

#### DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
<a href="http://www.dail.vermont.gov">http://www.dail.vermont.gov</a>
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

August 24, 2018

Ms. Kim Campbell, Administrator Maple Lane Nursing Home 60 Maple Lane Barton, VT 05822-9494

Dear Ms. Campbell:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 1, 2018**. 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.

Sincerely,

Pamela M. Cota, RN

amlaMCotaPN

Licensing Chief

PRINTED: 08/09/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			CTRICATION I	(X3) DATE SURVEY
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULT A BUILDIN		COMPLETED	
						C
		475042	B WING _	10 F WAR SEE		08/01/2018
NAME OF P	ROVIDER OR SUPPLIER				TADDRESS, CITY, STATE ZIP CODE	
	ANE NURSING HOM	F		00400400 acceptor	PLE LANE	
MAPLEL	ANE NURSING NOW			BARI	ON, VT 05822	ION IVE
(X4) ID PREFIX TAG	JEACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
E 000	Initial Comments		E 0	00	4	
F 000	conducted an unar		FO	000		
F 576 9S=C	an investigation of were conducted by Protection from 7/3 regulatory findings	Communication w/ Privacy		576 -	F576 483.10(g)(6)-(9)	
	reasonable access including TTY and the facility where carbeard. This income are the second and the second are	resident has the right to have so to the use of a telephone, TDD services, and a place in calls can be made without being cludes the right to retain and the resident's own	į		<ol> <li>No resident had a nas a result of the all practice.</li> <li>Residents that receithe potential to be a alleged deficient practice.</li> <li>Facility administrates</li> </ol>	eged deficient ve mail have affected by the actice
7	facilitate that reside individuals and enfacility, including re(i) A telephone, inc (ii) The internet, to facility; and (iii) Stationery, postine ability to send				reviewed and under requirement for material Residents will recessive scheduled postal details.  4. Audits will be done the administrator of monitor effectivence.	estands the fil delivery. five mail on all filivery days. file weekly by findesignee to
	and receive mail, and other materia	e resident has the right to send and to receive letters, packages Is delivered to the facility for the a means other than a postal	s e		Recunt 8/23	/18

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

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	C COD MEDICARE	& MEDICAID SERVICES			0	MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPL A BUILDING			(X3) DATE SURVEY COMPLETED
		002	A BOILDING			С
		475042	B WING			08/01/2018
NAME OF P	ROVIDER OR SUPPLIER		S	TREETAL	DDRESS, CITY, STATE, ZIP CODE	
MAPLEL	ANE NURSING HOM	E		MAPLE ARTON	ELANE 1, VT 05822	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO EACH CORRECTIVE ACTION SHOULD COSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
F 576	Continued From pa	nge 1	F 576	5	Results of the audits will	be
	service, including the	1700		J.	presented to the QAA co	
	(i) Privacy of such	communications consistent			x3 months at which time	
	with this section; ar	nd nery, postage, and writing			committee will determin	
	implements at the	resident's own expense.			frequency of the audits.	
*	0.400 407 1/01 71	in the state barra		6	Corrective action was co	mpleted
		resident has the right to have to and privacy in their use of		٥.	on August 1, 2018	
	electronic commun	ications such as email and			8	
		ons and for internet research.				
	(ii) At the resident's	available to the facility sexpense, if any additional				
	expense is incurred	d by the facility to provide such				
i e	access to the resid	lent comply with State and Federal		n.		(4
	law.					
		NT is not met as evidenced				
	by: Based on resident	and staff interviews, the				
	facility failed to ens	sure that residents receive				
		d other materials when there is I delivery. Findings include:				
	a scheduled posta	raenvery, rimanigs include.				
		ng the resident council special				8
		reported that the facility does the weekends. The residents				
	believed that there	is no staff available to deliver				
		The Social Worker confirmed facility has not delivered mail			<b>.</b> . ≃	92
	on Saturdays.	racinty has not delivered man				
		nts Before Transfer/Discharge (3)-(6)(8)	F 623	F623	483.15(c)(3)-(6)(8)	
30 0				1	. The identified residents	
	§483.15(c)(3) Noti	ce before transfer. Insfers or discharges a			negative affect as a resu	
	resident, the facilit	y must-			alleged deficient practic	
ĕ		ent and the resident's			identified residents rem	ain in the

