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

June 21, 2024

Ms. Katy Munzir, Manager
Maple Ridge Memory Care
6 Freeman Woods
Essex Junction, VT 05452

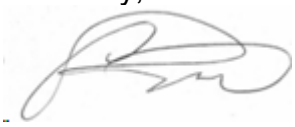
Dear Ms. Munzir:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 29, 2024.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,



Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING: _____ B. WING _____	C 04/29/2024

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: An unannounced on-site complaint investigation of 6 complaints was conducted commencing on 4/29/24 and concluded on 5/10/24 by the Division of Licensing and Protection. The following regulatory violations were identified:	R100		
R128 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.5 General Care 5.5.c Each resident's medication, treatment, and dietary services shall be consistent with the physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, there was a failure by staff to administer medications that were consistent with physician orders for 1 applicable resident (Resident #1) Findings include: Per record review Resident #1's physician ordered Lorazepam 0.5 mg give 2 tablets (1 mg) every four hours, was received on 4/28/24 for increased pain and shortness of breath. On 04/29/24 at approximately 8:00 AM Resident #1 was administered Lorazepam 0.5 mg one tablet without a current physicians' order. The facility's Policies and Procedures titled Medication Management last revised 12/2022 provided by the Director of Nursing on 4/30/24, states "Staff assisting residents with a routine or PRN medications should: Read the information regarding the medication in the resident's medication record, and must follow the 6 R's,	R128		

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R128	Continued From page 1 right resident, right medication, right dose, right route, right time, and right to refuse." Additionally, the policy states "medication errors are defined as an omission of medication, duplication of a medication, wrong drug, wrong dose, or wrong person." On the afternoon of 4/30/24 the Director of Nursing acknowledged medication errors had occurred at the facility. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents due to failure to administer medications according to the physician orders which ensures residents symptoms are being treated correctly and for the benefit of the resident.	R128		
R146 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.9.c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the Director of Nursing (DON), failed to ensure nursing oversight was provided for medication management of two facility residents (Resident #1 and #2) receiving end of life care. Per record review Resident #1 and Resident #2 were receiving collaborative care coordination with a Hospice provider and the RCH. The RCH	R146		

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R146	Continued From page 2 was to continue to provide nursing overview, individualized care and service and medication management. The facility's Policies and Procedures titled Medication Management states, "Staff assisting residents with a routine or PRN medications should: Read the information regarding the medication in the resident's medication record, and must follow the 6 R's, right resident, right medication, right dose, right route, right time, and right to refuse." Additionally, the policy states "medication errors are defined as an omission of medication, duplication of a medication, wrong drug, wrong dose, or wrong person." 1.) On 4/28/24 Resident #1 comfort orders for Lorazepam were increased to Lorazepam 0.5 mg tablets, give 2 tablets (1 mg) every 4 hours scheduled and Lorazepam 1 mg (2 tablets) every 2 hours PRN for anxiety. On the morning of 4/29/24 at 7:42 AM, the medication administration record documented Resident #1 was administered Lorazepam 0.5 mg (1 tablet) and not the ordered dose of Lorazepam 1 mg (2 tablets). Per interview on 4/29/24 at 2:40 PM, the DON confirmed Lorazepam 0.5 mg (1 tablet) was given on 4/29/24 at 7:42 AM. The RN confirmed to have spoken with unlicensed staff at the time of administration and instructed the administration of Lorazepam 0.5 mg, 1 tablet. The RN explained to be unaware the order was changed. The RN confirmed to not have asked or confirmed the orders with staff prior to instructing the administration of the incorrect dose. Additionally, per the Controlled Substance log Resident #1 supply for Lorazepam at the time of	R146		

