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

October 13, 2023

Ms. Katy Munzir, Manager
Maple Ridge Memory Care
6 Freeman Woods
Essex Junction, VT 05452

Dear Ms. Munzir:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 18, 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.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING: _____ B. WING _____	C 09/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE RIDGE MEMORY CARE	6 FREEMAN WOODS ESSEX JUNCTION, VT 05452

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R100	Initial Comments: On 9/18/23 the Division of Licensing and Protection conducted an unannounced on-site relicensure survey and investigation of 2 complaints and 1 facility reported incident.There were regulatory deficiencies identified during the investigations which resulted in the need for Immediate Corrective Action to be taken by the facility. The facility did provide an Immediate Corrective Action Plan at the time of survey exit on 9-18-23. Findings include:	R100		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the Registered Nurse failed to oversee the development of a written plan based on needs to assist the resident to maintain independence for 1 out of 6 residents of the applicable sample (Resident # 5). Findings include: Per record review Resident #5, nursing progress noted were documented to account for eight falls the resident sustained from February 2023- June 2023. Resident #5 received home health physical therapy for balance and gait training, with use of 2	R145	R145 Accepted on 10/12/23. Sherry Ross, RN	

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R145	Continued From page 1 wheeled walker, Resident #5 was discharged from home health services on 6/26/23. A documented fall occurred on 7/1/23. The plan of care was not updated to identity needs for Fall prevention to include interventions for prevention, safety and/or use of walker. Per interview on 9/18/23 at 12:45 PM, the RN confirmed the documented falls Resident #5 experienced and that the plan of care was not updated to reflect interventions to aide in fall prevention and the resident safety.	R145		
R167 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (5) 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; 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 was a failure to develop written plans for the	R167	R167 Accepted on 10/12/23. Sherry Ross, RN	

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R167	Continued From page 2 administration of PRN psychoactive medications for all residents of the home prescribed psychoactive PRNs. Findings include: On the afternoon of 9/18/23 the Director of Nursing confirmed written plans for the administration of PRN psychoactive medications by unlicensed staff had not been developed for all residents of the home prescribed PRN psychoactive medications to include the specific behaviors the medications are intended to address, the specific circumstances indicating the use of the medications, and the intended effects and undesired side effects of the medications.	R167		
R176 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (4) Medications left after the death or discharge of a resident, or outdated medications, shall 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 was a failure to dispose of outdated medications. Findings include: During a review of the medication storage area at approximately 3:30 PM on 9/18/23 the following outdated medications were observed to be stored in the medication cart: 1. Haloperidol 0.5 mg tablets belonging to	R176	R176 Accepted on 10/12/23. Sherry Ross, RN	

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R176	Continued From page 3 Resident # 7 expired on 8/26/23 2. Natralia Eczema and Psoriasis Cream expired July of 2022 without an identifying name 3. Refresh Lubricating Eye Drops expired March of 2023 without an identifying name 4. 3 containers of Freestyle Blood Glucose Test Strips belonging to Resident # 8. 5. House Stock Loperamide 2 mg tablets expired August 2023 These findings were confirmed by the Med Tech on duty during the review of the medication storage area and acknowledged by the Director of Nursing and Executive Director on the afternoon of 9/18/23.	R176		
R179 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents;	R179	R179 Accepted on 10/12/23. Sherry Ross, RN	

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R179	Continued From page 4 (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 3 out of 5 sampled staff completed all required yearly training's. Findings include: At 1:22 PM on 9/18/23 the Executive Director confirmed documentation of completion of the required yearly training's for 3 out of 5 sampled staff was not on file and available for review.	R179		
R190 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to complete criminal background and abuse registry checks for 1 out of 5 sampled staff. Findings include: At 1:19 PM on 9/18/23 the Executive Director confirmed criminal record and abuse registry checks were not completed on hire for 1 out of 5 sampled staff.	R190	R190 Accepted on 10/12/23. Sherry Ross, RN	

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R192 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12 Records/Reports 5.12.d Reports and records shall be filed and stored in an orderly manner so that they are readily available for reference. Resident records shall be kept on file at least seven (7) years after the date of either the discharge or death of the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview the Manager failed to ensure the proper storage of resident files for review. Findings include: Per interview on 9/18/23 at 11:15 AM the Executive Director was requested to provide resident records. Through the course of survey, the manager reported to not be able to locate the record for Resident #6. At 4:15 PM the manager confirmed the financial and health record for Resident #6 were unable to be located, and unavailable to review.	R192	R192 Accepted on 10/12/23. Sherry Ross, RN	
R206 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be contacted by calling toll-free 1-800-564-1612. Reports must be made to APS within 48 hours of learning of the suspected, reported or alleged incident.	R206	R206 Accepted on 10/12/23. Sherry Ross, RN	