representative(s) of the transfer or discharge and

facility.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		PLE CONSTRUC		(X3) DATE SURVEY COMPLETED
		475042	B. WING		en e	08/01/2018
	(EACH DESIGIENC		ID PREFIX TAG	60 MAPLE LA BARTON, V		.D BE COMPLETION
F 623	language and mar facility must send representative of the Long-Term Care Council (ii) Record the readischarge in the readischarge in the readischarge in the readischarge in the paragraph (c)(5) of \$483.15(c)(4) Tim (i) Except as specific (c)(8) of this section discharge require made by the facility resident is transfer (ii) Notice must be before transfer or (A) The safety of be endangered unthis section; (B) The health of be endangered, unthis section; (C) The resident's allow a more immunder paragraph (D) An immediate required by the required by the reunder paragraph (E) A resident has days.	e move in writing and in a mer they understand. The a copy of the notice to a he Office of the State ombudsman. sons for the transfer or esident's medical record in varagraph (c)(2) of this section; motice the items described in of this section. In this section, ing of the notice. If items in the notice of transfer or dunder this section must be the atleast 30 days before the red or discharged. Items as soon as practicable discharge when-individuals in the facility would inder paragraph (c)(1)(i)(C) of individuals in the facility would inder paragraph (c)(1)(i)(D) of the lediate transfer or discharge. (c)(1)(i)(B) of this section; I transfer or discharge is esident's urgent medical needs, (c)(1)(i)(A) of this section; or not resided in the facility for 30 intents of the notice. The written in paragraph (c)(3) of this section.		<ul><li>3.</li><li>4.</li><li>5.</li><li>6.</li></ul>	Resident requiring tradischarge out of the fithe potential to be affi alleged deficient prace. Facility administration reviewed and underst requirements for transand has revised the notice.  Education will be prostaff responsible for it transfer notice.  Weekly audits will be the Administrator or monitor effectiveness. Results of the audits presented to the QAA x3 months at which to committee will determ frequency of the audit Corrective action to by 8/31/2018	acility have fected by the stice on has cand the sfer notices otice to omponents  evided to ssuing a  e done by designee to s of the plan will be a committee time the mine further ts be complete

CENTER	S FOR MEDICAR	E & MEDICAID SERVICES	T		7 0939-0391			
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A BUILD		ONSTRUCTION	California		OMPLETED
		475042	B WING			•		C 8/01/2018
	PROVIDER OR SUPPLIER			60 N	ET ADDRESS, CIT IAPLE LANE RTON, VT 0582		Œ	
(X4) ID PREFIX TAG	FACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(FACH CORRI	S PLAN OF CORR ECTIVE ACTION SI ENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 623	(ii) The effective of (iii) The location to transferred or dis- (iv) A statement of	r transfer or discharge; late of transfer or discharge; o which the resident is	F	623				
	and telephone nureceives such recto obtain an apper completing the formation for the following request; (v) The name, and telephone number Long-Term Care (vi) For nursing far and development disabilities, the matelephone number telephone number to obtain the following such as the follo	mber of the entity which quests, and information on how al form and assistance in rm and submitting the appeal dress (mailing and email) and of the Office of the State Ombudsman; acility residents with intellectual that disabilities or related pailing and email address and of the agency responsible for	500					
	developmental di C of the Develop and Bill of Rights codified at 42 U.S (vii) For nursing f disorder or relate email address ar agency responsil advocacy of indiv	d advocacy of individuals with sabilities established under Part mental Disabilities Assistance Act of 2000 (Pub. L. 106-402, S.C. 15001 et seq.); and actility residents with a mental d disabilities, the mailing and id telephone number of the pole for the protection and riduals with a mental disorder in the Protection and Advocacy dividuals Act		a .			* *	
× =	If the information effecting the tran must update the	ranges to the notice. in the notice changes prior to sfer or discharge, the facility recipients of the notice as soon ace the updated information alle.			# 2 20			

