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

November 20, 2025

Heather Reynolds, Manager
Maple Ridge Memory Care
6 Freeman Woods
Essex Junction, VT 05452

Dear Ms. Reynolds:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **October 21, 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

Division of Licensing and 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 10/21/2025

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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R100	Initial Comments On 10/21/25 the Division of Licensing and Protection conducted an unannounced on-site annual re-licensure survey and investigations of two facility reported incidents and two complaints. The following deficiencies were identified:	R100	All corrective actions accepted by Jo A Evans RN on 11/19/25. Please see the attached document to review the accepted corrective actions.	
R141 SS=G	5.5c General Care Each resident's medication, treatment, and dietary services must be consistent with the licensed health care provider's order, the written plan of care, and the resident's preferences. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that medications and treatment orders were implemented as prescribed and the adequate measures were taken to relieve pain and provide comfort for one applicable resident (Resident #3). Findings include: The home's Change of Orders Policy states to "implement change in medication and treatment orders in a timely and efficient manner according to established procedures." Per record review, Resident #3 was documented to have cognitive and physical impairments requiring assistance with all activities of daily living (ADLs). The Resident's care plan identified a goal for the resident to remain pain-free and content, with interventions requiring the administration of medication as prescribed. Per record review conducted on the morning of	R141		

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R141	Continued From page 1 October 21, 2025, documentation in the nursing progress notes indicated that Resident #3 exhibited agitation on July 5, 9, 10, 12,13, and 17, 2025, and displayed signs of pain on July 17, 2025. The record documented Resident #3 as "Grimacing/yelling in pain and holding stomach." Additionally, Resident #3 was recorded as "grimacing" and unable to communicate needs on July 18, 2025, at 7:25 AM. Per record review, documentation in the nursing progress notes dated July 18, 2025, indicated that the family requested initiation of hospice services. The physician provided an urgent referral to hospice that afternoon and issued orders for Morphine and Lorazepam to be sent to the pharmacy. Per nursing progress notes dated July 18, 2025, an additional order was received to discontinue all oral medications except Lexapro once the Morphine and Ativan had been delivered. Per record review of the Medication Administration Record (MAR) for Resident #3, no documented orders for Morphine or Lorazepam are included with Resident #3's Medication Passing Detail. The MAR does indicate that Trazodone Tab 50 MG and APAP 500 MG caplets were documented as, "not given pending new orders." Per interview with the Nurse conducted on the afternoon of October 21st, 2025, the Nurse stated that in the early evening of July 18, 2025, Resident #3 showed evidence of decline in condition. The nurse reported that they "advocated" to get help for the resident to assist with their declining condition, but did not follow through to ensure that the prescribed medications were obtained to address the resident symptoms	R141		

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R141	Continued From page 2 and provide comfort as ordered. Per record review of correspondence from the Office of Patient and Family Advocacy regarding the Morphine and Lorazepam orders for Resident #3 dated July 18, 2025, documentation indicated that all the medications were ordered in a timely manner. The order further stated that, had the physician's office "been notified earlier that the prescription hadn't gone through, the on-call provider would have appropriately addressed the issue" with the home. Per record review of nursing progress notes, indicated that the medications were not obtained and the home did not contact the on-call provider to report the delay in receiving the ordered medications. Per record review of nursing progress notes, a note dated July 19, 2025, at 4:14 AM, indicated that at the beginning of the night shift, the Nurse informed the writer that the resident was experiencing "breathing problems." Subsequent documentation reflects that the resident was initially agitated but "calmed down" after being placed in bed. Later when given water, Resident #3 was agitated and "bit and chewed" the green foam covering a water cup. Per record review of nursing progress notes written on July 19th, 2025, at 2:04 PM identified as a late entry for 7:30 AM, the Nurse documented that they arrived to evaluate Resident #3 for increased discomfort and an overall decline in health status. The Nurse's documentation stated that no new orders had been entered for Resident #3, identifying that there was no Morphine or Lorazepam to give Resident #3.	R141		

