VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
www.dlp.vermont.gov

[phone] 802-241-0344
[fax] 802-241-0343

AGENCY OF HUMAN SERVICES

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

May 22, 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 two revisit surveys conducted on **April 24, 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 04/24/2025

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 4/22/25 - 4/24/25 the Division of Licensing and Protection conducted an unannounced on-site follow-up survey to determine if the facility was back in regulatory compliance subsequent to a follow-up survey conducted on 3/6/25. The facility was determined to not be back in compliance. Findings include:	{R100}		
{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 observations, staff interviews and record review, there is a failure to provide care in a safe environment related to 1 applicable resident's access to unsecured sharp items, which resulted in harm to to the resident (Resident #5). Findings include: Per record review the facility's Securing Potential Hazardous Substances policy, effective March 2025, states that its purpose is to create and maintain a safe environment within resident apartments for storage of chemicals and hazardous items. The policy identifies disposable razors as hazardous. Per the facility Safety Check policy effective March 2025, staff are to remain alert, attentive and responsive to occurrences at all times and accountable to each other for the protection and safety of all residents.	{R266}	R266 Accepted on 5/15/25 Susan Gregoire RN	

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 04/24/2025

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
{R266}	Continued From page 1 Per staff interview on 4/23/25 at 9:12 AM, the Manager stated the facility conducts hourly safety checks, which require care providers to visually confirm each resident's status and document their initials to verify the check. The hourly safety check sheet is hung in a locked cabinet located in the resident's room. An hourly safety check sheet was confirmed to be hung in Resident #5's cabinet at 12:18 PM on 4/23/25. Per record review, Resident #5 has a primary diagnosis of Alzheimer's Disease. The Resident demonstrates impaired verbal expression, characterized by the use of individual words without the ability to form coherent or meaningful sentences. Resident #5 is ambulatory, walking upright within their bedroom and throughout the facility. Per record review of Resident #5's Care Plan, Resident #5 was admitted into hospice care on 2/13/25. Per progress notes dated 4/12/25 at 3:47 AM, Resident #5 awoke during the night and was found handling a shaving razor in the bathroom. Upon discovery, the Resident had multiple cuts on the left arm with visible blood observed on the Resident's clothing. The Resident required a change of clothing due to the presence of blood. Additional documentation from 4/12/25 identified the incident as a skin tear and noted that the resident sustained razor cuts and burns to the left arm. A Hospice Nurse note dated 4/16/25 states Resident #5 has a puncture wound to their left hand sustained from a razor found in their room as they were attempting to scrape off a bump on their arm, and further stated the razor pierced the skin on the left palm of their hand. During an interview at 10:57 AM on 4/23/25, a Med Tech stated when they arrived for the day	{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 _____	R-C 04/24/2025

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
{R266}	Continued From page 2	{R266}		

shift prior to 7:00 AM on 4/12/25 they received report that Resident #5 had cut themselves with a unsecured razor. After receiving this report, the Med Tech went to check on Resident #5. Upon entering the Resident's room, the Med Tech found the cabinet that housed the razors unlocked, with razors accessible inside. The Med Tech confirmed that the incident had occurred the previous night and that the cabinet remained unsecured with additional razors still accessible.

During an interview on 4/23/25 at 11:31 AM, Resident #5's Legal Representative reported that on arrival to the facility on 4/12/25 at 10:40 AM they discovered the cabinet in Resident #5's room was unlocked, with razors unsecured and accessible. They observed that Resident #5 had a gauze bandage wrapped around their left arm. When the Resident was assisted to a standing position, a fresh wound was noted on the left hand, and the Resident verbally conveyed they were experiencing pain. The Legal Representative then sought out a Care Provider and was informed that Resident #5 had accessed unsecured razors during the night shift and had sustained multiple self-inflicted injuries.