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DEFAIL	MENT OF HEALTH	A MEDICALD CEDVICES				C	MB NO.	0938-0391
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	ONSTRUCTION		(X3) DATI	E SURVEY
AND PLAN O	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER.	A BUILD			more)		PLETED
		475042	B WING			*	1	01/2018
NAME OF P	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, S	STATE, ZIP CODE		
644DLE I	ANE NURSING HOM				APLE LANE			75.1
MAPLE	ANE NORSING HOM			BAR	TON, VT 05822	· · · · · · · · · · · · · · · · · · ·	ON	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC' CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOUL CED TO THE APPRO EFICIENCY)	DBE .	COMPLETION DATE
C 000	0 1 1 1		E	623				
F 623	Continued From pa		1777	023				
	\$483.15(C)(8) NOU	ce in advance of facility closure ty closure, the individual who is						
	the administrator of	f the facility must provide						
	written notification	prior to the impending closure						
	to the State Survey	Agency, the Office of the				(2)		
*	State Long-Term C	are Ombudsman, residents of						
	the facility, and the	resident representatives, as				∞ 55		
	well as the plan to	the transfer and adequate sidents, as required at §						
	483.70(I).	sidents, as required at 3						
	This REQUIREME	NT is not met as evidenced						
9	by:							
	<ul> <li>Based on staff int</li> </ul>	erview and record review, the						
	facility failed to not	ify 4 of 4 applicable residents			×		(a)	*
	in the sample (Res	sidents # 56, # 53, # 58, 47) i's representative(s) of the						
	transfer or dischar	ge and the reasons for the						
	move in writing in	a language and manner they						
	understand. Findir							
0.5		We all are add to the way the large						
	1. Resident # 56 v	vas discharged to an acute care and returned to the facility o						
1	7/18/18 There is a	no evidence in the clinical						
		e of discharge was provided to						
	the resident or the	resident's representative. This		*				
	was confirmed by	the Director of Nurses (DON)						
	on 8/1/18 at 9:28 a	AM.						
	2 Per record revi	ew, Resident #47 was						
9		cute illness on 6/29/18 and	8.					
	re-admitted 7/2/18	The facility did not provide						
1		quired notice of transfer had						

had been sent

been issued to the resident or the resident representative. On 8/1/18 at 12:50 PM, the Director of Nursing confirmed that no such notice

3. Per record review, Resident #58 was transferred to an acute care hospital on 6/1/18

CENTER	S FOR MEDICARE	& MEDICAID SERVICES					O	MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTI A BUILDIN					(X3) DATE SURVEY COMPLETED
		475042	B WING _					C 08/01/2018
	ROVIDER OR SUPPLIER ANE NURSING HOM	E	4	60 M	APLE L	RESS, CITY, STATE, ZIP C .ANE VT 05822	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EA	PROVIDER'S PLAN OF CO ACH CORRECTIVE ACTION SS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE COMPLETION
F 638	There is no evidence required notice of the resident representation of the resident representation of the resident representation of the had been set 4. Resident # 53 with facility on 7/30/2011 the clinical record to given to the responsible the hospital. The Dino evidence of noting 10:16.  Qrtly Assessment at CFR(s): 483.20(c)  §483.20(c) Quarter A facility must assequanterly review in and approved by Conce every 3 month This REQUIREME by.  Based on staff interfacility failed to assign residents (#38, #56 instrument specific by CMS ( Centers Services) not less months. Findings in Per record review, quarterly assessment completed until 7/11 completed u	rined to the facility on 6/7/18. The that the facility provided the ransfer to the resident or the ative. On 8/1/18 the Social rined that in fact no such int.  as discharged to an acute care in the anotice of discharge was sable party upon discharge to ON confirmed that there was ce of discharge on 8/1/2018 at int.  It Review Assessment is a resident using the strument specified by the State MS not less frequently than ins.  Note in the facility failed to complete in a timely manner for the induced for Medicare and Medicaid frequently than once every 3 include.  The facility failed to complete in a timely manner for the induced for Medicare and Medicaid frequently than once every 3 include.	F 62		<ol> <li>2.</li> <li>3.</li> <li>4.</li> </ol>	No identified res negative effect re alleged deficient Residents require MDS assessmen potential to be all An initial audit vand any identifie assessments wer An MDS coordinated for the facility administration of the requireme of MDS assessments of the requirement of MDS assessments were an accompleted	elated to practice ing school ing school its have feeted was comped late compenator had ility tration ents and	o the see eduled the mpleted or missing soleted as been is aware a schedules
		due 7/3/18 and not completed				- F - J		. A

