VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

February 1, 2024

Brianna Woodward, Manager
Maple Ridge Lodge
2 Freeman Woods
Essex Junction, VT 05452

Dear Ms. Woodward:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on December 12, 2023**.** 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
	0666	A. BUILDING: _____ B. WING _____	C 12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE RIDGE LODGE	2 FREEMAN WOODS ESSEX JUNCTION, VT 05452

(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 12/11/23 the Division of Licensing and Protection conducted an investigation of two complaints and one facility reported incident. The facility provided additional documentation on 12/12/23. The following regulatory deficiencies were identified as a result of the investigation:	R100	Plans of Correction for all tags accepted by Jo A Evand RN on 2/1/24. Please see attached document to review corrective actions for individual tags.	
R128 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure administration of topical antifungal medications, as ordered by the physician for one applicable resident (Resident #1). Findings include: The facility's policy titled VT Medication Guidelines includes procedure #10 titled Documentation which indicates "Proper documentation that med was administered as ordered" and documentation of "All refusals. Including why and follow up." is required. There was a failure to administer Resident #1's antifungal medications including Ketaconazole 2% topical cream and Clotrimazole Antifungal 1% cream as ordered. 1. Per record review, on 8/12/22 Resident #1's physician ordered Ketaconazole Cream 2%	R128		

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R128	Continued From page 1 Apply Topically to Left Underarm Daily. On 9/8/22, 9/15/22, 9/16/22, 9/22/22- 9/24/22, 9/27/22, 9/29/22,10/3/22 - 10/8/22, 10/10/22, and 10/13/22 Ketaconazole 2% Cream was documented as "Held" with the reason not given documented as "Treatment Not Needed". This medication was ordered as a scheduled medication, not as a medication to be given "As Needed". A signed physician's order is required in order to "hold" a scheduled medication. 2. Per record review, on 9/25/23 Resident #1's physician ordered Clotrimazole Anti-fungal 1 % Cream Apply Between Toes Twice a Day for 7 days. Administration of this medication began on the evening of 9/25/23 and was scheduled to continue through the evening of 10/2/23. On the days of 9/26/23, 9/29/23, and 10/2/23; and on the evening of 10/2/23 the medication was documented as "Missed" without documentation of the reason the medication was not given. These findings were confirmed by the Manager and Assistant Director of Nursing on the afternoon of 12/11/23. In conclusion this deficient practice is a risk for more than minimal harm to residents as evidenced by the high risk of inaccurate medication administration resulting in potentially harmful affects on the resident.	R128		
R134 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7 Assessment 5.7.a An assessment shall be completed for each resident within 14 days of admission,	R134		

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R134	Continued From page 2 consistent with the physician's diagnosis and orders, using an assessment instrument provided by the licensing agency. The resident's abilities regarding medication management shall be assessed within 24 hours and nursing delegation implemented, if necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to complete an admission assessment within 14 days after admission for one applicable resident (Resident #1). Findings include: The facility's policy on Assessments states, " Once admitted to facility, the Vermont state assessment will be completed within 14 days after admission." Per record review Resident #1 was admitted to the Assisted Living Residence on 2/18/22. The admission assessment form on file and available for review for Resident #1 was incomplete and did not include all required demographic information; cognitive patterns; information related to mobility, transfers, ability to perform activities of daily living; transportation and meal prep needs; ability to use a telephone; skills training; recent changes in urinary continence; diagnoses; height; and weight. The assessment form was signed as complete by the Registered Nurse on 2/9/22, which was 9 days prior to Resident #1's admission to the facility. On the afternoon of 12/11/23 the Manager and Assistant Director of Nursing confirmed Resident #1's admission assessment was incomplete and was not completed within 14 days after his/her admission to the facility.	R134		

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R134	Continued From page 3 In conclusion this deficient practice is a risk for more than minimal harm due to the high risk of inaccuracy to identify resident strengths, weaknesses, preferences, and needs which is the basis of resident care planning.	R134		
R138 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.5 Physician Services 5.8.b A resident has the right to refuse all medical care for religious reasons or other reasons of conviction, but in such cases, the home must assess its ability to properly care for the resident and document the refusal and the reasons for it in the resident's record. This REQUIREMENT is not met as evidenced by: Based on staff interview and resident record there was a failure to document refusals and the reason for refusing treatments and services including nail care and assistance with showers for one applicable resident (Resident #1). Findings include: 1. Per record review Resident #1's physical ordered Melatonin 5 mg One tablet by mouth at bedtime and recommended a routine warm bath or shower at bedtime coinciding with the administration of this medication to enable environmental cues for sleep. Per review of Resident #1's Treatment Records for August 2023 - October of 2023 the August Treatment Record indicated Resident #1 "Showers Independently" and was not updated to include a	R138		