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R141	Continued From page 3 Per record review, documented nursing progress notes dated, July 19, 2025, at 2:15 PM, indicated that Resident #3 was uncomfortable and restless during the shift, observed putting their legs over the side of their bed, groaning and grimacing. Resident #3 was documented as appearing agitated and combative, yelling, "I'm going to break your leg" and squeezing staff arms and hands. The note further indicated that hospice staff visited the home that afternoon to evaluate the Resident and determined that they should be transferred to the hospital via emergency services. Progress notes confirm that as of 2:28 PM on July 19, 2025, Resident #3 had not received the prescribed Morphine or Lorazepam and was transported to the hospital by ambulance. Per staff interview with the home's Executive Director, conducted on the afternoon of October 21, 2025, it was confirmed that the physician's orders for Resident #3 for Morphine and Lorazepam received on July 18th, 2025, were not implemented, and that no contact was made with the on-call provider to address the unavailability of the prescribed medications. The Executive Director acknowledged that this occurrence should not have happened. The home failed to follow its established policies to ensure that Resident #3 received prescribed medications as ordered, resulting in the resident experiencing unnecessary pain and distress.	R141		
R159 SS=D	5.9.c (2) Nursing Services For each resident requiring a nursing overview, administration of medication, or nursing care, the registered nurse must:	R159		

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R159	Continued From page 4 Develop a person-centered written plan of care within 14 days after admission, in accordance with the nursing process and professional standards of practice, for each resident that is based on abilities and needs as identified in the resident assessment. The resident, and if the resident chooses, resident representatives such as family or close supports, must be invited and allowed to participate in care planning meetings. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being, and must be revised as the resident?s abilities and needs change This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to develop a care plan which describes the care and service needs to assist in maintaining one applicable resident's well-being (Resident #1). Findings include: The facility's Care Plan policy effective 7/2022 and revised 3/2025 is consistent with this licensing rule. The Care Plan on file for Resident #1 includes a list of Standards of Care that identifies the resident and what the resident needs from staff to meet their individual needs as the most important aspect of a Care Plan. Per interview commencing at 11:38 AM on 10/21/25, the Resident Care Director reported Resident #1 has difficulty engaging in verbal communication, is resistant to care, and has a history of physically aggressive behaviors in	R159		

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R159	Continued From page 5 response to attempts to provide care. Resident #1's Progress Notes identify additional issues including urinary and bowel incontinence, constipation, and recent history of a seizure noted on 5/29/25. Per record review, the Care Plan on file for Resident #1 does not identify goals and interventions to address this Resident's needs related to resistance to care, difficulty with verbal communication, incontinence, constipation, and risk for seizure. On the afternoon of 10/21/25 the Resident Care Director confirmed Resident #1's Care Plan does not address identified needs.	R159		
R194 SS=F	5.10.d (3) Medication Management The registered nurse must accept responsibility for the proper administration of medications, and is responsible for: i. Teaching designated staff proper techniques for medication administration and providing appropriate information about the resident's condition, relevant medications, and potential side effects; ii. Establishing a process for routine communication with designated staff about the resident's condition and the effect of medications, as well as changes in medications; iii. Assessing the resident's condition and the need for any changes in medications; and iv. Monitoring and evaluating the designated staff performance in carrying out the nurse's instructions regarding medication administration and documentation. v. Ensuring that all applicable staff are trained and delegated before the staff are permitted to administer any newly prescribed medication to any resident.	R194		

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R194	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the Registered Nurse responsible for nursing oversight including teaching designated staff proper medication administration techniques failed ensure all applicable staff are trained and delegated before the designated staff prepares and administers any medication to residents of the home. Findings include: The home's Delegation of Nursing Skills policy effective May 2025 states "The Community will ensure that appropriate procedures are followed for the delegation of nursing tasks in accordance with licensing regulations and the Vermont State Board of Nursing regulations." On the morning of 10/21/25 a Med Tech was observed providing training and supervision to a Staff member who was practicing medication preparation and administration as part of their medication delegation process. At approximately 1:40 PM on 10/21/25 the Campus Director of Nursing described the home's medication administration training process and confirmed Med Tech trainees routinely perform the nursing task of preparing and administering medications under the supervision of a staff member other than a Registered Nurse. During the interview on the afternoon of 10/21/25, the Campus Director of Nursing confirmed this occurs prior to a Registered Nurse determining the Med Tech trainee's medication administration practices are safe and effective, and delegating the Med Tech trainee to administer specific medications to specific residents of the home.	R194		

