

## DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection

HC 2 South, 280 State Drive
Waterbury VT 05671-2060
<a href="http://www.dlp.vermont.gov">http://www.dlp.vermont.gov</a>
Survey and Certification Voice/TTY (802) 241-0480
To Report Adult Abuse: (800) 564-1612
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330

August 8, 2023

Mr. Rob Bride, Manager Maplewood Recovery Residence 195 Stratton Road Rutland, VT 05701

Dear Mr. Bride:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 18, 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,

Carolyn Scott, M.S.

State Long-Term Care Manager

Division of Licensing and Protection (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ B, WING 0614 07/18/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 195 STRATTON ROAD MAPLEWOOD RECOVERY RESIDENCE RUTLAND, VT 05701 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) R100 R100 Initial Comments: An unannounced on-site re-licensure survey in conjunction with a complaint investigations was conducted by the Division of Licensing and Protection on 7/18/23. The following regulatory Tag R179 Accepted on 8/8/2023 - S. Ross, RN violations were identified: R179 R179 V. RESIDENT CARE AND HOME SERVICES SS=E 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid: (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation, (5) Respectful and effective interaction with residents: (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced Division of Licensing and Protection (X6) DATE

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

TITLE

STATE FORM

ZZEJ11

If continuation sheet 1 of 6

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С
		0614	B. WING		07/18/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
MAPLEW	OOD RECOVERY RESID	ENCE	TON ROAD , VT 05701		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
R179	Continued From page	÷ 1	R179		
	was a failure to ensur	ew and staff interview there re 4 out of 5 sampled staff d yearly training. Findings			
	out of 5 staff that pro- not complete all the r- include: resident right evacuation, resident procedures, such as accidents, police, or a aid, policies, and pro- mandatory reports of exploitation, respectf with residents, gener	the Heimlich maneuver, ambulance contact and first cedures regarding abuse, neglect and ul and effective interaction al supervision, and care of onfirmed by the manager on			
R266 SS=F	IX. PHYSICAL PLAN	Т	R266	Tag R266 Accepted on 8/8/2	023 - S. Ross, RN
	9.1 Environment				
	9.1.a The home mus safe, functional, sani comfortable environn	•			
	by: Based on observatio interview the RCH fa environment. Finding Per record review on admitted to the Residuith a diagnosis of se	7/18/23 Resident #1 was lential Care Home (RCH) chizophrenia. Resident #1			
	Per record review on admitted to the Resid	7/18/23 Resident #1 was lential Care Home (RCH) chizophrenia. Resident #1			

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Division of Licensing and Protection (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_ C B. WING 07/18/2023 0614 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 195 STRATTON ROAD MAPLEWOOD RECOVERY RESIDENCE RUTLAND, VT 05701 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) R266 Continued From page 2 R266 schizophrenia throughout his/her stay at Maplewood Recovery Center including delusional thoughts, paranoia, distorted thinking, confusion, and maladaptive behavioral changes. Per record review s/he had become increasingly noncompliant with care and medication administration leading up to incident occurring on 4/9/21. Per record review on 4/9/21 at about 10:15 AM, resident was found smoking in his/her room. At the time of discovery staff attempted to redirect him/her but Resident #1 was not responsive to staff and continued to smoke until finished with cigarette, then continued to smoke two more cigarettes. At this time the Director of Adult Behavioal Health was called in to intervene and Resident #1 give a lighter to him/her. According to record review a plan to allow Resident #1 to smoke one cigarette at a time with staff supervision was implemented. On the afternoon of 4/9/21 Resident #1 asked staff for an additional cigarette and responded with verbally aggressive behavior towards staff and threatened self-harm when staff reminded him/her of the plan to have one cigarette at a time. Due to Resident #1's aggressive behavior staff went back into the RCH for safety. Resident #1 remained outside briefly then entered the home, went into his/her room for a few minutes, then entered the living room and sat down. The fire alarm sounded and when staff opened Resident #1's bedroom door, they observed flames approximately 2 feet high radiating from Resident #1's burning mattress. The building was evacuated and 911 was notified. Per interview on the afternoon of 7/18/23 the Director of Adult Behavioral Health stated

