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 28, 2019

Mr. Travis Bergeron, Administrator
Maple Lane Nursing Home
60 Maple Lane
Barton, VT 05822-9494

Dear Mr. Bergeron:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 12, 2019**. 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
Licensing Chief

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475042	A. BUILDING _____ B. WING _____	06/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE LANE NURSING HOME	60 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) COMPLETION DATE
E 000	Initial Comments An unannounced onsite emergency preparedness survey was completed by the Division of Licensing and Protection from 6/10-12/19. The facility was found in substantial compliance with emergency preparedness regulations.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite re-certification survey was completed by the Division of Licensing and Protection from 6/10-12/19. The following regulatory violations were identified:	F 000		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) *Notice before transfer.* Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the	F 623	F623 1. Resident 61 had no negative outcome of the alleged deficient practice. 2. Resident 61 has been provided with a written notice of the transfer that occurred on May 2, 2019. 3. The ombudsman has been notified of the transfers of the following residents; 51, 60, 61, 162, 54, 262. 4. Residents requiring transfer out of the facility have the potential to be affected by the alleged deficient practice. 5. We will provide education to the license nurses for the requirement for the transfer notice related to transfers from the facility. Social worker will be educated on requirement to notify ombudsman	

poc accepted 6/27/19 Jane Hammond

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 6/26/19

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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resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and

of all transfers.

6. Administrator or designee will do weekly audits for 3 months to assess the effectiveness of the plan.
7. Results of the audit will be reported to the QAA committee for 3 months and then committee will determine if further audits are required.
8. Corrective action date July 6, 2019.

PoC accepted 6/27/19
Jane Hosmer RN

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telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to notify the resident and/or the resident's representative in writing, of a transfer/discharge for 1 resident in a sample of 6, (Resident # 61). The facility also failed to notify a representative of the Office of the State Long-Term Care

POC accepted 6/27/19 Jane Hosmer RN

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Ombudsman as required for 6 of 6 sampled residents (Residents #51, #54, #60, #61, #162, and #262) . The findings include the following:

1. Per medical record review for Resident #61, a physician order was written for transfer to the hospital for acute care on 05/02/19. The resident returned to the facility the same day. There is no evidence identifying that the resident and/or family representative was provided with written notification of transfer/discharge.

Confirmation was made by the Social Service Director on 06/11/19 at approximately 3 PM, that s/he was not aware that a notice was to be issued if the resident is sent to the Emergency Room. S/he also confirms, that the office of the Long-Term Care Ombudsman was not notified of the transfer as required.

2. Per medical record review, Resident #51 was transferred to hospital for acute care on 5/4/19. As confirmed by the Director of Social Services on 6/12/19 at 12:15 PM, the Office of the State Long Term Care Ombudsman was not notified of the transfer as required.

3. Per medical record review, Resident #60 was transferred to hospital for acute care on both 3/20/19 and 5/16/19. As confirmed by the Director of Social Services on 6/12/19 at 12:15 PM, the Office of the State Long Term Care Ombudsman was not notified of the transfer as required.

4. Per medical record review, Resident #162 was transferred for in-patient hospital care on 5/9/19, and the stay lasted until re-admission on 6/7/19. As confirmed by the Director of Social Services on 6/12/19 at 12:15 PM, the Office of the State Long Term Care Ombudsman was not notified of

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the transfer as required.

5. Per medical record review, Resident #54 was transferred to the hospital for acute care on 3/29/19, readmitted to the facility on 4/2/19. On 4/7/19 they were again transferred to the hospital for acute care and readmitted to the facility on 4/8/19. On 4/15/19 they were transferred for in-patient hospital care and remained in the hospital until re-admitted to the facility on 4/19/19. As confirmed by the Director of Social Services on 6/12/19 at 11:09 AM, the Office of the State Long Term Care Ombudsman was not notified of the transfers as required.

6. Per medical record review, Resident #262 was transferred for in-patient hospital care on 6/1/19 and remained in the hospital until re-admitted to the facility on 6/5/19. As confirmed by the Director of Social Services on 6/12/19 at 11:09 AM, the Office of the State Long Term Care Ombudsman was not notified of the transfer as required.

F 623

F 655 Baseline Care Plan
SS=D CFR(s): 483.21(a)(1)-(3)

§483.21 Comprehensive Person-Centered Care Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information

F 655

F655

1. Resident 6 had no negative outcome of the alleged deficient practice.
2. Resident 6 has a comprehensive care plan in place.
3. New admissions to the facility have the potential to be affected by the alleged deficient practice.
4. We will provide education to care plan team on the requirement of the baseline care plan.