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R202	Continued From page 7	R202		
R202 SS=D	5.10.g Medication Management Homes must establish procedures for documentation sufficient to indicate to the licensed health care provider, registered nurse, manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this must include: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the home; (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a registered nurse has delegated administration; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects. (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there was a failure to administer medications as ordered for one applicable resident (Resident #2). Findings include: Per record review, the following medications were not administered to Resident #2 as ordered: 1. During an interview commencing at 5:34 PM on 10/21/25, the Resident Care Director confirmed an incorrect order for lorazepam 0.5	R202		

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R202	Continued From page 8 mg scheduled to be administered every 4 hours was entered into the Resident's July 2025 Medication Administration Record (MAR). Per the Resident Care Director, Resident #2 was admitted to the home on 7/28/25, and the incorrect order for scheduled lorazepam was not discovered until 7/29/25. Per the Resident Care Director's confirmation and review of Resident #2's July 2025 MAR, Resident #2 received 6 scheduled doses of Lorazepam between 8:00 PM on 7/28/25 and 4:00 PM on 7/29/25 which were administered per the order entered in error. 2. On the evening of 7/28/25 five medications prescribed for Resident #2 were not given as ordered including Genteal Tear Eye Drops, Doxazosin, Melatonin, Atorvastatin, and Quetiapine. These medication were documented as "Med not available - Backorder". Resident was admitted to the home on the date these errors occurred, indicating these medications were not obtained in a timely manner in preparation for the Resident's admission. During the interview commencing at 5:34 PM on 10/21/25 the Resident Care Director confirmed Resident #2's medications were not administered as ordered.	R202		
R208 SS=F	5.11.a Staff Services There must be a sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to ensure prompt, appropriate action in cases of injury, illness, fire or other emergencies.	R208		

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R208	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, there is a failure to ensure the home's dining rooms are sufficiently staffed during meal times to ensure prompt appropriate action to emergencies and maintain a safe healthy environment. Findings include: The home's Memory Care Dining Room Supervision policy effective April 2025 indicates one Dining Room Supervisor will provide dining room oversight for 1 hour during scheduled meal times. The staff performing this role will have no responsibilities other than observing resident behavior and general mealtime activity to ensure residents are accounted for at meal time and to ensure safety in the dining room during meals. Per this policy, if 3 or more residents remain in the dining room beyond the one-hour supervision period the Dining Room Supervisor should pass this responsibility to another staff member. Per observation, during lunch service on 10/21/25 a designated Staff member was not present in both dining rooms of the home to provide supervision and monitoring for all residents, ensure prompt response to issues or incidents, and maintain a safe and healthy environment according to facility policies and procedures. At 12:25 on 10/21/25 the Campus Director of Nursing confirmed a designated Staff member assigned the task of monitoring all residents for safety during meal service was observed to not be on duty in both of the home's dining rooms.	R208		
R210 SS=F	5.11.c Staff Services The home must provide, or arrange for the	R210		

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R210	Continued From page 10 provision of, at least twelve (12) hours of training upon hire and each year to each staff person providing direct care to residents. The manager may give credit towards the required 12 hours of training upon hire, for any formal training received in the twelve months preceding the date of hire, provided the home maintains documentation of the training and ensures competency in the subject matter. The training must include, but is not limited to, the following: (1)Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; (7) General supervision and care of residents; (8)Communication strategies, person-centered care, challenging behaviors and understanding dementia; (9) Recognition of and sensitivity to different cultures, belief systems, abilities, gender identities, sexual orientation; and (10) Trauma-informed care. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure completion of the required trainings for 10 out of 10 sampled staff. Findings	R210		

