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

April 2, 2025

Jane Samuelsen, Manager
Maple Ridge Memory Care
6 Freeman Woods
Essex Junction, VT 05452

Dear Ms. Samuelsen:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 6, 2025.** 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 03/06/2025

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 3/5/25 and 3/6/25 the Division of Licensing and Protection conducted an unannounced on-site investigation of 3 complaints and one facility reported incident. The following regulatory deficiencies were identified:	R100		
R178 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.a There shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to assure prompt, appropriate action in cases of injury, illness, fire or other emergencies. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure a sufficient number of staff are available at all times to provide necessary care, maintain a safe environment, and respond to emergencies promptly and appropriately. Findings include: 1. The facility's Staff Pattern policy effective January 2025 states the night shift staffing pattern ranges from 3-4 staff "based on acuity and level of care for residents". Per this policy, 3-4 staff are scheduled during the hours of 11:00 PM - 7:00 PM, with an additional 15 minute overlap with the evening and day shifts scheduled for shift change reporting. Per record review, the facility has 56 licensed beds. On 3/5/25, the facility was home to 46 residents. On the afternoon of 3/6/25 the Campus Executive Director stated a total of 4 staff are scheduled	R178		

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R178	Continued From page 1 during the night shift when the building is "full". The Campus ED confirmed the facility currently schedules 3 staff on the night shift including 1 Care Provider in each of the facility's 2 "neighborhoods" (areas of the home positioned on either side of a shared lobby) and 1 Med Tech who floats between both neighborhoods. Based on the current resident census on 3/5/25 and the current night shift staffing pattern, 1 Care Provider is responsible for the safety and care of 25 Residents in the "Junction" Neighborhood and 1 Care Provider is responsible for the safety and care of 21 Residents in the "Town" Neighborhood; with the 1 Med Tech available to assist in both neighborhoods as needed when not administering medications. Per the facility's Fire Drills /Emergency Evacuation policy effective January 2020, "ALL DOORS UNLOCK WHEN THE FIRE ALARM GOES OFF THEREFORE MUST BE MONITORED THE WHOLE TIME [sic]." Procedures outlined in this policy state "Staff will meet the Fire Department at the front desk", all RCA's (resident care staff) are expected to immediately respond to assigned doors, and all other staff will be assigned to respond to the hallway of the actual fire to assist when evacuation is needed. Per staff interview and record review the facility's night shift staffing practices do not ensure sufficient staff to follow the facility's policies and procedures governing emergency preparedness and emergency evacuation of the home. Per Staff interview on the afternoon of 3/6/25, there are 10 doors that open to the exterior of the facility. There is a locked interior door which prevents resident access to one of the exterior doors located near the kitchen. The remaining 9	R178		

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R178	Continued From page 2 exterior doors require monitoring to ensure resident safety when activation of the alarm system disarms security locks installed to prevent resident elopement and unsupervised access to the surrounding community. The 9 remaining exterior doors open to enclosed outdoor areas which would prevent evacuation to another location, and doors that open to parking areas, roadways, and the surrounding community. On the afternoon of 3/6/25 the Campus Executive Director acknowledged is not possible for 3 or 4 night staff to follow emergency evacuations procedures to include meeting the fire department at the front desk and monitoring exterior doorways. In addition to monitoring exterior doors, Staff on duty are also responsible for assisting residents to areas of the home behind fire doors while awaiting the arrival of emergency responders during an emergency that does not require evacuation. During an emergency requiring immediate evacuation, Staff are responsible for assisting residents out of the building to a designated location while awaiting the arrival of emergency responders. Per review of the Assignment Sheet for all residents of the home, there are 14 residents who require Staff assistance for mobility. On the afternoon of 3/6/25 the Resident Care Director and Campus Executive Director acknowledged these findings. During Staff interviews conducted on 3/5/25 one staff stated, "When I work overnights it is like the most unsafe thing ever, if the building went up in flames we would not be able to get people out, I constantly worry about that ... a lot of the residents need cueing and will not be able to get up and out of the building on their own." Another staff who works the night shift stated 3 staff would	R178		