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R138	Continued From page 4	R138		

nightly shower with staff support as recommended by the physician. Resident #1's September and October Treatment Records were updated to include "Showers Mon Thurs Evening Needs Cueing and Supervision"; however the September 2023 Treatment Record does not include any documentation of showers taken or refused or the reason for refusal, and the October 2023 Treatment Record indicate Resident #1 showered on 10/8/23, 10/14/23, and 10/16/23 with no documentation of refusals and the reason for refusal for the rest of the month.

2. Per review of Resident #1's Progress Notes and medication orders Resident #1 has a history of fungal foot infections, open sores on feet, and foot pain. The Manager and Assistant Director of Nursing were requested to provide documentation of foot and nail care performed at the facility. The Assistant Director of Nursing confirmed foot and nail care are included in the facility's resident services and are usually performed at shower time; however documentation of foot and nail care performed or refusal of foot and nail care was not on file and available for review in Resident #1's record.

At 4:47 PM on 12/11/23 the Manager and Assistant Director of Nursing confirmed there was a failure to maintain documentation of refusal of assistance with showers, and refusal of foot and nail care, on file and available for review in Resident #1's record.

This deficient practice is a risk for more than minimal harm to residents due to inability to provide accurate information regarding resident treatments and medications.

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R178	Continued From page 5	R178		
R178 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. This REQUIREMENT is not met as evidenced by: Based on interview and record review there was a failure to ensure a sufficient number of staff available at all times to provide necessary care and prompt appropriate action in case of emergency. Findings include: Per the Manager, the facility's overnight staffing pattern from the opening of the facility in 2021 until approximately one week before the survey on 12/11/23 was limited to two staff including one care provider and one care provider/med tech who was responsible for passing medications to residents from 5:00 am -7:00 AM, which left the other care provider responsible for all other resident needs. During an interview commencing at 11:49 AM on 12/11/23 the Manager confirmed the facility tends to be quiet until 5 am when the residents all begin to ring for assistance at once, and stated "the care providers were getting overwhelmed". Per the Manager the facility added one additional staff on the overnight shift following the Manager's discussion with two overnight staff who reported resident's needs could not adequately be met by 2 staff at night, and it was becoming too difficult to care for the facility's residents with only 1-2 staff on duty at night. During the interview on the morning of	R178		

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R178	Continued From page 6 12/11/23 the Manager confirmed the overnight staffing pattern did not ensure adequate staffing to meet resident needs including medication administration and responding to call lights, resident falls, and emergencies. Per review of the current Resident Roster provided by the Manager on request, there were 74 residents living at the facility on 12/11/23. Resident apartments are located on two floors in the facility. On the morning of 12/11/23 the Assistant Director of Nursing confirmed 14 current residents of the facility were unable to independently evacuate the building should an emergency evacuation be needed. Of the 14 residents, 12 residents are wheelchair dependent and 3 are visually impaired. During the interview commencing at 11:49 AM on 12/11/23 the Manager and the Assistant Director of Nursing confirmed the facility's current overnight staffing pattern is not adequate to safely evacuate the residents of the facility in a safe and timely manner during an emergency considering the number of residents who would require staff assistance to exit the facility. In conclusion this deficient practice is a risk for more than minimal harm for all residents due to inadequate staffing to attend to resident's needs, to maintain a safe environment, and to respond appropriately in case of an emergency.	R178		
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	R179		

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R179	Continued From page 7 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. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure completion of required yearly trainings for 2 out of 5 sampled staff. Findings include: The facility's policy for Inservice Training effective June 2021 states, "All staff will receive ongoing in-service trainings and education annually." The procedure for inservice training lists areas covered to including Resident Rights; Fire and Disaster Planning/Evacuation; Recognition of Abuse, Neglect, and Mistreatment; Infection Control; and General Supervision and Care. The facility's Inservice Training list fails to identify a	R179		

