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

January 29, 2019

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

Dear Ms. Lemery:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 8, 2019.** 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,

Pamela M. Cota, RN
Licensing Chief

PRINTED: 01/15/2019
FORM APPROVED

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
	0653	A. BUILDING _____ B. WING _____	01/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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
R100	Initial Comments: The Division of Licensing and Protection conducted a re-licensure survey on 1/8/19. The following regulatory deficiencies were identified as a result:	R100	Please see attached plans of correction.	
R126 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review and confirmed by staff interview, the facility failed to ensure that 1 of 5 applicable residents was provided necessary services to ensure the safety of all residents in the facility. Resident #1 wanders aimlessly and can demonstrate with aggressive behaviors. The findings include the following: On 1/8/19 at approximately 11:30 AM, the nurse surveyor entered Resident #1's room, the resident was not present. The surveyor attempted to locate the resident but was unsuccessful. The staff were asked by the surveyor if they knew the location of Resident #1. The response was, that they would look for him/her. Through walkie/talkie communication all staff were requested to conduct a search for Resident #1. At 12 noon the Resident Care	R126		

R126 - R179 POC's accepted 1/28/19 RTremblay RN/PMA

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R126	Continued From page 1	R126		

Director (Director) confirmed that the resident was in asleep in another female's room, who was not present. The resident was redirected out of the room and s/he began wandering about the facility. The surveyor did observe the resident in the front office at approximately 12:30 PM, sitting in a chair. His/her appearance was disheveled, with loose fitting clothing and was unkempt. The Director accompanied the resident back to his/her room and assisted the resident to bed. Confirmation was not made as to whether the resident was provided with a noon meal.

Per review of Resident #1's care plan dated 12/12/18, identifies a problem of being in constant motion, wandering the hallways, attempting to get into other rooms and has been aggressive. Interventions directs staff to monitor whereabouts when up and wandering halls. S/He is dependent on staff for personal hygiene, oral care and nutritional needs. On 12/8/18 the care plan was updated identifying that staff are to observe for wandering and entering in other resident rooms.

Confirmation was made by the Director on 1/8/19 at approximately 12:50 PM that the resident is difficult to manage and does wander aimlessly. The Director reviews the Junction Group 1 Assignment that directs staff to mark a check mark hourly as residents are sighted and staff are to sign the bottom of the sheet. The assignment instructs staff to have to have eyes on them. The Director confirms that the hourly sighting was not completed as per staff instructions. Per review of the check list the resident was last seen at 10 AM. Therefore, s/he was not accounted for two (2) hours.

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R136	Continued From page 2	R136		
R136 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure 1 of 5 applicable resident's assessment (Resident # 4) reflected a change in physical condition. Findings include: Per review of the Resident # 4's clinical record, the assessment did not reflect a change in dietary status. Resident # 4 was hospitalized on 9/29/18 with a diagnosis of aspiration pneumonia. The resident returned to the facility on 10/4/18 with an order from the hospital speech pathologist for a dysphagia 3 diet (this diet includes moist, cut up meats). The resident's physician also wrote an order for a dysphagia 3 diet on 10/22/18. The 11/5/18 assessment signed by the facility Registered Nurse did not reflect this diet change. This was confirmed by the facility Resident Care Director on 1/8/19 at 12:40 PM.	R136		
R152 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (9)	R152		

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R152	Continued From page 3 Review all therapeutic diets and food allergies with dietary staff as needed to assure nutritional standards are met and are consistent with physician orders; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to assure 1 of 5 sampled residents were provided the proper therapeutic diet (Resident # 4). Findings include: Per observation of the noon meal on 1/8/19, Resident # 4 was not provided a meal with the proper food texture. Resident # 4 was hospitalized on 9/29/18 with a diagnosis of aspiration pneumonia. The resident returned to the facility on 10/4/18 with an order from the hospital speech pathologist for a dysphagia 3 diet (this diet includes moist, cut up meats). The resident's physician also wrote an order for a dysphagia 3 diet on 10/22/18. The resident was served what was described by the Food Service Director (FSD) as fresh Vermont turkey. The turkey was sliced into approximately 4 " x 2" pieces. The resident was observed lifting a whole slice, uncut towards his/her mouth. Per documentation provided by the FSD form the Academy of Nutrition and Dietetics, a dysphagia 3 diet consists of moist and bite-sized pieces of meat and to avoid tough, dry meats and poultry. The FSD and the Resident Care Director both confirmed at the time of the observation that Resident # 4's meat should be cut up and that it was not.	R152		
R153 SS=D	V. RESIDENT CARE AND HOME SERVICES	R153		

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R153	Continued From page 4 5.9.c (10) Monitor stability of each resident's weight; This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and confirmed by staff interview the facility failed to monitor weights for 1 of 5 applicable residents sampled, who has had a 23.2-pound weight loss in 7 days, (Resident #1). The findings include the following: Per medical record review, Resident #1 was admitted on 11/29/18. The first documented weight was on 12/31/18. The resident weighed 153.4 pounds and seven (7) days later, on 1/7/19 the resident weighed 130.2 pounds. Per review of the care plan dated 1/3/19, Resident #1 has a problem that identifies the resident is resistive to care, but will drink, not eat. Interventions direct staff to continue to offer foods and drinks. Confirmation was made by the Rewsident Care Director on 1/8/19 at approximatley 12:50 PM, that s/he thought the Registered Dietician (RD) was to see Resident #1 on his/her next visit. The Food Service Director confirms on 1/8/19, that the RD did not evaluate the Resident #1 on his/her visit of 1/7/19.	R153		
R179 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff	R179		

