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

February 27, 2026

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 **February 2, 2026.** 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 02/02/2026

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 2/2/2026 the Division of Licensing and Protection conducted an unannounced on-site annual survey and investigation of one facility reported incident and one complaint. The following deficiencies were identified:	R100	Corrective actions for all tags cited accepted by Jo A Evans RN on 2/26/26 Please refer to the attached document to review all accepted corrective actions.	
R196 SS=F	5.10.d (5) Medication Management Staff other than a nurse may administer PRN psychoactive medications only when the home has a written plan for the use of the PRN medication which: describes the specific behaviors the medication is intended to correct or address; identifies any known triggers for the behaviors; specifies the circumstances that indicate the use of the medication; educates the staff about what desired effects or undesired side effects the staff must monitor for; and documents the time of, reason for and specific results of the medication use. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to develop written plans for the administration of PRN (as needed) psychoactive medications by staff other than a nurse which include the required information for all applicable residents. Findings include: During an interview commencing at 2:30 PM on 2/2/2026 the Director of Resident Services stated plans for the administration of PRN psychoactive medications by staff other than a nurse are entered in the Service Plans of the residents of the home who are prescribed psychoactive medications to be administered as needed. Per review of 2 sampled Service Plans, both sampled Service Plans do not include information	R196		

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R196	Continued From page 1 required in written plans for the administration of PRN psychoactive medications by staff other than a nurse. This finding was acknowledged by the Director of Resident Services on the afternoon of 2/2/2026.	R196		
R197 SS=F	5.10.d (5)(i) Medication Management Unlicensed staff must not administer anti-psychotic medications on a PRN or "as needed" basis, unless the delegating registered nurse gives verbal permission prior to administration for each dose, which must be documented. This REQUIREMENT is not met as evidenced by: Based on staff interview there is a failure to ensure the home's Med Techs receive verbal permission from the delegating Registered Nurse prior to administering PRN anti-psychotic medications to applicable residents of the home. Findings include: At 3:06 PM on 2/2/2026 the Director of Resident Services stated if a nurse is in the building the facility Med Techs can ask for permission to administer psychoactive PRN medications, and confirmed the home's Med Techs are not required to obtain verbal permission from the delegating Registered Nurse prior to administering anti-psychotic PRN medications to applicable residents of the home. The Director of Resident Services indicated they were not aware of this licensing rule.	R197		

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R203 SS=F	5.10.h (1) Medication Management All drugs, medicines and chemicals used in the home must be labeled in accordance with currently accepted professional standards of practice. Medication must be used only for the resident identified on the pharmacy label. (1) Resident medications that the home manages must be stored in locked compartments under proper temperature controls. Only authorized personnel must have access to the keys. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure secure storage of medications in locked compartments for 2 residents (Residents #1 and #2) who require medication administration and management by the home. Findings include: The facility's Medication Management Program policy states, "Medications shall be kept in a secure storage area at all times, as defined by state regulations in the community except when required to be kept by a resident on his/her person for frequent or emergency use." During a tour of the home commencing at 9:55 AM on 2/2/2026, unsecured medications were observed in the apartments of 2 applicable residents who require medication administration including: 1. In Resident #1's apartment Afrin Nasal Mist, Miconozole Nitrate 2% Antifungal Powder, Pimecrolimus 1% Cream, Tacrolimus 0.1% Ointment, and Ketoconozal 2% Shampoo were observed to be unsecured and accessible.	R203		

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R203	Continued From page 3 2. In Resident #2's apartment Carbamine Peroxide 6.5% Earwax Removal Aid, Vicks VapoRub Cough Suppressant and Topical Analgesic, DermaKlenz wound cleanser, Hydrophilic Topical Cream, Cerave Topical Cream, Miconozole Nitrate 2% Antifungal Powder, and Skintegrity Wound Cleanser. These findings were confirmed by the Director of Resident Services at 12:46 PM on 2/2/2026.	R203		
R206 SS=F	5.10.h (4) Medication Management Medications left after the death or discharge of a resident, or outdated medications, must be promptly disposed of in accordance with the home's policy and applicable standards of practice. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure prompt disposal of outdated medications stored in the home's Memory Care medication cart. Findings include: The facility's Medication Management Program policy states, any medication which has been prescribed but is no longer in use or is expired will be disposed. This policy does not indicate a time frame for disposal. During a medication storage review conducted on the afternoon of 2/2/2026, the medication cart in the Memory Care area of the home was observed to contain multiple outdated medications as follows:	R206		