Per observation and staff interview conducted at 12:13 PM on 4/23/25, the Nurse knocked on the door to Resident #5's room and entered. Resident #5 was present in the room. The cabinet designated for securing hazardous items was ajar. The nurse confirmed that the cabinet was unlocked. A large toenail clipper was observed inside the cabinet, accessible to the resident. The nurse locked the cabinet and verified that the locking mechanism was functional and acknowledged that per facility policy, the cabinet should have been secured to restrict access to hazardous items. Following the observation, the

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 04/24/2025

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
{R266}	Continued From page 3 caregiver assigned to Resident #5 reported during interview that they "sometimes" lock the cabinet, indicating inconsistent adherence to the facility's policy on securing hazardous items. In summary, the facility failed to ensure care in a safe environment for Resident #5, as evidenced by the resident gaining access to an unsecured razor and sustaining multiple injuries. The facility failed to follow its own policies regarding the securing of hazardous items and did not ensure consistent communication or staff adherence to required safety protocols. These failures resulted in actual harm to Resident #5 and demonstrated a breakdown in the system intended to protect vulnerable residents from preventable injuries. .	{R266}		

Deficiency Statement Plan of Correction (POC)

Survey Date: April 24, 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
R266 SS=G R266 Accepted on 5/15/25 Susan Gregoire RN	Staff have been re-trained on all shifts to the importance of alerting on-call nurse of any resident injuries, incident reporting and family notifications. On Call nurses re-trained on when to call the RN and what to report. Ensuring that the resident was looked over completely to ensure that all injuries are noted and addressed properly for safe healing. MT's on all shifts were trained individually on when to call the nurse on call/RN. Staff have been re-trained on safety checks, cabinet locks, and items not to be left in a resident apartment.	5/15/25	Orientation has been updated to include when to call the on call for all staff, safety checks, cabinet checks, hazard items not to be left in resident apartments. Environmental rounds are done daily by various staff and managers to ensure that cabinets are secure and items are not left in residents' apartment that are on the hazardous item list in the Memory Care storage of chemical policy and to secure any item with potential to cause injury or harm regardless of inclusion on the list for safe storage. Notification made to ED/Plant Operations/designee of additional item that was secured. This policy has been added to orientation and all current staff re-trained.	RN, Plant Operations Director Oversight by ED

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 04/24/2025

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 4/22/25 - 4/24/25 the Division of Licensing and Protection conducted an unannounced on-site follow-up survey to determine if the facility was back in regulatory compliance subsequent to a follow-up survey conducted on 3/6/25, which was a follow-up to the survey conducted on 1/17/25. The facility was determined to not be back in compliance. Findings include:	{R100}		
{R224} SS=G	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 observation, staff interview, and record review there is a failure to ensure 6 applicable residents remained free of abuse by other residents of the home (Residents #2, #3, #4, #5.#7, #8) 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 ..." 1. On the afternoon or 4/22/25 Resident #2 was inappropriately touched by Resident #1. Findings include: Resident #1 and Resident #2 are vulnerable adults who reside in the Memory Care facility and present with signs and symptoms of cognitive	{R224}	R224 Accepted on 5/15/25 Susan Gregoire RN	

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 04/24/2025

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 1	{R224}		

decline. 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. Resident #1 requires 1:1 monitoring during waking hours; demonstrates lack of ability to manage sexual impulses; and has a history of multiple incidents of verbally and physically abusive behaviors of a sexual nature directed towards other residents and staff including multiple incidents of touching and attempting to touch others inappropriately.

Per record review, at approximately 2:00 PM on 4/22/25 Resident #1 was seated in the facility's Junction activity room with a 1:1 Private Duty Care Provider and the facility's Activity Staff present when Resident #2 entered the room and sat down in a chair within reach of Resident #1. Per review of video footage recorded in the Junction activity room on the afternoon of 4/22/25, Resident #1's 1:1 care provider and facility staff failed to respond by moving Resident #1 away from Resident #2 to provide adequate distance between the residents to prevent an incident of abuse. Resident #1 was observed reaching over and grabbing Resident #2's chest area. Per staff interview and record review, Resident #2 responded by standing up and repeatedly stating Resident #2 had grabbed their chest. During an interview on 4/23/25, Staff confirmed Resident #2 was observed to be upset following this incident. Due to cognitive decline, Resident #2 reportedly did not recall what happened 10-15 minutes later. The Staff stated, "Even in activities [Resident #1] needs to be away from other residents, this could have been prevented."