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R179	Continued From page 5 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; (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 employee record review and confirmed by the Licensed Practical Nurse (LPN) interview, the facility failed to ensure that 3 of 5 direct care employees completed the required minimum 12 hours of annual training and all 5 employees have not met the required topics. The findings include the following: In the presence of the LPN Resident Care Director who confirmed on 1/8/19 at 10:18 AM and 1:45 PM, the following information evidences that the employee(s) did not meet the required annual training, nor did they meet all the required	R179		

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R179	Continued From page 6 topics: Employee #1 was hired on 9/12/17 and has a total of 12 hours of training for the 2018 calendar year. The employee has not completed the mandatory program in Abuse/Neglect/Exploitation; Employee #2 was hired on 10/17/17 and has a total of 12.75 hours of training for the 2018 calendar year. The employee has not completed the mandatory program in Abuse/Neglect/Exploitation; Employee #3 was hired on 3/17/17 and has a total of 13.5 hours of training for the 2018 calendar year. The employee has not completed the mandatory program in Abuse/Neglect/Exploitation; Employee #4 was hired on 10/17/17 and has a total of 8.5 hours of training for the 2018 calendar year. The employee has not met the required 12 hours of annual training and has not completed the mandatory programs in Resident Rights and Abuse/Neglect/Exploitation; Employee #5 was hired on 3/14/17 and has a total of 3.5 hours of training for the 2018 calendar year. The employee has not met the required 12 hours of annual training and has not completed the mandatory programs in Resident Rights, Emergency Response, Abuse/Neglect/Exploitation and Respectful Communication.	R179		

Maple Ridge
MEMORY CARE

January 22, 2019

Pam M Cota, RN
Licensing Chief
Vermont Agency of Human Services
Department of Disabilities, Aging and Independent Living
HC 2 South, 280 State Dr.
Waterbury, VT 05671-2060

Dear Pam Cota,

Please accept this as our plan of correction for the survey at Maple Ridge on January 8, 2019.

R126 SS=D

The corrective action put in place in regards to this deficiency is that all care providers when doing safety checks will document on their aide assignment sheet the location of each resident when doing their safety checks. The resident care supervisor will do random audits daily to ensure that staff are doing their hourly checks appropriately to ensure this action does not reoccur. The Director of Nursing and RN over-sight will be doing an in-service with all staff to educate regarding to safety checks, wandering, general care of residents, and aggressive behaviors. The DON and RN oversight will ensure that all staff are educated.
In regards to resident #1, Hospice services started on January 4, 2019, to assist with care and behaviors regarding this resident. Hospice will offer additional support to ensure the care and supervision of this resident is sufficient.
This action will be completed and implemented by February 20th, 2019.

R136 SS=D

The corrective action put in place in regards to this deficiency is that a readmission checklist was created to ensure that all steps for a readmission are completed including a new assessment for a change in condition. The DON will sign off on all checklists when complete to ensure all steps are followed and completed. In regards to Resident #4, his assessment has been updated.

The DON and ED will ensure that this action is followed.

This action will be completed and implemented by January 25th, 2019.

R152 SS=D

The corrective action put in place in regards to this deficiency is that nursing staff, who take an order for any dietary changes, will make a copy of the order and hand deliver to the kitchen. The Food Service Director will call the dietician on all new orders for clarification and any dietary menu changes that need to be made. In regards to Resident #4, the Food Service Director and the dietician have met to discuss what needs to be in place for Resident #4's current diet. His speech pathologist assessed resident on January 22, 2019 and updated nursing and kitchen with recommendations. All kitchen and care staff will be educated at an in-service regarding dysphagia 3 diet on February 5, 2019 with Bayada Speech Pathology.

The Food Service Director and ED will ensure this action is followed.

This action will be completed and implemented by February 11, 2019.

R153 SS=D

The corrective action put in place in regards to this deficiency is that the charge nurse will review all weights weekly. If a weight gain or loss of 5lbs is noted, the nurse will request a reweigh to ensure the weight is accurate. If yes, the dietician, MD, and family will be notified. The charge nurse and DON will meet monthly to discuss any weight concerns and action plans in the building.
In regards to resident #1, Hospice services started on January 4, 2019, to assist with care and behaviors regarding this resident. Hospice assessed and altered resident's diet to liquid only on 1/22/19. Hospice will offer additional support to ensure the care and supervision of this resident is sufficient.

The DON will ensure this action is followed.

This action will be completed and implemented February 1, 2019.

R179 SS=E

The corrective action put in place in regards to this deficiency is that mandatory meetings will happen every February for all employees. The seven mandatory trainings will happen at this time. Staff will be given multiple opportunities to attend. All staff receive the mandatory training upon hire, this will ensure that all staff get the training yearly. All staff will be accounted for via a Signature for attendance and recorded on their yearly in-service sheet. Any staff not accounted for will have individual follow up to ensure their mandatory trainings are done. The DON will review in-service hours for each employee prior to their anniversary date to ensure that the 12 hours are completed. If hours are needed, the DON will ensure these are offered and completed. In-services are scheduled currently for February 12-14, 2019.

The ED will ensure that action and implementation is followed.

This action will be completed by March 1, 2019.

Any questions please let me know.

Thank you,

Katy Lemery
Executive Director
Maple Ridge Memory Care