POC accepted 6/27/19 Jane Hosmer RN

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necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to develop a baseline care plan within 48 hours of admission for 1 applicable resident in the sample of 17 (Resident #6). The findings include the following:

Per review of the medical record on 06/12/19 for

5. DNS or designee will do weekly audits for 3 months to assess the effective of the plan.
6. Results of the audits will be reported to the QAA committee for 3 months and the committee will determine if further audits are required.
7. Corrective action date July 6, 2019.

POC accepted 6/27/19
Jane Hoffman RN

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Resident #6, the admission date was 03/13/19. The care plan dated 03/13/19 identifies only one problem related to Diabetes, and does not provide instructions regarding initial goals based on admission orders, dietary orders, and other person-centered general care.

Confirmation was made by the Licensed Practical Nurse (LPN) Unit Manager on 06/12/19 at 7:55 AM, that the care plan was developed late, 4 days after the required 48 hours and 6 days after admission.

F 656 SS=D Develop/Implement Comprehensive Care Plan
CFR(s): 483.21(b)(1)

§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR

F 655

F656

F 656

1. Resident 62 had no negative outcome of the alleged deficient practice.
2. Resident 62's care plan has been updated to address his wound care needs.
3. Residents residing the in the facility have the potential to be affected by the alleged deficient practice.
4. We will provide education to the IDT on the requirements of the comprehensive care plan to meet the care needs of the resident.
5. DNS or designee will do weekly audits for 3 months to assess the effectiveness of the plan.
6. Results of the audit will be reported to the QAA committee for 3 months and then committee will determine if further audits are required.
7. Corrective action date July 6, 2019

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recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and confirmed by staff interview, the facility failed to develop a plan of care for 1 of 17 residents (Resident #262) for wound care. Findings include:

Per record review Resident #262 was admitted to the facility on 5/13/19 with a wound to the right side of their forehead. The resident had a physician order to apply a Mepilex dressing to this wound. There was a flow sheet documenting the healing of the wound including weekly measurements. Per observation over 3 days of survey (6/10 - 6/12/19) Resident #262 had a bandage on their forehead located over their right eyebrow. However, there was no evidence in the clinical record that a care plan was developed to address Resident #262's wound care needs.

The Licensed Practical Nurse (LPN) confirmed on

PoC accepted 6/27/19 Jane Hosmer RN

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6/11/19 at 1:26 PM that as the Unit Coordinator s/he should have developed a plan of care to address the wound, and that there was no evidence in the clinical record that one had been developed.

F 656

F 658 Services Provided Meet Professional Standards
SS=E CFR(s): 483.21(b)(3)(i)

§483.21(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review the facility failed to ensure that care plans for residents were developed and revised, or approved by a Registered Nurse (RN) for 4 of 17 residents reviewed in the sample (Residents #6, #53, #61, and #63). This has the potential to affect all residents in the facility. The findings include the following:

1. Per medical record review, Resident #6 has a comprehensive care plan completed and reviewed on 03/19/19 and 05/28/19. Neither care plan shows signature evidence that either a Licensed Practical Nurse (LPN) or an RN were in attendance during the review. Further, there is no evidence that an RN approved the care plan if it was completed or revised by an LPN.

Confirmation was made by the Unit Manager LPN on 06/12/19 at 7:55 AM that care plans are initiated, developed and revised by the LPN Unit Managers, and no RN has approved the care plan for Resident #6. Confirmation was also

F 658 F658

1. No residents had any negative outcome as a result of the alleged deficient practice.
2. The care plans for residents 6, 53, 61, 63 have been review and approved by a RN.
3. Care plans for the residents residing in the facility have been review and approved by a RN.
4. Residents residing in the facility have the potential to be affected by the alleged deficient practice.
5. We will provide education to the licensed nurses on the requirements of the care plan meeting attendance and RN review and approval of the care plan.
6. DNS or designee will do weekly audits for 3 months to assess the effectiveness of the plan.
7. Results of the audit will be reported to the QAA committee for 3 months and then committee will determine if further audits are required.
8. Corrective action date July 6, 2019

POC accepted
6/27/19
Jane Hosmer RN

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made at this time that the LPN was in attendance at the 5/28/19 meeting, but neglected to sign in as present.

2. Per medical record review, Resident #61 has a comprehensive care plan completed and reviewed on 02/20/19 and 04/24/19. The care plan reviews show an LPN was in attendance for those meetings. However, there is no sign off by the RN approving the care plan.
Confirmation was made by the Unit Manager LPN on 06/12/19 at 4:00 PM that care plans are initiated, developed and revised by the LPN Unit Managers and no RN has approved the care plan for Resident #61.

