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

March 6, 2024

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 recertification survey conducted on **January 31, 2024.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN
Pamela M. Cota, RN
Licensing Chief

Enclosure

| 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 01/31/2024 |

| 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<br><br>An unannounced on-site re-certification survey was conducted by the Division of Licensing and Protection on 1/29/24- 1/31/24 including Emergency Preparedness Requirements for 42 CFR Part 483 requirements for Long Term Care Facilities. The result of the Emergency Preparedness Survey identified no regulatory violations. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and 3 complaint investigations, including report(s) # VT22598, VT22602 and VT22599, from 1/29/24 through 1/31/24 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal | F 550 | F550<br><br>1. Resident #7 had no negative effects as a result of the alleged deficient practice.<br>2. Resident's requiring assistance with care have the potential to be affected by the alleged deficient practice.<br>3. Staff will receive further in-servicing regarding the requirements for privacy, respect, and dignity to be provided during care and competencies will be completed.<br>4. Observation audits will be completed weekly x3 months by the Director of Nursing or designee to monitor effectiveness of the plan.<br>5. Results of the audits will be reported to the QAA committee x3 months at which time the committee will determine any further frequency of audits needed.<br>6. Corrective action to be completed by 3/16/2024. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/6/24.

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.

| 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 01/31/2024 |

| 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 550 | Continued From page 1<br>access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review the facility failed to ensure that the residents maintained the right to a dignified existence related to providing privacy during incontinence care for 1 of 27 residents sampled. (Resident #7). Findings include:<br><br>Per observation on 1/29/24 at 3:00 p.m. of two Licensed Nurse Aides (LNA) providing incontinence care to Resident # 7, the resident had to be transferred back to bed via a Hoyer lift to receive incontinence care. [A Hoyer lift is a mechanical lift that transfers a resident from one surface to another without using the physical | F 550 | **Tag F 550 POC accepted on 3/6/24 by N. Baker/P. Cota** | |

| 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 01/31/2024 |

| 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 550 | Continued From page 2 | F 550 | | |

power of the staff. It is commonly used for residents who cannot bear the weight to participate in a transfer.] Both LNAs had on isolation gowns, gloves, and masks as Resident #7 and roommate were both positive for COVID-19.

Resident #7's roommate was in the room as well, sitting in a wheelchair on their side of the room. The roommate was able to communicate and was able to see Resident #7 from where he/she was sitting. The privacy curtain was not pulled at any time during this procedure. Privacy was not provided to resident #7 as the roommate was able to view the entire procedure.

When the LNAs transferred Resident #7 back to his/her bed via the Hoyer lift, it was noted that they did not inform the resident that they were starting the transfer and the resident appeared startled when the Hoyer started to lift him/her. Resident #7 started grabbing at the LNAs when he/she was placed on the bed, one LNA handed Resident #7 a small stuffed animal stating "Here hold this".

The LNAs proceeded to take Resident #7's pants and incontinent product off so that incontinence care could be provided, exposing Resident #7's body from the waist down. During the incontinence care procedure, the LNA's did not have enough washcloths or incontinent wipes to properly clean Resident #7. The LNAs had to stop care 3 times to open the door and ask other staff to bring supplies, noted during this that the privacy curtain was not pulled so the resident was exposed from the waist down to anyone walking by the room as the LNA stood in the doorway, and waited for the supplies each time.

| 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 01/31/2024 |

| 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 550 | Continued From page 3 | F 550 | | |

Also, during the procedure, the door was opened by a 3rd staff member from the hallway, that staff member held the door open while he/she started talking to one of the LNAs about his/her schedule, again incontinent care was stopped as the resident was on the bed with his/her body exposed from the waist down.

A Record Review on 1/29/24 reveals that Resident #7 has a diagnosis of Alzheimer's, Vascular Dementia, and Anxiety. A review of Resident #7's current care plan reveals that he/she started palliative care on 12/18/23 and has the following interventions included in his/her care plan; "explain all procedures and treatments to the resident, provide adequate time and privacy for elimination, avoid sudden bumps/jarring with transfers or bed mobility".

A Review of the facility policy titled Resident Rights policy statement "Employees shall treat all resident with kindness, respect and dignity"

Per an interview on 1/29/24 at 3:30 p.m. with LNA #1 who was observed providing incontinence care to Resident #7 confirmed that the privacy curtain should have been closed to prevent Resident #7's roommate from being able to see Resident #7 receive incontinent care and to prevent persons from the hallway being able to view the resident receiving incontinent care.

Per an interview with LNA #2 on 1/29/24 at 3:40 p.m. who was observed providing incontinence care to Resident #7 also confirmed that they should have had enough supplies when they started the procedure so they would not have to open the door and that the privacy curtain should

| 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 01/31/2024 |

| 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 550 | Continued From page 4<br>have been pulled to ensure privacy to Resident #7.<br><br>An interview on 1/31/24 at 12:41 p.m. with the Social Services director he/she confirmed that staff should be knocking on doors and waiting for answers before entering a resident's room. He/she also confirms that the Privacy curtain should always be used when a resident is receiving care or otherwise needs privacy. | F 550 | | |
| F 561 SS=D | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, | F 561 | F561<br><br>1. Resident #22 had no negative effects related to the alleged deficient practice and is now receiving showers per his/her preference.<br>2. Residents residing in the facility that have preferences have the potential to be affected by the alleged deficient practice.<br>3. Education will be provided to staff regarding the right to self-determination and preferences.<br>4. Weelky audits will be completed by the Director of Nursing or designee x3 months to monitor effectiveness of the plan.<br>5. 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 needed.<br>6. Corrective action will be completed by 3/16/2024.<br><br>**Tag F 561 POC accepted on 3/6/24 by N. Baker/P. Cota** | |

| 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 01/31/2024 |

| 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 561 | Continued From page 5 | F 561 | | |

religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to provide weekly showers based on resident preference for 1 of 27 residents sampled (Resident #22). Findings include:

