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

November 18, 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 **October 21, 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 10/21/2024

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 10/21/24 the Division of Licesning and Protection conducted an unannounced on-site investigation of one complaint and two facility reported incidents. The following regulatory deficienies were identified:.	R100		
R162 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.c. Staff will not assist with or administer any medication, prescription or over-the-counter medications for which there is not a physician's written, signed order and supporting diagnosis or problem statement in the resident's record. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure written signed physician's orders were obtained for medications listed on the October 2024 Medication Administration Record for one applicable resident (Resident #2). Findings include: The facility's New Orders policy, which was provided by the Campus Executive Director for review on request for policies and procedures related to ensuring physician's signed orders are obtained for resident medications, is not consistent with this regulatory requirement. Per record review, signed physician's orders were not on file and available for review for the following hospice medication orders listed on Resident #2's October 2024 Medication Administration Record:	R162		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Katy Munger | TITLE: Senior Executive Director | (X6) DATE: 11/13/2024

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R162	Continued From page 1 a. Haloperidol LAC 2 mg/ml Concentrate 0.5 ml (1 mg) by mouth /sublingually every 6 hours as needed for agitation b. Hyoscyamine 0.125 mg tabs 1 tablet every 4 hours as needed for secretions c. Morphine Solution 20 mg/ml 0.25 ml (5 mg) every 3 hours as needed for shortness of breath/pain At 4:23 PM on 10/21/24 the Licensed Practical Nurse on duty confirmed written, signed physician's orders were not on file and available for review for the hospice medication orders identified above.	R162		
R163 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.5 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (1) A registered nurse must conduct an assessment consistent with the physician's diagnosis and orders of the resident's care needs as required in section 5.7.c This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to complete resident assessments according to Section 5.7 c of the Vermont State Residential Care Home Licensing Regulations effective 10/3/2000 for 2 applicable residents (Residents #2 and #3). Findings include: The facility's policies and procedures for	R163		

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R163	Continued From page 2 completion of Resident Assessments by the Registered Nurse are consistent with this regulation. 1. Per record review Resident #2 was admitted to the home on 8/27/24. At 4:40 PM on 10/21/24 the LPN on duty confirmed there were no Resident Assessments on file and available for review in Resident #2's record. 2. Per record review, Section 3a. of Resident #3's Admission Assessment signed as complete by the former Registered Nurse on 2/20/2024 indicates s/he is never physically abusive to others. Per review of Progress Notes on file for Resident #1, four incidents of physically aggressive behaviors were noted towards staff between 5/21/24- 9/24/24 including: a. 5/21/24- swung at a staff member b. 8/11/24 - hit a staff member while saying s/he was leaving c. 8/19/24- slapped a staff member's arm who came into room to prompt for dinner d. 9/24/24- kicked a staff member At 1:55 PM on 10/21/24 the Campus Executive Director confirmed a significant change assessment was not completed in response to Resident #3"s significant change in behavior to include physical aggressions towards staff.	R163		
R190 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.12.b.(4) The results of the criminal record and adult abuse registry checks for all staff.	R190		

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R190	Continued From page 3 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 criminal record checks for one applicable staff. Findings include: The facility's policies and procedures governing completion of staff background checks are consistent with the regulatory requirements. Per record review, the required national criminal background check was not completed as required for one applicable staff sampled during the investigation of a facility reported incident. This finding was confirmed by the Campus Executive Director at 1:42 PM on 10/21/24. This is a repeat citation.	R190		
R224 SS=D	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure one applicable resident (Resident #1) remained free of physical abuse by another resident (Resident #2). Findings include: The facility's Abuse and Neglect Policy effective	R224		

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R224	Continued From page 4	R224		

June 2024 states, "It is the policy that residents of our communities have the right to be free of abuse ..."