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R206	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the RCH (Residential Care Home) failed to report suspected cases of abuse between residents within the required 48 hours after learning of the suspected abuse incidents. Findings include: Resident #1 was admitted on 4/21/22, who has a diagnosis of unspecified dementia and a history of aggressive behaviors. Per the resident's Service Plan, a plan of care was developed to provide interventions to prevent escalation of Resident #1's aggressive behavior. These interventions include activities such as discussing work experiences, providing objects that can be held safely, providing space. Additional interventions include walking away from resident when s/he is angry, moving other residents away for safety, and/or bring Resident #1 to his/her room if s/he can be redirected safely, call his/her family to talk on phone or have family come sit with Resident #1, staff to provide 1:1 support to help Resident #1 calm down and continue discussion with daughter to hire private 1:1 care. On 5/11/23 at 6:30 PM, Resident #1 became agitated and demonstrated aggressive behavior. Resident #1 was witnessed by staff to be standing over Resident #2 in an aggressive manor. Staff stated that s/he was in the room but did not hear what Resident #1 and Resident #2 were discussing. Per review of the facility video recording Resident #1 was witnessed to approach Resident #2 who was seated in a common area, three times. After the third approach, Resident #2 stood up and held a chair between him/her and Resident #1. Resident #1 and Resident #2 struggled over the chair resulting	R206		

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R206	Continued From page 7 in Resident #2 falling with the chair on top of him/her. Resident #1 was then viewed placing his/herself on top of the chair and Resident #2. A timely report was never filed with The Department of Licensing and Protection (DLP) regarding this incident which required a review for abuse. A second event occurred involving Resident #1. On 9/13/23 at approximately 5:00 PM staff heard a sound and responded. Per Resident #1 chart Resident #1 was found to be holding Resident #3 around the mid-section. Staff instructed Resident #1 to let Resident #3 go and s/he dropped Resident #3 on the ground then proceeded to raise his/her fist toward staff members. At that time the facility called 911 for emergent secured transfer to the Emergency Room (ER) for evaluation of injury and increased behaviors. A timely report was never filed with The Department of Licensing and Protection (DLP) regarding this incident which required a review for abuse. Additionally, on the evening of 9/16/23 Resident #1 was witnessed in an altercation with another resident and staff members. Per interview with the Director of Nursing (DON) on 9/18/23 at 12:30 PM s/he stated that on 9/16/23 Resident #1 was witnessed to have physically assaulted Resident #4 by hitting him/her. Resident #1 then proceeded to physically assault two staff members. Per interview with the DON on the afternoon of 9/18/23 s/he confirmed that these incidences were not reported to the licensing agency stating that s/he "believed s/he did report these event to the appropriate agencies because s/he thought APS and DLP were the same". Per the RCH's Policy and Procedure entitled State reporting requirements: Abuse, Exploitation,	R206		

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R206	Continued From page 8 Neglect or Mistreatment. The licensee is required to report suspected or reported incidents of abuse, neglect, or exploitation to adult protective services (APS). 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 physicians' intervention results, or if there is a pattern of abusive behavior. The facility did report these incidences to APS however, the facility failed to file a report with DLP regarding these instances of abuse.	R206		
R224 SS=K	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview there was a failure to ensure the right to be free of abuse for 3 applicable residents (Resident #2, #3, #4). Findings include: 1. On 5/11/23 at 6:30 PM Resident #2 was involved in a physical altercation resulting in injury. Per review of the facility recording, Resident #2 was sitting in a common area and approached by Resident #1 three times. After the third approach, Resident #2 stood from the chair and placed a chair between him/her and Resident #1. Resident #1 and Resident #2 struggled over the chair resulting in Resident #2 falling against the wall, hitting the back of his/her head landing	R224	R224 Accepted on 10/12/23. Sherry Ross, RN	