During an interview on 1/31/24 at 3:16 PM, Resident #22 stated that he/she doesn't receive showers enough and would like to have showers more regularly. When asked how often showers are provided Resident #22 said "when they can, sometimes I go two weeks or more without one." A calendar hanging on Resident #22's wall that is used to track how often he/she is provided a shower indicates that during the month of January 2024 he/she had just two showers one January 3rd and one on January 17th. When asked if he/she has spoken to administration about it he/she stated "yes they know."

Per record review a care plan focus of Preferences states Resident #22's goal is "preferences will be honored and used to help [him/her] support [their] daily routine based on [their] preferences. Per care plan interventions the Resident #22 reported that he/she would like to receive a shower weekly.

Per interview with the Director of Nursing on 1/31/24 at 5:00 PM the only way to review when residents are bathed/showered is to look at each separate days documentation. There is no other way to review care provided or not provided. The DON confirmed that concerns related to Resident #22 have been brought forward. It was

| 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 01/31/2024 |

| 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 561 | Continued From page 6<br>discovered that when the Licensed Nursing Assistant (LNA) who is typically the Bath Aide is given a resident care assignment the LNAs are not giving the baths or showers to the residents who are scheduled. The Director of Nursing confirmed that Resident #22 has not been receiving weekly showers per their preference. | F 561 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(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<br>(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).<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)- | F 656 | F656<br><br>1. Resident #26's leg brace has been added to the care plan and there was no negative effect as a result of the alleged deficient practice.<br>2. Resident #219's requirement for foot care has been added to the care plan.<br>3. Residents residing in the facility have the potential to be affected by the alleged deficient practice.<br>4. Education will be provided to licensed nurses responsible for the development of care plans regarding the requirements to ensure resident needs are addressed in the plan of care.<br>5. Audits will be completed weekly x3 months by the Director of Nursing or designee to monitor effectiveness of the plan.<br>6. 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 needed.<br>7. Corrective action will be completed by 3/16/2024.<br><br>**Tag F 656 POC accepted on 3/6/24 by N. Baker/P. Cota** | |

| 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 01/31/2024 |

| 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 656 | Continued From page 7 | F 656 | | |

(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.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, and record review the facility failed to develop and implement a care plan related to a leg brace and to foot care for 2 of 27 residents sampled.(Resident #26 and Resident #219) Findings include:

1. An interview with Resident #26 on 1/29/24 at 4:55 p.m. reveals that the Resident uses a brace for his/her left foot/leg, it was observed that the brace was not on the Resident's left foot/leg at the time of the interview. Resident #26 states "The nurses tell me that they do not know how to put it on so, I put the brace on myself, or it does not get put on. "

Per record review, there was no order on the Electronic Medical Record (EMR) for the Left foot/leg brace. On review of the resident's care plan, the brace for the Left foot/leg was not found on the care plan.

| 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 01/31/2024 |

| 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 656 | Continued From page 8 | F 656 | | |

Per interview with a staff Registered Nurse (RN) on 1/31/24 at 2:55 p.m., the RN confirmed that the brace is not on Resident # 26 care plan and that he/she would expect that it would be. Per an interview with the Director of Nurses (DON) on 1/31/24 at 2:59 p.m. the DON was able to locate the order for Resident #26's foot/leg brace in the paper chart. (a paper chart is a resident medical record that includes documents that have not been entered into the EMR) This document reveals that Resident #26 has been trained by a Physical therapist to apply the brace. DON confirms that currently, the brace is not on Resident #26's care plan.

2. Per observation on 1/30/24 at 12:35 p.m., Resident # 219's feet have a large amount of edema (swelling caused by too much fluid trapped in the body's tissues.) The skin on the bilateral feet and extending up above his/her ankles has copious amounts of dry scaly skin that is yellow/brown in color. It is noted that the dry skin flakes fall off and can be seen on the carpet in front of the resident's chair. Resident #219's toe nails are long, thick, and jagged on the top and edges.

At the time of the observation, the Licensed Practical Nurse (LPN) gently separated the resident's toes so the skin between the toes could be observed. The skin between all the toes on the right foot is noted to be red, very moist, and has a foul odor when separated.