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R178	Continued From page 3 not be able to get the residents out of the building at night and there are not enough staff to meet the emergency evacuation plan to have one staff at each door when the alarms automatically unlock the doors. A third staff interviewed on 3/6/25 also expressed concerns about the staff being able to evacuate the residents from the building and follow the emergency evacuation plan with the current staffing levels. 2. The facility's Staff Pattern policy effective January 2025 states the facility's Policy is "To ensure adequate staff to meet the needs of all residents within the community." and states the night shift staffing ratios are "based on acuity and level of care for residents". Per surveyor observation, staff interviews, and record reviews the current staffing pattern utilized by the home does not provide sufficient staff to provide necessary care and maintain a safe environment. a. On the afternoon of 3/6/25 the Campus Executive Director confirmed a staff member is required to be present in the dining room during meal service at all times to monitor resident safety. In addition to staff monitoring to ensure the safety of all residents related to dietary services, Resident #1 requires staff monitoring in the dining area due to multiple incidents of physically aggressive and abusive sexual behaviors directed towards other residents. During an interview on the afternoon of 3/5/25 a Staff member stated Resident #1 " ...touches others a lot, if [Resident #1] is unattended you can walk in and have somebody's shirt up.[sic]" Per record review, Resident #1's Care Plan includes interventions to limit access to residents of a specified gender during meals and activities. These interventions were added to the Care Plan	R178		

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R178	Continued From page 4 after an incident on 1/18/25 during which Resident #1 inappropriately touched another resident's chest area in the dining room. Per record review, on 2/24/25 and 2/25/25 Resident #1 attempted to inappropriately touch other residents in the dining room. Resident #1's history of inappropriate touch and attempted inappropriate touch in the dining area is an example of the need for adequate staffing to ensure continuous monitoring of residents in the dining area during mealtimes. Per Surveyor observation of the dining areas during breakfast and lunch service on 3/5/25 and 3/6/25, Staff positioned in dining areas during meals were also responsible for completing tasks including medication administration and serving meals, which impeded continuous monitoring for resident safety during the observed mealtimes. b. The facility's Standards of Care included in all resident Care Plans states, "A safe home-like environment will be provided. The resident will be kept away from hazardous chemicals or building disrepair." Progress Notes dated 3/1/24 indicate Resident #5 was found covered with blood due to an elbow laceration requiring emergency medical care including 8 sutures. Resident #5's Progress Notes, indicate this incident occurred during the early morning hours of the night shift, when 1 Care Provider is responsible for 21 Town Neighborhood residents with the help of 1 Med Tech who is responsible for medication administration and assisting with care throughout the entire facility. Per record review, the Town 1 Assignment Sheet updated on 11/25/24 indicates Resident #5 requires hourly safety checks. Per Staff interview on 3/6/25, Resident #5 removed the false drawer facings from the bathroom vanity	R178		

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R178	Continued From page 5 in their apartment. Per Progress Notes, "sharp edges" exposed when Resident #5 removed the false drawers were identified by emergency medical responders as the potential cause of Resident #5's laceration. On the afternoon of 3/6/25 the Maintenance Director and Campus Executive Director confirmed Resident #5's injury resulted from the resident's removal of the false drawer facings. This incident resulting in harm to a resident indicates a need for adequate staffing to ensure the safety of residents. c. The facility's Staff Pattern policy effective January 2025 states, "Night shift ratios are based on acuity and level of care for residents." On the afternoon of 3/6/25 the Campus Executive Director confirmed the facility's current night shift staffing pattern is 3 staff. Per Staff interviews conducted on 3/5/25, Resident #6 frequently falls, and due to a decline in health the assistance of up to 5 staff is required to lift this resident after a fall. Per record review between 1/3/25-3/1/25 Resident #6 experienced 31 falls including 5 falls during the night shift when there are 3 staff on duty. During Staff interviews conducted on 3/5/25 one staff stated Resident #6 had recently fallen 4 times during one shift and stated Resident #6 requires "pretty much all staff there to get [the resident] up". A second staff stated Resident #6 requires 3 assists to stand and pivot for toileting, and when falls occur it takes 4-5 staff to get this resident up. This staff member also stated, "When we don't have enough staff we break our backs to get [Resident #6] up with a gait belt ..." and "When [Resident #6] falls during the day they need most of the staff to come get [the resident] up." On the afternoon of 3/6/25 the Campus Executive Director confirmed due to Resident #6's recent decline the resident requires 4-5 staff assists for lift assists.	R178		

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R178	Continued From page 6 Per staff interviews and record review, the facility's staffing pattern does not meet Resident #6's level of care needs related to falls that occur during the night shift. The facility's current staffing pattern also significantly limits the number of staff available to monitor and support other residents of the home when Resident #6 falls, and poses a risk for resident and staff injuries when there are not enough staff on duty to safely lift the resident after a fall. On the afternoon of 3/6/25 the Campus Executive Director acknowledged the facility's staffing patterns fails to ensure a sufficient number of staff are available at all times to provide necessary care, maintain safety, and respond to emergencies.	R178		
R206 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be contacted by calling toll-free 1-800-564-1612. Reports must be made to APS within 48 hours of learning of the suspected, reported or alleged incident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to report multiple incidents of one applicable resident's (Resident #1's) physically aggressive and abusive sexual behaviors	R206		