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R224	Continued From page 9 on his/her left side with the chair on top of him/her. Resident #1 was then viewed placing his/herself on top of the chair and Resident #2. Per facility progress notes staff intervened and separated Resident #1 from Resident #2. Resident #1 was redirected several times but continued to reapproach Resident #2 and the staff while hitting his/her fist in his/her other hand. Per the facility incident report, staff responded to the resident to resident altercation, after hearing a staff call for help. The writer of the incident report witnessed Resident #2 fall onto left side hitting head on the wall. Per observation made by staff, Resident #2 complained of pain to left lower extremity and stated "S/he attacked me", and began to cry. 911 emergency services were called, Resident #2 sustained a left hip fracture. 2. A second event occurred involving Resident #1. On 9/13/23 at approximately 5:00 PM staff heard a sound and responded. Per Resident #1's chart s/he was found to be holding Resident #3 around the mid-section. Staff instructed Resident #1 to let Resident #3 go and s/he dropped Resident #3 on the ground. Resident #1 then proceeded to raise his/her fist and went after staff members. At that time the facility called 911 for transfer to the Emergency Room (ER) for evaluation of injury of Resident #3 who sustained a broken rib. Additionally, Resident #1 was transported for emergency evaluation. 3. On the evening of 9/16/23 Resident #1 was witnessed in an altercation with another resident and staff members. Per interview with the Director of Nursing on 9/18/23 at 12:30 PM s/he stated that on 9/16/23 Resident #1 was witnessed to have physically assaulted Resident #4 by hitting him/her. Resident #1 then proceeded to	R224		

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R224	Continued From page 10 physically assault staff members. Per interview with the DON on the afternoon of 9/18/23 when asked what actions the facility had taken following the 9/13/22 incident to ensure facility and resident safety s/he stated that the facility had instructed Resident #1 family that they need to provide 1:1 care for Resident #1. S/he additionally stated that the incident on 9/16/23 occurred while Resident #1 had 1:1 care provided by the family. Per observation on 9/18/23 Resident #1 was observed to be unattended walking in the halls of the facility, sitting in his/her room, and sitting in the dining room among other residents. Per record review of facilities policies and procedure conducted on the afternoon of 9/18/23 it was noted that the facility does not have a written policy outlining effective management of aggressive behaviors or a policy for 1:1 care. An immediate plan of action for this defiicency was submitted at the time of survey exit and was accepted.	R224		
R246 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.a Each home must procure food from sources that comply with all laws relating to food and food labeling. Food must be 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 shall be rejected and kept separate until returned to the supplier.	R246	R246 Accepted on 10/12/23. Sherry Ross, RN	

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R246	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure food items were free of spoilage and safe for human consumption. Findings include: During the facility tour commencing at 8:40 AM on 9/18/23 expired and spoiled perishable food items were observed to be stored in the walk in refrigerator including cranberry chicken salad expired 9/11/23; bins of chicken casserole, tomato beef casserole, and an unlabeled orange item the Cook stated was nacho cheese all dated 9/12/23; beef teriyaki dated 9/2/23; a tray of sliced Taylor ham dated 8/26/23 with a box of salami placed directly on the tray; a tub of chocolate pudding dated 8/23/23; open cans of moldy tomato sauce dated 5/22 and an open can of moldy pimento peppers dated 6/8; oyster sauce dated 8/23 and 5/22; Mascarpone expired 9/6/23; opened ricotta cheese with mold expired 9/2/23 and an second unopened ricotta expired on 9/2/23. These findings were confirmed by the Cook on duty at 9:10 AM on 9/18/23 and by the Director of Nursing on the morning of 9/18/23.	R246		
R247 SS=F	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.b All perishable food and drink shall 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	R247	R247 Accepted on 10/12/23. Sherry Ross, RN	

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R247	Continued From page 12 heated prior to service. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure perishable food items were labeled and dated. Findings include: During the facility tour commencing at 8:40 AM on 9/18/23 the following perishable food items were observed in the kitchen: 1. In the kitchen beverage fridge opened items without dates included containers of apple juice, orange juice, and milk; an unlabeled undated glass of milk with plastic wrap over top; 3 opened containers of Ready Care Lemon Thickened Water; heavy cream; a single serving bottle of Gatorade; 5 gallon dispenser of lemonade; and a container of chocolate syrup. On a countertop bedside the beverage fridge there were 12 flavored syrups without the dates they were opened. 2. In the kitchen prep unit opened undated items included liquid eggs, strawberry milk, a gallon of milk, gallon sized and smaller squeeze bottles of salad dressings, and large containers of hot sauce and sour cream. 3. In the walk in fridge unlabeled, undated, unsealed, perishable items included: cranberry chicken salad opened without date; an unlabeled orange item the Cook stated was nacho cheese dated 9/12/23; an unlabeled undated unsealed bag of chicken chunks; a undated opened tub of turkey stock; a tray of sliced Taylor ham dated 8/26/23 with a box of salami placed directly on the tray; a large opened and undated container of sour cream; and an undated opened vanilla	R247		