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R179	Continued From page 8 training in Respectful and Effective Interactions with Residents and Resident Emergency Response procedures for the Assisted Living Residence's staff as required. Per review of documentation of completion of the required yearly trainings, 2 out of 5 sampled staff failed to complete all required trainings to include: a. One staff did not complete the required yearly trainings in Resident Rights; General Care and Supervision; Emergency Evacuation; Resident Emergency Response Procedures and First Aid Preparedness, Mandatory Reporting of Abuse. Neglect, and Exploitation, and Respectful and Effective Interactions with Residents b. One staff did not complete the required trainings in Respectful and Effective Interactions with Residents, and General Care and Supervision. At 3:34 PM on 12/11/23 the Manager confirmed 2 out 5 sampled staff had not completed the required yearly trainings. This deficient practice is a risk for more than minimal harm for all resident due to inadequate staff education and training to safely and effectively provide resident care. As stated in the facility's policies, staff education and training is provided "to promote safety and knowledge for the staff and associates".	R179		
R208 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation	R208		

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R208	Continued From page 9 5.18.c Incidents involving resident-to-resident abuse must be reported to the licensing agency if a resident alleges abuse, sexual abuse, or if an injury requiring physician intervention results, or if there is a pattern of abusive behavior. All resident-to-resident incidents, even minor ones, must be recorded in the resident's record. Families or legal representatives must be notified and a plan must be developed to deal with the behaviors This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to report one applicable resident's pattern of abuse behavior to the licensing agency (Resident #1). Findings include: The facility's policy on Abuse and Neglect revised 2021 states, "It is the policy the residents of our communities have the right to be free of abuse. Any abuse will be investigated and reported promptly to the appropriate state agencies, where applicable. Each resident will be treated with dignity and respect at all times." The facility's Abuse and Neglect procedure states, "Abuse means the willful infliction of injury, unreasonable confinement, intimidation, punishment with resulting physical harm or pain, mental anguish, or depriving an individual of goods or services that are necessary to attain or maintain physical, mental, or psychological wellbeing." The facility's policy on Incident Reporting revised April 2021 states, "Resident, staff, and visitor safety is a priority. It is the policy of this community to report and record all incidents affecting residents, visitors, and employees." Procedure #5 of this policy states, "The Executive Director, Resident Care Director, Wellness Nurse	R208		

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R208	Continued From page 10	R208		

or designee will report suspected cases of resident abuse, exploitation, neglect or mistreatment within 24 hours of receipt of said information to appropriate state agencies. "

Per record review Resident #1's diagnoses include Dementia with Behavioral Disturbances and Anxiety. Resident #2 is wheelchair dependent with a history of frequent falls; and has diagnoses including Parkinson's Disease, Dementia, and Major Depressive Disorder. Per review of Progress Notes, Resident #1 demonstrated a pattern of intrusive, aggressive, and abusive behaviors towards Resident #2 to include multiple incidents noted by staff between 8/6/23 - 11/26/23. While the facility reported a single incident of resident to resident abuse involving Resident #1 and Resident #2 occurring on 9/28/23 to the licensing agency; numerous incidents indicative of a pattern of abuse occurring before and after the reported incident on 9/28/23 were not reported to the licensing agency including:

1. Holding Resident #2's hands tightly and refusing to let go as s/he was noted to be screaming and crying out for help on 8/6/23.
2. Standing against Resident #2's door to prevent staff access to administer scheduled medications as staff heard Resident #2 saying "please help me", then pushing Resident #2 into the dining room against his/her will on 8/13/23.
3. Blocking Resident #2's door and refusing staff entry to assist Resident #2 as s/he yelled for Resident #1 to "get out" on 9/4/23.
4. Pushing Resident #2's wheelchair out of reach as s/he attempted to stand at the front desk to speak with the Concierge on 9/24/23, after which Resident #2 expressed s/he was afraid of Resident #1