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R210	Continued From page 11 include: The home's Staffing Training/Backgrounds policy effective April 2025 is consistent with the current licensing rules. During the survey conducted on 10/21/25 the Executive Director was requested to provide documentation of trainings completed for a sample of 10 staff. Per the documentation provided by for review, all sampled staff did not complete the required trainings. This finding was confirmed by the Business Office Manager at 5:20 PM on 10/21/25.	R210		
R225 SS=F	5.12. b (4) Records/Reports The home must keep and maintain the following records: The results of the criminal record and adult abuse registry checks for all staff: This REQUIREMENT is not met as evidenced by: Based on staff interview and record review there is a failure to ensure all required criminal record and abuse registry checks were completed as required for 4 out of 10 sampled staff. Findings include: The home's "Staffing Training/backgrounds [sic]"policy effective April 2025 includes procedures for completing criminal record and abuse registry checks prior to hire and annual which are consistent with the licensing rules. During the survey conducted on 10/21/25 the Executive Director was requested to provide	R225		

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R225	Continued From page 12 documentation of criminal record and abuse registry checks completed for a sample of 10 staff. Per the documentation provided by for review, background checks were not complete as required for 4 out of 10 sampled staff. This finding was confirmed by the Business Office Manager at 5:20 PM on 10/21/25.	R225		
R341 SS=D	5.14.e Restraints and Seclusion Residents have a right to be free from chemical restraints and unnecessary mechanical restraints. The use of chemical restraints is not permitted. Any time a mechanical or physical restraint is applied, or a drug is prescribed that could be used as a restraint, the resident, at the time the restraint is applied, must be notified of their right to challenge the use of the restraint. A resident has the right to meet with and discuss the challenge with the following individuals: (1) The home manager; (2) The licensing agency; (3) The Commissioner of the licensing agency; (4) The Office of the Long-Term Care Ombudsman. In the event that a resident does challenge the use of a restraint, the home operator must inform the licensing agency at the time the challenge is raised. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, there is a failure to ensure one applicable resident (Resident #1) remained free of physical restraint by staff. Findings include: The home's policies and procedures are	R341		

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R341	Continued From page 13 consistent with this licensing requirement. Per record review, Resident #1 has a history of a Traumatic Brain Injury and diagnoses including Early Onset Dementia with Behavioral Disturbances including aggressive behaviors. Per interview commencing at 11:38 AM on 10/21/25, the Residential Care Director reported Resident #1 has difficulty engaging in verbal communication, is resistant to care, and has a history of physically aggressive behaviors in response to attempts to provide care. Per review of a facility reported incident submitted to the licensing agency on 6/30/25 by the Executive Director, on the evening of 6/28/25 a Care Provider employed at the facility was observed yelling at Resident #1, grabbing them and pinning their arms up against the wall while attempting to escort the Resident to the shower. During an interview commencing at 9:48 AM on 10/21/25, the Executive Director stated video surveillance footage of this incident was no longer available and confirmed they had personally reviewed the video surveillance footage of this incident. The Executive Director described the incident, stating Resident #1 was pulling away and swatting at the Care Provider, which the Executive Director confirmed to be a physical response that evidenced Resident #1's refusal of care. Per the Executive Director, other staff on duty heard the Care Provider yelling at Resident #1 and attempted to direct them away from the Resident; however, the Care Provider re-approached Resident #1 and continued to engage in forceful actions including physically blocking the Resident #1 with their body. The Executive Director confirmed the Care Provider blocking the Resident to restrict their movement was a physical restraint of Resident #1.	R341		

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 10/21/2025

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R341	Continued From page 14 Per the Executive Director, two staff witnessed this incident on 6/28/25 and provided written statements. Per one Staff's written statement, at approximately 5:20 PM on 6/28/25 they heard Resident #1 repeatedly saying "no". then observed the Care Provider pulling at Resident #1, pushing the Resident against the wall, and telling the Resident they "had to get ready". Per the second written statement, a second Staff then observed the Care Provider yelling, grabbing Resident #1, and pulling the Resident down the hallway to their room as the Resident yelled. The second Staff stated they approached Resident #1's room and observed the Care Provider standing in the doorway with the Resident swinging their hands towards them. Per review of the "Summary of Investigation of abuse" for the incident that occurred on 6/28/25, the Care Provider was witnessed yelling at Resident #1, pulling on the Resident's arms, and "restraining [the Resident] with their body in an effort to get [the Resident] into the shower." The summary states Resident #1 clearly did not want to take a shower and communicated their needs through body language and short phrases such as no. Per this summary, it was determined the Care Provider used their body to restrain Resident #1 and did not honor Resident #1's rights, among other findings. Per interview with the Executive Director commencing at 9:48 AM on 10/21/25, the applicable Care Provider's employment was terminated following the facility's internal investigation of the incident that occurred on 6/28/25. During the interview on the morning 10/21/25, the Executive Director confirmed Resident #1 was physically restrained by the Care Provider during	R341		