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R206	Continued From page 4 1. Medications expired in 2026 included: a. Paroxetine tablet 20 mg, expired 01/01/2026 b. Senna 8.6 mg tablet expired 01/06/2026 c. Bisacodyl 5 mg tablet expired 01/06/2026 d. Loperamide capsule 2 mg, expired 01/13/2026 e. Tizanidine tablet 2 mg expired 01/23/2026 f. Cefuroxime tablet 500 mg, expired 01/25/2026 2. Medications expired in 2025 included: a. Centrum Men Multivitamin expired Jan 2025 b. Bisacodyl tablet 5 mg, expired 01/16/2025 c. Cetirizine 10 mg tablet expired 03/11/2025 d. Quetiapine 25 mg tablet expired 05/17/2025 e. Naproxen 220 mg tablet expired 06/15/2025 f. Fexofenadine tablet 60 mg expired 06/15/2025 g. Trazodone tablet 50 mg expired 07/04/2025 h. Prochlorperazine tablet 10 mg expired 07/13/2025 i. Hyoscyamine tablet 0.125 mg expired 07/13/2025 j. Hyoscyamine tablet 0.125 mg expired 07/21/20 k. Gold Bond Medicated powder expired 07/2025 l. Trazodone tablet 50 mg expired 08/23/2025 m. Doctor's Best Ubiquinol tablet 100 mg expired 09/2025 n. Ibuprofen tablet 600 mg expired 11/27/2025 o. Acetaminophen tablet 325 mg expired 11/29/2025 p. Sertraline hydrochloride tablet 50 mg expired 11/30/2025 q. Triamcinolone Acetonide Cream 0.1% expired Dec 2025 r. Senna 8.6 mg tablet expired 12/26/2025 3. Medications expired in 2024 included: a. Lily Hill CBD Oil 1000 mg/bottle expired 04/2024 b. Loperamide hydrochloride tablet 2 mg expired 08/2024	R206		

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R206	Continued From page 5 c. Debrox Earwax removal kit, expired 09/08/2024 d. Trazodone tablet 50 mg expired 07/04/2025 These findings were confirmed by the Med Tech on duty in the Memory Care area of the home at 2:15 pm on 2/2/2026 and acknowledged by the Executive Director on the afternoon of 2/2/2026.	R206		
R232 SS=E	5.12.c (5) Records/Reports Any reports, allegations, or incidents of abuse, neglect, exploitation of residents or misappropriation of resident property must be reported to the licensing agency. i. The licensee and staff must report any case of suspected abuse, neglect or exploitation of a resident to Adult Protective Services (APS). A separate report must also be made to the licensing agency. APS may be contacted by calling toll-free 1-800-564-1612. The licensing agency may be contacted by calling toll-free 1-888-700-5330. The home must make the reports to APS and to the licensing agency immediately but not later than within 48 hours of learning of the suspected, reported or alleged incident. ii. In addition to filing the reports as described above, a home must conduct its own investigation and must take immediate steps to prevent further abuse, neglect or exploitation from occurring. The results of the home ' s investigation must be reported to the licensing agency within 5 business days from the date of the initial report of the allegation. The home's investigation and determination must not delay reporting of the alleged or suspected incident to	R232		