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

OCITIEI			direct Charles T	IDIC COME	10110	TION	(X3) DATE SURV	(EV
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		IPLE CONS			COMPLETE	
AND PLAN U	F CORRECTION	construction of the control of the c	V ROICINE	NG		The state of the s	C	
		475042	B WING			(#C	08/01/20	18
		473042			DDBE	ESS, CITY STATE, ZIP CODE	1 00/01/20	10
NAME OF P	PROVIDER OR SUPPLIER			60 MAPL				
MAPLE L	ANE NURSING HOM	E				05822		
				DARTO		OVIDER'S PLAN OF CORRECTION	201 (	x5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	Cr	(EAC)	H CORRECTIVE ACTION SHOUL REFERENCED TO THE APPROL DEFICIENCY)	DBE COMP	LETION ATE
6	Data Set) consulta Encoding/Transmit CFR(s): 483.20(f)( §483.20(f) Automa requirement- §483.20(f)(1) Encoda facility completes facility must encode each resident in the (i) Admission assessing) Significant charter (ii) Annual assessing) Guarteriy reviee (v) A subset of item reentry, discharge, (vi) Background (fais no admission assessing) System infor contained in the M standard record la and that passes st CMS and the State §483.20(f)(3) Translated assessment, a face encoded, accurate the CMS System, (i) Admission assession asses	infirmed by the MDS ( Minimum int on 8/1/18 at 12:11 PM. Iting Resident Assessments 1)-(4)  Ited data processing ding data. Within 7 days after is a resident's assessment, a ethe following information for efacility. It is a session of the following information for efacility. It is a session of the following information for efacility. It is a session of the following information if there is a session of the following information, if there is session of the following information if there is a formation for each resident in the following in a formation of the following in the following. It is a formation of the following.		40	7. 8. 1. 2. 3. 4.	Audits will be done we the administrator or domonths to monitor effort the plan Results of the audits reported to the QAA x3 months at which to committee will determine the will determ	esignee x3 fectiveness will be committee ime the mine further ts. I be 8 ts had any d to the etice assessmens have the tice s have been it has been in is aware submit	
F 640	until 7/23/18' The above was condata Set) consultate Encoding/Transmit CFR(s): 483.20(f)(  §483.20(f) Automate requirement- §483.20(f)(1) Encodata facility completes facility must encode each resident in the (i) Admission assection (ii) Annual assessification (iii) Annual assessification (iv) Quarterly reviece (v) A subset of item reentry, discharge, (vi) Background (fais no admission assection (iii) Annual assessition (iii) System inforcontained in the Mistandard record la and that passes stom (iii) Annual assessition assection (iii) Annual assessition (iii) Annual assessition (iii) Annual assessition (iii) Annual assessition (iiii) Annual assessition (iiii) Annual assessition (iiiii) (iiiiiiiiiiiiiiiiiiiiiiiiiiiii	infirmed by the MDS ( Minimum int on 8/1/18 at 12:11 PM. Iting Resident Assessments 1)-(4)  Ited data processing ding data. Within 7 days after is a resident's assessment, a ethe following information for efacility. It is a session of the following information for efacility. It is a session of the following information for efacility. It is a session of the following information if there is a session of the following information, if there is session of the following information if there is a formation for each resident in the following in a formation of the following in the following. It is a formation of the following.	F 6	40	7. 8. 1. 2. 3. 4.	the administrator or demonths to monitor efforthe plan Results of the audits of reported to the QAA is a months at which the committee will determine the requency of the audit Corrective action will complete by 8/31/2014 83.20(f)(1)-(4) No identified resident negative effect relates alleged deficient prace Residents with MDS requiring submission potential to be affected alleged deficient prace All MDS assessments submitted at this point An MDS coordinator hired for the facility Facility administration of the requirement to MDS assessments with MDS assessments with the requirement to MDS assessments	esignee x3 fectiveness will be committee me the mine furthe ts. I be 8 ts had any d to the etice assessmen have the tice s have been the has been m is aware submit	į š

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES OR MEDICARE & MEDICAID SERVICES

