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 follow-up 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 _____	R-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 follow-up to an investigation of one complaint and five facility reported incidents conducted on 1/13/25 and 1/17/25. The following regulatory violations were identified to not be back in compliance with the Vermont Residential Care Home Licensing Regulations effective 10/3/2000:	{R100}		
{R208} SS=E	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 staff interview and record review there was a failure to report one applicable resident's pattern of abuse to the licensing agency (Resident #1). Findings include: The facility's State Reporting Requirements policy and procedures state, "Incidents involving resident to resident altercations, even minor ones, must be reported to the licensing agency regardless of pattern". The facility's policies and procedures do not address mandatory reporting	{R208}		

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 _____	R-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
{R208}	Continued From page 1 when a resident demonstrates a pattern of abuse. Resident #1 has diagnoses including 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 review of Progress Notes, between 12/12/24 - 3/5/25 Resident #1 engaged in multiple documented incidents of physically aggressive and abusive sexual behaviors directed towards other residents and staff. Incidents documented in Resident #1's Progress Notes during this time include physically aggressive and abusive sexual behaviors directed towards other residents of the home on 12/12/24, 12/13/24, 1/1/25, 1/13/25, 1/15/25, 1/18/25, 1/19/25, 1/22/25, 1/26/25, 2/2/25, 2/21/25, 2/24/25, and 2/25/25. While the incident of abuse on 1/18/25 was reported to the licensing agency on 1/21/25, the facility failed to report Resident #1's pattern of abuse occurring prior to the incident on 1/18/25 and the resident's continued pattern of abuse following the incident occurring on 1/18/25. These findings were confirmed by the Campus Executive Director on the afternoon of 3/6/25.	{R208}		
{R224} SS=F	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.	{R224}		

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 _____	R-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
{R224}	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure multiple residents of the home are free of abuse by another resident (Resident #1). Findings include: The facility's Abuse and Neglect Policy effective June 2024 states, "It is the policy that residents of our communities have the right to be free of abuse ..." The facility's Managing Aggressive Residents policy and procedures revised December 2024 identifies the objective of this document as "To ensure that all residents are living in a safe environment, free of abuse, exploitation, neglect [sic]"; and states "In all cases: Documentation in the chart is necessary [sic]." 1. 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: 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. The Progress Notes on file for the incidents occurring on 12/12/24 and 12/13/24 indicate staff "brought" Resident #1 to the nurse station for supervision following these incidents.	{R224}		

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 _____	R-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
{R224}	Continued From page 3 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. The LPN stated, "This writer educate resident [sic] " and reported Resident #1 "agrees not to touch anyone without their permission". 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 for 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 for 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 both hands while in the dining room. This incident is not documented in Resident #1's Progress Notes. Per Incident Reports provided for review,	{R224}		

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 _____	R-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
{R224}	Continued From page 4 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, on 1/19/25 Resident #1 reportedly inappropriately touched another resident. 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 also does not provide information about what occurred and who was involved, the report states two residents were separated, and 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 was readmitted to the facility on the afternoon of 1/21/25. g. On 1/22/25, Resident #1's Progress Notes	{R224}		

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 _____	R-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
{R224}	Continued From page 5 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 Resident #1's Progress Notes document staff observing the resident 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. Progress Notes indicate that approximately 6 hours after this incident 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; and Staff 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. 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	{R224}		

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 _____	R-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
{R224}	Continued From page 6 residents. and confirmed documentation has been identified as an issue at the facility, 2. 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. 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 the dining area during meals were also completing tasks including medication administration and serving meals, which impeded continuous monitoring for resident safety during the observed mealtimes. 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 208	{R224}		

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
R208 SS=E 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. Policy updated to include mandatory reporting when a resident demonstrates a pattern of abuse.	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. Resident Rights to be addressed at this meeting to educate our residents having the right to be in their home and feel safe and free of abuse. Policy on resident sexual behavior presented to staff and educated on importance of notifying appropriate leadership.	Director of Nursing and Resident Care Director Overseen by Executive Director/Manager

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