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 04/24/2025

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 The Campus Executive Director and Director of Health Services confirmed Resident #2 was physically abused by Resident #1 at approximately 2:00 PM on 4/22/25 following a review of the video recording of this incident conducted with Nurse Surveyors on the afternoon of 4/22/25. 2. On 4/19/25 Resident #3 was pushed to the ground by Resident #4. Findings include: Per record review, Residents #3 and #4 are vulnerable adults who reside in the Memory Care facility and present with signs and symptoms of cognitive decline. Resident #3's diagnoses include Dementia, Anxiety Disorder and Panic Disorder. Resident #4 was born with a genetic condition associated with intellectual and other developmental disabilities; and has diagnoses including Dementia and Memory Impairment. Per record review, at approximately 11:20 AM on 4/19/25 Resident #3 stood up from the couch in the facility's Towne living room where both residents were seated, approached and leaned in towards Resident #4; and Resident #4 responded by grabbing and pushing Resident #3. Facility Staff were alerted to this incident by a visitor as there were no Staff present in the living room when the incident occurred. A facility Incident Report indicates the visitor who reported the incident stated Resident #3 was aggressively invading the space of residents, got into Resident #4's way, and was pushed down by Resident #4. Per observation of a video footage recorded in the Towne living room recorded on the morning of 4/19/25, Resident #3 was observed wandering through the living room repeatedly as multiple	{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 04/24/2025

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 unattended residents including Resident #4 sat in the room. Resident #4 was observed watching the TV. After briefly sitting on the opposite end of the couch from Resident #4, Resident #3 got up and walked in front of Resident #4, impeding Resident #3's view of the TV screen. While observing the video recording of the incident with the Survey team on the afternoon of 4/22/24, the Campus Executive Director stated Resident #3 appeared to be leaning forward to hug Resident #4, and indicated this is not an unusual behavior for Resident #4. Resident #3 responded by pushing Resident #4 to the floor. Resident #4 landed on their side, maneuvered their body into a seated position in front of the TV, and Resident #3 left the room. Following review of the video recording of this incident on the afternoon of 4/22/24, the Campus Executive Director confirmed Resident #3 was physically abused by Resident #4 while unattended by Staff in the Towne living room on the morning of 4/19/25. 3. On the afternoon of Resident #6 physically struck Resident #5. Findings include: Per record review, Resident #5 is diagnosed with Alzheimer's Disease, History of Traumatic Brain Injury, and Cardiovascular conditions; and is on hospice. Resident #6's diagnoses include Alzheimer's Disease and multiple Mental Health Conditions with a history of episodes of psychosis, depression, anxiety, and mania. Both Residents are experiencing behavioral changes associated with cognitive decline. Per Incident Report review, at 3:50 PM on 4/17/25 Resident #5 placed their hands on the	{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 04/24/2025

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 shoulders of Resident #6, who then struck Resident #5. Per record review and interview with the Nurse who witnessed the incident Resident #6 stated, "you might disrespect others, but you will not disrespect me" to Resident #5 during the incident. Per observation of a video recording of this incident, Resident #6 was standing in the Nursing Office doorway with their back to the hallway as Resident #5 walked past a Staff, approached Resident #5 from behind, and placed their hands on Resident #6 shoulders. Resident #6 responded by turning around, raising their hand with a brief hesitation, then striking Resident #5 in the area near the top of their shoulder/crook of their neck. After observing the video recording of this incident with the Survey Team on the afternoon of 4/22/25, the Campus Executive Director confirmed Resident #5 did not appear to place their hands on Resident #6 in a physically aggressive or abusive manner; and confirmed Resident #6 responded by striking Resident #5 during the incident on the afternoon of 4/17/25. 4. On the morning of 3/28/25 Resident #7 was physically abusive during an incident with Resident #8 and Resident #9. Resident #7's diagnoses include Alzheimer's Disease, Restlessness and Agitation, and Unspecified Dementia with Behavioral Disturbance. Per review of Progress Notes, Resident #7 has a history of aggressive and abusive behaviors directed towards other residents including an incident during which they had their hands around Resident #4's neck on	{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 04/24/2025