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R146	Continued From page 3 increase in dosage (4/28/24 at 9:45 am) was 19 tablets. Allowing for 8 administrations. The controlled substance log documented the last available dose of 2 tablets (1mg) was administered on 4/29/24 at 3:09 AM, with a remaining supply of 1 tablet. Per interview on 4/29/24 at 2:00 PM the DON explained the pharmacy of choice, does not deliver medications on Sunday, and confirmed s/he did not instruct staff or facilitate a local dispense of the medication, from an alternative pharmacy, nor at the time dose was increased on 4/28/24 was the available medication supply reviewed in efforts to ensure medication supply would be adequate, in anticipating the comfort care needs for Resident #1. 2.) During observations of the facility on 4/29/24 at approximately 9:45 AM, it was made aware to the surveyors by an anonymous individual, that Resident #1 was not administered Morphine as ordered at 8:00 AM and 10:00 AM. This was confirmed by the Licensed Practical Nurse (LPN), indicating the facility is waiting for a supply to be delivered. In further review of Resident #1 records, on 4/28/24 at 9:45 AM medication orders were increased to Morphine 10 mg (5 mL) every 2 hours scheduled and Morphine 10 mg (0.5 mL) every 1 hour as needed (PRN) for pain/ shortness of breath. The controlled substance log indicates at the time the medication changes occurred, the supply for pre-filled Morphine syringes 0.25 mL was 17 (staff were required to use 2 syringes at each administration), the supply allowed for 8 administrations. Additionally Resident #1 had a Morphine supply in a bottle with an amount of 23 mLs, which allowed for 46 administrations.	R146		

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R146	Continued From page 4 Per interview on 5/8/24 at 11:15 AM, the DON confirmed the Controlled substance log, Morphine (in a bottle) was in supply and available for use on 4/29/24 for the 10:00 AM administration. The DON confirmed to be unaware of the available supply of Morphine in a bottle, stating "I was told we were out of pre-filled syringes of Morphine; I don't know why the bottle of Morphine was not used, I did not know there was a supply available." 3.) Per record review Resident #2 was to receive comfort care medications for end of life care. Resident #2 Morphine orders on the afternoon of 4/28/24 orders were increased to administer Morphine 0.5 mL (10 mg) every 4 hours scheduled and Morphine 0.5 mL (10 mg) every 1 hour as needed for pain/shortness of breath. The change in medication dosage required the staff to utilize 2 prefilled syringes of 0.25 mL (5mg) to administer the ordered dose. Per the Control Substance log, Resident #2 had 10, 0.25 mL pre-filled syringes available at the time the order changed. Resident #2 supply would allow for 5 administrations. The Controlled substance log documented Resident #2 last available supply was administered on 4/26/24 at 6:10 AM. Per interview on 5/8/24 at 11:20 AM the DON confirmed the orders changes on 4/28/24. The DON confirmed the pharmacy Resident #2 utilized is the preferred pharmacy within the facility and does not deliver on Sundays. The DON confirmed to not have coordinated with staff to procure a refill of Morphine to ensure adequate supply for administrations.	R146		

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R146	Continued From page 5 The deficient practice is a potential for more than minimal harm as nursing overview is to include medication management and the overseeing proper medications administrations as ordered, ensure medications are available to meet end of life care needs, and provide oversight with staff to anticipate the care needs of residents.	R146		
R160 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.a Each residential care home must have written policies and procedures describing the home's medication management practices. The policies must cover at least the following: (1) Level III homes must provide medication management under the supervision of a licensed nurse. Level IV homes must determine whether the home is capable of and willing to provide assistance with medications and/or administration of medications as provided under these regulations. Residents must be fully informed of the home's policy prior to admission. (2) Who provides the professional nursing delegation if the home administers medications to residents unable to self-administer and how the process of delegation is to be carried out in the home. (3) Qualifications of the staff who will be managing medications or administering medications and the home's process for nursing supervision of the staff. (4) How medications shall be obtained for residents including choices of pharmacies. (5) Procedures for documentation of medication	R160		

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R160	Continued From page 6 administration. (6) Procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal. (7) Procedures for monitoring side effects of psychoactive medications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the RCH failed to ensure policies were developed to account for all the facilities medication practices. Additionally, the Director of Nursing failed to ensure that established policies and procedures for Medication Administration were by followed licensed staff and unlicensed staff who administer medications. 1.) Per an email received on 5/13/24, the Manager confirmed a policy is not developed to account for staff procurement of medications for facility residents. 2.) The facility policy titled Medication Policy: Medication Management states "13. The nurse/LPN, Medication aide has a window of one hour before or after the assigned prescription time to administer the medication to the resident. Per record review, Resident #1 MAR Morphine was ordered to be administered every 4 hours. The MAR indicates administrations to occur at 8:00 AM, 10:00 AM, 12:00 PM, 4:00 PM, 8:00 PM and 12:00 AM. Per review of documented administrations times, Resident #1 received the 10:00 AM dose at 11:30 AM. Per interview on 4/29/24 at 11:30 AM the DON confirmed the medication was administered 90 minutes after the scheduled time, and 30 minutes	R160		