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Resident #1was often noncompliant; often showed behaviors such as aggression, paranoia,

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			B. WING		С
NAME OF D	ROVIDER OR SUPPLIER	0614		TE ZID CODE	07/18/2023
		195 STRAT	RESS, CITY, STA' <b>TON ROAD</b>	TE, ZIF GODE	
MAPLEW	DOD RECOVERY RESIDI	RUTLAND,	VT 05701		· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
R266 R291 SS=F	sexual remarks towar the Director was asked come to the RCH to sabout smoking in his/believed this occurred incident on 4/9/21. Dubetween s/he and Reagreed to give him/he in his/her possession  Per interview with factor/18/23 it was confirm discovered to be smoapproximately 10:15 stated that Resident focal store accompanibelieves on one of the purchased a pack of always accompanied he/she stated yes at 1:1 supervision. Whe customary to allow rehe/she stated "no, the breakdown in staff suthe manager acknow working at the RCH at 4/9/21. When question be 1:1 supervision wistated, "he/she could stated "clearly there we communication regar supervision".	ionally made inappropriate ds staff. During interview and if s/he was ever called to apeak with Resident #1 her room, s/he said yes and d a few days prior to the uring the conversation sident #1, Resident #1 er the lighter that h/she had defined in the lighters. The manager with the lighters when asked if staff Resident #1 to stores, that time Resident #1 was an questioned if it was sidents to purchase lighter, here was definitely are pervision. During interview dedged that he/she was at the time of the incident on ned who was scheduled to the Resident #1 manager not recall and additionally was a breakdown in staff ding Resident #1 care and	R266	Tag R291 Accepted on 8/8/20	23 - S. Ross, RN
	9.6 Plumbing				

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07/18/2023

(X3) DATE SURVEY COMPLETED

Division of Licensing and Protection STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING: \_

0614

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING\_

MAPLEW	OOD RECOVERY RESIDENCE	STRATTON ROAD LAND, VT 05701		
(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
R291	Continued From page 4	R291		
	9.6.d Hot water temperatures shall not exceed 120 degrees Fahrenheit in resident areas.			
	This REQUIREMENT is not met as evidenced by: Based on observation and staff interview there was a failure to ensure water temperatures did not exceed 120 degrees Fahrenheit in resident areas of the residential care home (RCH). Findings include:  Per observation on 7/18/23 at 9:50 AM water temperatures exceeded the recommended 120 degrees Fahrenheit in two resident areas. Resident restroom #1 water temperature was noted to be 124.5 degrees Fahrenheit, and the facility kitchens water temperature was noted to be 122.4 degrees Fahrenheit. This observation was confirmed by the facility's registered nurse at the time of findings.		Tag R999 Accepted on 8/8/2023 - S.	Ross, RN
R999 SS=D	MISCELLANEOUS	R999	·	
	4.13 (f) The residence shall make current written reports resulting from inspections readily available to residents and to the public in a place readily accessible to residents where individuals wishing to examine the results do not have to ask to see them. The residence shall post a notice of the availability of all other written reports in a prominent place. If a copy is requested and the residence does not have a copy machine, the residence shall inform the resident or member of the public they may request a copy from the licensing agency and shall provide the address and telephone number of the licensing agency.			
	Based on observation and staff interview there was a failure to ensure a current written report			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		0614	B. WING		C 07/18	3/2023
	ROVIDER OR SUPPLIER	ENCE 195 STRA	DRESS, CITY, STA TTON ROAD , VT 05701	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
R999	residents. The reside written report results available to residents readily accessible to wishing to examine the to see them. Findings During a tour of the facurrent written inspectant available to the present and available to the present written inspectant.	tion was readily available to nce shall make current from inspection readily and to the public in a place residents where individuals ne results do not have to ask	R999			