The facility's Standards of Care identified in each residents Plan of Care includes the statements, "The resident's dignity will be maintained with every interaction with them and their rights will be protected. " and "Care Plans will be updated with any additional changes in resident's status or when interventions needed to added or discontinued"

Per record review on 10/21/24, progress notes and staff reports indicate that during the early morning on 10/13/24 Resident #2 entered Resident #1's apartment and physically assaulted him/her. Reviewed Progress Notes and Staff reports on file consistently indicate Resident #2 grabbed Resident #1 and held him/her down. Per Progress Notes written on the morning of 10/13/24 by the Nurse on duty at the time of the incident, the Staff who heard Resident #1 "yelling for help" and responded. The Nurse reportedly observed Resident #2 holding Resident #1 down, hitting, and attempting to choke him/her. Resident #1 reportedly stated to the Nurse on duty that Resident #2 grabbed him/her by the wrists and held him/her down. Resident #1 reportedly denied pain and injury following the incident, and per Nursing Staff s/he was observed to be without signs or symptoms of physical injury as a result of the incident.

Per record review, Resident #2 was admitted to the home on 8/27/24 following a brief stay at another residential care home. On 8/23/24 the facility received documents from the home where Resident #2 previously resided which indicate Resident #2 demonstrated intrusive behaviors

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R224	Continued From page 5 with other residents and physical aggression towards staff at the previous home. During the investigation on 10/21/24, an Admission Assessment was not on file in Resident #2's record. Prior to the incident on 10/13/24, the Care Plan on file in Resident #2's record identified only needs related to assistance with activities of daily and did not address needs related to his/her history of intrusive behaviors, and physical aggression. During an interview on the afternoon of 10/21/24, the Licensed Practical Nurse (LPN) on duty stated Resident #2 had previously demonstrated physically assaultive behaviors during an altercation with Resident #1 on 10/10/24. The LPN also confirmed s/he had been struck by Resident #2 while providing care. During an interview commencing at 1:59 PM on 10/21/24, the Campus Executive Director confirmed Staff responded to Resident #1 yelling for help on the early morning of 10/13/24. Per the Campus Executive Director, the Staff who responded reported Resident #2 appeared to be choking Resident #1 and was not able to be redirected by prompts to let go of Resident #1. The Executive Director stated the Staff who responded removed Resident #2's hands from Resident #1's shoulders/collar bone area, then physically removed Resident #2 from Resident #1's room. On the afternoon of 10/21/24 the Campus Executive Director also confirmed the facility had received documents during Resident #2's admission process which indicated a history of intrusive and physically aggressive behaviors; a Resident Assessment was not on file and available for review in Resident #2's record; and the Care Plan on file for Resident #2 did not	R224		

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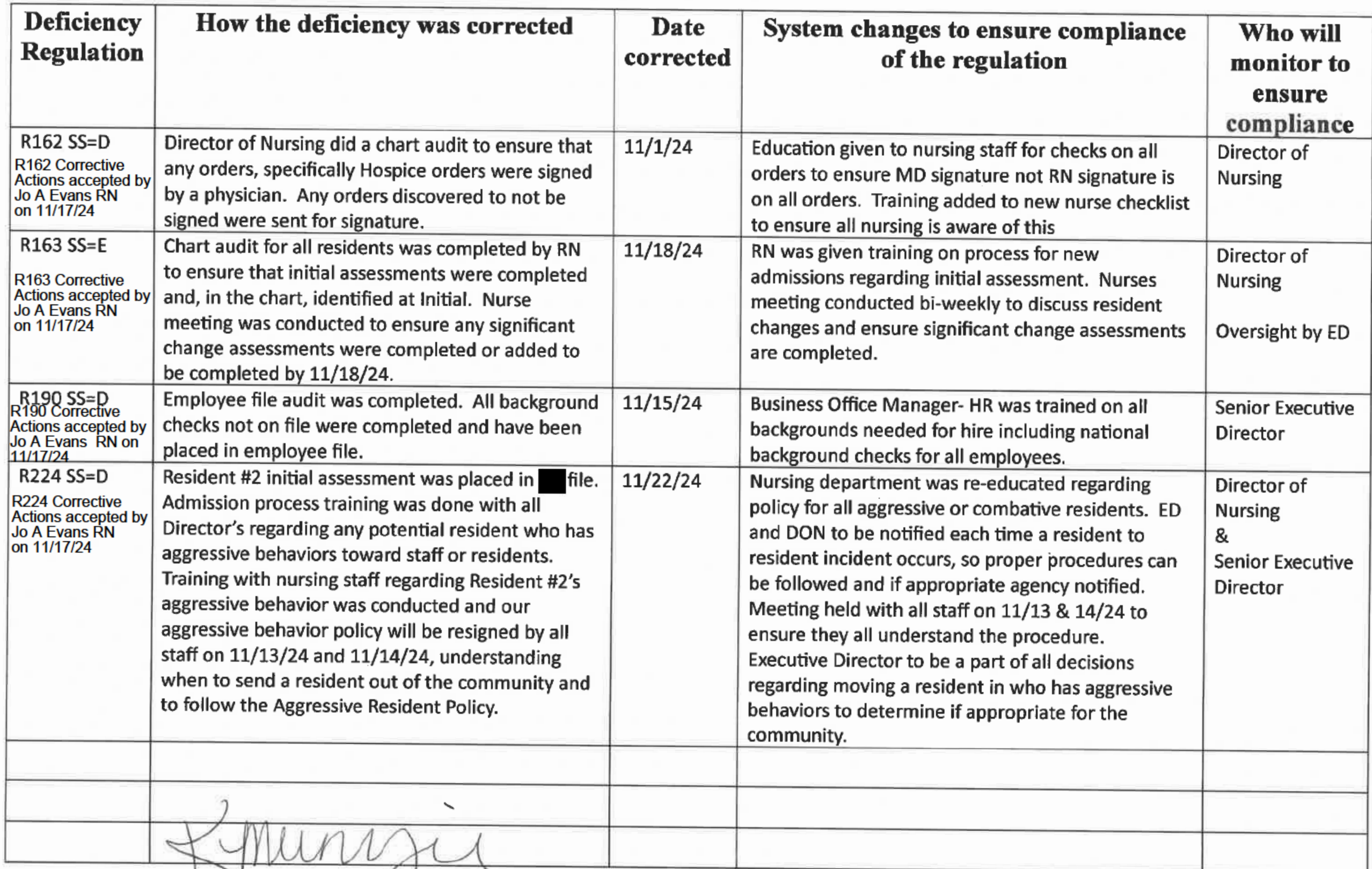
R224	Continued From page 6 address his/her history of intrusive and aggressive behaviors.	R224		