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 2/24/25; "grabbing at other residents" on 3/5/25; and "pulling on the arms of multiple residents and attempting to grab their hands" on 4/20/25. Resident #7's Plan of Care identifies a "Problem" of "Alterations in behavior [related to] diagnosis of agitation and use of psychotropic medications" and includes "Resident will not displace signs and symptoms of agitation or physical aggression against residents and staff" as a "Goal". Resident #8's diagnoses include Alzheimer's Disease and Adjustment Disorder with Mixed Anxiety and Depressive Mood; and Resident #9's diagnoses include Alzheimer's Disease and an "Unspecified Mood [Affective] Disorder (sic)". All three residents are experiencing behavioral changes due to cognitive decline. Per observation of the video recording of the 3/28/25 incident involving Resident #7, #8, and #9 conducted with the Campus Executive Director on the afternoon of 4/22/25, multiple residents including Resident #9 were seated in the dining room when Residents #7 and #8 entered the room and approached the table where Resident #9 was seated. The 3 residents were observed to be engaged in discussion which appears to be a verbal altercation based on their gestures and movements. It is important to note the facility's recordings do not include sound and there were no Staff present in the area, therefore the content of their conversation is not known. Resident #9 stood up and walked towards Residents #7 and #8 who were at the other side of the table. Resident #7 and #9 were observed pushing their arms towards each other and making physical contact; and Resident #8 was observed sitting down in a chair at the table. After Resident #9 returned to their seat at the other side of the table, Resident #7 was observed engaging in	{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 04/24/2025

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 physically abusive behavior towards Resident #8 including grabbing and pulling Resident #7's chin in what appears to be an attempt to force Resident #7 to get up and leave the area with them. Approximately 4 minutes after this incident began facility Staff were observed entering the room to intervene. While observing of the video recording of the incident involving Residents #7, #8, and #9 with the Survey Team on the afternoon of 4/22/24, the Campus Executive Director confirmed the Residents involved were unattended by Staff when the incident occurred; and confirmed Resident #7's actions including grabbing and pulling at Resident #8's chin during this incident were physically abusive.	{R224}		

Deficiency Statement Plan of Correction (POC)

Survey Date: April 24, 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
R224 SS=G R224 Accepted on 5/15/25 Susan Gregoire RN	Resident #1 has a scheduled 1x1 24/7. The care staff are to intervene and assist if needed with behaviors. Resident is not to sit with women in dining room, activities or any common areas in the community. 1x1 staff are to report any incidents they had to intervene with resident to nursing staff. The 1x1 that was attending to resident on 4/22/25 was terminated from their assignment with resident. Staff have been trained regarding leaving a room full of residents unattended. When activity staff have completed an activity and are to start another activity, they should ensure that another staff member is in the room attending to the residents as indicated or necessary. Staff have been re-trained on abuse, resident to resident incidents and intrusive behaviors. Staff trained on what to look for in regard to intrusive behaviors- personal space and non-verbal cues from residents. Staff re-trained on monitoring the hallways, common areas, activity spaces regarding residents in groups together. Staff must not walk by residents, but stop and checking on residents that are not engaged at that moment.	5/16/25	Orientation training to include resident to resident incidents and intrusive behaviors. Cues from residents of being uncomfortable with another resident. Training regarding monitoring on the community while walking around. Ensuring all areas are checked for groups of residents. Staff doing environment rounds through-out the day to check all areas of the community to ensure safety of residents. Community will be hiring additional activity staff to encourage more engagement. Resident profiles/Intro visits to be reviewed with new staff to ensure they are educated in the specific resident preferences and any issues.	RN- DON Oversight by ED