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R160	Continued From page 7 beyond the time of administration per facility policy. 3.) The facility policy titled Medication Policy: Medication Management in section "Medication Errors", states "A medication error is defined as an omission of medication duplication of a medication wrong drug wrong dose wrong person or injury related to assistance with any medication management system (self-administer or medication administration.) 1. In the event of a medication error an incident report must be filed per medication error policy." On 5/8/24 during an additional follow up visit, it was identified within the Controlled Substance log Resident #1 had a supply of Morphine in a bottle with 17.75 mL available for use on 4/29/24. Per interview on 5/8/24 at 11:15 AM, the DON confirmed to be unaware on 4/29/24 the supply Morphine in a bottle was available. The DON confirmed a medication error report was not completed to account for the missed 8:00 AM dose, and late administration of 10:00 AM. or to investigate why staff was unaware of the controlled medication supply within the medication cart assumed by staff on 4/29/24 at 8:30 AM. The deficient practice is a potential for more than minimal harm as, all staff, Managers, Nurses and unlicensed staff who administer medications are to reference the policies and procedures to ensure proper medication management within the home and ensure residents health related care needs are appropriately managed with medications.	R160		

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R177	Continued From page 8	R177		
R177 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (5) Narcotics and other controlled drugs must be kept in a locked cabinet. Narcotics must be accounted for on a daily basis. Other controlled drugs shall be accounted for on at least a weekly basis. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the RCH failed to ensure controlled medications including narcotics were accounted for per the facility policy. The facility policy titled Assisting with Controlled Medications states "6. At every change of shift or when medication keys change hands, the number of each controlled medications on hand must be counted by two staff members together, with this number compared to the last number "Amount Remaining" column on the Narcotic Inventory sheet. On 4/29/24, during the on-site visit, it was identified Resident #1, was unable able to receive administrations of Morphine as ordered due to the supply not available. At time of finding licensed staff confirmed, Resident #1 last available dose was administered on 4/29/24 at approximately 7:30 AM. The facility organized a re-fill and received a delivery from the pharmacy at approximately	R177		

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R177	Continued From page 9 11:35 AM on 4/29/24. Per interview on 4/29/24 at 11:00 AM, the Registered Nurse confirmed a Morphine supply was unavailable for the administrations for the scheduled dose of 10:00 am. Upon review of documents, the Director of Nursing emailed on 5/6/24, Resident #1 had a supply of Morphine in a bottle available with a measurement of 17.75 mL available for administration on 4/29/24. Per interview on 5/8/24 at 11:00 AM the Director of Nursing confirmed on 4/29/24 it was indicated there was not a supply of Morphine available, however there was a supply available in bottle form. The DON was unable to confirm as to why staff were unaware of the available supply of Morphine. The DON confirmed the "believe" the control substance count occurred between staff at 8:30 AM on 4/29/24. Per interview on 5/9/24 at 9:00 AM, the Manager indicated an internal investigation was being conducted to review the discrepancy of medication supply. In the afternoon of 5/9/24 the Manager confirmed, through the investigation it was identified staff did not perform a controlled substance count on the morning of 4/29/24, and the LPN assuming the cart was unaware of the available supply to be able to administer medications as ordered to Resident #1. This deficient practice is risk for more than minimal harm to all facility residents as, medication management including narcotic medication counts is a requirement to ensure the securement and accounting of the medications. Further the practice, orients the oncoming shift of	R177		

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R177	Continued From page 10 the controlled medications supply, amount available for use and confirms the supply available to the documented as amount available within the control substance log.	R177		
R205 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.17 Death of a Resident 5.17.c When a resident dies unexpectedly or within 48 hours of a fall or injury, in addition to notifying the medical examiner, the licensee shall send a report to the licensing agency with the following information: (1) Name of resident; (2) Circumstances of the death; (3) Circumstances of any recent injuries or falls; and (4) A list of all medications and treatments received by the resident during the two (2) weeks prior to the death. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the Residential Care Home (RCH) failed to report a residents death occurring within 48 hours of a fall or injury to the licensing agency. Findings include: Per record review conducted on the morning of 5/8/24 it was noted that on 4/27/24 Resident #2 was found by facility staff to be lying on the floor. On further review of residents' record, it was recorded that Resident #2 passed away on 4/29/24. The facility's Policies and Procedures titled Death	R205		

