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

March 6, 2024

Ms. Caitlin Bernardini
Maple Lane Retirement Home
33 Maple Lane
Barton, VT 05822-9494

Dear Ms. Bernardini:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 13, 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

Division of Licensing and Protection

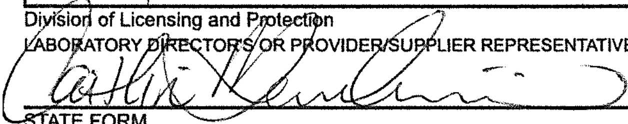
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0140	A. BUILDING: ____ B. WING ____	C 02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE LANE RETIREMENT HOME	**33 MAPLE LANE** **BARTON, VT 05822**

(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 2/13 24 the Division of Licensing and Protection conducted an unannounced on -site investigation of one complaint. During the investigation deficient practices were identified which resulted in the need for Immediate Corrective Action to be taken by the facility, and an Immediate Corrective Action Plan was provided by the facility before the survey exit on 2/13/24. Findings include:	R100		
R171 SS=L	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall 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 nurse has delegated administration; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects. (6) All incidents of medication errors.	R171		

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE Manager

(X6) DATE 3-6-2024

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This REQUIREMENT is not met as evidenced by:
Based on observation, staff and resident interviews, and record review there was a failure to ensure administration of medications as ordered; and a failure to consistently and accurately document medication administration. Findings include:

The facility policy for Administering Medications effective April 2019 states:
* "Medications are administered in a safe and timely manner, and as prescribed."
* "Medications are administered in accordance with prescriber orders, including any required time frame."
* "Medication errors are documented, reported, and reviewed by the QAPI [Quality Assurance and Performance Improvement]committee to inform process changes and or the need for additional staff training."
* "Mediations are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before or after meal orders)."
* "The individual administering medications verifies the resident's identity before giving the resident his/her medications."
* "The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication."
* "If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for the drug and dose."
* "The individual administering the medication initials the resident's MAR on the appropriate line

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after giving each medication and before administering the next ones. "

The facility's Medication Error Report policy indicates the Director of Nursing will interview the Nurse that made the med error and discuss cause and resolution; and states the purpose of the policy is prevention, resident protection, and identification if there is a pattern.

1. On 2/13/24 the facility Administrator was requested to provide documentation of medication orders the occurred during the previous 6 months. Per review of the 18 Medication Error Reports filed between 8/23/23 - 2/11/24 and Medication Administration Records (MARs) it was determined there was a failure to ensure policies and procedures for administration of medications and documentation of medication administration were implemented, which resulted in the following medication administration and documentation errors for 5 applicable residents (Residents #1, #2, #3, #4, and #5).

A. Resident #1:

*On 8/23/29 Hydroxyzine 50 mg was ordered for "itching" and 75 mg was given. On 11/8/23 a scheduled dose of Magnesium Oxide 500 mg (for magnesium deficiency) was not given. On 11/13/23 twice the prescribed dose of Olanzapine (antipsychotic) was given, and a scheduled dose of Diazepam (for anxiety) was not given .

B. Resident #2:

* On 9/6/23: Resident #2 was given twice the prescribed dose of all morning oral medications including medications to treat Diabetes, Heart

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R171	Continued From page 3 Failure, Kidney Disease, and Parkinsons Disease; and antipsychotic, antidepressant, anti-convulsant, muscle relaxant, and diuretic medications. * The antibiotic Bactrim DS 800 mg/160 mg was prescribed twice daily for 7 days from the evening of 9/3/23 to the morning of 9/11/23. On the morning of 9/10/23 seven pills remained in stock, indicating 5 missed doses; however Staff signatures in the MAR indicate 3 of the missed doses were given, and inconsistent administration of this antibiotic continued for 5 days after the prescribed stop date. * On 9/26/23 Resident #2's Lorazepam 1 mg dose (for anxiety) was signed out of the Narcotic Count Book, and the medication was reportedly not given. The MAR indicates this medication was also not given on 9/17/23, however a missed dose on 9/17/23 was not reported . * On 10/18/23 a scheduled to receive a weekly subcutaneous injection of the Diabetes medication Trulicity was not given. The medication was documented as given in the MAR, and the error was not discovered and reported for two days. *The antibiotic Levofloxacin 500 mg was prescribed once daily for 10 days. On 10/24/23 the Manger reported a dose was given in error at an unknown time resulting in an inadequate amount of tablets to complete the prescribed course of treatment. * On 11/13/23 all morning oral medications were not given including medications to treat Diabetes, Heart Failure, Kidney Disease, and Parkinsons Disease; and antipsychotic, antidepressant,	R171		

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anti-convulsant, and diuretic medications.

* On 1/3/24 Lorazepam 1 mg (for anxiety) was not given at bedtime, however the medication was signed as given in the MAR.

