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

August 7, 2026

Danielle Nickerson, Manager
The Village At White River Junction
101 Currier Street
White River Junction, VT 05001

Dear Ms. Nickerson:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 13, 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 07/13/2026

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

(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 7/13/2026 the Division of Licensing and Protection conducted an unannounced on-site investigation of 3 facility reported incidents and 1 complaint. The following deficiencies were identified:	R100	Corrective actions for all deficiencies cited accepted by Jo A Evans, RN on 8/6/2026. Please see the attached document to review all accepted corrective actions.	
R166 SS=D	5.9.c.(9) Nursing Services For each resident requiring nursing overview, administration, or nursing care, the registered nurse must; Ensure that the resident's record documents any changes in a resident's condition as well as the nursing actions taken; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to document nursing actions taken in response to a significant change in one applicable resident's condition (Resident #1). Findings include: Resident #1 was a traditional assisted living resident admitted to the home with multiple chronic conditions. Resident #1 passed away at the home on 6/9/2026 during a critical incident which occurred following significant changes in condition documented in this Resident's record on 6/8/2026 and 6/9/2026. Per review of a report submitted to the licensing agency and Progress Notes on 6/8/2026 Resident #1 shared with a Licensed Practical Nurse (LPN) that they were experiencing hallucinations which the Resident described as seeing people and things that could not be seen by others. Per this report, Resident #1 had a	R166		

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R166	Continued From page 1 scheduled appointment to see their doctor on 6/11/2026 and planned to discuss this change in condition during this scheduled appointment. Progress Notes written by two different LPN's on 6/8/2026 and 6/9/2026 indicate Resident #1 demonstrated a significant change in presentation to include increased confusion, hallucinations, and refusal of medication. During interviews conducted on 7/13/2026, staff reported that leading up to Resident #1's death on 6/9/2026 this Resident also presented with increased difficulty breathing and loss of ability to participate when staff were providing personal care in addition to increased confusion and hallucinations. Per review, Resident #1's record does not include documentation of actions taken by a Registered Nurse employed by the home including, but not limited to, completing an assessment of Resident #1 and updating Resident #1's Care Plan to address changing needs in response to this Resident's significant change in presentation. This finding was confirmed by the Executive Director at approximately 5:30 PM on 7/13/2026.	R166		
R210 SS=F	5.11.c Staff Services The home must provide, or arrange for the provision of, at least twelve (12) hours of training upon hire and each year to each staff person providing direct care to residents. The manager may give credit towards the required 12 hours of training upon hire, for any formal training received in the twelve months preceding the date of hire, provided the home maintains documentation of the training and ensures competency in the subject matter. The training must include, but is	R210		

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R210	Continued From page 2 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, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; (7) General supervision and care of residents; (8)Communication strategies, person-centered care, challenging behaviors and understanding dementia; (9) Recognition of and sensitivity to different cultures, belief systems, abilities, gender identities, sexual orientation; and (10) Trauma-informed care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review 4 out of 5 sampled staff did not complete the required annual training. Findings include: The facility's In Service Training, All Staff policy is consistent with licensing rules. Documentation of training completed by 5 sample staff was requested on the morning of 7/13/2026. Per review of the documentation provided, the required annual training were not completed by 4 out of 5 sampled staff.	R210		

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R210	Continued From page 3 This was acknowledged by the Executive Director of the facility on the afternoon of 7/13/2026.	R210		
R232 SS=D	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 Adult Protective Services and to the licensing agency. iii. Incidents involving resident-to-resident abuse must be reported to the licensing agency any time	R232		

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R232	Continued From page 4 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 an alleged incident of resident-to-resident abuse to the licensing agency and the Adult Protective Services as required. Findings include: Per Progress Notes entered on 5/13/2026, Resident #2 requested staff assistance when another resident (Resident # 3) wandered in their room. Staff redirected Resident # 3 and Resident #2 was encouraged to return to their room and lock their door. This note stated that five minutes later Resident #2 was observed running away from the Resident #3 and asking for help; and "it was noted" that Resident #3 grabbed and punched by Resident #2. Additionally, per this Progress Note Resident #2 reported they were pushed by Resident #3 . Per record review, a report regarding this incident was not submitted to the licensing agency by the home. On the afternoon of 7/13/2026 the Executive Director confirmed the incident involving Residents #2 and Resident #3 occurred	R232		