CENTER	IS FOR MEDICARE	& MEDICAID SERVICES	,				1 10:000 000
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED		
							C
		475042	B WING				08/01/2018
574.51	ROVIDER OR SUPPLIER ANE NURSING HOM	E		60 MA	PLE L/	RESS, CITY, STATE, ZIP CODE ANE 'T 05822	
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F 640	Continued From pa	age 7	F 6	640	6.	Audits will be comple	ted weekly
		ection of prior full assessment.			v.	by the Administrator	
	(v) Significant corre	ection of prior quarterly	59			to monitor effectivene	
	assessment. (vi) Quarterly review	A/	51			plan	
		ms upon a resident's transfer,			7.	Results of the audits v	vill be
	reentry, discharge,					presented to the QAA	
		ace-sheet) information, for an of MDS data on resident that				x3 months at which ti	
		admission assessment.				committee will determ	
	C402 20/6/4) Data	format. The facility must				frequency of the audit	ts.
		format. The facility must be format specified by CMS or,			8.	Corrective action will	
	for a State which h	as an alternate RAI approved mat specified by the State and				completed by 8/31/20	18
		NT is not met as evidenced					
37	by:	erview and record review, the					
		ctronically transmit encoded.	2				9
<b>a</b>		plete Minimum Data Set					
		Centers for Medicare & ystem in a timely manner for 9					
	of 21 applicable re	sidents (Residents #1, #2, #14,					
	#56, #30, #161, #2 include:	10. #211, #310). Findings					
	include.						
		ew, Resident # 56 had an					
	August the contract of the con	inpleted 6/20/18. The not submitted to CMS until					
	7/12/18.						
	2 Per record revise	w, Resident # 30 had a					
		npleted 6/8/18. The					
	Assessment was n	ot submitted to CMS until					
	7/12/18.	w, the admission MDS					
		ent #210 was never					,

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES					OMB NO	0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ME NEW CONSESSOR		ONSTRUCTION		(X3) DATE SURVE COMPLETED	
		475042	B WING				08.	C (01/2018
CONVERMINATION FORCE OF	ROVIDER OR SUPPLIER	E		60 M	ET ADDRESS, CITY.	STATE, ZIP COD	7.E.	Ŷ s
WATELL	ANE NONOMO TOM			BAR	RTON, VT 05822			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID: PREFI TAG	×	(EACH CORRECT CROSS-REFERENCE)	PLAN OF CORRE TIVE ACTION SH CED TO THE APP EFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 640	with target date 12/	w, the MDS for Resident #211 29/17 was submitted to CMS	F 6	540		49		
	5. Per record revier Quarterly MDS con Assessment was a more than 14 days  6. Per record revier Significant Change Assessment was a more than 14 days	w, Resident #310 had an inpleted 1/10/18. The submitted to CMS on 2/26/18, after completion.  w, Resident #14 had a input MDS completed 4/16/18 The submitted to CMS on 6/14/18, after completion.		(d)				
	admission MDS for of 3/23/18 was sub than 14 days after 8 Per record revise admission MDS for	ew and staff interviews, the r Resident #2 with a target date nitted to CMS on 4/9/18, more				4,		
	quarterly MDS for I date of 1/5/18 was	ew and staff interviews, the Resident #161 with a target submitted to CMS on 3/26/18, after the assessment.	x		8	# (9)		g
	Consultant at the fa surveyors that the	not electronically submitted to juired timeframe g for MD & ID	F®	545				er e

§483.20(k) Preadmission Screening for

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FIGIENCIES RECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION.  A BUILDING		(X3) DATE SURVEY COMPLETED C	
475042	B. WING _		08/01/2018
		STREET ADDRESS, CITY, STATE, ZIP COE 60 MAPLE LANE BARTON, VT 05822	E
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		JEACH CORRECTIVE ACTION ST	HOULD BE COMPLE
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  475042  IER  OME  **STATEMENT OF DEFICIENCIES FNCY MUST BE PRECEDED BY FULL	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  475042  B. WING  IER  IOME  *STATEMENT OF DEFICIENCIES FINCY MUST BE PRECEDED BY FULL  (X2) MULT A. BUILDIN B. WING PREFIX	(X2) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  475042  B. WING  STREET ADDRESS, CITY, STATE, ZIP COD  60 MAPLE LANE BARTON, VT 05822  STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL ENCY MUST BE PRECEDED BY FULL ENCY MUST BE PRECEDED BY FULL TAG CROSS-REFERENCED TO THE AP

F 645 Continued From page 9 individuals with a mental disorder and individuals with intellectual disability.

§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:
(i) Mental disorder as defined in paragraph (k)(3)
(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and

- (B) If the individual requires such level of services, whether the individual requires specialized services; or
- (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission.
- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
- (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-