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R232	Continued From page 6 Adult Protective Services and to the licensing agency. iii. Incidents involving resident-to-resident abuse must be reported to the licensing agency any time a resident alleges, or the licensee or staff observe or suspect, verbal, physical or mental abuse; sexual abuse, if an injury has resulted; or if there is a pattern of abusive behavior. (A) All resident-to-resident incidents, even minor ones, must be recorded in the resident ' s record. (B) The home must notify legal representatives and families (if permitted) about the incident(s) and must document the report and the plan the home developed to address the behaviors. the following reports with the licensing agency: This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to report one applicable resident's pattern of verbally and physically abusive behavior to the licensing agency (Resident #4). Findings include: The home's Abuse, Neglect, and Exploitation Prohibition and Prevention policy effective 7/1/2024 states the organization that manages the home adheres to and is familiar with definitions contained in any state specific laws and regulations governing abuse, neglect, and exploitation. This policy does not address mandatory reporting of a pattern of abuse. Per record review, Resident #4 is living with the signs and symptoms of advanced Dementia with aggressive behaviors. Per review of Progress Notes on file, Resident #4 demonstrated a pattern	R232		

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R232	Continued From page 7 of verbal and physical aggression and abusive behaviors directed towards other residents and staff including: a,.On 9/30/2025 Resident #4 was reported to be physically aggressive with staff and residents; left a bruise on one staff; and repeatedly put their hands around a nurse's neck. b. On 10/3/25 and 10/7/2025 there were incidents of Resident #4 grabbing staff. c. On 10/8/2025 Resident #4 reportedly charged towards staff and other residents, and grabbed staff . Staff reportedly put themselves between Resident #4 and the other residents, and Resident #4 was noted to be an "immediate risk to residents' safety." d. On 10/10/2025 Resident #4 reportedly lunged at another resident while yelling I hate you, then grabbed and put their hands around the neck of the staff who stepped between Resident #4 and other resident to prevent contact. e. On 10/11/2025 Resident #4 reportedly grabbed another resident who was walking past them by the upper arms and screamed "I hate you!" at the other resident repeatedly. f. On 10/12/2025 is was noted that Resident #4 was walking through the halls grabbing at staff while screaming "I hate you!" g. On 10/13/2025 Resident #4 reportedly grabbed 3 separate staff by the throat. h. On 11/14/2025 Resident #4 was noted to have repeatedly grabbed and hit staff multiple times while yelling "I hate you!".	R232		

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R232	Continued From page 8 i. A Progress Note dated 11/24/2025 stated Resident #4 was screaming at another resident and very aggressive towards staff. During this incident Resident #4 was reportedly observed by the nurse grabbing staff then physically aggressed towards the nurse who responded. j. On 12/4/2025 staff responded to Resident #4 who was trying to grab another resident and not responsive to redirection. Per review of reports made to the licensing agency by the home, the incident occurring on 10/11/2025 was the only incident of Resident #4's verbal and physical aggression and abusive behaviors directed towards other residents and staff listed above that was reported to the licensing agency. The facility's report to the licensing agency on 10/13/2025 regarding the incident on 10/11/2025 was a report of a single incident that was not identified as part of a pattern of abuse demonstrated by Resident #4. At 5:45 PM on 2/2/2026 the Executive Director confirmed incidents of Resident #4 engaging in aggressive and abusive behaviors other than the incident on 10/11/2025 had occurred, and acknowledged this finding as a potential pattern of abuse.	R232		
R358 SS=F	6.10 Resident's Rights The resident's right to privacy extends to all records and personal information. Personal information about a resident must not be discussed with anyone not directly involved in the resident's care. Release of any record, excerpts from or information contained in such records are subject to the resident's written approval, except as requested by representatives of the licensing	R358		

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R358	Continued From page 9 agency to carry out its responsibilities or as otherwise provided by law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure residents' personal information in securely stored and remains inaccessible to anyone who is not directly involved in their care. Findings include: The facility's HIPAA Authorizations policy states, "The community obtains a written authorization from the resident before using or disclosing any protected health information (PHI)...". This policy does not state residents' PHI will remain secure and inaccessible to anyone not directly involved in their care. 1. During a tour of the home commencing at 9:55 AM on 2/2/2026 the Wellness office on the third floor of the home was observed unattended by staff with an open door. Resident's personal information was observed to accessible in this open office including in binders stored on the office counter top and in folders stored in an unlocked file cabinet under the desk. This finding was confirmed by the Director of Resident Services at 12:46 PM on 2/2/2026. 2. During an observed med pass in the Memory Care Center conducted during the facility tour several pieces of paper with residents' personal information were observed to be placed on top of the medication cart. When a Surveyor returned to this medication cart to review this medication storage area 1:42 PM on 2/2/2026, the papers	R358		