Deficiency Statement Plan of Correction (POC)

Survey Date: 10/21/24

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
R162 SS=D R162 Corrective Actions accepted by Jo A Evans RN on 11/17/24	Director of Nursing did a chart audit to ensure that any orders, specifically Hospice orders were signed by a physician. Any orders discovered to not be signed were sent for signature.	11/1/24	Education given to nursing staff for checks on all orders to ensure MD signature not RN signature is on all orders. Training added to new nurse checklist to ensure all nursing is aware of this	Director of Nursing
R163 SS=E R163 Corrective Actions accepted by Jo A Evans RN on 11/17/24	Chart audit for all residents was completed by RN to ensure that initial assessments were completed and, in the chart, identified at Initial. Nurse meeting was conducted to ensure any significant change assessments were completed or added to be completed by 11/18/24.	11/18/24	RN was given training on process for new admissions regarding initial assessment. Nurses meeting conducted bi-weekly to discuss resident changes and ensure significant change assessments are completed.	Director of Nursing Oversight by ED
R190 SS=D R190 Corrective Actions accepted by Jo A Evans RN on 11/17/24	Employee file audit was completed. All background checks not on file were completed and have been placed in employee file.	11/15/24	Business Office Manager- HR was trained on all backgrounds needed for hire including national background checks for all employees.	Senior Executive Director
R224 SS=D R224 Corrective Actions accepted by Jo A Evans RN on 11/17/24	Resident #2 initial assessment was placed in ██ file. Admission process training was done with all Director's regarding any potential resident who has aggressive behaviors toward staff or residents. Training with nursing staff regarding Resident #2's aggressive behavior was conducted and our aggressive behavior policy will be resigned by all staff on 11/13/24 and 11/14/24, understanding when to send a resident out of the community and to follow the Aggressive Resident Policy.	11/22/24	Nursing department was re-educated regarding policy for all aggressive or combative residents. ED and DON to be notified each time a resident to resident incident occurs, so proper procedures can be followed and if appropriate agency notified. Meeting held with all staff on 11/13 & 14/24 to ensure they all understand the procedure. Executive Director to be a part of all decisions regarding moving a resident in who has aggressive behaviors to determine if appropriate for the community.	Director of Nursing & Senior Executive Director

Pronouns removed by DLP 11-18-2024