(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital

#### F 645 F 645 483.20(k)(1)-(3)

- 1. Resident #20, 35, and 310 have had no negative effect as a result of the alleged deficient practice. All 3 residents have now had a PASARR completed as required
- 2. Residents admitted to the facility have a potential to be affected by the alleged deficient practice
- 3. The Social Service Director has reviewed and understands the requirements for PASARR screening and timeframes
- 4. An audit will be completed weekly by the administrator or designee to monitor effectiveness of the plan
- 5. Results of the audits will be presented to the QAA committee x3 months at which time the committee will determine further frequency of the audits.
- 6. Corrective action will be completed by 8/31/2018

pe and \$23/8 KC/S

CENTER	S FOR MEDICARE	& MEDICAID SERVICES		rim r so	METRUCTION		ATE SURVEY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			NSTRUCTION	, , c	OMPLETED
AND PLAN OI	CORRECTION	MANUAL NEW W	CA CACHELLA		WINDOWS - 100 - 10		C
		475042	B. WING				08/01/2018
NAME OF P	ROVIDER OR SUPPLIER	<u></u>			TADDRESS, CITY, STATE, ZIP	CODE	
					APLE LANE		
MAPLEL	ANE NURSING HOM			BAR	TON, VT 05822 PROVIDER'S PLAN OF CO	DRRECTION	(X5)
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	COMPLETION
ERAS	Continued From p	page 10	F	645		es es	ē
F 043	(ii) The State may	choose not to apply the					
	preadmission scre	eening program under-					
	paragraph (k)(1) o	of this section to the admission					
	to a nursing facilit	y of an individual- ed to the facility directly from a					
	hospital after rece	eiving acute inpatient care at the					
	hospital						
	(B) Who requires	nursing facility services for the h the individual received care in					
	the hospital, and	II the marriage reserved out on					
	(C) Whose attend	ling physician has certified,			at a		
	before admission	to the facility that the individual		Ñ	581		
	is likely to require facility services.	less than 30 days of nursing					*
	1580						
	§483.20(k)(3) De	finition For purposes of this					
	section-	s considered to have a mental					
	(I) An Individual IS	lividual has a serious mental					
	disorder defined	in 483.102(b)(1).					
	(ii) An individual i	s considered to have an					
	intellectual disabi	lity if the individual has an lity as defined in §483.102(b)(3)					
-	or is a person wit	h a related condition as					
	described in 435.	1010 of this chapter.					
		ENT is not met as evidenced					
	by: Based on record	review and staff interviews, the					
X 92	facility failed to co	omplete a Preadmission					
	Screening and R	esident Review (PASARR) for					
	Mental Illness or	Intellectual Disability for 3 of 21 applicable sample (Resident #20					
	#35 & #310) Fir	nding Include.	5				
			_				
	Record review	indicated that Resident #20 was Jursing Facility (NF) on 1/24/17.	5				
	The list of diagno	oses includes a Psychiatric					
į.	Disorder which w	vould potentially entitle the			·*	1627	1 - 11
	resident to additi	onal specialized services			ax and	8/23/ 18	Replan

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	F DEFICIENCIES	CIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER A BUILDING			TE SURVEY MPLETED	
		475042	B WING_	.,	08/01/201	
	OVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP 60 MAPLE LANE BARTON, VT 05822	CODE	
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F 645 Continued From page 11 provided by the state.

> "Specialized Services" are those services the State is required to provide or arrange, that raise the intensity of services to the level needed by the resident. That is, specialized services are an "add-on" to NF services-they are of a higher intensity and frequency than specialized rehabilitation services, which are provided by the NF

> During an interview on 7/31/18, the Social Worker (SW) confirmed that the facility did not complete the PASARR screening. She provided the surveyor with a copy of the PASARR that was completed while the resident was at the hospital, as part of the discharge process and the form accompanies the resident on admission to the NF However, the form she provided indicated a short stay of 30 days or less. She confirmed that the facility failed to re-screen the resident as required when it was determined the stay would exceed 30 days

> 2. Per record review, Resident #310 was admitted to the facility on 6/29/17 with a PASSAR screening that was completed by the hospital before discharge to the NF. The physician checked the box on the form that indicated the Nursing Home placement was expected to be less than 30 days. The resident remained at this facility for long term placement, and there was no evidence that the resident was re-screened when the stay exceeded the 30 day timeframe. Per interview on 8/1/18 at 9.40 AM, the Social Worker confirmed that the re-screening was not completed as required