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R358	Continued From page 10 were observed in the same place while the cart was unattended by staff. The Med Tech on duty in the Memory Care Center confirmed the papers containing residents' personal health information are routinely stored on top of the medication cart 1:45 PM on 2/2/2026.	R358		
R360 SS=D	6.12 Resident's Rights Residents must be free from mental, verbal or physical abuse, neglect, and exploitation. Residents must also be free from restraints and seclusion as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure one applicable resident (Resident #4) remained free of physical abuse by another resident (Resident #3). Findings include: The home's policies and procedures governing abuse are consistent with this licensing rule. Per record review Resident #3 and Resident #4 are both living with the signs and symptoms of advanced Dementia. Both Residents have a history of aggressive behaviors. Per review of Progress Notes and facility Incident Reports, at approximately 9:45 PM on 1/2/2026 Resident #3 was heard yelling "get out of my room" in the hallway of the home's Memory Care Center. Staff responded and witnessed Resident #3 chasing Resident #4 down the hall in their wheelchair, grabbing Resident #4's left forearm, and kicking Resident #4's left leg. During an interview commencing at 4:57 PM on 2/2/2026 the Director of Resident Services stated Resident #3 is very	R360		

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R360	Continued From page 11 territorial and on the night of 1/2/2026 Resident #4 had wandered into Resident #3's room. During the interview conducted at 4:57 PM, the Director of Resident Services confirmed Resident #3 grabbed and kicked Resident #4, and acknowledged the incident that occurred between Resident #3 and Resident #4 on the night of 1/2/2026 as an incident of resident-to- resident physical abuse.	R360		
R381 SS=F	7.2.a Food Safety and Sanitation Each home must procure food from sources that comply with all laws relating to food and food labeling. The home must ensure that all food is safe for human consumption, free of spoilage, filth or other contamination. All milk products served and used in food preparation must be pasteurized. Cans with dents, swelling or leaks must be rejected and kept separate until returned to the supplier. This STANDARD is not met as evidenced by: Based on observation and staff interviews there is a failure to ensure all perishable foods and beverages are free of spoilage and contamination. Findings include: 1. During a tour of the home commencing at 9:55 AM on 2/2/2026 potentially spoiled and contaminated foods were observed in the Memory Care area including an unlabeled uncovered dish of ice cream stored in the kitchen freezer with visibly desiccated surfaces indicating this perishable item had been exposed to the open air in the freezer for an extended period of time. An unlabeled unsealed clear plastic cup	R381		

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R381	Continued From page 12 containing partially consumed ice cream was observed in the freezer door of the refrigerator in the Memory Care cooking area of the activity room, which is open and accessible to residents with cognitive impairment. These findings were confirmed by the Director of Resident Services at 12:46 PM on 2/2/2026. 2. At 12:32 PM on 2/2/2026 expired foods and beverages were observed in the third floor Smith and Son kitchen including: a. Instant decaffeinated coffee expired on 4/4/2020 b. Instant coffee expired 4/26/2021 c. Powdered mocha coffee beverage expired on 4/6/2023 d. Vanilla syrup expired on 8/29/2025. e. The refrigerator in the Smith and Son kitchen contained a partially consumed half gallon of milk which expired on 1/21/2026, chocolate syrup which expired on 6/30/2024, and caramel syrup which expired on 7/31/2024. These findings were confirmed by the Executive Director on the afternoon of 2/2/2026.	R381		
R382 SS=F	7.2.b Food Safety and Sanitation 7.2.b All perishable food and drink must 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. (3) Staff must monitor the temperature of temperature-controlled food storage areas. Staff must conduct regular temperature checks of prepared food to ensure proper food safety and must document the time and results of	R382		