Resident #219 has a history of issues that require close monitoring of feet. Per record review on 1/30/24 reveals that Resident #219 has a diagnosis of Diabetes type 2, a right heel wound,

| 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 01/31/2024 |

| 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 656 | Continued From page 9<br>ingrown toe nail, and Peripheral Venous Insufficiency [which occurs when the walls and/or valves in the veins are not working effectively, making it difficult for blood to return to the heart]. Resident #219 was sent to the Emergency room on 10/7/23 for the removal of maggots from the right foot's 3rd, 4th, and 5th toes, at that time the resident was also diagnosed with Stasis Dermatitis of both feet and lower legs. [Stasis dermatitis is a chronic skin condition that happens when the veins can no longer pump blood back to the heart. This condition causes a red or brown scaly rash or sores from the pooling of the blood. This condition usually affects the lower legs and feet.]<br><br>Per a review of Resident #219's care plan, foot care is not addressed in the care plan. Per an interview with the Director of Nurses (DON) on 1/31/24 at 11:10 a.m., the DON confirms that there should be a care plan related to foot care in place. | F 656 | | |
| F 687 SS=D | Foot Care<br>CFR(s): 483.25(b)(2)(i)(ii)<br><br>§483.25(b)(2) Foot care.<br>To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:<br>(i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and<br>(ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.<br>This REQUIREMENT is not met as evidenced | F 687 | F687<br><br>1. Resident #219 did in fact have an appointment made on 1/19/2024 for podiatry per hospital orders and was seen by podiatry on 2/2/2024 with follow up appointments scheduled. It should be noted that prior to this the resident was being followed regularly by Vascular Surgery for his/her foot care needs.<br>2. Orders have been put into place and a care plan developed for the need for foot care for resident #219.<br>3. Residents requiring foot care needs have the potential to be affected by the alleged deficient practice. | |

| 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 01/31/2024 |

| 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 687 | Continued From page 10<br>by:<br>Based on observation, interview, and record review the facility failed to ensure that residents received proper treatment and care to maintain good foot health for 1 of 27 residents sampled. (Resident # 219) Findings include:<br><br>Per observation on 1/30/24 at 12:35 p.m., Resident # 219's feet have a large amount of edema (swelling caused by too much fluid trapped in the body's tissues.) The skin on the bilateral feet and extending up above his/her ankles has copious amounts of dry scaly skin that is yellow/brown in color. It is noted that the dry skin flakes fall off and can be seen on the carpet in front of the resident's chair. Resident #219's toe nails are long, thick, and jagged on the top and edges.<br><br>At the time of the observation, the Licensed Practical Nurse (LPN) gently separated the resident's toes so the skin between the toes could be observed. The skin between all the toes on the right foot is noted to be red, very moist, and has a foul odor when separated.<br><br>Per record review of a discharge summary from an acute care facility for Resident #219 dated 1/18/24 reveals under follow-up appointments and procedures " ...follow up with podiatry." There is no evidence that this appointment was made or that Resident #219 saw a Podiatrist.<br><br>Resident #219 has a history of issues that require close monitoring of feet. Per record review, a nursing progress noted dated 10/7/23 at 1:45 p.m. states that the nurse noted maggots on Resident #219's right foot between the 3rd, 4th and 5th toes, the Physician was notified and gave | F 687 | F687 cont<br><br>4. In-servicing will be completed for staff regarding foot care and monitoring.<br>5. Audits will be completed weekly x3 months by the Director of Nursing or designee to monitor effectiveness of the plan.<br>6. 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 needed.<br>7. Corrective action to be completed by 3/16/2024.<br><br>**Tag F 687 POC accepted on 3/6/24 by N. Baker/P. Cota** | |

| 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 01/31/2024 |

| 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 687 | Continued From page 11 | F 687 | | |

order to send to the Emergency room for evaluation. The Emergency Room Physician report dated 10/7/23 that Resident #219 has a diagnosis of Diabetes type 2, a right heel wound, ingrown toe nail, and Peripheral Venous Insufficiency [which occurs when the walls and/or valves in the veins are not working effectively, making it difficult for blood to return to the heart]. The report states that Resident #219 was seen in the Emergency Room for the removal of Maggots from the Right foot between the 3rd, 4th, and 5th toes. (Maggots are fly larvae they come from places where adult flies lay eggs).

This report states under Extremities Assessment "Significant chronic dependent edema with stasis dermatitis noted". [Stasis dermatitis is a chronic skin condition that happens when the veins can no longer pump blood back to the heart. This condition causes a red or brown scaly rash or sores from the pooling of the blood. This condition usually affects the lower legs and feet.] Further review of this Emergency Room report reveals under the instructions section instructions for stasis dermitis, to moisturize the skin, and if any more maggots are noted they can be washed off.

A Nursing progress note dated 10/9/23 at 5:47 a.m. reveals that the right foot toes were cleansed and dried at Resident #219 request, there was an odor observed during this procedure. This note indicates there was no order to cleanse or check the condition of the toes or feet, this was done at the residents request.

A Review of Resident #219 Medication Administration Record (MAR) and Treatment Administration Record (TAR) for the months of

| 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 01/31/2024 |

| 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 687 | Continued From page 12 | F 687 | | |

October 2023 and November 2023 finds no monitoring for further maggot infestation in place, no order for cleaning or for monitoring where the maggots were found, and no monitoring or treatment order for stasis dermatitis.

Per review of Resident #219's care plan, foot care is not addressed in the care plan. Per further record review of a document titled Scheduled Events for [Resident #219] from 7/14/23 to 3/19/24, there is no noted Podiatry services appointment for Resident #219 on this schedule.

A review of the facility's policy on Foot Care states under Policy Interpretation and Implementation Section #3: "Residents are assisted in making appointments and with transportation to and from specialist (podiatrist, endocrinologist, etc.) as needed" #5. States "Residents with foot disorders or medical conditions associated with foot complications are referred to qualified professionals ..."