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MAPLE RIDGE MEMORY CARE	6 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
R247	Continued From page 13 icing;opened undated Melba Sauce with the lid not screwed on and plastic wrap on top. In the walk-in freezer undated opened 3 gallon tubs of ice cream and opened undated breaded chicken were observed. These findings were confirmed by the Cook on duty at 9:10 AM on 9/18/23, and the Director of Nursing on the morning of 9/18/23.	R247		
R249 SS=E	VII. NUTRITION AND FOOD SERVICES 7.2 Food Safety and Sanitation 7.2.d The home shall assure that food handling and storage techniques are consistent with safe food handling practices. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure food storage consistent with safe food handling practices. Findings include: Per observation boxes containing food were stored directly on the floor of the dry storage room and the walk-in freezer. The storage of food directly on the floor was confirmed by the Cook on duty at 9:10 AM on 9/18/23 and acknowledged by the Executive Director and the Director of Nursing on the afternoon of 9/18/23.	R249	R249 Accepted on 10/12/23. Sherry Ross, RN	
R253 SS=E	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment	R253	R253 Accepted on 10/12/23. Sherry Ross, RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING: _____ B. WING _____	C 09/18/2023

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MAPLE RIDGE MEMORY CARE	6 FREEMAN WOODS ESSEX JUNCTION, VT 05452

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R253	Continued From page 14 7.3.c All food service equipment shall be kept clean and maintained according to manufacturer's guidelines This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to keep all food service equipment clean. Findings include: During the facility tour commencing at 8:40 AM on 9/18/23 all 3 bays of the kitchen sink were over filled with dirty dishes and containers of food to be discarded leaving the sink inaccessible for use during meal service. The kitchen cooking surfaces and prep areas were in need of cleaning. These findings were confirmed by the Cook on duty at 9:10 AM on 9/18/23 and by the Director of Nursing on the morning of 9/18/23.	R253		
R258 SS=F	VII. NUTRITION AND FOOD SERVICES 7.3 Food Storage and Equipment 7.3.h All garbage shall be collected and stored to prevent the transmission of contagious diseases, creation of a nuisance, or the breeding of insects and rodents, and shall be disposed of at least weekly. Garbage or trash in the kitchen area must be placed in lined containers with covers. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure trash in the kitchen areas	R258	R258 Accepted on 10/12/23. Sherry Ross, RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING: _____ B. WING _____	C 09/18/2023

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R258	Continued From page 15 was stored in containers with covers. Findings include: At 9:10 AM on 9/18/23 the Cook on duty confirmed the trash receptacles in the kitchen and kitchen entryway of the Town unit were open and without covers.	R258		
R266 SS=H	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on review of complainant information, observation, staff interview, and record review there was a failure to ensure care in a safe, functional, sanitary, homelike environment. Findings include: 1. The facility failed to ensure a safe care environment following resident to resident physical interaction occurring on 9/13/23 with Resident #1. The plan of care was not updated to include facility provided safety measures to prevent Resident #1 from interactions resulting in alterations with other residents. The facility implemented that the family provide supervision to the resident on a 1:1 support level, without implementing staff interventions to ensure a safe environment. Refer to R-224. Per interview conducted on the afternoon of	R266	R266 Accepted on 10/12/23. Sherry Ross, RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING: _____ B. WING _____	C 09/18/2023