*On 1/15/24 a scheduled dose of Carvediol prescribed to prevent kidney damage from high blood pressure was not given. The MAR indicated the med was administered on 1/15/23, however the medication was still in the medication pack the following day.

* A med error report states Cyclobenzaprine (muscle relaxer) and Gabapentin (anticonvulsant) were not given on 2/5/24, however the MAR indicates the medications were given 3 times on 2/5/24 as ordered. The Medication Error Report does not indicate which doses were not given.

C. Resident #3:

* Morning doses of the Quetiapine (antipsychotic) and Memantine (for memory loss) were not given as ordered on 1/10/24, however the MAR indicates the medications were given. On 1/15/24 the Manager administered twice the prescribed dose of Memantine, and reported "wrong day was given, resulting in a double dose ...I didn't think it had been passed. "

D. Resident #4:

*Both scheduled 50 mg doses of the pain medication Tramadol HCl were not administered on 2/11/24. The MAR indicates both missed doses were given.

E. Resident #5:

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Continued From page 5

* An order for Magnesium Gluconate 250 mg twice daily (for Hypocalcemia) was incorrectly entered in the MAR to be administered once daily, which resulted in 7 missed evening doses from 1/22/24 - 1/28/24. On 1/28/24 the morning dose of Magnesium Gluconate was also not given on, resulting in 2 missed doses of Magnesium Gluconate on this day.

*Per med error report dated 2/5/24, Meclizine 25 mg was ordered "BID" [TWICE daily] for 3 days and was "not given at all during its three day course". The MAR indicates on 1/31/24 Meclizine (for dizziness) 25 mg scheduled 3 times daily for 3 day was ordered with instructions to resume the PRN (as needed) dose following the 3 day course of scheduled doses. Four different staff failed to administer the 9 scheduled doses as ordered. Additionally, the PRN order for Meclizine in the MAR was not blocked out to prevent administration during the 3 day period the scheduled dose was ordered.

2. Per review of Resident #2's September 2023 and February 2024 MARs there was a failure to document administration or refusal of medications as indicated by missing initials in the areas provided for staff initials. Per review of Medication Error Reports provided for review, the error reports on file do not reflect discovery of these omissions and reporting of the failure to document administration as medication errors.

A. Per review of the September 2023 MAR there was a failure to document administration or refusal for the following medications:
On Page #1:
* Pantoprazole on 9/19/23.
* Aripiprazole, Atrovastatin, Citalopram, Farxiga, and Pantoprazole at 8:00 AM on 9/22/24.

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On Page #2:
* Carvedilol, Entresto, and Magnesium Oxide on 9/10/23.
* Symbicort inhaler on 9/13/23, Lantus Solostar insulin on 9/17/23, and Gabapentin on 9/27/23
* Cyclobenzaprine on 9/10/23, 9/15/23, and 9/27/23.

On Page #3:
* Rytary on 9/12/23, 9/15/23, 9/17/23, 9/25/23, 9/26/23, 9/27/23, and 9/29/23.
* Ipratropium/Albuterol Nebulizer treatment once on 9/13/23, twice on 9/15/23, once on 9/16/23, 9/17,23, and 9/18/23; twice on 9/25/23; once on 9/26/23; three times on 9/27/23; twice on 9/28/23; and once on 9/29/23 and 9/30/23.
* Mirtazapine on 9/17/23 and 9/21/23.
* Novolog Insulin Flex Pen once on 9/5/23, 9/8/23, 9/15/23 and 9/20/23; twice on 9/22/23, three times on 9/27/23; and twice on 9/28/23 and 9/29/23.
* Furosemide on 9/7/23, 9/15/23, 9/28/23, and 9/29/23.

B. Per review of the February 2024 MAR there was a failure to document administration or refusal of the following medications:
* Gabapentin and Ipratropium /Albuterol Nebulizer treatment at 2:00 PM on 2/8/24
* Novolog Insulin Flex Pen at 11:30 AM on 2/8/24
* Cyclobenzaprine at 8:00 AM on 2/3/24 and 2/4/24

3. During an observed med pass commencing at 2:30 PM on 2/13/24 a Med Delegated Staff was observed signing out a controlled substance given during the morning medication pass at 2:35 PM. Due to this observation a review of the controlled substance count process was initiated by the surveyor. While the controlled substance count was correct, review of documentation

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during the count indicated the count process as described by the Med Delegated staff is not consistently completed by all staff. Additionally, during the observed med pass the med tech identified a medication pack for the 4 PM med pass that had been opened and taped shut, however the medication to be administered was not inside the taped med pack. These findings were acknowledged the Manager following the observed med pass and controlled substance count.