Per an interview with the Director of Nurses (DON) on 1/31/24 at 11:10 a.m. DON confirms there was no monitoring of Resident #219's, toes after he/she returned from the ER visit when Maggots had been removed from the resident's right foot 3rd,4th and 5th toes, also there was no monitoring or treatment for the stasis dermatitis diagnosis. The DON confirms that there should have been monitoring in place for these issues. The DON confirms there is not a podiatrist that comes to the facility to see the residents, the facility must make outside appointments and transfer the residents to the appointments. The DON confirms the resident has not seen a podiatrist for his/her foot concerns.

| 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 01/31/2024 |

| 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 725 | Continued From page 13 | F 725 | F725 | |
| F 725 SS=E | Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)<br><br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure a sufficient number of skilled licensed nurses, nurse aides, and other nursing personnel to provide care and respond to each resident's basic needs and individual needs as required by the resident's diagnoses, medical condition, plan of care, and | F 725 | 1. No residents were negatively affected by the alleged deficient practice.<br>2. Residents residing in the facility have the potential to be affected by the alleged deficient practice.<br>3. Facility leadership is aware of the staffing requirements and will continue to monitor staffing levels on a daily basis to ensure adequate staffing is available to meet the needs of residents.<br>4. Maple Lane will continue to recruit additional staffing via on-line platforms, local newspapers, and social media venues.<br>5. Maple Lane has the ability to conduct their own LNA classes. Maple Lane will continue to actively recruit potential candidates for this class and train candidates to be successful as LNA's.<br>6. In the event of emergency staffing, Maple Lane will continue to work closely with contracted staffing agencies and recruit as appropriate. In addition, Maple Lane has the ability to draw from licensed management staff and sister facility staff in the event of emergency/crisis staffing levels.<br>7. The administrator will report staffing ratios to the QAA committee x3 months at which time the committee will determine further frequency of reporting needed.<br>8. Corrective action to be completed by 3/16/2024.<br><br>**Tag F 725 POC accepted on 3/6/24 by N. Baker/P. Cota** | |

| 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 01/31/2024 |

| 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 725 | Continued From page 14 | F 725 | | |

facility assessment. Findings include:

1. During an interview on 1/31/24 at 3:16 PM Resident #22 stated that he/she doesn't receive showers enough and would like to have showers more regularly. When asked how often showers are provided Resident #22 said "when they can, sometimes I go two weeks without one." A calendar hanging on Resident #22's wall that is used to track how often he/she is provided a shower indicates that during the month of January 2024 he/she had showers on January 3rd and January 17th, every other week. When asked if he/she has spoken to administration about it he/she stated "yes they know."

Per interview with the Director of Nursing (DON) on 1/31/24 at 5:00 PM management was aware that Resident #22 had requested weekly showers and had not received them. The DON stated that there had been a bath aide assigned to showers and baths, but when there was a lack of staff they would give the bath aide an assignment rather than providing baths and showers. When this occurred residents had not been given their baths are showers.

2. During observations on 1/31/24 at 11:45 AM a Licensed Nursing Assistant (LNA) was heard telling the Medication Nurse that the resident in room #118 was upset because he/she hadn't gotten their morning medication yet. The nurse told the LNA that he/she was preparing the medications. At this time the medication nurse was interviewed and confirmed that the resident had not received their 9:00 AM medications. The nurse said that he/she still had "a couple" residents left to administer medications to. He/she stated that he/she was behind due to the

| 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 01/31/2024 |

| 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 725 | Continued From page 15<br>need for applying personal protective equipment each time he/she went in and out of each room. When asked if he/she had made anyone aware that the medications were late the nurse said "no."<br><br>Per interview with the Director of Nursing (DON) at 12:00 PM he/she was not aware of any concerns related to medications being administered late. when this surveyor informed him/her that the medication nurse was still passing the 9:00 AM medications he/she stated that he/she were not aware and went to the unit. The DON approached the nurse and asked him/her how many resident's 9:00 AM medications were left and the nurse responded that she had two or three left. The DON confirmed that the medications were late and they should have been given on time.<br><br>3. Review of facility direct care staff schedules and PPD (direct care staff to resident ratios) for December 2023 and January 2024 reveals that the facility failed to maintain required minimum staffing levels to allow for 2.0 hours of direct care per resident per day (PPD) on a weekly average by Licensed Nursing Assistants (LNAs) for 2 of the 5 weeks sampled in December 2023 and January 2024. The facility also failed to maintain required minimum staffing levels to allow for 3.0 hours of direct care per resident per day (PPD) on a weekly average including nursing care, personal care, and restorative nursing care for 2 of 5 sampled weeks in December 2023 and January of 2024. See S320. | F 725 | | |
| F 726 SS=E | Competent Nursing Staff<br>CFR(s): 483.35(a)(3)(4)(c) | F 726 | F726<br><br>1. No residents were negatively affected by the alleged deficient practice. | |

