident #4 is diagnosed with Severe Vascular Dementia Resident #5's diagnoses include Restlessness and Agitation, Alzheimer's Disease, and Severe Unspecified Dementia with Agitation. Per record review, at approximately 9:45 PM on 5/9/25 Resident #3 was standing at the serving window in the dining room watching a Staff member working in the kitchen. As the Staff in the kitchen approached Resident #3 to ask if they	{R224}	This education will also be reviewed by the Quality Assurance Performance Improvement Committee monthly for further monitoring and recommendations. R224 – Resident #1 and Resident #2 have new seating arrangements in the dining room apart from each other. All residents that enjoy taking their meals in the dining room have had their seating arrangements reviewed to ensure that it is a pleasant dining experience for all. The table arrangements have been reconfigured to allow for more space and comfort	5.23.25

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{R224}	Continued From page 3 would like something to eat the Resident #3 turned and yelled out "I told you to sit down" at Resident #4 who was also in the dining room. Resident #3 then pushed Resident #4 in the chest, causing Resident #4 to stumble. There were no reported injuries as a result of this incident. Per a Progress Note written at 12:23 AM on 5/10/25, Resident #3 was increasingly agitated throughout the day on 5/9/25, and was noted to have been observed yelling at other residents and exit seeking. Per Progress Notes and Staff's written statements, at approximately 6:40 AM on 5/10/25 Resident #3 grabbed Resident #5's right arm and pushed them into the wall as the residents were walking near each other in a hallway. Resident #3 was redirected to their room by the Licensed Practical Nurse (LPN) who responded to the incident. When the LPN returned to Resident #5 in the hallway and asked this Resident if they were hurt, Resident #5 reportedly pointed to their left hip and indicated they felt pain in this area. Per record review, the LPN examined Resident #5 and observed a small, reddened area on Resident #5's left hip. Per interview with the Memory Care Director on the afternoon of 5/20/25 and review of Resident #5's Progress Notes, the Memory Care Director determined the appropriate course of action following this incident was for the LPN to continue to observe for any signs and symptoms of distress. Resident #5 was not assessed by a Registered Nurse for injury or need for medical care until 5/12/25. There were no reported injuries as a result of this incident. On the afternoon of 5/20/25 the Executive Director, Interim Director of Nursing, and Memory Care Director confirmed Resident #1, Resident	{R224}	for the residents. These arrangements will be reassessed on an ongoing basis by the Director of Health Services with input from other staff to continue to promote a positive, safe, dining experience for all. R244- Resident #1 and Resident #2 Medical providers were notified of the incident. There were no new recommendations or orders from the provider for either resident. both residents continue to be monitored for safety and offered support and reassurance as needed. All residents are monitored for condition changes and behavioral concerns, and	5.23.25

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{R224}	Continued From page 4 #4, and Resident #5 were physically abused by other residents of the home.	{R224}	Residents and family members or responsible parties are updated as needed The Director of Health Services or designee to monitor. Recommendations will be Brought to the Quality Assurance/ Performance Improvement Committee for further review and Recommendations. 5.28.25 R244- Residents #3 #,4,#5 medical Providers and responsible parties were notified of the incident.The Executive Director had a telephone Conversation with Resident #3 DPOAHC,	

and the medical provider also had
a conversation with Resident #3 DPOAHC
on 5/10/25. The Executive Director
also had a conversation with DPOAHC's
for resident #3 and Resident #4, 5/10/25
All were offered support and assistance
Residents #3, 4, 5 have increased
monitoring on the unit for preventative
measures.
Staff have been re-educated regarding
Registered Nurse notification and
Assessment of the resident as needed.
There is an on call Registered Nurse
Schedule posted for events that
require a Registered Nurse assessment
24 hours per day, 7 days per week.
The Director of Health Services or designee
Will monitor and will be reviewed
By the Quality Assurance/Performance
Improvement committee as needed
For further action and recommendations 5.28.25

R224 Plan of Correction accepted by Jo A Evans RN on 6/5/25.