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R341	Continued From page 15 the incident on 6/28/25. Please refer to tags 360 and 363	R341		
R358 SS=F	6.10 Resident's Rights The resident's right to privacy extends to all records and personal information. Personal information about a resident must not be discussed with anyone not directly involved in the resident's care. Release of any record, excerpts from or information contained in such records are subject to the resident's written approval, except as requested by representatives of the licensing agency to carry out its responsibilities or as otherwise provided by law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure resident's right to privacy related to records, including private health information. Findings include: Per the home's Resident Rights Policy, included in the home's Residency Agreement, residents' right to privacy extends to all records and personal information. Per observation during the facility tour on the morning of October 21, 2025, the Controlled Substance Documentation Book was found unsecured and unattended on top of the medication cart in a first- floor common hallway. This book contained individually labeled pages identifying residents who were prescribed controlled substances, including each resident's	R358		

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R358	Continued From page 16 name, the specific medication, dosage, scheduled administration times and staff signatures verifying administration. Additionally, the medication cart computer was observed open, displaying protected health information, including a resident's name, morning medications and their medical diagnoses. In both instances, private health information was accessible to residents, visitors and unauthorized personnel, constituting a failure to safeguard protected health information in violation of State Rules. Per interview conducted on the morning of October 21, 2025, the Manager confirmed these findings.	R358		
R360 SS=D	6.12 Resident's Rights Residents must be free from mental, verbal or physical abuse, neglect, and exploitation. Residents must also be free from restraints and seclusion as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, there is a failure to ensure one applicable resident (Resident #1) remained free of abuse by staff. Findings include: The home's policies and procedures are consistent with this licensing rule. Per record review, Resident #1 has a history of a Traumatic Brain Injury and diagnoses including Early Onset Dementia with Behavioral	R360		

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R360	Continued From page 17 Disturbances including aggressive behaviors. Per interview commencing at 11:38 AM on 10/21/25, the Residential Care Director reported Resident #1 has difficulty engaging in verbal communication, is resistant to care, and has a history of physically aggressive behaviors in response to attempts to provide care. Per review of a facility reported incident submitted to the licensing agency on 6/30/25 by the Executive Director, on the evening of 6/28/25 a Care Provider employed at the facility was observed yelling at Resident #1, grabbing them and pinning their arms up against the wall while attempting to escort the Resident to the shower. During an interview commencing at 9:48 AM on 10/21/25, the Executive Director stated video surveillance footage of this incident was no longer available and confirmed they had personally reviewed the video surveillance footage of this incident. The Executive Director described the incident, stating Resident #1 was pulling away and swatting at the Care Provider, which the Executive Director confirmed to be a physical response that evidenced Resident #1's refusal of care. Per the Executive Director, other staff on duty heard the Care Provider yelling at Resident #1 and attempted to direct them away from the Resident; however, the Care Provider re-approached Resident #1 and continued to engage in forceful actions including physically blocking the Resident #1 with their body. The Executive Director confirmed the Care Provider blocking the Resident to restrict their movement was a physical restraint of Resident #1. Per the Executive Director, two staff witnessed this incident on 6/28/25 and provided written statements. Per one Staff's written statement, at approximately 5:20 PM on 6/28/25 they heard	R360		