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R206	Continued From page 7 directed towards other residents to the Adult Protective Services (APS). Findings include: The facility's State Reporting Requirements policy and procedures state, "The licensee is required to report suspected or reported incidents of abuse, neglect, or exploitation to the Adult Protective Services." Resident #1's diagnoses include Non-Alzheimer's Dementia, Cognitive Deficits, and "Other Sexual Disorders". Resident #1 has experienced behavioral changes related to these conditions including an increase in sexual behaviors. Per record review, between 12/12/24 - 2/25/25, Resident #1 engaged in multiple incidents of physically aggressive and abusive sexual behaviors directed towards other residents of the home which were not reported to APS. Per Progress Notes, Resident #1 reportedly inappropriately touched other residents on 12/12/25 and 12/13/25; touched the buttocks and side of another resident on 1/1/25; inappropriately touched other residents on 1/13/25, 1/15/25, and 1/19/25; hit another resident on the bottom twice on 1/22/25; touched another resident's "butt" on 1/26/25; and placed a hand up another resident's shirt on 2/2/25. Progress Notes also indicate Resident #1 attempted to touch or grab other residents on 1/22/25, 2/21/25, 2/24/25, and 2/25/25 without documentation of Resident #1 making physical contact. On the afternoon of 3/6/25 the Campus Executive Director confirmed the documented incidents of Resident #1 engaging in physically aggressive and abusive sexual behaviors directed at other residents listed above were not reported to the Adult Protective Services as required.	R206		

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R206	Continued From page 8 Please refer to tag 213.	R206		
R213 SS=H	VI. RESIDENTS' RIGHTS 6.1 Every resident shall be treated with consideration, respect and full recognition of the resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to ensure residents of the home are treated with dignity and respect related to one applicable resident's (Resident #1's) physically aggressive and abusive sexual behaviors directed towards other residents. Findings include: 1.The Standards of Care policy included in the Care Plan for every resident of the facility states, "The resident's dignity will be maintained with every interaction with them and their rights will be protected." Resident #1's diagnoses include Non-Alzheimer's Dementia, Cognitive Deficits, and "Other Sexual Disorders". Resident #1 has experienced behavioral changes related to these conditions including an increase in sexual behaviors. Per record review, between 12/12/24 - 2/25/25 Resident #1 engaged in multiple incidents of physically aggressive and abusive sexual behaviors directed towards other residents including:	R213		

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R213	Continued From page 9 a. On 12/12/24 and 12/13/24 Resident #1 inappropriately touched other residents who are not specifically identified in Resident #1's Progress Notes. b. On 1/1/25 A Progress Note written by a Licensed Practical Nurse (LPN) indicates Resident #1 inappropriately touched Resident # 2's buttocks and side. An Incident Report regarding this incident was not provided for review on request for all facility Incidents on file during this time period. c. On 1/13/25 a resident who was not specifically identified in Resident #1's Progress Notes stated they have been inappropriately touched by Resident #1 and they do not want Resident #1 to sit at a table with them. The unidentified resident who made this report was moved to another table. There is no documentation indicating this incident was reported to the Nurse on duty, and an Incident Report regarding this incident was not provided on request for all facility Incidents on file during this time period. d. On 1/15/25 Resident #1 inappropriately touched other residents who were not specifically identified in Resident #1's Progress Notes. Resident #1's record does not include documentation indicating the Nurse on duty was notified of this incident, follow-up care interventions are not documented, and an Incident Report regarding this incident was not provided on request for all facility Incidents on file during this time period. e. On the afternoon of 1/18/24 Resident #1 placed their hands under Resident #3's shirt and inappropriately touched this resident's chest with	R213		

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R213	Continued From page 10 both hands while in the dining room. This incident is not documented in Resident #1's Progress Notes. Per Incident Reports provided for review, Resident #1 stated they were touching the other resident's chest and Resident #2 was unable to state what happened. During an interview on the afternoon of 3/5/25, Staff who responded to this incident stated Resident #2 did not appear to know what Resident #1 was doing. Per Incident Reports regarding this incident, the Nurse on duty was notified. There is no documentation of follow-up care provided for both residents after they were separated by Staff. An additional Incident Report documents a second resident to resident incident involving Resident #1 in the facility lobby at 9:00 PM on 1/18/25. While this Incident Report does not provide information about what occurred and who was involved, this report indicates Resident #1 "stated they wanted to touch other residents" and was "moved" from the area by the Staff who wrote this report. f. Per Staff interview on the afternoon of 3/5/25, Resident #1 reportedly inappropriately touched another resident on 1/19/25. An Incident Report dated 1/19/25 documents a resident-to-resident altercation which occurred in the facility lobby at 11:30 AM. While this Incident Report does not provide information about what occurred and who was involved, the report states two residents were separated and indicates the on-call nurse and Emergency Medical Services were notified. A Progress Note written by the Campus Executive on 1/19/25 indicates Resident #1 was transported to the emergency department due to increased sexual behaviors, and states Resident #1 was seeking out and touching both staff and residents of a specified gender "repeatedly daily". This Note describes Resident #1's behavior as "unwanted touching". Resident #1 remained at	R213		