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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
R382	Continued From page 13 each check. The U.S. Department of Agriculture provides guidance for time and temperature curves to ensure prepared foods remain outside of the 'danger zone' for food safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure perishable foods and beverages are labeled with the dates the items are opened or prepared. Findings include: The facility's Dry Food Storage policy provided on request states, "All open food items must be dated, labeled, and sealed." However, this policy is limited to dry food items. During a tour of the Assisted Living Residence commencing at 9:55 AM on 2/2/2026 the following perishable items were observed to be without labels indicating dates the items were opened or prepared: 1. In the main kitchen opened containers of heavy cream and 2% milk stored in the walk-in refrigerator, open unsealed boxes of baked goods in the walk in freezer, 4 opened bags of pasta in the dry goods storage area, and an opened gallon of marsala cooking wine were observed without labels indicating the dates these perishable items were opened. 2. In the Memory Care kitchen refrigerator multiple open bottles of soda and in the freezer multiple containers of ice cream were without labels indicating the dates these perishable items were opened.	R382		

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 02/02/2026

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THE VILLAGE AT WHITE RIVER JUNCTION	101 CURRIER STREET WHITE RIVER JUNCTION, VT 05001

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R382	Continued From page 14 These findings were confirmed by the Director of Resident Services at 12:46 PM on 2/2/2026. 3. Opened perishable items without dates were observed in the third floor Smith and Son Kitchen at 12:32 PM on 2/2/2026 including bottles of chocolate and caramel syrup. This finding was confirmed by the Executive Director on the afternoon of 2/2/2026.	R382		
R403 SS=F	9.1.c Environment The home must ensure that the resident environment remains as free of accident hazards as possible. Maintaining a safe environment must include the safe storage and clear labeling of chemical agents, which must include secure storage of such agents if the home has residents with cognitive impairment. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there is a failure to ensure care in a safe environment related to the unsecured storage of chemicals, storage of sharp knives, and use of oxygen without posting cautionary signage. Findings include: The facility's Environmental Rounds Program states, the organization that manages the home will promote the safety of the residents in their private living spaces and will conduct environmental rounds on a weekly basis. The Assisted Living Residence is home to residents with various abilities to safely manage access to hazardous items.	R403		

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	0660	A. BUILDING: _____ B. WING _____	C 02/02/2026

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R403	Continued From page 15 During a tour of the home commencing at 9:55 AM on 2/2/2026 the following safety concerns were observed: 1. The facility's Housekeeper's Guidebook 2023 states, "The Housekeeper must keep all chemicals locked in the cabinet when not in direct custody and control of the cart." This policy does not address chemical storage in areas other than the housekeeping carts and storage cabinets. Unsecured cleaning chemicals and other hazardous chemical agents were observed to be stored in areas of the home accessible to residents including: a. The unlocked fourth and fifth floor laundry areas were observed with unsecured detergents, stain removing products, odor eliminating products, sanitizers and disinfectants, furniture polish, and window cleaning products. b. An unsecured disinfectant was observed in the Paw Prints animal recreation area of the home. c. An unsecured insecticide was observed in the Miller Stage theater area of the home. d. Unsecured Sani-Cloth wipes labeled with instructions to avoid inhalation and contact with skin and eyes were observed in areas of the home including the third floor exercise room. The exercise room was observed with an open door, and the wipes were visible from the hallway. e. Unsecured cleaning agents were observed in two resident rooms on the fourth floor of the home and one resident room on the fifth floor of the home including	R403		