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R208	Continued From page 11 5. Pushing a nurse who intervened as Resident #1 transferred Resident #2 from his/her wheelchair in an unsafe manner, and not letting Resident #2 choose where to sit in the dining room on 10/3/23. 6. Pulling Resident #2's wheelchair away from the dining room table to prevent interaction with another resident as Resident #2 yelled "stop" and stated s/he did not want to leave on 10/7/23. 7. Wedging his/her body between staff and Resident #2 and attempting to shove staff away from Resident #2 to prevent transfer from wheelchair to a bench during breakfast on 10/9/23. 8. Striking, shoving, and poking staff attempting to intervene after Resident #1 refused to leave Resident #2's apartment as s/he was heard repeatedly yelling out for him/her to leave on 10/19/23. Resident #2 stated s/he was scared after Resident #1 entered his/her locked apartment and subsequently informed staff Resident #2 was not getting his/her keys back on 10/19/23. 9. On 10/31/23, 11/8/23, 11/24/23, and 11/26/23 Resident physically attacked staff attempting to provide care for and administer medications to Resident #1. 10. Pushing Resident #2's wheelchair too fast causing his/her feet to hit the walls and get caught under the wheelchair on 11/5/23. Resident #2 was noted to be crying, yelling and stating Resident #2 was hurting him/her during this incident. This was followed by Resident #1 wheeling Resident #2 into his/her bathroom, refusing to leave while staff assisted with toileting, and physically attacking the two caregivers tending to Resident #2's needs. 11. On 11/6/23 the Nurse noted Resident #2 appeared scared and tearful while trying to prevent being pushed into his/her apartment by	R208		

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R208	Continued From page 12 Resident #1. 12. On the night of 11/9/23 Resident #2 fell out of bed and sustained a clavicle fracture. On the morning of 11/10/23 the Med Tech observed Resident #1 holding on to Resident #2's affected arm as s/he was crying in pain and screaming at Resident #1 to let go. As the Med Tech called for assistance Resident #1 closed the apartment door and held the door handle to prevent Resident #2 from exiting. The Med Tech noted Resident #2 was crying and shouting hysterically; and stated multiple staff and several attempts to redirect were required to get Resident #1 to let go of the door handle and leave the room. That afternoon another incident occurred requiring 4 staff to redirect Resident #1 when s/he was observed in a common area of the home holding Resident #2's wheelchair and refusing to let go. At 12:41 PM on 12/11/23 the Manager confirmed one facility reported incident was submitted to the licensing agency related to Resident #1's behaviors, and stated additional incidents were documented only in Resident Progress Notes. This deficient practice is a potential safety risk as all facilities are required to report all incidents of abuse to the licensing agency to aid in the protection of all residents. Please refer to tag 224.	R208		
R224 SS=H	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.	R224		

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(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 13	R224		

This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review there was a failure to ensure facility residents remained free of mental and physical abuse. Findings include:

The facility's policy on Abuse and Neglect revised 2021 states, "It is the policy the residents of our communities have the right to be free of abuse... Each resident will be treated with dignity and respect at all times.". The facility's Abuse and Neglect procedure states, "Abuse means the willful infliction of injury, unreasonable confinement, intimidation, punishment with resulting physical harm or pain, mental anguish, or depriving an individual of goods or services that are necessary to attain or maintain physical, mental, or psychological wellbeing."

1. Per record review Resident #2 is wheelchair dependent; has frequent falls; and has diagnoses including Parkinson's Disease, Dementia, and Major Depressive Disorder. Resident #2 is in a relationship with Resident #1, who has diagnoses including Dementia with Behavioral Disturbances and Anxiety. Progress Notes for Resident #1 document multiple incidents between 8/6/23 - 11/26/23 during which s/he displayed intrusive, aggressive, and abusive behaviors which impeded provision of care necessary for Resident #2's well-being; physically restrained or confined Resident #2; and caused physical pain and/or mental anguish as evidenced by Resident #2 crying, stating Resident #1 was hurting him/her, screaming and yelling out for help, and expressing s/he was afraid of Resident #1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0666	A. BUILDING: _____ B. WING _____	C 12/12/2023

