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

October 18, 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 **September 18, 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

Pamela M. Cota, RN
Licensing Chief

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 _____	C 09/18/2019

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 000	INITIAL COMMENTS An unannounced onsite investigation of seven entity self-reports was investigated by the Division of Licensing and Protection on 9/18/19. The following regulatory violations were identified.	F 000		
F 656 SS=E	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 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.	F 656	F656 1. Identified residents care plans have been reviewed to ensure care needs are addressed. 2. Residents with a potential for resident to resident altercations have the potential to be affected by the alleged deficient practice. 3. Care plans for other residents residing on the unit have been reviewed. 4. We will provide education to the staff regarding the prevention of resident to resident altercations and resident supervision needs. 5. DNS or designee will do weekly environmental rounds for 3 months to ensure adequate supervision levels. 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 October 18, 2019. F656 POC accepted 10/16/19 JHesmerRN/pmc	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/10/19

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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F 656	Continued From page 1	F 656		

(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 observations, record review and staff interview, the facility failed to effectively implement the written plan of care regarding staff supervision while out of the room for 6 of 8 residents (Residents #1, 2, 3, 4, 5, 6) in the applicable sample. Findings include:

1. Per documentation provided by the facility, on 7/1/19 Resident #1 and Resident #2 were discovered in the hallway near the main dining room of the lower level unit. Resident #2 was on the floor with walker device nearby, and Resident #1 was standing over Resident #2. Both residents have dementia diagnoses. On 6/20/19 the written care plan of Resident #2 was revised to state that staff should monitor while out of the room and attempt to prevent intruders. The incident happened just outside the room of Resident #2. Resident #1 had a history of multiple resident altercations related to behaviors of intrusion and wandering. In fact, the surveyor observed Resident #1 attempting to enter the room of Resident #2 who opened her/his door on 9/18/19 at approximately 2:30 PM. It happened that the DNS was nearby and able to prevent intrusion.

2. Per record review, Resident #3 has a history of

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F 656	Continued From page 2	F 656		

aggressive behaviors and making derogatory comments toward men. Per review of the record, Resident #3 had made statements specifically about Resident #4, calling him/her derogatory names and stating that s/he did not like him/her. Resident #4 also has dementia, and walks back and forth on the unit independently, and can walk very quickly. Resident #3 has a care plan that indicates staff are supposed to provide constant supervision when Resident #3 is out of bed to avoid conflicts between residents. Also the plan of care includes the intervention of making sure other residents do not enter the room of Resident #3. On 6/21/19, Resident #4 was walking past Resident #3 in the hall; Resident #3 exchanged words with Resident #4, and Resident #4 punched Resident #3 who also struck back. This was witnessed by the hairdresser, who alerted the nurse. The staff intervened and separated them. Per interview on 9/18/19 at 11:25 AM, the DNS confirmed that there was no close supervision provided at the time these two residents came into contact with each other in the hallway.

3. Resident #5 has dementia, poor eyesight, and a history of sexually inappropriate actions toward staff at times. On 9/5/19, Resident #5 was found in the room of Resident #6, who also has dementia, and had their hands inside the pants and touching the thigh of the other resident. The plan of care revision on 9/5/19 for Resident #5 states that staff are to "monitor very closely when out of room to whereabouts and prevent resident from being alone with female residents". Prior to this addition, the care plan on 8/14/19 also identified that the resident had the potential for altercations with other residents and

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F 656	Continued From page 3 inappropriate touching/sexual behaviors, and directed staff to monitor whereabouts when out of bed, and to place an alarmed strip on door when Resident #5 was in their room so they would know when the resident came out of the room. On 9/18/19 at 2:50 PM, one of two surveyors on site was observing the corridor near the lower level dining room. No staff were present when Resident #5 crawled on hands and knees under the alarmed STOP sign across his/her doorway and crawled directly across the hall to the room of Resident #6. As the surveyor walked up the corridor to alert a staff person, Resident #6 came around the corner and was going to his/her room. The surveyor detained Resident #6 with conversation and waved to staff in the common area, summoning assistance. Two Licensed Nurse Assistants responded and re-directed both residents. The nurse and DNS were advised of the situation and the lack of supervision in that corridor during the incident. Per interview on 9/18/19 at 11:30 AM and again at 3:30 PM, the DNS confirmed that this is the care plan as written, and that the residents had instances when they were not closely monitored by staff.	F 656		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689	F689 1. Identified residents have been reviewed for appropriate placement in the facility to allow for adequate supervision. 2. Residents residing on the unit have the potential to be affected by the alleged deficient practice. 3. The environment has been assessed and reviewed. Environment and staff assignments have been revised to allow for adequate supervision. 4. We will provide education to staff on preventing resident to resident altercations, adequate supervision and resident specific triggers. 5. DNS or designee will do weekly environmental rounds 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 October 18, 2019.	