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R213	Continued From page 11 the Emergency Department until the afternoon of 1/21/25. g. On 1/22/25, Resident #1's Progress Notes document an incident during which the resident hit Resident #4 on the "bottom" twice. An Incident Report regarding this incident was not provided on request for all Incident Reports filed during this time period. Resident #1's Progress Note related to this incident does not document interventions and follow up care after this incident. h. On 1/26/25 A Progress Note states staff observed Resident #1 inappropriately touching an unidentified resident's "butt". An Incident Report regarding this incident was not provided for review on request for all Incident Reports filed during this time period. There is no documentation indicating the Nurse of duty was notified regarding this incident. Per Progress Notes, approximately 6 hours after this incident occurred Resident #1 was observed engaging in an act of self-stimulation in the Theater Room and was not easily redirected by Staff. i. On 2/2/25 Resident #1's Progress notes document an incident during which the resident placed a hand up an unidentified resident's shirt. A Progress Note in Resident #1's record indicates Staff were notified this incident was occurring in the Theater Room. Staff reportedly responded by "removing" Resident #1 from the Theater and bringing this resident back to their room. An Incident Report documenting this incident was not provided for review on request for all Incident Reports filed during this time period, and there is no documentation of Staff notifying the Nurse on duty in Resident #1's Progress Notes. Per Progress Notes, Resident #1 has also	R213		

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R213	Continued From page 12 attempted to inappropriately touch other residents without successfully making physical contact with the targeted resident on multiple occasions including: a. On 1/22/25 a Home Care Provider observed Resident #1 attempting to inappropriately touch 2 other residents b. On 2/21/25 Resident #1 was observed making comments and trying to inappropriately touch other residents as they passed by. c. On 2/24/25 and 2/25/25 Resident #1 reportedly attempted to inappropriately touch other residents in the dining room On the afternoon of 3/6/25 the Campus Executive Director confirmed Resident #1 has engaged in multiple incidents of physically aggressive and abusive sexual behaviors directed towards other residents. 2.The facility's Care Plans policy states, "A Care plan is a systematic process for planning, reviewing and revising services to a resident, which details individualized services. Services are provided to meet the needs of the resident as identified in the service care plan." and states, "The care plan is individualized to identify tasks required for daily care needs." Per record review, Resident #1's Care Plan initiated on 1/21/25 lists interventions for an identified "Problem" of Sexual Behaviors including reporting sexual behaviors in a behavioral log, reporting sexual behaviors to the nurse on duty, and ensuring Resident #1 is not seated with residents of a specified gender during meals and activities.	R213		

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 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE RIDGE MEMORY CARE	6 FREEMAN WOODS ESSEX JUNCTION, VT 05452

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R213	Continued From page 13 Per record review, a behavior log is not maintained on file and utilized to document Resident #1's sexual behaviors. Per Surveyor observation of the facility dining rooms during breakfast and lunch service on 3/5/25 and 3/6/25, Staff positioned in dining areas during meals were also completing tasks including medication administration and serving meals, which impeded continuous monitoring for resident safety during the observed mealtimes. Per Progress Notes and Incident Reports, Resident #1 has a history of inappropriately touching and attempting to touch other residents in the dining room. On the afternoon of 3/6/25 the Campus Executive Director confirmed a behavioral log is not utilized to monitor sexual behaviors for Resident #1, and confirmed a staff member is required to be in present in the dining room during meal service at all times to monitor resident safety. Please refer to tag 206	R213		
R266 SS=G	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, staff interview, and record review there was a failure to ensure care in a safe environment related to the disrepair of a	R266		