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R224	Continued From page 14 Progress notes documented incidents of Resident #1's abusive behaviors affecting Resident #2 including: a. On 8/6/23 Resident #2 screamed and cried out for help as Resident #1 restrained him/her by tightly holding his/her hands b. On 8/13/23, 9/4/23, and 11/10/23 Resident #1 blocked Resident #2's doorway to prevent staff from entering and Resident #2 from leaving as s/he called out for help and/or yelled for Resident #2 to get out. c. On 9/24/23 Resident #1 moved Resident #2's wheelchair out of reach as s/he attempted to stand at the front desk, after which s/he expressed fear of Resident #1. d. On 10/3/23, 10/9/23, 10/31/23, 11/5/23, 11/8/23, 11/24/23, and 11/26/23 Resident #1 physically aggressed towards staff attempting to intervene during incidents or provide care for Resident #2 e. On 8/13/23, 9/28/23, 10/3/23, 10/7/23, 11/5/23, and 11/10/23 Resident #1 took control of Resident #2's wheelchair against his/her will. On 11/5/23 Resident #2 was observed crying, yelling and stating Resident #1 was hurting him/her as s/he pushed the wheelchair so fast Resident #2's feet were hitting the wall and getting caught under the chair; and on 11/6/23 staff noted Resident #2 appeared scared and fearful while trying to prevent being pushed into his/her apartment. f. On the night of 11/9/23 Resident #2 fell out of bed and sustained a clavicle fracture. On the morning of 11/10/23 the Med Tech observed Resident #1 holding on to Resident #2's affected arm as s/he was crying in pain and screaming at Resident #1 to let go. As the Med Tech called for assistance Resident #1 closed the apartment door and held the door handle to prevent Resident #2 from exiting. The Med Tech noted	R224		

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R224	Continued From page 15 Resident #2 was crying and shouting hysterically while confined in his/her apartment. At 12:41 PM on 12/11/23 the Manager described the relationship between Resident #1 and Resident #2 as "very confusing to both of them" and confirmed "they had a relationship where [Resident #1] felt s/he needed to take care of [Resident #2]... [staff] tried to redirect [Resident #1] and s/he would get upset when they tried to provide care". The facility reported a single episode of resident to resident abuse involving Resident #1 and #2 to the licensing agency following an incident on 9/28/23 when Resident #1 confined Resident #2 in a corner of his/her apartment by holding his/her wheelchair; however multiple incidents indicative of a pattern of abuse occurring before and after the reported incident on 9/28/23 were not reported to the licensing agency. While it is important to understand aggressive and abusive behaviors often result from unintentional and uncharacteristic changes observed in people with dementia, it is also important to recognize Resident #2's right to be free of abuse, the impact of Resident #1's behaviors on Resident #2's psychological and physical well-being, and the facility's responsibility to ensure all residents remain free of abuse. 2. Additionally, Progress Notes document several facility residents feeling unsafe and fearful of harm due to Resident #1 entering their apartments without consent, threatening harm, and displaying intrusive and aggressive behaviors to include: a. One resident noted by staff to be "verbally and visibly upset" reported s/he did not "feel safe" after Resident #1 entered his/her room on 10/26/23. b. One resident was reported to be scared when	R224		

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R224	Continued From page 16 Resident #1 entered his/her room and refused to leave on 10/30/23. c. One resident reported Resident #1 came into his/her room repeatedly at night and stated s/he did not like the "harm potential" of these occurrences on 10/31/23. d. One resident was noted to be weeping as s/he reported Resident #1 entered his/her room, refused to leave, took personal items and refused to give the items back on 11/5/23. e. Three residents were noted to be upset after witnessing Resident #1 display disruptive behaviors and aggressiveness towards staff on 11/1/23. In conclusion, this deficiency is cited as actual harm affecting multiple residents. Physical and mental harm is evidenced by Resident #2 expressing of fear, crying and calling out for help, and stating Resident #1 was hurting him/her. Harm caused by Resident #1's behaviors extended to additional residents who were observed to be upset and reported feeling unsafe in their home in response to Resident #1's intrusive, aggressive, and abusive behaviors. Please refer to tag 208.	R224		
R302 SS=F	IX. PHYSICAL PLANT 9.11 Disaster and Emergency Preparedness 9.11.c Each home shall have in effect, and available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed periodically and kept informed of their duties under the plan. Fire drills shall be conducted on	R302		