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R232	Continued From page 5 on 5/13/2026; and the Executive Director was requested to provide documentation of reports made to the licensing agency and the Adult Protective Services regarding this incident. Per the Executive Director's confirmation via email on 7/15/2026, the incident between Resident #2 and Resident #3 was not reported to the licensing agency and the Adult Protective Services as required.	R232		
R349 SS=D	6.1 Resident's Rights Every resident must be treated with consideration, respect and full recognition of the resident ' s dignity, individuality, and privacy. Care provided to residents must be person-centered. A home may not ask a resident to waive the resident's rights. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review there is a failure to ensure one applicable resident (Resident # 4) was treated with dignity and respect by staff. Findings include: Per record review Resident #4 resides in the assisted living section of the home and has diagnoses including multiple chronic medical conditions and psychological conditions. Per record review Resident #4 is living with chronic pain due to medical conditions and trauma, and right-sided weakness/paralysis subsequent to a cerebrovascular accident. Resident #4 's plan of care indicates they are dependent on staff for assistance with activities of daily living including bathing, hygiene and grooming, dressing, transfers and mobility.	R349		

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R349	Continued From page 6 Per record review and staff interviews, on 4/29/2026 a Staff member told Resident # 4 they would not take care of them anymore and called the Resident "mean" during an incident that occurred while the Staff was assisting Resident #4 with showering. Per record review and staff interview, after assisting Resident #4 with getting into bed the Staff shoved the Resident's walker into a door. Per documentation of interviews conducted after this incident, Resident #4 stated the Staff was "rough" with them, yelled at them, and made them feel uncomfortable. During an interview with Resident #4 on the afternoon of 7/13/2026, Resident #4 did not appear to recall this incident. These findings were confirmed by the Executive Director at approximately 11:40 AM on 7/13/2026.	R349		
R356 SS=F	6.8 Resident's Rights A resident may complain or voice a grievance without interference, coercion or reprisal. Each home must establish a written grievance procedure for resolving residents ' concerns or complaints that is explained to residents at the time of admission. The grievance procedure must include at a minimum, time frames, a process for responding to residents in writing, and a method by which each resident filing a complaint will be made aware of the role and contact information of the Office of the Long-Term Care Ombudsman and Disability Rights Vermont as an alternative or in addition to the home's grievance mechanism. This REQUIREMENT is not met as evidenced by:	R356		

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R356	Continued From page 7 Based on observation, staff interview, and record review, there is a failure to ensure the posted grievance procedure includes time frames for the grievance process. Findings include: The facility's Grievance/Complaints, Filing policy is consistent with the licensing rules. Based on observation and record review, during a tour of the facility on the morning of 7/13/2026, the facility's grievance procedure, titled Grievance/Residents' Rights Violations, was observed to be posted on the wall between the elevators of each floor. Although the facility's Grievance/Complaints, Filing policy noted in the Administrative Policies and Procedures is consistent with the licensing rules, the posted grievance procedure did not include the required time frames for the grievance process. These findings were confirmed by the Executive Director on 7/13/2026 at approximately 6:20 PM.	R356		
R364 SS=D	6.16 Resident's Rights Residents have the right to formulate advance directives, to have in place DNR and clinician-ordered life-sustaining treatment (COLST) documents, as provided by state law, and to have the home follow the residents ' wishes. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure one applicable resident's wishes regarding life-sustaining care were followed by the home (Resident #1). Findings	R364		

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R364	Continued From page 8	R364		

include:

The Statement of Resident's Rights provided to residents by the home includes this licensing rule.

The home's Injury and First Aid Response Policy effective as of 2021 states signed DNR (Do Not Resuscitate) documents will be kept in multiple places including on the back of resident's apartment door, in the resident's records, in the Emergency Books. This policy also states, "DNR lists shall be kept in the community at the front desk, in the Communication logs, and in the Main Kitchen." Per this policy, the Resident Care Director will update the DNR list with each move-in or change in status code and at least once a week, and distribute the updated list as noted above.