## Areas noted for improvement based on 7/18/23 Survey Visit:

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R179	V. Resident Care and Home Services		8/14/23
SS=E	Based on record review and staff interview there was a failure to ensure 4 out of 5 sampled staff completed all required yearly training. Findings include:  Per record review on 7/18/23 it was noted that 4 out of 5 staff that provide direct patient care did not complete all the required yearly training to include: resident rights, fire safety and emergency evacuation, resident emergency response procedures, such as the Heimlich maneuver, accidents, police, or ambulance contact and first aid, policies, and procedures regarding mandatory reports of abuse, neglect and	Management uses the Relias training Platform to track completion of necessary training. Staff's training plan within this program ensures the 12hours required within the 7areas as outlined by licensing regulations. Staff who are not in compliance with training will be required to complete outstanding training and be in "good standing" prior to providing on-the-floor services/supports.  The supervisor will review staff compliance with training on a bi-weekly	
	exploitation, respectful and effective interaction	basis and review deficiencies in	
	with residents, general supervision, and care of residents. This was confirmed by the manager on	supervision.	
	7/18/23 at time of finding.	The manager will review staff compliance with training every two months.	
R266 SS=F	IX. Physical Plant	Procedures were immediately assessed and revised following the identified	Week of 4/12/21
	9.1 Environment	incident including:	
	9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment.  This REQUIREMENT is not met as evidenced by:	Safety Levels & Smoking: -Clients on level one will not be able to use the lighter. Clients on level two can use the lighter outside with staff and immediately return	
	Based on observation, record review, and staff interview the RCH failed to provide care in a safe environment. Findings include:  Per record review on 7/18/23 Resident #1 was admitted to the Residential Care Home (RCH) with a diagnosis of schizophrenia. Resident #1 displayed many symptoms related to schizophrenia throughout his/her stay at  Maplewood Recovery Center including delusional thoughts, paranoia, distorted thinking, confusion,	it to staffClients on level three will be able to use the lighter independently and will return it to staff when they enter the building. Individuals on level three would also be subject to a search if in the community without staff to ensure that no weapons or dangerous belongings are brought in to the facility.	
	and maladaptive behavioral changes. Per record review s/he had become increasingly noncompliant with care and medication administration leading up to incident occurring on 4/9/21.  Per record review on 4/9/21 at about 10:15 AM, resident was found smoking in his/her room. At	Staff were provided training on how to safely engage and set limits with someone who is dysregulated, delusional, paranoid, and/or has a history of being loud and intimidating. Staff were provided with training on how and when to contact the RMHS CRISIS team.	

8/10/23

the time of discovery staff attempted to redirect him/her but Resident #1 was not responsive to staff and continued to smoke until finished with cigarette, then continued to smoke two more cigarettes. At this time the Director of Adult Behavioral Health was called in to intervene and Resident #1 give a lighter to him/her. According to record review a plan to allow Resident #1 to smoke one cigarette at a time with staff supervision was implemented. On the afternoon of 4/9/21 Resident #1 asked staff for an additional cigarette and responded with verbally aggressive behavior towards staff and threatened self-harm when staff reminded him/her of the plan to have one cigarette at a time. Due to Resident #1's aggressive behavior staff went back into the RCH for safety. Resident #1 remained outside briefly then entered the home, went into his/her room for a few minutes, then entered the living room and sat down. The fire alarm sounded and when staff opened Resident #1's bedroom door, they observed flames approximately 2 feet high radiating from Resident #1's burning mattress. The building was evacuated and 911 was notified. Per interview on the afternoon of 7/18/23 the Director of Adult Behavioral Health stated Resident #1was often noncompliant; often showed behaviors such as aggression, paranoia, confusion; and occasionally made inappropriate sexual remarks towards staff. During interview the Director was asked if s/he was ever called to come to the RCH to speak with Resident #1 about smoking in his/her room, s/he said yes and believed this occurred a few days prior to the incident on 4/9/21. During the conversation between s/he and Resident #1, Resident #1 agreed to give him/her the lighter that h/she had in his/her possession.