4. Per interview commencing at 3:22 PM on 2/13/24 Resident #1 stated "there are lots of issues with meds here", and medications are often administered late even though the medication times had been changed to accommodate staff difficulty administering medications on time. On the afternoon of 2/13/24 the Manager confirmed adjustments had been made to the medication times to accommodate staff having difficulty managing timely medication administration.

Per review of Medication Error Reports and Delegation Training Records every med delegated staff member including the Manager of the home made multiple errors occurring between 8/23/23 and 2/11/24. During an interview commencing at 5:57 PM on 2/13/24 the Manager confirmed numerous medication errors had occurred at the home and stated the main cause of the errors is staff signing the MAR then not removing the medications from the medication packs for administration. When asked how the errors have been addressed the Manager stated when errors are found the staff responsible are informed, and errors are discussed in staff meeting. The Manager stated medication training occurs "very often", then confirmed the annual

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R171	Continued From page 8 med delegation training was overdue. Per review of the 18 Medication Error Report forms provided for review, 6 were not signed by the Director of Nursing, 3 did not include corrective actions, and 8 did not include measures to prevent further errors. Corrective actions documented on the forms included "Staff trained further by LPN" and "education at staff meeting". Documented measures taken to prevent the recurrence of similar errors included "Med tech training being planned" and "Med tech training next month". Per the Manager, the nursing oversight process in place to ensure medications are administered as ordered includes a Licensed Practical Nurse on site twice a week to go over the MARs, the Registered Nurse one site Monday - Friday to answer any questions, and monthly MAR audits by the Manager. The Manager stated policies and procedures related to medication errors had not been developed and implemented, however policies and procedures for medication administration provided for review during the investigation on 2/13/24 included a document entitled "Medication Error Report" which states the purpose of med error reporting is prevention, resident protection, and to "identify if a pattern"; and lists procedures for medication error reporting including "the Director of Nursing will interview Nurse that made the med error and discuss cause and resolution" and "Q.A. will review med errors quarterly and report to the Q.A. meeting". The procedures do not include a process to address medication errors made by staff delegated to administer medications by the Director of Nursing. There is no indication quarterly Quality Assurance reviews were conducted in response to the medication	R171		

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R171	Continued From page 9 errors between August 2023 and February 2024; and the Administrator reported one staff member was removed from the schedule following review of the medication error reports during the investigation on 2/13/24. 5. The Manager and Administrator acknowledged the investigation finding that the scope and severity of medication errors occurring over the previous 6 months indicated deficient practices related to the home's medication administration system which are an immediate and significant risk for harm to all facility residents, and a plan for immediate corrective actions signed by the Administrator, the Manager, and the Registered Nurse was provided and implemented on the evening of 2/13/24 to include: *An Immediate Action Plan beginning on 2/13/24 at the 6 PM medication pass for the Registered Nurse to observe at least one medication pass on each shift until all current staff demonstrate competency and proficiency and receive necessary re-education on the proper process of passing medications. All competencies to be completed within 7 days of 2/13/24 at 6 PM. * An Extended Action Plan following the initial competency evaluations and education of all staff which states the Registered Nurse will be observing medication passes twice weekly for a duration of one month and ensuring continued competency of all med delegated staff. For an additional two months the Registered nurse will be observing medication passes once weekly and ensuring continued competency of all med delegated staff. The deficient practices identified during the investigation on 2/13/24 are an immediate risk to the health and safety of all residents due to the	R171		

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R171	Continued From page 10 failure to administer medications as ordered and to accurately document medication administration can cause serious harm or death.	R171		

Maple Lane Retirement Home

33 Maple Lane, Barton V.T. 05822

802-754-2323

2/13/24

Re: Anonymous Complaint Survey

Issue/Concern:

During the investigative process, a pattern of concern was identified by the surveyor in regard to medication errors.

Immediate Action Plan:

Beginning on 2/13/24 at the 6pm medication pass time, RN [redacted] will be observing at least 1 medication pass on each shift, until all current staff demonstrate competency and proficiency and receive necessary re-education on the proper process of passing medications. All competencies and education will be completed within 7 days of 2/13/24 at 6pm.

Extended Action Plan:

Following the initial competency evaluations and education of all staff. [redacted] RN, will be observing medication passes 2x weekly for a duration of 1 month. Ensuring continued competency of all med delegated staff.

For an additional 2 months, [redacted] RN, will be observing medication passes 1x a week. Ensuring continued competency of all med delegated staff.

Immediate plan of action accepted by J. Evans on date of survey 2/13/24

Respectfully Submitted,

[signature] 2/13/24

Travis Bergeron, Administrator

[signature] 2/13/24

Caitlin Bernardini, Level 3 Manager

[signature] D Hutchins RN

Donna Hutchins, RN Manager

Phone (802) 754-8575, Fax (802)754-2113

Name removed by DLP 3/6/24