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R205	Continued From page 11 of a Resident last revised 12/2022 provided by the Executive Director on 5/13/24, states "If a resident dies unexpectedly or within 48 hours of a fall or injury, in addition to notifying the medical examiner, the DON or Executive Director shall send a report to the licensing agency." Per interview with the facility Director of Nursing (DON) on 5/8/24 at approximately 2:00 PM s/he stated that Resident #2 did sustain a fall on 4/27/24 and additionally confirmed that s/he did not report this event to the licensing agency.	R205		
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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the RCH failed to ensure controlled medications were administered to residents in which medication were prescribed and medications were not misappropriated to facilitate care needs. Per record review of the controlled substance book, Resident #2 had an order for Morphine for end-of-life comfort care. The controlled substance log is documented to account for Resident #1 Morphine, indicating the last use of available supply was administered on 4/29/24 at 7:10 AM. The Medication Administration Record documented a dose was given on 4/29/24 at 8:45	R224		

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R224	Continued From page 12 AM. In comparison to the control substance log, Resident #1 supply was exhausted on 4/29/24 at 7:10 AM. Per interview on 5/8/24 at 11:10 AM the DON reviewed Resident #2 MAR and confirmed the documented administrations on 4/29/24 at 7:10 AM and 8:45 AM. The DON confirmed to have instructed staff to administer a dose of Morphine, by utilizing a supply belonging to Resident #3 for the 8:45 AM administration. The DON stated, "The morphine prescribed to Resident #3 was not being utilized and was to expire in a few days and that Resident #2 was in the end stages of life and required comfort medication." DON acknowledged Resident #2 orders for Morphine were increased on Sunday 4/28/24 in the afternoon and did not procure additional supply to ensure Morphine would be available to administered for end-of-life comfort care. Per an email on 5/13/24, the Manager confirmed a policy is not established by the facility for the procurement of medications for residents. The deficient practice is risk for more than minimal harm for all facility residents, as each Resident has the right to be free from misappropriation of resident property, to include prescribed medications.	R224		
R266 SS=F	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and	R266		

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(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 13 comfortable environment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview there was a failure to ensure the Residential Care Home (RCH) maintained a safe, homelike environment related to the storage of cleaning products, personal care items, and other hazardous items in accordance with Section 9.1a of the Vermont Residential Care Home Licensing Regulations effective 10/3/2000. Findings include: During the facility environmental tour conducted on 04/29/24 at approximately 9:00 AM cleaning products, poisonous chemicals, and other personal care items were noted to be unattended, unsecured, and without locking mechanism in 10 resident rooms. These items include disposable razors, a metal dental cleaning kit, Clear Eyes eye drops, Lysol cleaning spray, Clorox whips, Scrubbing bubbles cleaning spray, and nail polish. Per review of the facilities policy and procedure titled Securing Potential Hazardous Substances effective April 2024 states "To create and maintain a safe environment for individuals in memory care. To maintain a safe space within the residents' apartments for storage of chemicals and hazardous substances. These hazardous substances include but are not limited to mouthwash, toothpaste, hand soap, body lotion, cleaning supplies, nail polish remover, nail polish, deodorant, disposable razors, small electric appliances, scissors, and clippers. On 04/29/24 at approximately 2:30 PM the facility Maintenance Director confirmed that multiple	R266		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0653	A. BUILDING: _____ B. WING _____	C 04/29/2024

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R266	Continued From page 14 resident rooms contain cabinets without locking mechanism in place stating, the facility was actively working on replacing them. In conclusion this deficient practice is a potential risk for more than minimal harm for all facility residents related to risk of exposure to poisonous compounds and other harmful materials.	R266		

Maple Ridge

AN ASSISTED LIVING &
MEMORY CARE CAMPUS

June 3, 2024

State Long Term Care Manager
Vermont Agency of Human Services
Department of Disabilities, Aging and Independent Living
HC 2 South, 280 State Dr.
Waterbury, VT 05671-2060

Dear DAIL,

Please accept the attached as our plan of correction for the survey at Maple Ridge Memory Care on April 29, 2024.