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R360	Continued From page 18 Resident #1 repeatedly saying "no". then observed the Care Provider pulling at Resident #, pushing the Resident against the wall, and telling the Resident they "had to get ready". Per this written statement, the Care Provider continued to grab and pull Resident #1 until the Resident repeatedly struck them. Per the second Staff's written statement, at approximately 5:20 PM on 6/28/25 they received report from the first Staff that they witnessed the Care Provider grabbing Resident #1's arm and wrist, and pushing Resident #1 against the dining room wall. The second staff stated after receiving this report they observed the Care Provider yelling, grabbing Resident #1, and pulling the Resident down the hallway to their room as the Resident yelled. The second Staff stated they approached Resident #1's room and observed the Care Provider standing in the doorway as the Resident was swinging their hands towards them. Per review of the "Summary of Investigation of abuse " for the incident that occurred on 6/28/25, the Care Provider was witnessed yelling at Resident #1, pulling on the Resident's arms, and "restraining [the Resident] with their body in an effort to get [the Resident] into the shower." Per this summary, after the other staff on duty intervened, the Care Provider continued to "aggravate the situation" by going to Resident #1's room. The summary states Resident #1 clearly did not want to take a shower and communicated their needs through body language and short phrases such as no. Per this summary, it was determined the Care Provider was being rough with Resident #1, using their body as restraint, and did not honor Resident #1's rights, among other findings. Per interview with the Executive Director commencing at 9:48 AM	R360		

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R360	Continued From page 19 on 10/21/25, the applicable Care Provider's employment was terminated following the facility's internal investigation of the incident that occurred on 6/28/25. During the interview on the morning 10/21/25, the Executive Director confirmed Resident #1 experienced abuse by the Care Provider during the incident on 6/28/25. Please refer to tags 341 and 363	R360		
R363 SS=D	6.15 Resident's Rights Residents have the right to refuse care to the extent allowed by law. This includes the right to discharge themself from the home. The home must fully inform the resident of the consequences of refusing care. If the resident makes a fully informed decision to refuse care, the home must respect that decision and is absolved of further responsibility. If the refusal of care will result in a resident's needs increasing beyond what the home is licensed to provide, or will result in the home being in violation of these rules, the home may issue the resident a thirty (30) day notice of discharge in accordance with section 5.3.a of these rules. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, there is a failure to ensure one applicable resident's right to refuse care (Resident #1). Findings include: The home's policies and procedures are consistent with this licensing rule.	R363		

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R363	Continued From page 20 Per record review, Resident #1 has a history of a Traumatic Brain Injury and diagnoses including Early Onset Dementia with Behavioral Disturbances including aggressive behaviors. Per interview commencing at 11:38 AM on 10/21/25, the Residential Care Director reported Resident #1 has difficulty engaging in verbal communication, is resistant to care, and has a history of physically aggressive behaviors in response to attempts to provide care. Per review of a facility reported incident submitted to the licensing agency on 6/30/25 by the Executive Director, on the evening of 6/28/25 a Care Provider employed at the facility was observed yelling at Resident #1, grabbing them and pinning their arms up against the wall while attempting to escort the Resident to the shower. During an interview commencing at 9:48 AM on 10/21/25, the Executive Director stated video surveillance footage of this incident was no longer available and confirmed they had personally reviewed the video surveillance footage of this incident. The Executive Director described the incident, stating Resident #1 was pulling away and swatting at the Care Provider, which the Executive Director confirmed to be a physical response that evidenced Resident #1's refusal of care. Per the Executive Director, two staff witnessed this incident on 6/28/25 and provided written statements. Per one written statement, at approximately 5:20 PM on 6/28/25 a Staff member heard Resident #1 repeatedly saying "no". then observed the Care Provider pulling at Resident #1, pushing the Resident against the wall, and telling the Resident they "had to get ready". Per the second written statement, another	R363		

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R363	Continued From page 21 Staff member then observed the Care Provider yelling, grabbing Resident #1, and pulling the Resident down the hallway to their room as the Resident yelled. Per review of the "Summary of Investigation of abuse [sic]" for the incident that occurred on 6/28/25, the Care Provider was witnessed yelling at Resident #1, pulling on the Resident's arms, and "restraining [the Resident] with their body in an effort to get [the Resident] into the shower." This summary states Resident #1 clearly did not want to take a shower and communicated their needs through body language and short phrases such as no. Per this summary the Care Provider did not honor Resident #1's rights. Per interview with the Executive Director commencing at 9:48 AM on 10/21/25, the applicable Care Provider's employment was terminated following the facility's internal investigation of the incident that occurred on 6/28/25. During an interview conducted on the morning 10/21/25 the Executive Director confirmed the failure to ensure Resident #1's right to refuse care in assistance in receiving a shower during the incident that occurred on 6/28/25. Please refer to tags 341 and 360	R363		
R381 SS=F	7.2.a Food Safety and Sanitation Each home must procure food from sources that comply with all laws relating to food and food labeling. The home must ensure that all food is safe for human consumption, free of spoilage, filth or other contamination. All milk products served and used in food preparation must be pasteurized. Cans with	R381		