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R403	Continued From page 16 These findings were confirmed by the Director of Resident Services at 12:46 PM on 2/2/2026. Additionally, at 12:32 PM on 2/2/2026 unlocked cabinets in the third floor Smith and Son community kitchen were observed to contain unsecured cleaning chemicals including a multi-purpose cleaner and a disinfectant. This finding was confirmed by the Executive Director on the afternoon of 2/2/2026. 2. A bucket containing multiple sharp knives was observed to the stored in the open walkway between the first floor dining area and main kitchen. 3. During the tour of the home on the morning of 2/2/2026, supplemental oxygen was observed to be in use in Apartment 3206 without cautionary signage placed on the door. The facility's Environmental Rounds Program lists a lack of oxygen signage in place for those with oxygen as a hazard that shall be addressed immediately. Findings observed during the facility tour conducted on the morning of 2/2/2026 were confirmed by the Director of Resident Services at 12:46 PM.	R403		
R999 SS=F	Miscellaneous This REQUIREMENT is not met as evidenced by: 4.9.b The new licensee must provide each resident with a new uniform consumer disclosure and a new written admission agreement that describes all rates and charges as set forth in 5.2.a and 5.2.b.	R999		

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R999	Continued From page 17 Compliance with licensing rule 4.9.b is NOT MET as evidenced by: During an interview with commencing at 11:55 AM on 2/2/2026 the Executive Director stated the Assisted Living Residence (ALR) was purchased by a new company with an official start date for the new licensee's management of the home on 12/15/2025. Per the Executive Director's confirmation at 3:20 PM on 2/2/2026, all residents of the ALR were not provided a new Uniform Consumer Disclosure statement and a new written Admission Agreement in response to the change of ownership.	R999		

Deficiency Statement Plan of Correction (POC)

Survey Date: 2/2/2026

Martha Ilsley Executive Director 2/26/26

Facility Name: The Village at White River Junction

Deficiency Tag	How the deficiency was corrected	How other potential residents identified, and corrective action taken	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R196 Plan of Correction accepted by Jo A Evans RN on 2/26/2026.	Two residents were affected. Their service plans were updated to include information that a nurse is administering PRN psychoactive medications.	An audit is being conducted of current residents on PRN psychoactive medication to ensure that care plans are updated to indicate a nurse will administer the psychoactive medication.	3/16/26	The facility practice is to have a nurse administer PRN psychoactive medications.	The Director of Resident Services/designee will monitor compliance. The Director of Resident Care/designee will complete audits of medication records for residents receiving PRN psychoactive medications will be conducted monthly x 3 months. Bi-monthly medication audits will be completed on 10% of residents receiving medication to ensure ongoing compliance. Audit results will be presented to the Quality Assurance Performance Improvement Committee for review; the Committee initiates alternate corrective action if required.

R197 Plan of Correction accepted by Jo A Evans RN on 2/26/2026.	No specific resident(s) was affected.	A nurse is to administer anti-psychotic medications on as needed basis (consistent with nursing standards).	3/16/26	1. A nurse administers PRN anti-psychotic medication. 2. In the event an unlicensed staff needs to administer an anti-psychotic medication, a Registered Nurse will give verbal permission prior to administration. The unlicensed staff will document in the resident record the reason for the medication and that permission was given prior to administration. 3. Education to nurses and unlicensed staff regarding the practice of administration of PRN-anti-psychotics will be completed.	The Director of Resident Services will monitor compliance/ or designee. Audits of medication records for residents receiving PRN psychoactive medications will be conducted monthly x 3 months. Bi-monthly medication audits will be completed on 10% of residents receiving medication to ensure ongoing compliance. Audit results will be presented to the Quality Assurance Performance Improvement Committee for review; the Committee initiates alternate corrective action if required.
R203 Plan of Correction accepted by Jo A Evans RN on 2/26/26.	1. Resident #1 and Resident #2 medications were immediately secured in locked cabinets. 2. Education was provided to Resident # 1 and Resident # 2 about the	An audit of current residents residing in Assisted Living will be conducted to ensure that medications that the home manages are stored in locked compartments. Only authorized personnel will have access to the keys.	3/16/26	The Resident Services Director, or designee, will perform a weekly audit on 10% of resident apartments to ensure that resident's medications are secured.	The Director of Resident Services or designee will monitor. Audit results will be presented to the Quality Assurance Performance Improvement Committee for review; the Committee initiates alternate corrective action if required.