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MAPLE RIDGE MEMORY CARE	6 FREEMAN WOODS ESSEX JUNCTION, VT 05452

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R266	Continued From page 16 9/18/23 with staff who wish to remain anonymous s/he stated that Resident #1 is often aggressive and that s/he is afraid to engage resident. S/he confirmed that on 9/16/23 Resident #1 did have a 1:1 caregiver present at the time of incident, however this caregiver did not seem to understand what 1:1 care meant. S/he was witnessed on multiple occasions to be visiting with other residents and walking around the facility leaving Resident #1 unattended. Per interview on the afternoon of 9/18/23 the Executive Director confirmed that a facility driven plan was not in place to ensure a safe environment for all residents. Additionally, s/he confirmed the family was asked to provide 1:1 supervision and the facility staff was currently not providing that 1:1 supervision. 2. During the tour of resident rooms commencing at 10:01 AM on 9/18/23 hazardous chemicals including nail polish remover, plant fertilizer, and Lysol spray were observed to be stored and accessible in resident rooms. This finding was confirmed by the Director of Nursing during the tour of resident rooms on 9/18/23.	R266		
R291 SS=E	IX. PHYSICAL PLANT 9.6 Plumbing 9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure water temperatures did	R291	R291 Accepted on 10/12/23. Sherry Ross, RN	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R291	Continued From page 17 not exceed 120 degrees Fahrenheit in the rooms of two applicable residents. Findings include: During a tour of resident rooms commencing at 10:01 AM on 9/18/23 the water temperature in Resident # 9's Room was observed to be 128.8 degrees Fahrenheit and the water temperature in Resident # 10's room was observed to be 127.9 degrees Fahrenheit. During the tour the Director of Nursing confirmed the water temperatures in Residents #9's and #10's rooms were above 120 degrees Fahrenheit.	R291		

Maple Ridge

AN ASSISTED LIVING &
MEMORY CARE CAMPUS

September 28, 2023

Carolyn Scott, LMHC, M.S.
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 Carolyn Scott,

Please accept this as our plan of correction for the survey at Maple Ridge Memory Care on September 18, 2023.

R145 SS=D

The corrective action put in place in regards to this deficiency is that the Director of Nursing will update any and all care plans in regards to falls, medical changes, therapies and behaviors. The nursing team will meet weekly with the DON to discuss any resident updates or changes. The DON will then ensure that the care plan is updated with the changes. Resident #5 noted in the survey is no longer a resident at Maple Ridge and therefore their care plan was not updated. The DON will do monthly audits of the care plans to ensure they are updated for the next 3 months. The Executive Director will attend the nurse meeting weekly for the first month and then monthly to ensure care plans are updated.

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

This action will be implemented and care plans updated by October 6th, 2023.

R145 Accepted on 10/12/23.
Sherry Ross, RN

R167 SS=E

The corrective action put in place in regards to this deficiency is that all residents on a psychoactive PRN will have a written behavior/intervention plan that is to be followed prior to giving a PRN. The written behavior/intervention plans will be in a binder on the med cart and in the wellness rooms to ensure all who need access to this will have it. The Director of Nursing will meet with the nursing team to create the behavior/intervention plan and update them when care plans are as needed and annually.

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

This action will be completed by Friday, October 6th, 2023.

R167 Accepted on 10/12/23.
Sherry Ross, RN

R176 SS=E

The corrective action put in place in regards to this deficiency is that a med cart audit will be completed weekly to ensure that all medications are disposed of if expired. The charge nurse will audit the med cart each Wednesday and ensure that all medications are within the limits of expiration. This audit will then be turned into the Director of Nursing for approval. When a resident is discharged or passed away all medications will be disposed of as part of the move out process.

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

This action will be implemented to start Monday, October 2nd, 2023.

R176 Accepted on 10/12/23.
Sherry Ross, RN

R179 SS=F

The corrective action put in place in regards to this deficiency is that upon hire new staff files will be flagged unless all trainings have been signed off as completed. 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. The Business Office Manager will go through all employee files to ensure all employees currently have all the annual trainings needed by Friday, October 13th, 2023.

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

This action will be implemented on immediately.

R179 Accepted on 10/12/23.
Sherry Ross, RN

R190 SS=D

The corrective action put in place for this deficiency is that all employees whether house staff or agency staff, will have up to date criminal back ground checks done on them prior to starting employment. The employee file will not be completed for hire unless all background checks are completed and up to date. All staff including agency staff will have up to date backgrounds done.

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

This action was implemented immediately.

R190 Accepted on 10/12/23.
Sherry Ross, RN

R192 SS=D

The corrective action put in place for this deficiency is that large filing cabinets are place in the storage room. All resident files will be filed in order of years to be able to be easily located as needed. Medical and business files will be filed together as one file.

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

This action will be completed by October 27th, 2023.

R192 Accepted on 10/12/23.
Sherry Ross, RN

R206 SS=E

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.