3. Per record review, Resident #63 was admitted for short term rehab on 4/2/19, and discharged to home on 4/12/19. There was a baseline care plan in place signed by an RN on 4/2/19. The comprehensive nursing care plan dated 4/10/19 was written by the LPN Unit Manager with no evidence of RN oversight. Per interview on 6/11/19 at 3:45 PM, the Director of Nursing confirmed that there was no evidence on Resident #63's 4/10/19 care plan that the entries made by the LPN were reviewed and approved by an RN.

4. Per medical record review, Resident #53 has a comprehensive care plan dated 3/30/18 with multiple updates, including the last update on 6/6/19. On the signature page for the 6/6/19 care plan review meeting, a Licensed Practical Nurse (LPN) was in attendance. There is no evidence in the medical record that a Registered Nurse (RN) developed, revised, reviewed or approved any portion of the care plan. There are no signatures on many of the pages, so it is not

POC accepted 6/27/19
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known who actually was involved in writing the care plan. The signatures that are present, are LPN's.

The LPN [who is also the Unit Coordinator] confirmed on 6/11/19 at 1:26 PM that care plans are initiated, developed and revised by the LPN Unit Managers, and there is no process in place at this time for an RN review.

Professional reference:

In the Vermont State Board of Nursing document titled Determining Scope of Practice Position Statement and Decision Tree, approved November, 2009, the following is stated:
"LPN role in assessment, planning, and implementation of a strategy of care:
-LPNs may not independently assess the health status of an individual or group and may not independently develop or modify the plan of care. LPNs may contribute to the assessment and nursing care planning processes; however, patient assessment and care plan development or revision remain the responsibility of the RN/APRN/licensed physician/licensed dentist.
-LPNs may not modify a patient care protocol. If the situation and/or data collected by the LPN are not clearly consistent with a protocol, the LPN must consult with the supervising professional or authorized provider before taking action or making a recommendation to a patient."

F 842 SS=E Resident Records - Identifiable Information
CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) — F 842

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is

POC accepted 6/27/19
Jane Hosmer RN

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475042	A. BUILDING _____ B. WING _____	06/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE LANE NURSING HOME	60 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) COMPLETION DATE
F 842	Continued From page 11	F 842	F842	

resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical

1. No residents had a negative outcome for the alleged deficient practice.
2. Care plan have been reviewed for residents residing in the facility for missed information and identified missing information has been corrected.
3. Residents residing the in the facility have the potential to be affected by the alleged deficient practice.
4. We will provide education to the IDT on the requirements of the complete and accurate information of the comprehensive care plan.
5. DNS or designee will do weekly audits for 3 months to assess the effectiveness of the plan.
6. Results of the audit will be reported to the QAA committee for 3 months and then committee will determine if further audits are required.
7. Corrective action date July 6, 2019

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Jane Stoner RN

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record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review the facility failed to ensure that resident care plans are maintained for each resident according to professional standards of practice, to include but not limited to completeness and are accurately documented, for 6 of 17 residents in the sample (Residents #6, #53, #57, #61, #63, and #262). This has the potential to affect all residents in the facility. The findings include the following:

1. Per medical record review during the survey (06/10/19-06/12/19), comprehensive care plans for Residents #6, #57 and #61 have the following missing/incomplete and inconsistent

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Jane Hosmer RN

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

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	475042	A. BUILDING _____ B. WING _____	06/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE LANE NURSING HOME	60 MAPLE LANE BARTON, VT 05822

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F 842	Continued From page 13	F 842		

documentation: no dates identifying when the problem was initiated or revised, no staff signature identifying who had written the care plan entries, no identification as to the discipline responsible for various interventions, no medical record number identifying the appropriate record, missing resident names on some problems and resident identification by last name only.

Confirmation was made by the Licensed Practical Nurse Manger during the identified time frame that care plan documentation for Residents #6, #57 and #61, is not consistently completed and in some instances disorganized and difficult to read that could result in inaccuracies.

2. Per record review, Resident #63 was admitted for short term rehab on 4/2/19. The comprehensive care plan developed on 4/10/19 did not include the name of the resident on multiple pages of the care plan, had no dates as to when it was developed, and no staff signatures to indicate who had written the care plan entries. Per interview on 6/11/19 at 3:45 PM, the Director of Nursing confirmed the care plan was missing resident name, staff signatures, and date of its development.