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 03/06/2025

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R266	Continued From page 14 bathroom fixture in the apartment of one applicable resident causing injury (Resident #5). Findings include: The Standards of Care outlined in each resident's Care Plan states, "A safe home-like environment will be provided. The resident will be kept away from hazardous chemicals or building disrepair." Resident #5 has advanced memory impairment and cardiovascular conditions. Per Progress Notes, on the morning of 3/1/25 Resident #5 was found in their apartment covered with blood due to a deep right elbow laceration. The Staff who responded to this incident noted a trail of blood was found leading from the bathroom to the resident's bed. Resident #5 was transported via ambulance to the emergency department where the laceration required 8 sutures. On the morning of 3/1/25 a Registered Nurse noted the Emergency Responders identified "drawers missing with sharp edge" as a potential cause of the injury. Additionally, on the morning of 3/2/25 the Med Tech who responded to the incident documented an update on Resident #5's skin tear indicating Maintenance Staff removed screw drivers sticking out from the area under the resident's sink. This note does not indicate if the screwdrivers were accessible to the resident prior to the incident or were left accessible following actions taken by Staff after the incident. During an interview commencing at 10:35 AM on 3/6/25 Resident #5 did not recall the incident or the injury. Following this interview, the Resident's bathroom vanity and kitchen sink base cabinet were observed to be without the false drawers, leaving open areas in the cabinet facings. A nail head was observed to be protruding from the lower right corner in the open area of the	R266		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R266	Continued From page 15 bathroom vanity cabinet facing. During an interview commencing at 11:08 AM on the morning of 3/6/25, the Director of Maintenance confirmed Resident #5 has a history of taking off the false drawer facings on multiple occasions and stated on each occasion different methods of reattaching the facings have been utilized in an attempt to ensure the false drawers could not be removed again. The Director of Maintenance confirmed several residents have removed the false drawer facings from the cabinets in their apartments, and stated the incident with Resident #5 on 3/1/25 was the first time a resident has been injured due to removal the false drawer facings. During an interview commencing at 12:51 PM on 3/6/25, the Campus Executive Director confirmed the false drawer facings of cabinets installed in the home have been removed by residents on multiple occasions; and confirmed Resident #5 was injured after removing false drawer facings on 3/1/25. This deficiency is cited at a harm level due to Resident #5 requiring emergency medical care for the injury caused by metal left exposed after the resident removed false drawer facings.	R266		

Deficiency Statement Plan of Correction (POC)

Survey Date: March 5th & 6th, 2025

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
R178=SS=F Plan of Correction accepted by Jo A Evans RN on 3/31/25	Staffing policy was updated to state that minimum number of care staff including med tech on night shift will be 5 and based on census and acuity staff numbers would be between 5-7 for night shift. 2 contracted agency staff were started for night shift on 3/25/25 to ensure that 4 care staff and 1 med tech are scheduled at all times for the night shift. Meal service staffing has increased to add an additional staff member to meal service for all meals. Activities, housekeeping and kitchen staff have a rotating schedule for service.	3/25/25	Staffing policy was updated to reflect increase in staffing rations and additional staff assistance.	Executive Director/Manager
R206 SS=F Plan of Correction accepted by Jo A Evans RN on 3/31/25	Day Charge nurse during the time period of unreported resident incidents was terminated by facility on March 6th, 2025. Nursing staff including new day charge LPN, Resident Care Director and Director of Nursing were educated by Executive Director regarding resident-to-resident incidents and when to report to state. State sent RCD a clear guideline regarding when to report and to who. Resident who was involved with the sexual incidents currently has 24-hour 1x1.	3/25/25	Staff meeting scheduled for 4/3/25 related to education for all staff on resident-to-resident incidents. Tracking spreadsheet created for all state reportable incidents to be checked and updated by DON/RCD daily.	Director of Nursing and Resident Care Director Overseen by Executive Director/Manager
R213 SS=H Plan of Correction accepted by Jo A Evans RN on 3/31/25	Resident #1 has 24-hour private [redacted] care staff with [redacted] This care staff was educated on resident's behaviors and did additional training on Sexuality and intimacy for professional care partners and understanding human sexuality through their agency [redacted]	3/25/25	Staff meeting scheduled for 4/3/25 related to education on our aggressive resident policy to remind staff this includes behaviors sexual in nature and our abuse policy.	Director of Nursing and Resident Care Director Overseen by Executive Director/Manager

Pronouns and agency name removed by DLP 3-28-25

R266 SS=G Plan of Correction accepted by Jo A Evans RN on 3/31/25	Plant Operations Director addressed the issue with the false drawer cover. Mechanism was place on the backside of the false drawer to be fastened onto the cupboard. Maintenance and other staff tested the strength of the drawer and were unable to remove with full strength.	3/25/25	Maintenance to check daily for 30 days to ensure it is still securely fastened and then add to monthly checks.	Maintenance Director Overseen by Executive Director/Manager