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R302	Continued From page 17 at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and night. The date and time of each drill and the names of participating staff members shall be documented. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to maintain an accessible written disaster and emergency preparedness plan to ensure access to the plan by staff responsible for following the procedures in case of emergency. Findings include: The facility's written disaster and emergency preparedness plan titled Emergency Preparedness Written Program effective 6/14/21 states, "The purpose of this document is to communicate the Maple Ridge Emergency Preparedness program to the community's staff. The steps that should be taken to protect the residents and themselves in the event of a disaster." On the afternoon of 12/11/23 the Manager was asked to provide a copy of the facility's disaster and emergency preparedness plan for review. After looking for a printed copy of the plan in the reception and office areas of the facility the Manager stated a copy of the plan was not available on site, and a copy was printed from a share drive. At 1:53 PM on 12/11/23 the Manager confirmed the Emergency Preparedness Written Program was not available for review by the surveyor on request and for use by staff in case of	R302		

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R302	Continued From page 18 emergency; and confirmed the Share Drive the plan was stored on was not available to all staff and to residents. This deficient practice is a potential for more than minimal harm to all residents due to the failure ensure staff have access to instructions for how to respond to emergencies to ensure proper protection of residents.	R302		

Maple Ridge

AN ASSISTED LIVING &
MEMORY CARE CAMPUS

January 15, 2023

State Long Term Care Manager
Vermont Agency of Human Services
Department of Disabilities, Aging and Independent Living
HC 2 South, 280 State Dr.
Waterbury, VT 05671-2060

Dear DAIL,

Please accept this as our plan of correction for the survey at Maple Ridge Lodge on December 12, 2023.

R128 SS=E

The corrective action put in place in regards to this deficiency is re-training for all Med Techs and Nurses regarding documentation on refusals. Education to Med Techs to alert nurse if medication or treatment is missed or refused and why to ensure nurse follow up with resident, family and physician. Daily audit of EMAR dashboard by Director of Nursing/Designee daily to be alerted of any medications that are refused, or missed to ensure follow up. Weekly audit sent to ED by DON regarding daily audit. We will be doing a weekly audit for 6 weeks until 2/24/24. Then we will do bi-weekly audits for 4 weeks until 3/23/24. Then monthly audits for April, May and June 2024. Then quarterly going forward.

The Director of Nursing/Designee will ensure that this action is followed.

This action has been implemented immediately, with training to be completed by Wednesday, January 17TH, 2024.

R128 Plan of Correction accepted by Jo A Evans RN on 2/1/24.

R134 SS=D

The corrective action put in place in regards to this deficiency is a chart audit to be completed by Director of Nursing/Designee to ensure all 14-day assessments are completed and in resident charts along with labeled accurately. All initial assessments are to also remain in the chart. Re-training and education to all nursing staff regarding assessments and state regulations. All new resident 14-day state assessment are to be signed off by Director of Nursing to ensure completion. Resident #1 assessment was mislabeled as admission assessment but was the pre-admission assessment.

Director of Nursing/designee will ensure this action is followed.

This action was implemented immediately with training completed on January 10, 2024.

R134 Plan of Correction accepted by Jo A Evans RN on 2/1/24

R138 SS=E

The corrective action put in place in regards to this deficiency is when a new order for an ADL recommendation or update for care providers is needed, the charge nurse taking the order will then make a copy of the order, highlight the appropriate information for care staff and attached change form to the copy. Copies will go to DON, ADON and Day Shift Supervisor. Day Shift Supervisor/Designee will update aide sheets, treatment book and alert staff. Director of Nursing will ensure care plan is updated as needed. Bi-weekly resident tracking meeting to be held with nursing and Day shift supervisor/Designee to review any resident changes in acuity or ADL function. Day Shift Supervisor/Designee to then make additional changes to care sheets and treatment sheets as needed with resident acuity changes. Bi-weekly tracking sheets to be audited by Executive Director/Designee to ensure that updates are followed.
The corrective action put in place in regards to medication/treatments being refused is re-training for all Med Techs and Nurses regarding documentation on refusals. Education to Med Techs to alert nurse if medication or treatment is missed or refused and why to ensure nurse follow up with resident, family and physician. Daily audit of EMAR dashboard by Director of Nursing/Designee daily to be alerted of any medications that are refused or missed to ensure follow up. Weekly audit sent to ED by DON regarding daily audit. We will be doing a weekly audit for 6 weeks until 2/24/24. Then we will do bi-weekly audits for 4 weeks until 3/23/24. Then monthly audits for April, May and June 2024. Then quarterly going forward.