| 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 01/31/2024 |

| 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 726 | Continued From page 16<br>§483.35 Nursing Services<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br><br>§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.<br><br>§483.35(c) Proficiency of nurse aides.<br>The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure sufficient nursing staff with appropriate competencies and skill sets to care for the resident's needs for 7 of 8 staff in the applicable sample. Findings Include:<br><br>On 1/31/24 at 8:10 AM, a Licensed Practical | F 726 | F726 Cont<br><br>2. Residents residing in the facility have the potential to be affected by the alleged deficient practice.<br>3. Required competencies will be completed for staff with further training as needed.<br>4. The Director of Nursing will monitor the completion of competencies on a monthly basis to monitor effectiveness of the plan.<br>5. The results of the completion of competencies will be reported to the QAA committee x3 months at which time the committee will determine further frequency of reporting needed.<br>6. Corrective action will be completed by 3/16/2024.<br><br>**Tag F 726 POC accepted on 3/6/24 by N. Baker/P. Cota** | |

| 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 01/31/2024 |

| 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 726 | Continued From page 17<br>Nurse (LPN) was observed doffing (removing) personal protective equipment (PPE) after administering medications and obtaining Vital Signs of a resident with COVID-19. The LPN stood in the open doorway of the resident's room and removed her gloves, first touching her soiled gown with her bare hands. S/he then removed the gown, placing her contaminated equipment between her knees while she put her soiled gown in a plastic bag. She then carried the contaminated equipment to the medication cart, placed it on the clean cart, and opened the cart's drawers without cleaning her hands.<br><br>S/he stated that s/he had received brief video training on using PPE upon hire and had not received any follow-up training or demonstrated competency in performing the procedure correctly to prevent contamination.<br><br>A record review reveals that 7 of 8 sampled staff records did not contain complete evidence of competencies.<br>An interview with the Director of Nursing and the Assistant Director of Nursing on 1/31/24 revealed that the facility was behind on competencis related to high staff turnover. They confirmed that the LPN was not adequately trained, and that the facility had not provided documentation of competencies. | F 726 | | |
| F 730 SS=C | Nurse Aide Peform Review-12 hr/yr In-Service<br>CFR(s): 483.35(d)(7)<br><br>§483.35(d)(7) Regular in-service education.<br>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these | F 730 | F730<br><br>1. No residents were negatively affected by the alleged deficient practice.<br>2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. | |

| 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 01/31/2024 |

| 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 730 | Continued From page 18<br>reviews. In-service training must comply with the requirements of §483.95(g).<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record reviews, the facility failed to complete performance reviews of every nurse aide at least once every 12 months. It also failed to provide in-service education based on the outcome of these reviews for 3 of the 4 sampled records.<br>Findings Include:<br><br>Record review indicates that of the applicable sample 3 Licensed Nursing Assistants (LNA), they did not have annual performance evaluations and did not receive subsequent in-service education based on the performance review.<br><br>An interview on 1/31/2024 at approximately 1:55 PM with the Director of Nursing and the Assistant Director of Nursing confirmed they were behind on performance evaluations; they stated they were giving in-services as they could but were not applying them to performance evaluations. | F 730 | F730 Cont<br><br>3. Facility leadership is aware of the requirement to provide yearly performance reviews and provide education based on those reviews for nurse aids.<br>4. Performance reviews and education based on those reviews will be completed for nurse aids.<br>5. The Director of Nursing or designee will monitor the ongoing compliance with yearly reviews and education and report the results of this monitoring to the QAA committee x3 months at which time the committee will determine further frequency of reporting needs.<br>6. Corrective action will be complete by 3/16/2024.<br><br>**Tag F 730 POC accepted on 3/6/24 by N. Baker/P. Cota** | |
| F 742 SS=D | Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1)<br><br>§483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that-<br>§483.40(b)(1)<br>A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; | F 742 | F742<br><br>1. Resident #25 had no negative affects as a result of the alleged deficient practice and had no plan to commit suicide.<br>2. Resident #25 receives weekly psychological services in the facility.<br>3. Residents with expressions or indications of stress have the potential to be affected by the alleged deficient practice.<br>4. Education will be completed for staff regarding the requirements for steps to take in the event a resident is exhibiting signs of distress and may be suicidal. | |

| 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 01/31/2024 |

| 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 742 | Continued From page 19<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to assess the residents' expressions or indications of distress to determine if services were needed for 1 of 5 sampled residents. (Resident # 25)<br><br>Per record review, Resident # 25 was admitted to the facility on 7/15/23 with the following diagnoses: post-traumatic stress disorder and vascular dementia. A nursing note dated 1/5/24 indicated Resident #25 voiced that s/he would like to die by suicide, a plan was not identified, and the nursing supervisor was to contact Resident #25's counselor for assistance.<br><br>A review of her/his care plan indicates "Staff will either stay with [Resident #25] or monitor [him/her] closely during times of triggered flashbacks and fear to return [him/her] to a sense of safety and calm. Staff should utilize a gentle approach to re-orienting [him/her] back to the present. It could take some time and several attempts over the course of a day or more to get [him/her] back to the here and now."<br><br>A review of a facility policy that is titled Suicide Threats reveals that "after assessing the resident in more detail, the nurse supervisor/charge nurse shall notify the resident's attending physician and responsible party and shall seek further direction from the physician. All nursing personnel involved in caring for the resident shall be informed of the suicide threat and instructed to report changes in the resident's behavior immediately. If the resident remains in the facility, staff will monitor the resident's mood and behavior and update care plans accordingly until a physician has | F 742 | F742 Cont<br><br>5. The Social Services Director will conduct staff interviews weekly x3 months to ensure staff continue to be aware of the necessary steps.<br>6. The results of the interviews will be reported to the QAA committee x3 months at which time the committee will determine further frequency of the interviews needed.<br>7. Corrective action will be completed by 3/16/2024.<br><br>**Tag F 742 POC accepted on 3/6/24 by N. Baker/P. Cota** | |