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

This action was implemented immediately.

R206 Accepted on 10/12/23.
Sherry Ross, RN

R224 SS=K

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 removed from the community on 9/22/23 by 911-Police presence. [redacted] was discharged the same day via Emergency Discharge process. Prior to [redacted] being discharged [redacted] had 24 hour 1x1 care providers provided by the community.

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

This action will be implemented immediately with training for all staff to be completed by Friday, October 13th.

R224 Accepted on 10/12/23.
Sherry Ross, RN

R246 SS=F

The corrective action put in place for this deficiency is that the Food Service Director will do a weekly food audit to ensure that all items are within the appropriate date. Anything that is close or has expired will be thrown away. Food Service Director will train all kitchen staff in regards to labeling and dating all food that is opened. Label will state when opened and when to discard plus clearly what the item is. Food Service Director will turn the audit into the Executive Director weekly after completion.

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

This action will be implemented to begin Monday, October 2nd, 2023.

R246 Accepted on 10/12/23.
Sherry Ross, RN

R247 SS=F

The corrective action put in place for this deficiency is that the Food Service Director will do a weekly food audit to ensure that all items are within the appropriate date and are covered and sealed appropriately. Anything that is close or has expired or is not sealed appropriately will be thrown away. Food Service Director will train all kitchen staff in regards to labeling, dating and sealing all food that is opened. Label will state when opened and when to discard plus clearly what the item is. Food Service Director will turn the audit into the Executive Director weekly after completion. Executive Director or designee will do random audits in kitchen to ensure being followed.

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

This action will be implemented to begin Monday, October 2nd, 2023.

R247 Accepted on 10/12/23.
Sherry Ross, RN

R249 SS=E

The corrective action put in place for this deficiency is that a training will take place for all current food service staff and upon hire for all new staff regarding food safety and sanitation. Sign off will ensure all staff are aware that no food boxes are to be stored on the ground anywhere in the kitchen including the dry storage room and the freezer. Food Service Director will walk through the kitchen at the start and stop of his day to ensure the areas are clear. Executive Director or designee will do random audits in kitchen to ensure being followed.

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

This action has been implemented immediately.

R249 Accepted on 10/12/23.
Sherry Ross, RN

R253 SS=E

The corrective action put in place for this deficiency is that cleaning of the refrigerator or freezer will not take place before a food service time to ensure that dirty dishes are not left in the sink area. The kitchen staff will follow a kitchen cleaning schedule to be signed off daily and turned into the Food Service Director to ensure that all areas of the kitchen are cleaned appropriately daily, weekly and as needed. In-service training will be conducted to ensure all kitchen staff and new hires at orientation are trained on what is expected of them.

The Executive Director and Food Service Director/designee will ensure that this is followed.

This action will be implemented by Friday, October 6th.

R253 Accepted on 10/12/23.
Sherry Ross, RN

R258 SS=F

The corrective action put in place for this deficiency is that all trash cans containing garbage in them in the kitchen will have lids on them. The Food Service Director will purchase all new lids if necessary. All

kitchen staff will be trained on the sanitation importance of this. Plant Operations director will add garbage lids to his environmental walk throughout the building monthly to ensure lids are secure.

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

This was implemented immediately with training scheduled for October, 4th 2023.

R258 Accepted on 10/12/23.
Sherry Ross, RN

R266 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.

Room audits will also be done weekly by the Housekeeping Supervisor to ensure that there are no dangerous chemicals or products left out in resident apartments or common areas of the facility. A letter will be sent to families reminding them all of the importance of keeping anything hazardous locked up. Training for staff in regards to hazardous materials being left out in resident's room or around the facility will be conducted and signed off by the ED and DON.

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

This was implemented immediately with training scheduled for October 12th & 13th 2023.

R266 Accepted on 10/12/23.
Sherry Ross, RN

R291 SS=E

The corrective action put in place for this deficiency is that the Plant Operations Manager will ensure that water temperature checks are done weekly until we can ensure the water temperatures are staying within normal range. Once there is a month of consistent normal temperatures we will go back to our monthly checks. This will be brought to the Q/A quarterly and discussed.

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

This will be implemented on Monday, October 2nd, 2023.

R291 Accepted on 10/12/23.
Sherry Ross, RN

Any questions please let me know.

Thank you,

Katy Munzir, CDP
Senior Executive Director
Maple Ridge Memory Care