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

July 23, 2021

Ms. Jennifer Hanley, Manager
Maple Ridge Memory Care
6 Freeman Woods
Essex Junction, VT 05452

Dear Ms. Hanley:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 6, 2021.** 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

Pamela M. Cota, RN
Licensing Chief

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 _____	C 07/06/2021

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: An unannounced onsite complaint investigation was conducted on 7/6/21 by the Division of Licensing and Protection. The following regulatory violations were identified.	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 RCH nurse failed to update the care plan to reflect behavioral interventions and dietary monitoring for 1 applicable resident. (Resident #1) Findings include: 1. Per record review on 7/6/2021, the care plan for Resident #1 failed to reflect ongoing concerns related to Resident #1's wanderings and persistent intent to enter other resident rooms, specifically Resident #2. Per family request, Resident #1 was not to be entering and staying behind closed doors with Resident #2. Updated interventions and monitoring had not been incorporated into Resident #1's care plan. In addition, Resident #1 was diagnosed with Lactose Intolerance, however the Care Plan does not address and monitor this problem or address	R145		

R145 - R266 POC's accepted 7/21/21 FMcIntoshRN/PMC

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R145	Continued From page 1 dietary interventions as needed. This was acknowledged by the Director of Nurses at 2:55 PM on 7/6/2021.	R145		
R152 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (9) 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 staff interview and record review, the facility failed to ensure 1 of 3 residents where provided the proper therapeutic diet. (Resident #1) Findings include: Per record review, Resident #1 has experienced multiple bouts of loose stool and was diagnosed with Lactose Intolerance. On 5/28/2021 the Physician Assistant prescribed Lactase 3,000 units (an enzyme used to digest sugar found in dairy products) orally 3 times daily with meals. On 7/6/2021 at 10:00 AM during a tour of the RCH kitchen, a posting of resident pictures with dietary requirements was noted. Resident #1 was not identified to have any dietary requirements or restrictions related to dairy products and/or substitutions. This was later acknowledged on the afternoon of 7/6/2021 by the RCH Director.	R152		
R266 SS=D	IX. PHYSICAL PLANT 9.1 Environment	R266		

Division of Licensing and Protection

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R266	Continued From page 2 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 observation, staff interview and record review, the RCH failed to maintain a safe environment which ensured residents did not have unauthorized and unsupervised access to other resident rooms and failed to prevent resident access to over-the-counter topical ointments. Findings include: Per Nurse's Note dated 6/19/2021 at 18:45 states ".....Got called to the hallway outside of room [#XX] to observe the resident holding [his/her] eyes with a cool compress covering them. While applying Icy Hot (a topical pain reliever) to resident in Room [XX's] back [Resident #1] accidentally put it in [his/her] eyes....brought to the eye flushing station immediately for a thorough flushing. After [his/her] eyes were flushed they remained red but at this time the pain had subsided..." Per record review, over the past 3-4 months Resident #1, with diagnosis of dementia; anxiety; cognition deficits and behavioral issues had developed an attachment to Resident #2. Family for Resident #1 had requested RCH staff and administration to monitor and redirect Resident #1 away from Resident #2, specifically not to allow Resident #1 to be alone with the resident in his/her room. Although staff are required to conduct hourly safety checks on assigned residents' whereabouts and their safety, review of 6/19/2021 Junction 1 Assignment Sheet it was recorded Resident #1 was observed out and about within	R266		

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R266	Continued From page 3 the community common area and walking around between 18:00 -19:00. However, in between this observation time frame Resident #1 gained entrance into Resident #2's room accessing the resident's bathroom and obtained the Icy Hot topical cream (ingredients include menthol and precautions state avoid eye contact). At the time of the incident, staff was unaware Resident #1 had gained unsupervised access to Resident #2's room; accessed the topical analgesic and applied the Icy Hot to Resident #2's back. RCH staff was not aware Resident #2 had the topical pain reliever in his/her possession. During the late morning of 7/6/2021 random checks of other resident rooms/bathrooms observed multiple stored bathing/pericare cleansing products, mouthwash, deodorants and lotions. Per observation on 7/6/2021 at 3:30 PM of Resident #1's room noted multiple toiletries items also stored in bathroom to include ointments; cosmetics; shampoos; bathing products and lotions. Per interview on 7/6/2021 at 2:55 PM the Director, Assistant Director and Director of Nurses were not aware of the multiple toiletries in Resident #1's room and also those noted in other resident rooms. Despite a community of residents living at the RCH with cognition deficits; dementia; wandering and memory loss, a safety environmental assessment had not been conducted after the event on 6/19/2021 to ensure all residents were free from potential harm by possible access/misuse of multiple stored toiletries in each individual resident's room. Per interview at 12:05 PM Resident #2 stated s/he keeps his/her room door locked to prevent Resident #1 and other residents from entering. When there is a knock on his/her room door,	R266		

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R266	Continued From page 4 Resident #2 stated s/he will open the door which can result in Resident #1 or other residents entering uninvited. At this time Resident #2 is choosing to stay in his/her room to avoid any further uninvited interactions. Per record review, Resident #2 had signed on 9/12/2020 a "Resident Locked Door Authorization" to "...avoid other residents or staff from entering without permission." Resident #2 stated s/he was told a "peep hole" was going to be installed in his/her door so the resident can visualize who is at his/her suite door seeking entrance. As of 7/6/2021 this has not been installed.	R266		

Maple Ridge
MEMORY CARE

July 16, 2021

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 July 6, 2021.

R145 SS=D

The corrective action put in place in regards to this deficiency is the resident #1's care plan for behaviors and dietary change was updated on 7/9/21. RN will update any care plan for behaviors or dietary changes upon notification of changes. Report per shift will go to the Resident Care Director and all appropriate directors and any changes that need updating will be noted. The RCD will do behavior care plan audits weekly for 4 weeks starting 7/19/21 and then monthly starting 8/16/21. RCD updated the telephone order to include an action to update the care plan for dietary changes. ED and RCD will meet monthly to discuss resident updates.

The RCD and AED will ensure this action is followed.

This action will be implemented and completed July 19th.

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. Nursing will have the dietician review new orders monthly when they are in house. The Food Service Director will update the resident picture board outside the dining room, to ensure that dietary changes are reflected. RCD will meet with all nursing staff to ensure they know and understand the process for new diet orders. RCD will update Care Plan and Aide Assignments sheet with all dietary changes. Resident #1 has updated care plan, aide sheet, and picture board as of 7/9/21.

The RCD and AED will ensure this action is followed.

This action was completed by 7/9/21.

R266 SS=D

The corrective action put in place in regards to this deficiency is that weekly room audits of all resident apartments will be completed by AED and housekeeping staff to ensure that there are no safety concerns in apartments (i.e. medicated ointments, medication, cleaning supplies). If any such items are located, they will be immediately taken out of the apartment, given to the AED, and family will be notified of removal. Weekly room audits will be done for 1 month effective 7/19/21. Audits will go to monthly effective 8/19/21. AED will keep an updated binder of all room checks in her office. All incidents that occur or items that are removed will be discussed quarterly at the QA meeting to ensure no other action needs to be done to ensure safety. AED and RCD meet monthly to discuss resident updates. When a resident update includes wandering and/or the possibility of wandering into other resident's apartments, the AED will ensure the resident whose apartment it is feels safe. They will offer a key and the option to keep their apartment locked at all times and/or have a peep hole installed by our maintenance department to be able to see outside before opening a door.

The AED will ensure this action is followed

This action will be implemented 7/19/21.

Any questions please let me know.

Thank you,

Jennifer Hanley
Assistant Executive Director
Maple Ridge Memory Care