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

September 4, 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 **August 6, 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 08/06/2024

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: On 8/5/25 and 8/6/24 the Division of Licensing and Protection conducted an unannounced on-site annual relicensure survey, and an investigation of two facility reported incidents and one complaint. The following regulatory deficiencies were identified during the survey and investigation:	R100	Plans of Correction for all tags accepted by Jo A Evans RN on 9/4/24. Please refer to the attached document to review accepted corrective actions for each individual tag.	
R172 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h All medicines and chemicals used in the home must be labeled in accordance with currently accepted professional standards of practice. Medication shall be used only for the resident identified on the pharmacy label. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure insulin pens are labeled with the date opened in accordance with currently accepted professional standards of practice. Findings include: The Medication Management policy effective 7/2022 is consistent with the regulatory requirements related to the handling of medications in accordance with applicable standards and the labeling of insulin pens when opened. When an insulin pen is opened, the current professional standard is to label the pen with the date the pen was opened to prevent use of this medication beyond the expiration date.	R172		

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R172	Continued From page 1 On the afternoon of 8/5/24 three insulin pens including 1 Lantus Solostar Pen and 2 Novolog Flex Pens were observed to be opened and stored in the medication cart without labels indicating the dates the pens were opened . This finding was confirmed by the Med Tech on duty at 1:30 PM on 8/5/24, and by the Campus Executive Director a 1:55 PM on 8/5/24.	R172		
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; (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.	R179		

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R179	Continued From page 2 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 the required yearly trainings. Findings include: The facility's policy and procedures governing staff training effective September 2023 are consistent with requirements outlined in the licensing regulations. Per record review, documentation indicating completion of the required yearly trainings was not on file and available for review for 3 out of 5 sampled staff. This finding was confirmed by the Campus Executive Director at 4:23 PM on 8/5/24.	R179		
R190 SS=F	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 ensure completion of all required background checks for 4 out of 5 sampled staff. Findings include: The facility's policy and procedures governing staff criminal record and abuse registry background checks effective September 2023 are consistent with requirements outlined in the licensing regulations.	R190		

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R190	Continued From page 3 Per record review all required criminal record and abuse registry background checks were not completed for 4 out of 5 sampled staff. At 4:34 PM on 8/5/24 the Campus Executive Director confirmed this finding.	R190		
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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure dented cans are rejected and kept separate from foods to be served to residents of the home. Findings include: During the tour of the kitchen and food storage areas commencing at 10:15 AM on 8/5/24, seven dented cans were observed to be stored with foods to be served to residents of the home. During the tour of the kitchen on the morning of 8/5/24 the Food Services Director stated the procedure followed when dented cans are discovered is to open any dented cans to determine if the contents are safe to eat. On 8/5/24 the facility's policy and procedure related to dented cans on file and available for review	R246		

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R246	Continued From page 4 states all dented cans should be discarded due to possible contamination. This finding was confirmed by the Campus Executive Director and the Food Services Director at 10:45 AM on 8/5/24.	R246		
R266 SS=F	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 observation, and interviews with Staff and a family member of one applicable resident (Resident #1), there was a failure to ensure care in a safe, functional and homelike environment related to the condition of the facility courtyards. Findings include: The facility's Standards of Care outlines expectations for the care provided to all residents with cognitive impairment and states a safe home-like environment will be provided and residents will be kept away from building disrepair. During a facility tour on the morning of 8/5/24 the Campus Executive Director stated the doors to the facility's center courtyards are unlocked daily after breakfast and remain unlocked and accessible until 8:00 PM. Two additional facility courtyards remain locked unless attended by	R266		

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R266	Continued From page 5 Staff due to safety concerns. The facility's courtyards are enclosed areas to ensure the right to be outdoors in a safe and secure setting for residents with varying progression of cognitive impairment. During lunch service on 8/5/24 Resident #1 was observed with metal staples in his/her scalp which staff reported was the result of an injury sustained during from a fall. During an interview commencing at 10:50 AM on 8/6/24, Resident #1's partner, who is also his/her Designated Power of Attorney (DPOA), stated on the evening of 7/26/24 Resident #1 tripped and fell while unattended in the courtyard and was found by Staff between 8:00 - 8:40 PM when the doors to the courtyard doors were supposed to be locked. During a tour of the applicable courtyard with Resident #1's DPOA on the morning of 8/6/24, the walkways were observed with an inadequate amount of soil and stone fill surrounding them, creating a risk for falls and injury due to uneven surfaces and areas with significant drop - offs around the pavers that form the walkways. On the morning of 8/6/24 Resident #1's DPOA stated the walkways of the courtyard had been in this condition since Resident #1 was admitted to the home in January of 2024; and reported s/he first noticed this was a safety hazard "about a month ago" after s/he observed Resident #2 fall from his/her wheelchair because a wheel went go over the edge where there isn't enough stone or dirt around the border of the walkway. During an interview commencing at 12:20 PM on 8/6/24, the Campus Executive Director confirmed resident falls have occurred in the courtyard and stated yearly attempts to add rocks to level the surface have not successfully addressed this	R266		

