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 9, 2024

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 **June 4, 2024.** 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

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 06/04/2024

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 unannouned onsite complaint investigation and facility reported incident was conducted by the Division of Licensing and Protection on 6/4/24. Regulatory deficiencies were identified related to the Facility reported incident. Findings include:	R100		
R145 SS=E	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 observation, record review and staff interview, the RCH failed to ensure developed care plans identified resident's needs were individualized to provide person centered care and care staff were knowledgeable of the care plans developed and consistent with the care staff care sheets for 2 applicable residents (Resident #1 and #2). Per record review Resident #1 care plan indicates the resident requires: a.) Supervision with mobility, ambulation, and transfers, the interventions indicate no assistive devices and contact guard with transfer. The care plan identifies residents to have fallen in the past, however the care plan indicates to be able to	R145		

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R145	Continued From page 1	R145		

safely lowers self to the floor or may spend long times on floor refusing to stand. The care plan does not include fall prevention interventions. The care sheets indicate Resident #1 to use a walker, however, do not include directions to staff of transfer status or fall prevention interventions.
b.) Support Dementia with behaviors, the plan identifies to encourage attendance of facility activities, preferred music genre, and feelings of fear of being alone. The care sheets do not include the interventions for activity engagement, music, or interventions with behavioral expressions.

Per interview on 6/4/24 at 12:05 PM, Staff confirmed Resident #1 was not in attendance at the lunch meal and indicated Resident #1 has refused to receive care (up to time of interview). Staff indicated to have minimal direction in meeting Resident #1 needs, when refusing care, attendance to meals and/or activities. Staff confirmed to not reference the plan of care for Resident #1, stating "we use our care sheets."

The facility policy titled "Care Plans" indicates on listed items #3.) The care plan is individualized to identify tasks required for daily care needs and #6.) The care plan will be revised as needs change. When a care plan is updated the Resident Aide Assignment Sheets will be updated to reflect changes.

Per interview on 6/4/24 at 12:50 PM, the Manager confirmed the care plan for Resident #1 and the care sheets staff utilize are not up to date to identify care interventions for Resident #1.

The deficient practice has a potential for more than minimal harm as the RCH is to identify resident care needs in all areas and to direct staff

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R145	Continued From page 2 to ensure residents identify care needs are provided through the interventions developed on the care plan.	R145		
R208 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 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 record review and staff interview the RCH failed to report an occurrence of Resident to Resident incident to the licensing agency within 48 hours of incident. Per record review of Resident #1 Progress notes, on 5/7/24 an entry of incident titled: Aggressive Behavior identified an interaction Resident #1 had with Resident #3 on the evening of 5/7/24. The incident indicates a nurse responded to the sound of "Help, help." The notes states, "This nurse needed to take the hands of Resident #1 off the wrist, Left of Resident #3." The progress notes the Director of Nursing was notified. The facility policy titled State Reporting Requirements states "Incidents involving resident	R208		

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R208	Continued From page 3 to resident altercations, even minor ones, must be reported to the licensing agency regardless of pattern." Per interview on 6/4/24 at 12:55 PM, the Manager confirmed the progress notes indicates a resident to resident interaction occurred on 5/7/24 and confirmed the occurrence was not reported to the licensing agency. The deficient practice is a potential for more than minimal harm, as facilities are required to report all incidents of resident-to-resident physical interaction to the licensing agency to aid in the safety and protection of residents.	R208		

Deficiency Statement Plan of Correction (POC)

Survey Date: 06/04/24

Facility Name: Maple Ridge Memory Care

Deficiency Regulation	How the deficiency was corrected	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R145 SS=E	Resident #1's care plan was updated to reflect a more personalized line of care for [redacted] The process of updating the care plan and flowing to the Care Sheets was established to ensure the person updating the care plan is also updating the care sheets for adequate care for resident.	6/19/24	Nursing department to update all care plans to include individualized plans of care. All Care Plans will be located in a binder in the care provider wellness room to be utilized by care staff.	RN Executive Director to oversee
R208 SS=D	All resident-to-resident incidents will be reported to the interim Director of Nursing and the Executive Director at time of incident. Executive Director will ensure that reporting is completed within 48 hours of incident to both state reporting agencies.	Immediately	Nursing department is aware that RN and Executive Director are to be notified immediately regarding a resident-to-resident incident for direction and reporting responsibilities.	Executive Director

R145 Accepted
Jenielle Shea, RN 7/9/24

R208 Accepted
Jenielle Shea, RN 7/9/24

Pronouns removed by DLP 6/25/24