This plan of correction is submitted as required under State and/or Federal law. The submission of this Plan of Correction does not constitute an admission on the part of the Community as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence, corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

Any questions please let me know.

Thank you,

K Munzir

Katy Munzir
Senior Executive Director
Maple Ridge Memory Care

Deficiency Statement Plan of Correction (POC)

Survey Date: 04/29/2024

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
R128 SS=F R128 Accepted 68/24 Jenielle Shea, RN	Med Techs and Nurses will be going through re-training with RN. All Med Techs will go through Med Tech class again and be signed off for competency and re-education regarding medication administration.	7/1/2024	Med Tech class has been revised. Competency checklists will be done Bi-annually on all Med Techs by RN or nurse delegate.	RN Overseen by Executive Director
R146 SS=F R 145 Accepted 68/24 Jenielle Shea, RN	Director of Nursing was terminated from the facility on 5/23/24. Med Techs and Nurses will be going through re-training with RN. All Med Techs will go through Med Tech class again and be signed off for competency and re-education regarding medication administration. Vice President (VP) of Resident Services did re-training with all Nurses and Med Tech's regarding Narcotics and Narcotic Administration on 5/22 & 5/23/24. Review of narcotic book was completed and verified by VP of Resident Care. Policy has been written for community on Procurement of Medication. Training to be done with all nursing staff.	7/1/2024	Med Tech class has been revised. Competency checklists will be done Bi-annually on all Med Techs by RN or nurse delegate. New DON will be trained by VP of Resident Services and Regional RN for management company.	RN Overseen by Executive Director
R160 SS=F R160 Accepted 68/24 Jenielle Shea, RN	Policy written on Procurement of Medications and all staff trained regarding the process. Med Techs and Nurses will be going through re-training with RN. All Med Techs will go through Med Tech class again and be signed off for competency and re-education regarding medication administration. Nurses re-trained on Medication Error reporting on June 13th, 2024.	7/1/2024	Med Tech class has been revised. Competency checklists will be done Bi-annually on all Med Techs by RN or nurse delegate. New DON will be trained by VP of Resident Services and Regional RN for management company.	RN Overseen by Executive Director
R177 SS=F R177 Accepted 68/24 Jenielle Shea, RN	Vice President (VP) of Resident Services did re-training with all Nurses and Med Tech's regarding Narcotics, Narcotic Administration, and Narcotic count on 5/22 & 5/23/24. LPN who did not do the narcotic count was terminated from facility on 5/23/24.	5/23/24	Med Tech class has been revised. Competency checklists will be done Bi-annually on all Med Techs by RN or nurse delegate.	RN Overseen by Executive Director

R205 SS=F R205 Accepted 68/24 Jenielle Shea, RN	Executive Director re-train all nursing staff regarding policy on death of a resident.	6/15/2024	All new nurses will be trained on this policy upon hire and yearly thereafter as a reminder. The policy is also posted in the nurse's station as a reminder	Executive Director
R224 SS=F R224 Accepted 68/24 Jenielle Shea, RN	Policy written on Procurement of Medications and all staff trained regarding the process. Med Techs and Nurses will be going through re-training with RN. All Med Techs will go through Med Tech class again and be signed off for competency and re-education regarding medication administration. Training on Procurement to be completed by RN on 6/13/24	6/15/24	All new nurses will be trained on this policy upon hire and yearly thereafter as a reminder. The policy is also posted in the nurse's station as a reminder Med Tech class has been revised. Competency checklists will be done Bi-annually on all Med Techs by RN or nurse delegate.	RN Overseen by Executive Director
R266 SS=F R266 Accepted 68/24 Jenielle Shea, RN	Locks have been secured on all cabinet locks in the resident apartments. Two residents have requested and been cleared by nursing to leave items out due to independence in care. Those apartments have always locked locks on the apartment door preventing residents from being able to enter the apartment. Random room checks are done daily by the Memory Care Director or delegated person to ensure hazardous items are locked and secure.	6/15/2024	Maintenance will check locks monthly as part of monthly checks to ensure they are in working order and have back up locks in place.	Maintenance Director Overseen by Executive Director