F689 POC accepted 10/16/19 JHesmerRN/PMC

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F 689	Continued From page 4	F 689		

by:
Based on observations, record review and staff interview, the facility failed to effectively supervise 6 of 8 residents (Residents #1, 2, 3, 4, 5, 6) in the applicable sample, resulting in opportunities for negative resident to resident encounters. Findings include:

1. Per documentation provided by the facility, on 7/1/19 Resident #1 and Resident #2 were discovered in the hallway near the main dining room of the lower level unit. Resident #2 was on the floor with walker device nearby, and Resident #1 was standing over Resident #2. Both residents have dementia diagnoses. On 6/20/19 the written care plan of Resident #2 was revised to state that staff should monitor while out of the room and attempt to prevent intruders due to his/her tendency to strike out at others. Resident #1 had a history of multiple resident altercations related to behaviors of intrusion and wandering, and the written care plan instructed staff to redirect him/her from intruding. Residents #1 and #2 were unwitnessed by staff when they had the physical altercation on 7/1/19, as confirmed by the Director of Nursing (DNS) in the summary report dated 7/5/19. In fact, the surveyor observed Resident #1 attempting to enter the room of Resident #2 who opened her/his door on 9/18/19 at approximately 2:30 PM. It happened that the DNS was nearby and able to prevent intrusion. Per interview on 9/18/19 at approximately 3:30 PM, the Administrator and DNS described plans to improve visibility of the corridor where this incident happened [not yet in effect] and acknowledged the current lack of visibility off the common area corridor.

2. Per record review, Resident #3 has a history of

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F 689	Continued From page 5	F 689		

aggressive behaviors and making derogatory comments toward men. Per review of the record, Resident #3 had made statements specifically about Resident #4, calling him/her derogatory names and stating that s/he did not like him/her. Resident #4 also has dementia, and walks back and forth on the unit independently, and can walk very quickly. Resident #3 has a care plan that indicates staff are supposed to provide constant supervision when Resident #3 is out of bed to avoid conflicts between residents. Also the plan of care includes the intervention of making sure other residents do not enter the room of Resident #3. On 6/21/19, Resident #4 was walking past Resident #3 in the hall; Resident #3 exchanged words with Resident #4, and Resident #4 punched the Resident #3 who also struck back. This was witnessed by the hairdresser, who alerted the nurse. The staff intervened and separated them. Per interview on 9/18/19 at 11:25 AM, the DNS confirmed that there was no close supervision provided at the time these two residents came into contact with each other in the hallway.

3: Resident #5 has dementia, poor eyesight, and a history of sexually inappropriate actions toward staff at times. On 9/5/19, Resident #5 was found in the room of Resident #6, who also has dementia, and had their hands inside the pants and touching the thigh of the other resident. The plan of care revision on 9/5/19 for Resident #5 states that staff are to "monitor very closely when out of room to whereabouts and prevent resident from being alone with female residents". Prior to this addition, the care plan on 8/14/19 also identified that the resident had the potential for altercations with other residents and

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F 689	Continued From page 6	F 689		

inappropriate touching/ sexual behaviors and directed staff to monitor whereabouts when out of bed, and to place an alarmed strip on door when Resident # 5 was in their room so they would know when the resident came out of the room.
On 9/18/19 at 2:50 PM, one of two surveyors on site was observing the corridor near the lower level dining room. No staff were present when Resident #5 crawled on hands and knees under the alarmed STOP sign across his/her doorway and crawled directly across the hall to the room of Resident #6. As the surveyor walked up the corridor to alert a staff person, Resident #6 came around the corner and was going to his/her room. The surveyor detained Resident #6 with conversation and waved to staff in the common area, summoning assistance. Two Licensed Nurse Assistants responded and re-directed both residents. The nurse and DNS were advised of the situation and the lack of supervision in that corridor during the incident.
Per interview on 9/18/19 at 11:30 AM and again at 3:30 PM, the DNS confirmed that these residents had instances when they were not closely monitored by staff to prevent altercations or sexually inappropriate behaviors.