Per staff interviews and record review, Resident #1 identified their wishes for life sustaining care in documents including an Advanced Directive and MOLST / POLST forms (Orders for Life Sustaining Care) which state this Resident was a "DNR" (Do Not Resuscitate).

Per staff interview and record review, on the afternoon of 6/9/2026 staff responded to a call for assistance, found Resident #1 on the floor in their room and called for nursing assistance. Per staff interview and record review, Resident #1 stopped breathing and the Nurse began performing CPR (cardiopulmonary resuscitation) as instructed by the 911 Operator. As the Nurse performed CPR, staff entered the room and informed the Nurse that Resident #1 was "a DNR". Per staff interview, as the Emergency Medical Technicians (EMTs) arrived and took over life sustaining measures, Staff encountered difficulty finding and printing documentation of Resident #1's DNR

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R364	Continued From page 9 status, which EMTs stated they were required to obtain and verify prior to stopping CPR. On the afternoon of 7/13/2026 the Executive Director confirmed these findings.	R364		
R366 SS=C	6.18 Resident's Rights The enumeration of residents ' rights will not be construed to limit, modify, abridge or reduce in any way any rights that a resident otherwise enjoys as a human being or citizen. A copy of the Residents Rights set forth in this section must be written in clear language, large print (font size 18), given to residents on admission, and posted conspicuously in a public place in the home. The home's grievance procedure and directions for contacting the Office of the Long-Term Care Ombudsman and Disability Rights Vermont also must be written in the same font size, provided to each resident, and posted in the same location as the statement of Residents ' Rights. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, there is a failure to ensure the facility's grievance procedure is posted alongside the Residents' Rights. Findings include: During a tour of the facility, commencing at approximately 10:15 AM on 7/13/2026, the Residents' Rights was observed to be posted on the wall of the first floor mail area, above the Residents' mail boxes. Additionally, it was observed that the facility's grievance procedure	R366		

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R366	Continued From page 10 was not posted alongside the Resident's Rights. These findings were confirmed by the Executive Director at approximately 6:20 PM on 7/13/2026.	R366		

Deficiency Statement Plan of Correction (POC)

(Please use additional pages if needed)

DLP Use Only:

Survey Date: 7/13/2026

Facility Name: The Village at White River Junction

Deficiency Tag:	R166- Change in Condition
How the deficiency was corrected:	The current Policy for Resident Evaluation and Re-Evaluation was reviewed with the nursing team. Education for the re-evaluation process was reviewed to ensure they understand the guidelines for a change in condition.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	An audit of resident records was conducted to ensure that no further significant changes in condition criteria were identified in accordance with our policy and if one was identified, the appropriate documentation and assessment was completed.
System changes to ensure compliance with the regulation:	Review 24-hour nursing notes and communication log daily over the next 30 days to identify significant changes in condition requiring re-evaluation, assessment and change to care plan. We will review weekly for another 30 days to ensure we are complying.
Date corrected:	9/15/2026
Who will monitor to ensure compliance:	Residential Care Director or designee
DLP Use Only	R166 Plan of Correction accepted by Jo A Evans, RN on 8/6/2026.

Deficiency Tag:	R210
How the deficiency was corrected:	All associates will have the appropriate annual training which include 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, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; (7) General supervision and care of residents; (8)Communication strategies, person-centered care, challenging behaviors and understanding dementia; (9) Recognition of and sensitivity to different cultures, belief systems, abilities, gender identities, sexual orientation; and (10) Trauma-informed care.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	An Audit was done to identify if there were any associates that have not completed the annual trainings. Any associate that was identified as not having completed the annual mandatory training received the appropriate education to ensure all staff comply.
System changes to ensure compliance with the regulation:	All new hires complete orientation and online education to ensure they receive the annual training requirements. Yearly training will be completed using online education and live trainings.
Date corrected:	9/15/2026
Who will monitor to ensure compliance:	Executive Director or designee
DLP Use Only	R210 Plan of Correction accepted by Jo A Evans, RN on 8/6/2026.