	importance of securing their medications.	Re-education on Environmental Rounds policy will be completed with nurses, aides, housekeepers, and Department Managers.			
R206 Plan of Correction accepted by Jo A Evans RN on 2/26/26.	No resident was affected, but the medications noted as expired or no longer in use during the medication storage review on 2/2/26 were disposed of, no later than 02/03/26	1. All medication carts and medication storage areas will be audited for medications that are discontinued or expired and will be promptly disposed of. 2. Nurses and medication assistants will be re-educated on the Medication Management Policy regarding removing the medications from the medication carts to a medication storage area for prompt disposal.	3/16/26	An audit on 10% residents' medications and mediation storage areas will be conducted bi-monthly to ensure that left after the death or discharge of a resident, or outdated medications, are promptly disposed of in accordance with the facility policy.	The Director of Resident Services or designee will monitor. Audit results will be presented to the Quality Assurance Performance Improvement Committee for review; the Committee initiates alternate corrective action if required.
R232 Plan of Correction accepted by Jo A Evans RN on 2/26/26.	Resident #4's physician was contacted regarding resident's pattern of abuse. A review of resident's medication regime was	An audit of internal incidents from January 2026 to current will be conducted to identify any potential abuse allegations.	3/16/26	The community and staff will report on any case of suspected abuse, neglect, or exploitation of a resident to Adult Protective Services (APS). A separate report	The Executive Director or designee will monitor The audit will be conducted monthly for 3 months and results Audit

	conducted with the resident's physician and residents' decision maker. Resident is also treated by hospices and hospice was also consulted regarding the residents patterns of abuse and behaviors. Staff have also been educated and Resident #4 service plan updated regarding communication techniques with this resident, as well as redirection techniques that may be tried when this resident is experiencing aggressive behaviors.	Staff have been re-educated regarding reporting allegations of abuse, or incidents of abuse, neglect, exploitation of residents or misappropriation of resident property, and patterns of abuse.		will also be made to the licensing agency. The make the community will report to APS and to the licensing agency immediately but not later than 48 hours of learning of the suspected, reported, or alleged incident. Executive Director or designee will conduct monthly audits of internal incidents for the next three months.	results will be presented to the Quality Assurance Performance Improvement Committee for review; the Committee initiates alternate corrective action if required.
R358 Plan of Correction accepted by Jo A Evans RN on 2/26/2026.	Residents' personal information will be securely stored and inaccessible to anyone who is not directly involved in their care. 1. The Wellness Office, which is also the Director of Resident Services Office is now always locked when the Director or a designated staff member is not in the office.	Routine rounds will be conducted in the community and audited to ensure that all resident information is securely stored and inaccessible to anyone not involved in their care. Re-education on HIPAA safeguards will be conducted with Nurses, Med Techs, Aides and Department Heads.	3/16/26	The audits will be conducted weekly for the next three months Staff have been re-educated regarding privacy and securely storing resident privacy information	The Director of Resident Services or the Executive Director will monitor. Audit results will be presented to the Quality Assurance Performance Improvement Committee for review; the Committee initiates alternate corrective action if required.

	2. No information is stored on top of the medication cart. All private resident information is secure.				
R360 Plan of Correction accepted by Jo A Evans RN on 2/26/26.	Resident # 3 and Resident #4 were immediately re-directed at the time of the incident. There was no injury or harm to either resident. Both residents' providers were notified of the incident; Resident # 4 has had a medical review of medications by their provider. Staff have an increased awareness of both residents on the unit as an attempt to prevent any further interactions between each resident. The residents' service plans have been updated to include interventions as an attempt to prevent any further incidents.	An audit of internal incidents from January 1st, 2026, to current will be conducted to identify any additional residents affected.	3/16/26	The Executive Director, or designee will complete monthly audits for the next three months concerning allegations of abuse. Staff have been re-educated on the community's Abuse Prevention and Prohibition policy and procedures.	The Executive Director or designee will monitor. Audit results will be presented to the Quality Assurance Performance Improvement Committee for review; the Committee initiates alternate corrective action if required.
R381 Plan of Correction accpeted by Jo A Evans RN on 2/26/26	The uncovered dish of ice cream stored in the kitchen freezer was disposed of. The unsealed clear plastic	An audit is being conducted of all refrigerators and food storage areas to ensure that no outdated foods	3/16/26	The Dining Service Director will complete a weekly audit for the next three months. Kitchen staff will be re-educated on Dry Food	Dining Service Director or designee will monitor. Audit results will be presented to the Quality Assurance Performance