Per interview with facility Manager, at 3:00 PM on 7/18/23 it was confirmed that Resident #1 was discovered to be smoking in his/her room at approximately 10:15 AM on 4/9/21. The manager stated that Resident #1 occasionally took trips to local store accompanied by staff, and that he/she believes on one of these outings Resident #1 purchased a pack of lighters. When asked if staff always accompanied Resident #1 to stores, he/she stated yes at that time Resident #1 was 1:1 supervision. When questioned if it was customary to allow residents to purchase lighter, he/she stated "no, there was definitely are breakdown in staff supervision". During interview the manager acknowledged that he/she was

Supervisor and Manager will review with staff admission process that includes these levels of care as outlined above.

The manager will ensure that applicants for open beds will be informed prior to admission of rules related to smoking, safety, and inventory of items.

	working at the RCH at the time of the incident on		
	4/9/21. When questioned who was scheduled to		
	be 1:1 supervision with Resident #1 manager		
	stated, "he/she could not recall" and additionally		
	stated "clearly there was a breakdown in staff		
	communication regarding Resident #1 care and		
	supervision".		
R291	IX. PHYSICAL PLANT	Maintenance adjusted the water	7/18/23
SS=F	9.6 Plumbing	temperature during the Licensing Visit. Staff will continue to check the water temperature and keep a log, to ensure	
	9.6.d Hot water temperatures shall not exceed	compliance with regulation. Staff will be	
	120 degrees Fahrenheit in resident areas.	expected to contact maintenance if he	
	This REQUIREMENT is not met as evidenced	temperature is over 120 degrees	
	by:	Fahrenheit. The supervisor will check the	
	Based on observation and staff interview there	log weekly to ensure compliance.	
	was a failure to ensure water temperatures did		
	not exceed 120 degrees Fahrenheit in resident		
	areas of the residential care home (RCH).		
	Findings include:		
	Per observation on 7/18/23 at 9:50 AM water		
	temperatures exceeded the recommended 120		
	degrees Fahrenheit in two resident areas.		
	Resident restroom #1 water temperature was		
	noted to be 124.5 degrees Fahrenheit, and the		
	facility kitchens water temperature was noted to		
	be 122.4 degrees Fahrenheit. This observation		
	was confirmed by the facility's registered nurse at		
	the time of findings.		
R999	MISCELLANEOUS	Previous audit and corrective action plan	7/19/23
SS=D	THIS CLAIM WELD OD	are posted next to facility license in	7713723
<b>33</b> B	4.13 (f) The residence shall make current written	building.	
	reports resulting from inspections readily	bunding.	
	available to residents and to the public in a place		
	readily accessible to residents where individuals		
	wishing to examine the results do not have to ask		
	to see them. The residence shall post a notice of		
	the availability of all other written reports in a		
	, , , , , , , , , , , , , , , , , , ,		
	prominent place. If a copy is requested and the		
	residence does not have a copy machine, the		
	residence shall inform the resident or member of		
	the public they may request a copy from the		
	licensing agency and shall provide the address		
	and telephone number of the licensing agency.		
	Based on observation and staff interview there		
	was a failure to ensure a current written report with		
	results of inspection was readily available to		
	residents. The residence shall make current		
	written report results from inspection readily		
	available to residents and to the public in a place		
	readily accessible to residents where individuals		
	wishing to examine the results do not have to ask		
	to see them. Findings include:		1

During a tour of the facility on 7/18/23 a copy of a current written inspection report was not posted and available to the public and residents. This was confirmed by the manager on 7/18/23 at 11:30 AM.	