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R381	Continued From page 22 dents, swelling or leaks must be rejected and kept separate until returned to the supplier. This STANDARD is not met as evidenced by: Based on observation and staff interview, the home failed to ensure expired food was removed from storage, perishable items were properly labeled and maintained at appropriate temperatures, and dented cans were removed from food storage areas. Findings include: The home's Standard Kitchen Policy states that all food should be labeled with the date when opened and once food is opened it needs to be dated and labeled when to be discarded. The home's Temperatures Policy states that all food and beverages will be stored in a manner to prevent cross contamination and food borne illness due to improper food storage. It goes on to say that Serve Safe Guidelines of the National Restaurant Association and practices will be followed. During a tour of the home's kitchen and food storage areas, commencing on the morning of October 21, 2025, two six-pound cans of expired Chili Con Carne, four dented cans of Pink Salmon and two dented cans of Bush's Baked Beans were observed in the dry storage area and available for use in food preparation. At 9:22 AM, multi packs of condensed chicken noodle soup labeled, "Store in a Cool, Dry Place", were observed stored in an area where the temperature measured 83 degrees Fahrenheit. In addition, the walk-in refrigerator contained a tray of desserts that was observed not covered, a container of pasta was observed without a label identifying its contents or date of preparation, expired Mexican Chicken was observed and	R381		

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R381	Continued From page 23 opened bags of spinach were observed unlabeled. These findings were confirmed by the Manager on the morning of October 21, 2025.	R381		

Deficiency Statement Plan of Correction (POC)

Survey Date:10/21/2025

Facility Name: Maple Ridge Memory Care

Deficiency Tag	How the deficiency was corrected	How other potential residents identified, and corrective action taken	Date corrected	System changes to ensure compliance of the regulation	Who will monitor to ensure compliance
R141-General care; med management Accepted by Jo A Evans RN 11/19/25	An investigation into the incident was conducted immediately. There were several factors to this case; a meeting with Health Direct was conducted as they enter our meds into the system; conversations with the medical office were conducted to talk about the type of scripts being sent to the pharmacy and training was conducted with charge nurses and med techs. Measures were promptly put into place such as a Comfort care med box added to the med cart.	A medication review was completed to identify any other residents.	08/04/2025	We contacted Health Direct; education was conducted with health direct and our facility concerning entering our orders into the system timely. We don't enter our own orders. We have also conducted conversations with our physicians' offices concerning script types that go to Health Direct to prevent confusion and mis-communication. The facility nursing staff is monitoring all new orders that come in to ensure that the meds are entered into the system and filled by the pharmacy timely. This has been resolved.	DON/RCD
R159-Nursing Services; person-centered care plan Accepted by Jo A Evans RN 11/19/25	For resident #1: The resident care plan was reviewed and updated to reflect the goals and needs related to [redacted] resistance to care.	A care plan review was completed to identify any other residents that don't contain person-centered goals and interventions.	Will be completed by 11/14/2025	All care plans will be entered with person centered care going forward. An initial care plan will be entered within 24 hours after admitting; person centered by day 14. Updated on 30 day and annually. Care plans will also be	DON/RCD