The Director of Nursing/Designee will ensure that this action is followed.

This action has been implemented immediately, with training to be completed by Wednesday, January 17TH, 2024.

R138 Plan of Correction accepted by Jo A Evans RN on 2/1/24

R178 SS=F

The corrective action put in place in regards to this deficiency is a staff member was added to the night shift changing the staff pattern to 1 Med Tech plus 2 Care Providers. An audit of the call bell system is being conducted along with a time/need study to ensure call bells are being answered timely and resident safety/satisfaction is taking place. A mock evacuation will take place to ensure the adequate timely evacuation for all residents with the Fire Marshall. In the event there is an emergency in the community we are a defend in place community. Necessary residents would be horizontally evacuated beyond additional fire door and 911 will be dispatched. Senior management will be notified and electric phone tree will be utilized alerting staff in a need to respond to the community. Once fire department is on site they take over for full evacuation if indicated.
Staffing pattern will be adjusted with acuity changes of residents. Electronic daily report is sent to all department heads in regard to resident needs and changes. ED/DON/designee will ensure that changes are made to schedule immediately as needed to ensure residents needs are adequately met.

The Senior Executive Director/designee will ensure that this action is followed.

This action has been implemented immediately, with training and evacuation to be completed by February 1st, 2024.

R178 Plan of Correction accepted by Jo A Evans RN on 2/1/24

R179 SS=F

The corrective action put in place in regards to this deficiency is that annually trainings will be completed in Relias Learning and monitored by the Executive Director to ensure they are completed on time to stay in compliance. All agency staff that is hired for the community will also have all training completed upon starting in the community. Executive Director will audit Relias to ensure all staff is current with annual trainings.

The Executive Director/designee will ensure this is followed and implemented.

This action will be implemented immediately and audit will be completed by Friday, January 26th.

R208 SS=E

R179 Plan of Correction accepted by Jo A Evans RN 2/1/24

The corrective action put in place for this deficiency is that the Director of Nursing will file any reports of suspected abuse, neglect or exploitation with both APS and DLP within 48 hours. The DON will alert the Executive Director after each report is made. This will be audited quarterly and discussed at the Quarterly Q/A meeting. All staff to be re-trained on what should be reported regarding abuse, neglect and exploitation.

The Executive Director and Director of Nursing/designee will ensure this is followed.

This action was implemented immediately and training to be completed by Friday, January 26th 2024.

R208 Plan of Correction accepted by Jo A Evans RN on 2/1/24

R224 SS=H

The corrective action put in place for this deficiency is that when there is a first-time aggressive resident that results in a resident-to-resident incident specifically with injury resulting, the resident will be sent to the ER for evaluation. If returned, 1x1 care by facility will be implemented for the first 48 hours then evaluated by the RN and if no aggressive behaviors noted 1x1 can be stopped otherwise will continue. If there is a pattern of aggressive behaviors with a resident and no medical interventions such as; urinalysis, blood work, med changes, MD follow up are successful, next steps will be discussed with the family. All staff will be trained on the Aggressive Resident Policy and 1x1 policy and signed off by the DON. And these policies will be added to our new hire orientation.

The resident with aggressive behaviors in this tag was discharged from the community on November 30, 2023.

The Executive Director and Director of Nursing/designee will ensure this is followed.

This action will be implemented immediately. Training with staff will be completed by Friday, January 26th.

R224 Plan of Correction accepted by Jo A Evans RN on 2/1/24

R302 SS=F

The corrective action put in place for this deficiency is that the written disaster and emergency preparedness plan will be in the Policy and Procedure book at all times. Book is located behind the front desk. The policy and procedure book is accessible to all staff and staff are trained at orientation to the location. Staff to be re-trained regarding location of policy and procedure book.

The Executive Director will ensure this is followed.

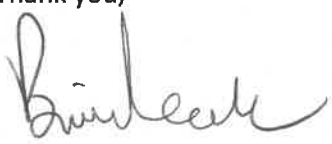
This action will be implemented immediately and training to be completed by Friday, January 26, 2024.

R302 Plan of Correction accepted by Jo A Evans RN 2/1/24

This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn thereform. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Any questions please let me know.

Thank you,



Brianna Woodward, CDP
Assistant Executive Director/Manager
Maple Ridge Lodge