Survey Date: 7/13/2026

Facility Name: The Village at White River Junction

Deficiency Tag:	R232
How the deficiency was corrected:	Provide education to Department Directors and nursing team on the Reporting and Investigating Resident and Visitor Incidents policy; which includes allegations, or incidents of abuse, neglect, exploitation of residents or misappropriation of resident property, along with the timeline for reporting these incidents and how to report to the appropriate agencies.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	We identified the need to educate management and the nursing team on our Reporting and Investigating Resident and Visitor Incidents policy. This includes the timeline for reporting any incidents and who to report to.
System changes to ensure compliance with the regulation:	Review 24-hour nursing shift notes and incident reports completed daily over the next 30 days to identify any potential state reportable events and if identified report timely to the appropriate agency.
Date corrected:	9/1/2026
Who will monitor to ensure compliance:	Executive Director or designee
DLP Use Only	R232 Plan of Correction accepted by Jo A Evans, RN on 8/6/2026.

Deficiency Tag:	R349
How the deficiency was corrected:	Education was provided to all associates in all departments on resident rights as well as treating all residents with dignity and respect.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	We identified the need to educate all staff to ensure they understand resident rights and how to treat residents with dignity and respect to make sure we are in full compliance.
System changes to ensure compliance with the regulation:	Human Resources will ensure that all newly hired associates receive the appropriate Resident Rights training prior to associates assisting residents. All associates will review resident rights and acknowledge understanding of these rights each year.
Date corrected:	9/1/2026
Who will monitor to ensure compliance:	Residential Care Director or designee
DLP Use Only	R349 Plan of Correction accepted by Jo A Evans, RN on 8/6/2026.

Survey Date: 7/13/2026

Facility Name: The Village at White River Junction

Deficiency Tag:	R356 Resident Rights
How the deficiency was corrected:	The Grievance Policy will be reviewed and updated as needed, ensuring to include the timeframe in which we will respond to a concern. All residents, families and associates will be informed of the new grievance policy.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	All grievance policies that were posted throughout the community have been updated to include the response timeline.
System changes to ensure compliance with the regulation:	The updated grievance policy to include our response timeframe will be visible within the community. The resident documents for new admissions to our community will reflect the policy.
Date corrected:	9/1/2026
Who will monitor to ensure compliance:	Executive Director or designee
DLP Use Only	R356 Plan of Correction accepted by Jo A Evans,RN on 8/6/2026.

Deficiency Tag:	R364
How the deficiency was corrected:	The current Policy for Injury and First Aid response was reviewed with the nursing team to ensure they understand where the DNR information is posted and available throughout the community; which includes on the back of apartment doors, a list located at the front desk, in the communication logs for memory care and assisted living, and in the main kitchen.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	An audit was completed to review resident census and current DNR status to ensure we have the most up to date information. Once that was completed all residents who have a DNR now have it posted on the back of their apartment door.
System changes to ensure compliance with the regulation:	Going forward the Resident Care Director or nurse will update the DNR list with each move-in or change in code status. This will be reviewed weekly for two months.
Date corrected:	9/15/2026
Who will monitor to ensure compliance:	Resident Care Director or designee.
DLP Use Only	R364 Plan of Correction accepted by Jo A Evans, RN on 8/6/2026.

Survey Date: 7/13/2026

Facility Name: Danielle Nickerson

Deficiency Tag:	R366 Resident Rights
How the deficiency was corrected:	All Resident Rights postings throughout our community were moved to be posted alongside our Grievance Policy.
How you identified and applied the correction to other applicable aspects of your facility to ensure all potential deficiencies are corrected:	An audit was done within our community to make sure that resident rights postings are next to our community's grievance policy.
System changes to ensure compliance with the regulation:	Resident Rights that are posted on each floor of our community will be posted alongside our grievance policy.
Date corrected:	9/1/2026
Who will monitor to ensure compliance:	Executive Director or designee
DLP Use Only	R366 Plan of Correction accepted by Jo A Evans, RN on 8/6/2026.