| 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 01/31/2024 |

| 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 742 | Continued From page 20<br>determined that the risk of suicide does not appear to be present."<br><br>An interview with a Registered Nurse (RN) on 1/29/2024 at 2:54 PM indicates that the RN did not contact the resident's provider or counselor. A record review indicates there is no documentation of further assessment or follow-up of the resident regarding the suicide statement.<br><br>In an interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 1/30/2024 at 3:12 PM, they confirmed they failed to take adequate action and provide services to Resident # 25. In addition, they did not follow the steps outlined in their policy for a suicide threat. | F 742 | | |
| F 880 SS=E | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual | F 880 | F880<br><br>1. No residents had a negative effect related to the alleged deficient practice.<br>2. The identified LPN no longer works at the facility.<br>3. Residents residing in the facility have the potential to be affected by the alleged deficient practice.<br>4. Education and competencies will be completed for licensed staff regarding infection control practices to include transmission-based precautions.<br>5. Observation audits will be completed by the Director of Nursing or designee at least weekly x3 months to monitor effectiveness of the plan.<br>6. 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 needed.<br>7. Corrective action to be completed by 3/16/2024. | |

| 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 01/31/2024 |

| 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 880 | Continued From page 21<br>arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and | F 880 | **Tag F 880 POC accepted on 3/6/24 by N. Baker/P. Cota** | |

| 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 01/31/2024 |

| 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 880 | Continued From page 22 | F 880 | | |

transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based upon observation, interview, and record review, the facility failed to implement infection control measures related to transmission-based precautions regarding 1 staff member and 2 residents [Res.#43 & Res.#65] of 28 sampled residents on transmission-based precautions, and related to wound care treatment for 1 resident [Res. #219] of 1 sampled resident with identified wounds.
Findings include:

1). Per observation on 1/31/2024 at 8:12 AM a Licensed Practical Nurse [LPN] was observed exiting the room of a resident on transmission-based precautions after administering medications and obtaining vital signs. [Per the Centers for Disease Control and Prevention [CDC]: "Transmission-Based Precautions are the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission"]. While removing their gown and gloves outside of the precautions room, s/he was observed placing the soiled equipment (Blood pressure cuff, thermometer, and pulse oximeter] between h/her knees while they rolled up their soiled gown and gloves; they then placed their gown into a plastic bag and walked to the medication cart where they placed the soiled

| 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 01/31/2024 |

| 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 880 | Continued From page 23 | F 880 | | |

equipment on top of the clean cart. The LPN then opened the cart with unsanitized hands and rifled through the drawers. The LPN then took gauze from the cart, squirted it with hand sanitizer, and proceeded to hold each piece of equipment and wipe it down with hand sanitizer.

Review of CDC guidelines for Isolation Precautions includes :
-Remove gown and perform hand hygiene before leaving the patient's environment;
-After gown removal, ensure that clothing and skin do not contact potentially contaminated environmental surfaces that could result in possible transfer of microorganism to other patients or environmental surfaces;
- Wear PPE [Personal Protective Equipment] (e.g., gloves, gown), according to the level of anticipated contamination, when handling patient-care equipment and instruments/devices that are visibly soiled or may have been in contact with blood or body fluids;
-Use EPA-registered disinfectants that have microbiocidal (i.e., killing) activity against the pathogens most likely to contaminate the patient-care environment.
[Isolation Precautions | Guidelines Library | Infection Control | CDC https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html]

An interview was conducted with the Director of Nursing/Infection Preventionist [DON/IP] on 1/31/24 at 2:00 PM. The DON/IP confirmed that improper Hand washing and equipment sanitizing issues were identified during the observation of the staff LPN when caring for a resident on transmission based precautions.

| 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 01/31/2024 |

| 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 880 | Continued From page 24 | F 880 | | |

2). Review of Res.#43's Care Plan reveals the resident was assessed as "wanders and is an elopement risk as evidenced by verbalizes a desire to leave the facility, impaired safety awareness and disoriented to place. Significantly intrudes on the privacy or activities of others" and has identified behaviors that includes "wandering hallways and occasionally into rooms". On 1/29/24 Res.#43 tested positive for COVID 19 with the Care Plan updated to include "Droplet Precautions".

[Per the Centers for Disease Control and Prevention regarding Droplet Precautions: "Source [of the infection] control: put a mask on the patient. Limit transport and movement of patients outside of the room to medically-necessary purposes. If transport or movement outside of the room is necessary, instruct patient to wear a mask and follow Respiratory Hygiene/Cough Etiquette"].

Res.#43's Care Plan also included ""Offer resident facial covering during care provided such as tissues or cloth mask, Isolation into a private room or cohorted with other positive COVID 19 residents if able."
Review of Physician Orders for Res.#43 include "Monitor adherence to isolation and hygiene".

Per observation on 1/30/24 at 1:40 PM, Res.#43 exited their room without a mask. The resident had a moist cough and did not cover their mouth while coughing. The resident was observed briefly wandering in the hallway before entering a resident room next to theirs. Unlike Res.#43, the resident in the next room had not tested positive for COVID and was not on isolation precautions. Res.#43 was observed entering the room while

| 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 01/31/2024 |

| 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 880 | Continued From page 25 | F 880 | | |

the resident was present, and after a brief time exited the room and continued to wander the hallway where facility staff stated, "Here comes [Res.# 43]". The staff did not offer the resident a mask or attempt to redirect the resident back into their isolation room.