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R266	Continued From page 6 safety concern because rainfall causes the rocks to settle and sink down. The Executive Director stated by paving the area, the faicilty would be able to keep the doors open more often. The Executive Director confirmed multiple residents have fallen in the courtyard due to this issue including Resident #1's fall. The Executive Director also confirmed Resident #2 uses a wheelchair when outside of his/her apartment and has fallen in the courtyard about 4 times in the last 3 years or so; which s/he stated has not caused Resident #2 physical injury. At 12:37 PM on 8/6/24 the Campus Executive Director was requested to provide all incident reports and internal investigations related to falls with injuries in the courtyard for review. The requested documentation was not provided for review following a second request on the afternoon of 8/6/24.	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 are maintained below 120 degrees Fahrenheit in areas accessible to residents. The facility's Water Temperatures policy and procedures effective 12/2023 are consistent with the regulatory requirements.	R291		

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R291	Continued From page 7 During the facility tour commencing at 10:10 AM on 8/5/24 water temperatures in areas of the home were observed at temperatures greater than 120 degrees Fahrenheit in the following resident rooms: Room #49 122.9 degrees Room #38 123.1 degrees This finding was confirmed by the Campus Executive Director during the facility tour on the morning of 8/5/24. Following adjustments made by the facility's Maintenance Director to the boilers which supply water to the affected areas of the home water temperatures were observed to be sustained below 120 degrees Fahrenheit on the afternoon of 8/5/24. This is a repeat citation.	R291		

Deficiency Statement Plan of Correction (POC)

Survey Date: 08/06/24

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
R172 SS=E Plan of Correction accpeted by Jo A Evans RN on 9/4/24	Med cart audit was conducted to ensure that all medications including insulin pens, eye drops are labeled and dated.	9/13/24	Going forward a med cart audit will be done weekly for 2 months then monthly. Med Tech meeting is scheduled for Thursday, September 5th, 2024 to re-educate regarding labeling of all medications.	RN Executive Director
R179 SS=F Plan of Correction accepted by Jo A Evans RN on 9/4/24	HR manager conducted an audit of all staff to ensure that all mandatory trainings have been completed per state guidelines.	10/1/24	HR manager will do a monthly check of all trainings on employees to ensure anyone in the window of 12 months has their trainings completed. Anyone not in compliance will be taken off the floor until completed.	HR Manager Overseen by Executive Director
R190 SS=F Plan of Correction accepted by Jo A Evans RN 9/4/24	HR manager conducted an audit on all staff to determine who needed criminal background checks and abuse checks done for their 12-month mark. All staff had checks completed immediately.	9/1/24	HR manager will do a monthly check for all employees hitting 12 months of employment and conduct their criminal background and abuse checks to be printing and put in their employee file.	HR Manager Overseen by Executive Director
R246 SS=F Plan of Correction accepted by Jo A Evans RN on 9/4/24	Food Service Director did an immediate audit of all cans in the kitchen and dry storage. Any cans discovered with dents were taken out of rotation.	9/1/24	Food Service Director or designee will audit each food order when it comes in to ensure not cans have dents in them. The dented cans will be returned to the vendor. Food Service Director or designee will audit the kitchen and dry storage monthly to ensure no new dents have appeared for any items.	Food Service Director Overseen by Executive Director
R266 SS=F Plan of Correction accepted by Jo A Evans RN on 9/4/24	Staffing are monitoring the courtyards frequently until renovations can occur in the courtyard to ensure safety and keep resident free to go outside while still nice out. Fencing will be placed along the entire edge of the cement to the stones to ensure a barricade for safety. Awaiting date to be installed.	10/15/24	Fencing will be placed around the edge of cement to the stones during September 2024. Getting quotes from a number of vendors to remove the vegetation and flatten the entire courtyard with cement or a-like substance to remove tripping hazards.	Plant Operations Director Overseen by Executive Director

R291 SS=E Plan of Correction accepted by Jo A Evans RN on 9/4/24	Temperature was regulated by the Plant Operations Director immediately upon notification and temperature was within regulatory limits.	9/1/24	Plant Operations Director/designee will do weekly water temperature checks to ensure that the temperature stays within limit of below 120 degrees F. If temperatures stay within normal range for 2 months then checks will go to monthly.	Plant Operations Director Overseen by Executive Director

K Munzie 9/3/24
Senior Executive Director