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

July 5, 2023

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 complaint investigation conducted on **June 19, 2023.** 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 06/19/2023

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 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced onsite investigation of one complaint on 6/19/23. The following regulatory violations were cited.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to update the care plan for one of three residents sampled (Resident #1). Findings include:	F 657	F657 1. Resident #1 no longer resides in the facility. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. IDT members are aware of the requirement to ensure care plans are updated to reflect current needs and appropriate interventions. 4. An initial audit will be completed for other residents residing in the facility to ensure the care plan addresses appropriate concerns and interventions. 5. The Director of Nursing or designee will conduct audits weekly to monitor the effectiveness and compliance of the plan. 6. The results of the audits will be reported to the QAA committee x3 months at which time the committee will determine further frequency of the audits. 7. Corrective action will be completed by 7/4/2023. **Tag F 657 POC accepted on 7/5/23 by H. Fox/P. Cota**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 6/30/23.

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 657	Continued From page 1	F 657		

The care plan for Resident #1 was not updated to accurately reflect the number, location and care required for actual impaired skin.
Resident #1 has diagnosis including paraplegia status post motor vehicle accident, schizoaffective disorder, developmental disorder and hypertension.
During an investigation into a complaint regarding the hospitalization of Resident #1 for serial debridement of pressure ulcers in the left ischium and right labial area the care plan was reviewed.
The care plan contained 3 separate entries for "Skin actual impairment" these entries were compared to the most recent wound documentation prior to hospitalization.

On 5/31/23 the following wounds were documented:
Left thigh/butt crease 8cm (centimeter) x 7.5 cm
Right labia and inside 5cm x 6.3 cm
Right thigh 7.4 x 3.3 cm
Right thigh/butt crease 3 cm x 3.3 cm
Sacral 2.6 x 1/8 with 4 cm tunnel between 3 and 4 o'clock

Care plan entries:

#1 dated 6/23/22 reviewed 5/23/23.
Skin actual: Resident exhibits alteration in skin integrity as evidence by stage IV to sacral area upon admission, resistive/refusal of care/repositioning. Bilateral heel pressure ulcers. Left heel resolved 5/10/23.
#2 dated 3/7/23 reviewed 5/23/23.
Skin actual exhibits alteration in skin integrity as evidenced by breakdown on heels and purple area on other heel and right outer aspect of foot. [name

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F 657	Continued From page 2 removed] is non-compliant with treatment which increases his/her risk for complications. #3 dated 5/10/23 reviewed 5/23/23. Actual alteration in skin integrity related to inner left thigh, right shin. Entry #1 was not updated to reflect the right heel was healed. Entry #2 was not updated to reflect both heels and right outer aspect of foot have healed. Additionally it is not clear which foot had been involved. Entry #3 lacks clarity entirely. There is no mention of 4 of the 5 areas of impaired skin integrity in the care plan. During an interview with the Director of Nursing on 6/19/23 at 1:30 PM s/he confirmed the care plan was not accurate and had not been updated.	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility	F 686	F686 Note area of the left ischium was reported to MD on 5/26/2023 and a treatment was ordered. 1. Resident #1 no longer resides in the facility. 2. Residents with the risk of pressure ulcers have the potential to be affected by the alleged deficient practice. 3. Nurses will be educated on the clinical protocol for Pressure Ulcers/Skin Breakdown. 4. The Director of Nursing or designee will conduct audits weekly to monitor the effectiveness and compliance of the plan. 5. The results of the audits will be reported to the QAA committee x3 months at which time the committee will determine further frequency of the audits.	

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F 686	Continued From page 3 failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing for one of three residents sampled (Resident #1). Findings include: The provider was not notified of a newly discovered pressure ulcer and a treatment that was not ordered was provided to Resident #1. On 6/19/23 during an investigation of a complaint regarding the hospitalization of Resident #1 it was noted in the electronic health record that on 5/27/23 a facility Licensed Practical Nurse (LPN) documented, "multiple mepilexis applied to bottom upper thigh region and vaginal area, washed with VOSH (wound cleanser), area to gluteal fold cleansed yellow discharge taken from the area and medihoney placed in wound bed, area to labia is bleeding and raw, cleansed and mepilex secured amap (as much as possible) ...refuses to go back to bed for repositioning after getting out of bed in the AM". Per record review the wound in the vulvar region was new. Additionally, there was no order to apply medihoney to any current wound. On 5/31/23 the wounds were viewed by the Director of Nursing (DON) and Assistant Director of Nursing who serves as the wound care nurse. The provider was updated and due to the resident's condition, immobility and history of wounds requiring surgical debridement, s/he was sent to the local hospital to have the new wound evaluated, where it was determined s/he would be admitted. Resident was found to have a newly developed pressure injury in the area of the left ischium and right labia which has required serial	F 686	6. Corrective action will be completed by 7/4/2023. **Tag F 686 POC accepted on 7/5/23 by H. Fox/P. Cota**	

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F 686	Continued From page 4 operative debridement. Per Pressure Ulcers/Skin Breakdown - Clinical Protocol which was provided by the DON under the heading Treatment/Management. 1. The physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.) and application of topical agents. During an interview with the DON on 6/19/23 at 1:30 PM, s/he admitted the provider had not been notified of the newly discovered area of impaired skin integrity during the holiday weekend and that Resident #1 did not have an order for Medihoney to be used on the gluteal fold area.	F 686		