3). Per review of Res.#65's medical chart, the resident tested positive for COVID 19 on 1/29/24 with the Care Plan updated to include "Droplet Precautions" along with interventions that included:
"Offer resident facial covering during care provided such as tissues or cloth mask, Isolation into a private room or cohorted with other positive COVID 19 residents if able."
Res.#65's Care Plan also includes the resident assessed as having a "diagnosis of dementia, a primary language of French creating a language barrier", and "Staff should be aware that [Res.#65] will wander on the unit" and "Staff should monitor [Res.#65's] whereabouts when s/he is out on the unit."

Per observation on 1/29/24 at 11:03 AM, Res.#65 was observed wandering in the hallway and into the communal dining area. The resident had a facemask that was positioned underneath their chin, exposing their nose and mouth. Res.#65 went into the communal refrigerator and removed 2 items. Per observation, there were 2 other residents in the communal dining area without masks. There were no staff present, and Res.#65 returned to their room.
Per observation on 1/30/24 at 3:01 PM Res.#65 was out in common area. The resident was wearing a mask that was positioned below their chin. There were no staff present. The resident returned to their room, then at 3:12 PM was

| 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 01/31/2024 |

| 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 880 | Continued From page 26 | F 880 | | |

observed at the nurse's station with no mask on. The resident was redirected by staff back to their room. At 3:26 PM, Res. #65 returned to the common area unaccompanied, with a mask below their chin. The resident sat in the common area for 20 minutes, then stood and wandered in the hallway. At 4:14 PM, Res.#65 returned to the common area. There was one other resident present. Res.#65 was wearing a mask below their chin. Dietary staff offered the resident soup. Staff did not redirect the resident back to their room or direct the resident to pull the mask up to cover their mouth and nose.

An interview was conducted with the Director of Nursing/Infection Preventionist [DON/IP] on 1/31/24 at 2:00 PM. The DON/IP confirmed isolation precautions per Physician Orders, Resident Care Plans, and CDC guidelines were not being properly implemented for COVID positive for Res.#43 and Res.#65.

4. Per observation on 1/30/2024 at 12:35 p.m. of wound care performed by a Licensed Practical Nurse (LPN) of Resident # 219's right heel ulcer, the following breaches in infection control were identified during the procedure:

a. The LPN entered the room with a gown, gloves, and mask on. S/he removed resident #219's lunch tray from the room and did not change his/her gloves or sanitize his/her hands after this action.

b. The LPN then placed a barrier down, a clean towel for a clean field to lay clean supplies on, on the resident's table that he/she had just removed the lunch tray from. The LPN did not clean or

| 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 01/31/2024 |

| 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 880 | Continued From page 27<br>sanitize the table before laying the barrier down.<br><br>c. The nurse went behind Resident #219's chair, touched the chair to recline it, and did not change gloves or sanitize their hands.<br><br>d. Resident #219's feet were now elevated by the recliner chair; the LPN did not place a barrier between the chair surface and the resident's feet. The resident's feet were touching the dirty recliner surface throughout the entire procedure.<br><br>e. The LPN removed the resident's heel booties and placed them on top of the clean dressing boxes that were stored on a stand that had other personal items on it. The LPN did not change gloves or sanitize hands after removing the booties.<br><br>f. The LPN gathered supplies that included kerlix (a type of dressing used to wrap dressings to protect and keep the dressing in place), and gauze while still having soiled gloves on.<br><br>g. The LPN removed the dirty ace wraps that were on Resident #219's legs, folded them, and placed them on the table next to his/her clean barrier field potentially contaminating the clean field. The LPN did not change gloves or sanitize their hands after this.<br><br>h. The LPN then used regular household scissors that were on a stand that had Resident #219's other personal items on it. It was noted that the stand and items on the stand had a thick coat of dust on the surfaces. The household scissors were used to cut the Kling dressing from the resident's foot. The LPN did not clean the scissors before s/he used them to remove the | F 880 | | |

| 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 01/31/2024 |

| 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 880 | Continued From page 28 | F 880 | | |

dressing or after the dressing was removed. He/she then proceeded to place the scissors back on the personal item stand. The LPN did not change gloves or sanitize his/her hands.

i. The LPN removed the old dressing from the right heel, which had heavy drainage on it, and threw it in a garbage bag that was placed on the floor by the end of the recliner chair. The LPN did not change gloves or sanitize his/her hands after the removal of the soiled dressing.

j. The LPN then picked up a bottle of Vashe solution (a solution used to clean wound beds) with the same gloves that he/she had removed the soiled dressing with, he/she proceeded to wet the clean gauze with the Vashe solution and used the gauze to clean the wound bed, still without changing gloves or sanitizing hands before cleaning the wound.

k. The LPN now changes gloves but failed to sanitize his/her hands. The LPN applied clean gloves and then applied sterile gloves over his/her clean gloves. The sterile gloves were too big for his/her hands. The LPN then lifts Resident #219's leg up so the wound could be visualized. The heel appeared to have an open area approximately the size of the diameter of a baseball. There was noted yellow tissue covering the wound bed. There was an odor coming from the heel.