	cup of partially consumed ice cream was disposed of. The expired foods noted on the third floor Smith and Son kitchen were disposed of on 2/2/26 immediately.	are being stored or unlabeled items being stored.		Storage Policy regarding the importance of dating and labelling all food items.	Improvement Committee for review; the Committee initiates alternate corrective action if required.
R382 Plan of Correction accepted by Jo A Evans RN on 2/26/2026.	All perishable food and drink will be labeled and dated with the date that the item is opened or prepared and held at proper temperatures. In the main kitchen the milk was immediately disposed of, as were the open boxes of baked goods, the four opened bags of pasta and the opened gallon of marsala cooking wine. In the memory care kitchen, the open bottles of soda and ice cream were disposed of. The items in the Smith and Son kitchen were also immediately disposed of.	An audit is being conducted of all refrigerators and dry food storage areas to ensure that all items are safely stored, labelled, and dated. Staff have been re-educated regarding Food safety and Sanitation to include labelling and dating items.	3/16/26	The Dining Service Director or designee will conduct weekly x 3 months	Dining Service Director or designee will monitor. Audit results will be presented to the Quality Assurance Performance Improvement Committee for review; the Committee initiates alternate corrective action if required.
R403 Plan of Correction accpeted by Jo A Evans RN on 2/26/26	The community will ensure the resident environment remains as free of accident hazards as possible, including the safe storage and clear	Environmental rounds were conducted on a to ensure that the residents' environment remains as free of accident hazards as possible. The environmental rounds	3/16/26	The Plant Operations Director or designee will conduct monthly audits using the Safety Awareness tool for the next three months. Staff will be re-educated regarding the safe storage	The Plant Operations Director of designee will monitor. Audit results will be presented to the Quality Assurance Performance Improvement Committee for review; the

	labelling of chemical products. The fourth and fifth floor laundry areas are now secure. The disinfectant in the Paw Prints animal recreation area was removed. The insecticide that was in a locked closet in the Miller Stage area was removed. The Sani-cloth wipes were removed from the third-floor exercise room. Cleaning agents were removed from the two resident rooms on the fourth floor and the one resident room on the fifth floor. The unlocked chemicals in the Smith and Son kitchen were removed. The sharp knives were removed from the open walkway between the first-floor dining area and main kitchen. The resident without oxygen signage immediately had signage put in place on 2/2/26. All the above issues were corrected on 2/2/26	will include ensuring the safe storage and labeling of chemical agents.		of chemicals, labeling of chemicals, oxygen signage, and safe storage of knives.	Committee initiates alternate corrective action if required.
R999 Plan of Correction accepted by Jo A Evans RN on 2/26/26.	Residents who moved in prior to 12/15/2025 are affected. Each such resident or their	Residents who moved in on/after 12/15/2025:	2/28/26	An audit was conducted to ensure that each resident or their designee has been	Executive Director to monitor.

	designated decision maker has been provided with a new uniform consumer disclosure and a new written admission agreement, which describes all rates and charges as set forth in 5.2.a and 5.2. b	• Each resident has been provided with the current version of the uniform consumer disclosure. • Residents have been provided with the new residency agreement at time of move-in.		provided with copies of each new document.	

Note: The filing of this Plan of Correction does not constitute admission regarding the alleged findings, deficiencies or violations. The Plan of Correction is filed in compliance with applicable law and demonstrates the community's continuing commitment to quality care.