> 3. Per record review. Resident # 35 was admitted

F 645

If continuation sheet Page 12 of 16

DEFINIT	S FOR MEDICARE	R MEDICAID SERVICES				Ol	VIB NO. 0938-039 I	1
CENTERS FOR MEDICARE & MEDICAID SERVICES		(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A BUILDING				COMPLETED	
AND PLAN O	r CORRECTION .		A SUICE	1140		14	С	
		475042	B. WING		v:		08/01/2018	
		4/5042	London		EET ADDRE	SS CITY, STATE, ZIP CODE	1 0000112010	
NAME OF PROVIDER OR SUPPLIER					APLE LA			
MARIEL	ANE NURSING HOM	1E	_		RTON, VT			
men c.c.	-rumine and the sense are			L BA			N (X5)	=
(X4) ID PREFIX TAG	<ul> <li>FACH DEFICIENC</li> </ul>	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(FAC)	OVIDER'S PLAN OF CORRECTION GORRECTION SHOULD REFERENCED TO THE APPROPRICIENCY)	BE COMPLETION	
F 645	Continued From page	age 12	F	645				
1 0 10		re was no evidence of a						
7	PASSAR found in	the clinical record. The Social				*		
	Worker confirmed	that a PASSAR screening was						
g.	not available in the	e clinical record.		ne 66558				
F 695		eostomy Care and Suctioning	F	695	F695	483.25(i)		
SS=D	CFR(s): 483.25(i)					Resident #31 and 48 b		
	2 102 05/11 0	tana ana ingluding			60			
	§ 483.25(I) Respir	atory care, including and tracheal suctioning.				negative effects relate		
	The facility must e	nsure that a resident who				alleged deficient prac	tice and the	
	needs respiratory	care, including tracheostomy				oxygen tubing was re	placed	
	care and tracheal	suctioning, is provided such		9	2.	Residents requiring re	spiratory	
	care, consistent w	ith professional standards of				care have the potentia		
	practice, the comp	prehensive person-centered				affected by the alleged		
	and 483 65 of this	dents' goals and preferences,					1 deficient	
	This REQUIREME	ENT is not met as evidenced			100	practice		
	by:				3.	Education to be provi		
	Based on observa	ations, staff interviews, and				licensed nurses regard	ling the	
	record review, the	facility failed to provide				standards of practice !	for infection	
	respiratory care co	onsistent with professional				control as it relates to		
	for 2 out of 3 appli	ice regarding infection control, cable residents in the sample				care	P	
İ		nd #48). Findings include:			4			
e:	(1100)Conto no car	3			4.	Audits will be comple	35.	ŝ.
		on 7/30/2018 at 2:34 PM,			*	by the Director of Nur		
	Resident # 31's ox	kygen lubing on the oxygen				designee to monitor e	ffectiveness	
	concentrator that	was in use was not dated and				of the plan		
	the oxygen tubing	on the portable oxygen was not in use was also not			5.	Results of the audits v	vill be	
		ed Practical Nurse Unit				presented to the QAA		
		Coordinator, (LPN) (UC), confirmed that the tubing should be dated and that it was not on				x3 months at which ti		
		PM. The UC also stated that				committee will determ	and the second of the second o	
		ng should be documented in			8	frequency of the audit		
1		ord, (TAR). There was no			6.	Corrective action will	be	
		AR that the tubing had been				completed by 8/31/20	18	

CENTERS FOR MEDICAR			CONCERNICATION	(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	N 100	CONSTRUCTION	COMPLETED
		S S S S S S S S S S S S S S S S S S S		C
	475042	B WING		08/01/2018
NAME OF PROVIDER OR SUPPLIE	3		REET ADDRESS, CITY, STATE, ZIP CODE	
MAPLE LANE NURSING HO	ME	3	MAPLE LANE ARTON, VT 05822	
			PROVIDER'S PLAN OF CORRECTION	)N (X5)
PRECY (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
2		E 605		
F 695 Continued From		F 695	*	
nurse confirmed	hat it was policy to document vas changed in the TAR and that			
it was not docum	ented in the TAR.			
it was not decail.	# I I a			
Resident # 48's of was not dated. O UC, confirmed the date and that it we	m Review-12 hr/yr In-Service	F 730	F730 483.35(d)(7)  1. No residents were neg	gatively
The facility must of every nurse ai months, and muse education based reviews. In-serving requirements of This REQUIREM by:  Based on staff in facility failed to e Assistants (LNAs evaluations and required. Finding Per review of the not receive the 1 required by regulation of Nurse AM. Additionally, in the facility have evaluations for significant requirements.	enterview and record review, it ensure that Licensed Nursing is received annual performance at least 12 hours of training as sinclude:  training records, 24 LNAs did 2 hours of annual training as ation. This was confirmed by the is (DON) on 7/31/18 at 11:00 the DON confirmed that no staff e had annual performance everal years.  nt,Store/Prepare/Serve-Sanitary		affected by the allege practice  2. Residents in our care potential to be affecte alleged deficient prac  3. Facility administratio reviewed and is aware requirements for LNA and performance evaluantially  4. LNA staff will receive required hours of train corrective action date  5. LNA staff will receive performance evaluation corrective action date	have the d by the tice n has e of the training uations e the ning by the
SS=F CFR(s): 483.60(	)(1)(2)		Ĭ.	

