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

October 25, 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 **September 30, 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 09/30/2024

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 9/30/24 the Division of Licensing and Protection conducted an unannounced on-site investigation of two complaints. The following regulatory deficiencies were identified:	R100		
R128 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure treatment consistent with physician's orders as outlined in on applicable resident's Clinician's Orders for Life Sustaining Treatment (COLST) form (Resident #2). Findings include: The facility's Emergency Response policy effective June 2024 states, "If a resident has a DO NOT HOSPITALIZE order, a copy of this with the COLST form will be in the resident chart. If a medical emergency occurs that the facility is not equipped for , responsible party and physician will be notified and resident may be set out [sic]..." This policy further states the attending physician should be informed. Per review, Resident #2's record includes a completed a Clinician's Orders for Life Sustaining Treatment (COLST) form which is a legal document identifying Resident #2's wish to receive only comfort focused treatment allowing	R128		

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 09/30/2024

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
R128	Continued From page 1	R128		

for a natural death. This document was signed by Resident #2's Primary Care Provider on 7/28/22, and entered into Resident #2's record upon admission to the facility on 8/4/22. Resident #2's COLST form states s/he does not want to be transferred to the hospital for life sustaining treatments, and only wants to be transferred if comfort needs cannot be met in his/her current location.

Per record review, on 8/4/24 Resident #2 was transferred to the emergency department after s/he was observed to be unresponsive while seated in the activities room. While at the hospital blood tests were performed and contrasted Computerized Tomography imaging (a CT Scan) of the blood vessels of his/her head and neck was performed before the resident's family member was informed and notified the hospital regarding Resident #2's wishes as defined in the COLST. The hospital discharge summary indicates Resident #2 was seen for an undetermined change in mental status and states a miscommunication occurred between the facility and the emergency department regarding Resident #2's previously stated wishes and the resident was returned to the facility.

Per interview commencing at 3:32 PM on 9/30/24, the Licensed Practical Nurse (LPN) who responded to the facility Staff's call for assistance on 8/4/24 observed Resident #2 breathing but not responsive and with an elevated heart rate of 126 beats per minute. The LPN who responded typically works at a nearby facility owned by the organization that manages the facility. During the interview on the afternoon of 9/30/24, the LPN stated s/he placed a call to a second LPN who regularly works with Resident #2 and made the decision to transport Resident #2 to the hospital

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 09/30/2024

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
R128	Continued From page 2	R128		

following the second LPN's indication that Resident #2's reported condition was not consistent with his/her normal presentation. A Progress Notes dated 8/4/24 written by the attending LPN states,"This Nurse in to assess Resident" and during the interview conducted on the afternoon of 9/30/24 the attending LPN confirmed a Registered Nurse was not notified regarding an assessment prior to Resident #2's transport to the Emergency Department. The LPN stated Resident #2 was not observed with signs of pain or discomfort during this incident, and the decision to transport was based on unresponsiveness which s/he described as a blank stare "without even blinking".

Per interviews conducted on the afternoon of 9/30/24 with the LPN who responded and Staff who assisted in preparing the paperwork for transport, it is unclear if a copy of Resident #2's COLST was given to the emergency medical service workers who transported Resident #2 to the emergency department; and the LPN could not recall if a nurse report was completed with the emergency room staff. It is important to note the facility LPN was not on duty at the time of the interview on 9/30/24, and s/he did not have access to notes regarding the incident during the interview. Progress Notes related to the incident do not include documentation indicating the resident's physician was notified or a nurse report was provided to the emergency room staff. Per interview with the LPN and the Staff member present during the incident on the afternoon of 9/30/24, both recalled that Resident #2 did not display signs of pain or discomfort prior to transport to the emergency department.

Per interview on 9/30/24, the Campus Executive Director confirmed Resident #2 had a COLST on

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 09/30/2024

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
R128	Continued From page 3 file in his/her resident record indicating his/her wishes to not be transferred to the hospital unless his/her comfort needs could not be met at the facility; and stated this incident prompted questions at the facility regarding what happens when Staff feel someone needs transport even if the resident has a do not transport order. On the afternoon of 9/30/24 the Director of Nursing confirmed Resident #2 was transported to the hospital without reported observation of signs and symptoms of pain or discomfort indicative of unmet comfort needs as defined in the COLST signed by Resident #2's Physician.	R128		
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 there was a failure to ensure completion of a yearly assessment for one applicable resident (Resident #1). Findings include: Per record review Resident #1 was admitted to the home on 1/27/22. The date the most recent yearly Resident Assessment on file was initiated is 6/20/23, however this resident assessment	R136		

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 09/30/2024

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
R136	Continued From page 4 form was not signed as completed by an RN. On the afternoon of 9/30/24 the DON confirmed a completed current yearly resident assessment form was not on file and available for review. This finding was confirmed by the Director of Nursing on the afternoon of 9/30/24.	R136		
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 staff interview and record review there was a failure to develop a plan of care to address care and services required to maintain well-being for 2 applicable residents (Residents #1 and #2). Findings include: The facility's policies and procedures for Care Plans are consistent with the regulatory requirements. Per record review, Resident #1 has diagnoses related to cardiovascular conditions with a history of Transient Ischemic Attacks, Stroke with a subsequent visual deficit, Syncopal Episodes with Collapse, and is prescribed the anticoagulant	R145		

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 09/30/2024

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
R145	Continued From page 5 medication Eliquis which is a risk for bleeding increased by his/her high risk for falls. S/he has a history of Diverticulitis resulting in a bowel perforation. Resident #1's Plan of Care does not address care and services required to meet needs associated with these conditions. Per record review, Resident #2 has a diagnoses including Atrial Fibrillation and Hypertension and is prescribed the anticoagulant medication Eliquis. S/he has a history of a Stroke resulting in softening of the affected area of his/her brain, and poor blood circulation to the small vessels of his/her brain which increases the importance of effective management of Hypertension. Additionally, s/he has a history of hypokalemia (inadequate supply of potassium in the bloodstream). Resident #2's Plan of Care does not address care and services required to meet needs associated with these conditions. The Director of Nursing confirmed these findings at 2:09 PM on 9/30/24	R145		

Deficiency Statement Plan of Correction (POC)

Survey Date: 09/30/24

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
R128 SS=D R128 Plan of Correction accepted by Jo A Evans RN on 10/24/24	Facility policy on sending a resident to the ER and COLST form has been updated. Education with all nurses and med tech's regarding the process for sending a resident out and what documents are to be looked at ahead of time, physician/POA called if do not transfer order is in place. Education to families on admission or up date to COLST regarding what we will send out for due to level of license in community.	11/1/24	Meeting held with all nurses and med techs to ensure education on new process. Signed off on policy that they understand the procedure.	Director of Nursing Oversight by ED
R136 SS=D R136 Plan of Correction accepted by Jo A Evans RN on 10/24/24	Director of Nursing did chart audits of all charts for the community. Ensured all assessments for 14 day and current assessment for annual or change of condition were in chart and signed. Director of Nursing to complete any assessments that were needed.	11/1/24	Director of Nursing has spreadsheet with all resident names, move in dates and assessment due dates that tracks when annuals are due. After initial assessment is completed, ED will approve prior to DON signing and assessment being put in chart.	Director of Nursing Oversight by ED
R145 SS=E R145 Plan of Correction accepted by Jo A Evans RN on 10/24/24	Director of Nursing did chart audit to review care plans and need for additional medical diagnosis that needed care plans completed. Director of Nursing will then complete all new care plans.	12/1/24	Director of Nursing has been educated regarding care plans and what problem areas are in need of a care plan going forward.	Director of Nursing Oversight by ED