Pronoun redacted by DLP 11-18-2025

Reynolds ED 11/18/25

				updated with any sig change.	
R194-Med Delegation Accepted by Jo A Evans RN 11/19/25	RN has performed delegation for all full time and regular part time med techs right after the survey.		10/24/2025	A new process has been identified. The new med techs will shadow experienced med techs for a period of two weeks; one week each unit. The RN will complete a med pass with the new med tech to determine competency and delegate. More training will be provided if the med tech is not found competent.	DON
R202-Medication Management Accepted by Jo A Evans RN 11/19/25	The hospice agency sent over a med list that contained meds that were not active, showing active medications. The RCD questioned this number of medications. The charge nurse was directed to review the meds with hospice. The meds were not reviewed as directed and were faxed to pharmacy as active meds. A review was conducted with the hospice agency, and the unnecessary meds were removed. The charge nurse is no longer with us.	Residents on Hospice; meds were reviewed. A meeting was conducted with Hospice to come up with a process to ensure that meds being sent from the provider are correct.	07/29/2025	All meds sent from the hospice agency or providers office are reconciled with the hospice nurse for accuracy prior to being sent to the pharmacy. This is reviewed with the RCD.	RCD/DON

R208-Staff Services, Dining room Accepted by Jo A Evans RN 11/19/25	All Staff are being in-serviced to be in the dining room while residents are present. The charge nurses will ensure that the med techs are monitoring the dining room for each meal.		10/22/2025	The med techs will complete the "I am ok" program forms and turn them into the charge nurse for Review Daily	The RCD.
R210-Staff Services; Training Accepted by Jo A Evans RN 1/27/24	All staff records have been audited. The ED is conducting a 2-day mandatory in-service fair to ensure that all mandatory training for the year is complete		In-service scheduled for Nov 19-20	As part of QAPI/PI, a staff performance improvement program has been created to outline the 2-day orientation process; each department will also conduct department specific training. A full schedule of the next years' mandatory in-services has been presented as part of QAPI. These are conducted at the Town Hall. All in-services are recorded and filed in the QAPI/PI manual. Additionally, all agency staff receive orientation of our expectations. This check-off list will be in QAPI/PI as well. .	ED/Human Resources
R225-Records/Report Accepted by Jo A Evans RN 11/19/25	All agency staff backgrounds checks will be requested and filed in a binder. All staff background checks are in their files prior to October.1. All employees from OCT. 1 forward can also be		10/22/2025	Human resources will monitor and evaluate the background check binder for both agencies and staff.	Human Resource/ED

	accessed from the on-line portal				
R341-Restraints & Seclusion Accepted by Jo A Evans RN 11/19/25	The staff member involved was suspended and terminated. All staff were given additional training on resident rights and restraints.	Additional training on abuse and resident rights was conducted.	06/30/2025	Education on abuse and resident rights are performed upon hire, through annual mandatory training and anytime a director sees the need for additional training.	ED
R358-Resident Rights: PHI Accepted by Jo A Evans RN 11/19/25	In-service training on PHI; computer privacy screens have also been purchased.		10/22/2025	The nurses are to round daily to ensure that all med techs have their carts locked, PHI secured.	RCD
R360: Resident Rights: Accepted by Jo A Evans RN 11/19/25	This staff member was suspended, terminated, and reported. Additional abuse training was conducted right away.	Resident rights and abuse training was conducted with all staff.	06/30/2025	On-going education on resident's rights will continue to be conducted and filed in the QAPI/PI binder as part of new hire, annual mandatory training, and if a director sees the need.	Human Resources/ED
R363: Resident Rights; Refusing Care Accepted by Jo A Evans RN 11/19/25	This staff member was suspended, terminated, and reported. Training for all staff on abuse and resident rights was conducted.	Abuse training and resident rights was conducted for all staff.	06/30/2025	On-going training is being provided on resident rights and abuse. Staff are educated on what to look for and who to report to with any suspicions. All training is filed in the QAPI/PI binder. Training is provided upon hire, as part of annual mandatory training, and as a director sees the need.	Human Resources/ED
R381: Food Safety & Sanitation Accepted by Jo A Evans RN 11/19/25	The expired items and dented cans have been addressed. In-service for kitchen staff is conducted. The heat is due to a vent from the walk-in freezer.	An audit of the kitchen was conducted and all expired food and dented cans were removed.	10/22/2025	Audits will be conducted 3 times a week to ensure that there are no expired food, unlabeled food, or dented cans. The current cans are being moved to a temporary	ED/Plant Ops/Dining Director

	Maintenance is looking into ways to have this vented out of the building			location to ensure temperature control. The building is looking to install a heat pump system	