-	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					T 0930-0391
51	TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PHOVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDIN			CTION	(X3) DATE SURVEY COMPLETED
			475042	B. WING _				C 08/01/2018
1	VAME OF E	PROVIDER OR SUPPLIER	L	T	STRE	ETADDE	RESS, CITY, STATE, ZIP CODE	
			e.			APLE L		
-	MAPLE	ANE NURSING HOM	E		BAR		/T 05822	
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SCIDENTIFYING INFORMATION)	ID PREFIX TAG	3	(FA	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD S-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
	F 695	Continued From pa	ge 13 at it was policy to document	F 69	95			
		when the tubing wa it was not documen	is changed in the TAR and that	÷ =		4 1		
	F 730 SS=C	Resident # 48's oxy was not dated. On UC, confirmed that date and that it was Nurse Aide Peform CFR(s): 483.35(d)(  §483.35(d)(7) Regulate The facility must confevery nurse aide months, and must peducation based or reviews. In-service requirements of §44 This REQUIREMENT by:  Base: on staff interfacility failed to ensure Assistants (LNAs) reserved.	Review-12 hr/yr In-Service 7)  Itar in-service education. Implete a performance review at least once every 12 provide regular in-service in the outcome of these training must comply with the 83.95(g).  Note in the education of the evidenced review and record review, the ure that Licensed Nursing eceived annual performance east 12 hours of training as	F 73	30	250 H	Ongoing tracking and a be done monthly to rev required training hours performance evaluation. The tracking and audits presented to the QAA ox 3 months at which time committee will determine frequency of audits. Corrective action will be complete by 8/31/2018	and and as due s will be committee and
		not receive the 12 h required by regulation Director of Nurses ( AM. Additionally, the in the facility have he evaluations for seve	Store/Prepare/Serve-Sanitary	F 81	2			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/09/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER			(X3) DATE SURVEY COMPLETED
		475042			08/01/2018
- 1100000000000000000000000000000000000	VIDER OR SUPPLIE E NURSING HO			STREET ADDRESS, CITY, STATE, ZIP CODE 60 MAPLE LANE BARTON, VT 05822	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROPROFICIENCY)	D BE COMPLETION	

#### F 812 Continued From page 14 §483.60(i) Food safety requirements. The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.

(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.

(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.

(iii) This provision does not preclude residents from consuming foods not procured by the facility.

\$483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced

Based on staff interview and record review, 9 facility failed to prepare, distribute and serve food in accordance with professional standards for food service safety regarding monitoring the temperatures of served food items. Findings include:

Per review of the food temperature logs for the past 4 months (April, May , June, July 2018), there is no indication that hot or cold beverages' temperatures were monitored. Additionally, there are 13 meals labeled "cold plate" with no temperatures for the food. There are 31 meals that have only one food item with a temperature. There are also 11 meals that no food temperatures were taken

The above was confirmed by the Dietary Manager

#### F812 483.60(i)(1)(2)

- 1. No residents had any negative effect related to the alleged deficient practice
- 2. Residents receiving food and beverages in the facility have the potential to be affected by the alleged deficient practice
- 3. Education will be provided to dietary staff regarding the requirements for monitoring temperature of food and beverages to include cold plates
- 4. Audits will be done weekly to monitor effectiveness of the plan
- 5. Results of the audits will be presented to the QAA commit : x3 months at which time the committee will determine further frequency of the audits
- 6. Corrective action will be completed by 8/31/2018

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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID 5JDX11

PRINTED: 08/09/2018 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391							
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A BUILDING	C				
	475042	B. WING	08/01/2018				
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CIT	STATE, ZIP CODE				
MAPLE LANE NURSING HOM		60 MAPLE LANE BARTON, VT 05822					
PREEIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRE	S PLAN OF CORRECTION (X5) COTIVE ACTION SHOULD BE COMPLETION INCED TO THE APPROPRIATE DATE DEFICIENCY)				
F 812 Continued From page 1	(7)	F 812					
on 7/30/18 at 1:20	PM						
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