l. The LPN then took the household scissors from the stand that he/she had placed them on prior, picked up the new dressing, and cut the clean dressing to the size of the wound with the household scissors. The LPN did not clean the scissors, change gloves, or sanitize his/her

| 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 01/31/2024 |

| 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 880 | Continued From page 29 | F 880 | | |

hands.

m. After the LPN cut the dressing to size, he/she then picked up the medi honey tube (a medication that is ordered for wound healing) and applied the medi honey to the Q-Tips that s/he had opened earlier. The LPN attempted to apply the medi honey on the Q-Tips to the open wound, but it did not apply and just rolled around the wound in lumps.

n. The LPN then picked up the medi honey tube and applied it to the clean dressing touching the opening of the tube to the clean dressing. He/she did not change gloves or sanitize their hands.

o. The LPN then applied the dressing with the medi honey to the wound with the same soiled gloves. He/she then wraps the clean kling around Resident #219 heel and leg with the same soiled gloves.

p. When the LPN was done dressing the wound, he/she asked the resident to grab the bandage tape for him/her, which the resident does. The LPN then secures the dressing with the tape.

q. The LPN then removes both the sterile gloves and the clean gloves from their hands, picks up the clean field and the trash bag, opens the door, and discards them in the trash, there was no observation made of the LPN sanitizing hands after this glove removal.

Per interview on 1/30/24 at 1:20 p.m. the LPN that was observed during the wound dressing change, confirmed that during the procedure he/she should have changed gloves when the gloves became "dirty" [Soiled] and that when

| 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 01/31/2024 |

| 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 880 | Continued From page 30<br>changing gloves hands should have been sanitized. The LPN also confirms that the bandage scissors should have been cleaned before, between, and after each use.<br><br>An interview with the Director of Nurses (DON) on 1/31/24 at 11:10 a.m DON informed of the wound care observation that was done on 1/30/24 of Resident #219 Right Heel. DON confirms that the LPN should have been more "dilligent" about the infection control techniques that he/she used for the dressing change and that the LPN would be reeducated. | F 880 | | |

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 |
|---|---|---|---|
| | 475042 | A. BUILDING: _____ B. WING _____ | C 01/31/2024 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| S320 SS=E | 7.13 (d)(1) QUALITY OF CARE - STAFFING LEVELS<br><br>7.13 (d)(1) The facility shall maintain staffing levels adequate to meet resident needs.<br><br>1. At a minimum, nursing homes must provide:<br><br>i. no fewer than three (3) hours of direct care per resident per day, on a weekly average, including nursing care, personal care and restorative nursing care, but not including administration or supervision of staff; and<br><br>ii. of the three hours of direct care, no fewer than two (2) hours per resident per day must be assigned to provide standard LNA care (such as personal care, assistance with ambulation, feeding, etc.) performed by LNAs or equivalent staff and not including meal preparation, physical therapy or the activities program.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to maintain the required minimum staffing levels to allow for 2.0 hours of direct care per resident per day (PPD) on a weekly average by Licensed Nursing Assistants (LNAs) for 2 of the 5 sampled weeks and failed to maintain required minimum staffing levels to allow for 3.0 hours of direct care per resident per day (PPD) on a weekly average, including nursing care, personal care, and restorative nursing care for 2 of 5 sampled weeks. Findings include:<br><br>A review of the daily nursing PPD hours shows that the average direct care PPD by LNA staff was below the minimum of 2 hours per day during | S320 | S320<br><br>1. No residents had a negative effect as a result of the alleged deficient practice.<br>2. Residents residing in the facility have the potential to be affected by the alleged deficient practice.<br>3. Facility leadership is aware of the minimum staffing requirements and will continue to review staffing on a daily basis to ensure adequate staffing to meet the needs of the residents.<br>4. Maple Lane will continue to recruit additional staffing via on-line platforms, local newspapers, and social media venues.<br>5. Maple Lane has the ability to conduct their own LNA classes. Maple Lane will continue to actively recruit potential candidates for this class and train candidates to be successful as LNA's.<br>6. In the event of emergency staffing, Maple Lane will continue to work closely with contracted staffing agencies and recruit as appropriate. In addition, Maple Lane has the ability to draw from licensed management staff and sister facility staff in the event of emergency/crisis staffing levels.<br>7. The administrator will report staffing ratios to the QAA committee x3 months at which time the committee will determine further frequency of reporting needed.<br>8. Corrective action to be completed by 3/16/2024.<br><br>**Tag S 320 POC accepted on 3/6/24 by N. Baker/P. Cota** | |

| 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 01/31/2024 |

| 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) COMPLETE DATE |
|---|---|---|---|---|
| S320 | Continued From page 1<br>the following weeks in January.<br><br>1/1/2024-1/7/2024 = 1.95<br>1/22/2024-1/28/2024=1.95<br><br>Per review of the daily nursing PPD hours, the average direct care PPD by direct care staff, including nursing care, personal care, and restorative nursing care, was below the required 3 hours per day minimum during the following week in December and January.<br><br>12/25/2023-12/31/2023=2.43<br>1/1/2024-1/7/2024= 2.97<br><br>Per interview on 1/31/2023 at approximately 2:00 PM, the Director of Nursing stated that the facility has been short-staffed, as staff has been out with Covid. S/he confirmed that the direct care PPD, as referenced above, did not meet the 2.0 and 3.0 hours. | S320 | | |