VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
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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 20, 2026

Lesleigh Costello, Manager
Maple Ridge Memory Care
6 Freeman Woods
Essex Junction, VT 05452

Dear Ms. Costello:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 28, 2026.** 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 04/28/2026

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

R142 Accepted May 20, 2026
Susan Canas Gregoire RN

(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 4/28/2026, the Division of Licensing and Protectrion conducted an unannounced on-site investigation of 2 facility reported incidents and 2 complaints. The following deficiencies were identified:	R100		
R142 SS=D	5.5.d General Care A home must provide each resident with adequate supervision and must facilitate obtaining assistive devices sufficient to prevent accidents, and/or to mitigate risk of injury due to accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, there was a failure to ensure adequate supervision to prevent accidents and/or to mitigate risk of injury for one applicable resident (Resident #1). Findings include: The facility's policies and procedures regarding falls and supervision of residents are consistent with the licensing rules. Per care plan review on the morning of 4/28/2026, Resident #1 is identified as a high fall risk, effective 11/25/2025. Resident #1 has been assessed as having an unsteady gait and intermittently requiring physical assistance to mobilize. Resident #1 was known to walk with their head hanging down at baseline. Additionally, Resident #1 was noted to have a total of 9 falls between 3/11/2026 and 4/19/2026. Per staff interview, conducted the morning of 4/28/2026, staff reported that Resident #1 was	R142		

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R142	Continued From page 1 observed to have a laceration approximately 1-1.5 inches in length to the back right side of their head, on 3/24/2026, with unknown etiology. This staff member then decided to look back at the facility's video footage to determine if Resident #1 had fallen earlier in the day. Per review of the video footage, staff was able to determine that Resident #1 sustained an unwitnessed fall at approximately 6:30 AM on 3/24/2026. Video footage was provided to surveyor for review on the morning of 4/28/2026. Per observation of video footage, Resident #1 is seen being guided out of Resident #1's room by a caregiver and the caregiver closed the room door behind Resident #1, leaving Resident #1 alone in the hall. At 6:32 AM, Resident #1 is seen walking down the hallway, stumbling, out of camera view. Shortly after, 2 caregivers were seen leaving the resident's room and looking in Resident #1's direction before walking down the hallway in the opposite direction. At 6:33 AM Resident #1 comes back into camera view and is seen walking in the hallway alone, appearing unsteady and stumbling occasionally. Resident #1 eventually faced the wall and rested their head on the wall for a brief period. Resident #1 is then seen falling backwards, striking their head on the door jamb of their room. Resident #1 then crawled across the hallway and used the handrail to bring themselves into a standing position. The video clip ends with Resident #1 walking in the hallway towards an area where staff were present. Per record review, the facility notified Resident #1's spouse of incident on 3/24/2026 and spouse asked that Resident #1 not be sent to the emergency department. Resident #1's spouse arrived at the facility on 3/24/2026 to assess	R142		

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R142	Continued From page 2 Resident #1 and confirmed the earlier decision not to send Resident #1 to the emergency department. Resident #1 was then showered (with no further bleeding noted), wound was cleaned, and dressing was applied to wound. These findings were confirmed by the Residential Services Supervisor the afternoon of 4/28/2026.	R142		

R142 Accepted May 20, 2026
Susan Canas Gregoire RN

Deficiency Statement Plan of Correction (POC)

Survey Date: April 28, 2026

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
R142 General Care	The travel aid in question was immediately terminated and reported to APS.	Other potential residents will be identified during tracking meetings and updated care plans. RCA's will be notified of care plan updates in huddles and department meetings.	04/29/2026	*Mandatory orientation is being conducted for travelers to include abuse, neglect, and resident supervision. * Nurse manager and reflections director will ensure that travelers receive and sign these policies.	Reflections director, ED, and RCD. All agency orientation will be tracked weekly and placed in a binder for review.