3. Per medical record review, Resident 53 was admitted 11/30/11. The comprehensive care plan that was included in the medical record had several pages dated 3/30/18 with multiple updates, and the last care plan review meeting was held 6/6/19. Throughout the document there is missing/incomplete and inconsistent documentation: no dates identifying when the problem was initiated or revised, no staff signature identifying who had written the care

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Jane Hosmer RN

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	475042	A. BUILDING _____ B. WING _____	06/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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plan entries, no identification as to the discipline responsible for various interventions, no medical record number identifying the appropriate record, missing resident name on some pages and resident identification by last name only and first initial.

4. Per medical record review, Resident #262, was admitted 5/13/19. The comprehensive care plan that was included in the medical record had a date of 5/13/19 on several pages, with other pages having no dates at all. The last care plan review meeting was held on 5/17/19. Throughout the document there is missing/incomplete and inconsistent documentation: no dates identifying when the problem was initiated or revised, no staff signature identifying who had written the care plan entries, no identification as to the discipline responsible for various interventions, no medical record number identifying the appropriate record, missing resident name on some pages.

During interview on 6/11/19 the Licensed Practical Nurse Manger (LPN) confirmed that care plan documentation for Residents #53 and #262, is not consistently completed, there is potentially crucial information missing and, in some instances, they are disorganized and difficult to read which could result in inaccuracies.

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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE
	475042	A. BUILDING _____ B. WING _____	6/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE LANE NURSING HOME	60 MAPLE LANE BARTON, VT

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 625	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to notify the resident and/or resident's representative in writing of the bed hold policy for 1 of 6 sampled residents, (Resident #61). The findings include the following: Per record review, Resident #61 was transferred to the Emergency Room on 05/2/19 for medical evaluation and returned to the facility the same day. Confirmation was made by the Social Service Director on 06/11/19 at approximately 3:00 PM, that s/he was not aware that a bed hold notice was to be provided if the resident is sent to the Emergency Room. *This is an "A" level citation, no plan of correction is required; however, the facility is required to correct. POC accepted 6/27/19 Jane Hosmer RN

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

The above isolated deficiencies pose no actual harm to the residents

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
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S 000	Initial comments During the course of an annual recertification survey, completed 6/10/19-6/12/19 by the Division of Licensing and Protection, the following violation of the Licensing and Operating Rules for Nursing Homes was identified.	S 000		
S240 SS=B	3.14 (e-f) TRANSFER AND DISCHARGE - CONTENTS 3.14 (e) The written notice specified in this subsection shall be on a form provided by the licensing agency or one that is substantially similar and must include the following: 1. the reason for transfer or discharge; 2. the effective date of transfer or discharge; 3. the location to which the resident is being transferred or discharged; 4. a statement in large print or large point type that the resident has the right to appeal the facility's decision to transfer or discharge to the State, with the appropriate information regarding how to do so as set forth in 3.14 h. below; 5. the name, address and telephone number of the State Long Term Care Ombudsman; 6. a statement that the resident may remain in place pending the appeal; 7. for nursing home residents with developmental disabilities, the mailing address and telephone number of the Developmental Disability Law Project and that of the Department's Developmental Disabilities Services Division; and/or 8. for nursing facility residents with mental illness, the mailing address and telephone number of Disability Rights Vermont. 3.14 (f) Transfer or Discharge Agreement. If the resident agrees to the transfer or discharge, the transfer or discharge may occur prior to the	S240	S240 1. No residents had a negative outcome for the alleged deficient practice. 2. Residents requiring transfers have the potential to be affected by the alleged deficient practice. 3. The transfer notice form has been updated to have the section related to the appeal section in a larger print. 4. Corrective action date July 6, 2019 BC accepted 6/27/19 Jane Hosmer RN	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 6/26/19

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
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S240	Continued From page 1 effective date of the notice. This REQUIREMENT is not met as evidenced by: Based on review of transfer notices provided by the facility for 5 of 6 residents in the applicable sample (Residents #51, 54, 60, 162, and 262), the facility failed to ensure that large print or large point type was used for the section on right to appeal to the State regarding the facility initiated transfer. Findings include: The Director of Social Services (SS) provided copies of the notices provided when Residents #51, 54, 60, 162, and 262 were transferred from the facility to hospital for acute care. However, as confirmed by SS on 6/11/19 at 2:00 PM, the section outlining the appeal rights was in part bolded, but it did not contain large print or large point type.	S240	POC accepted 6/27/19 Jane Hosmer RN	