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.dlp.vermont.gov
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

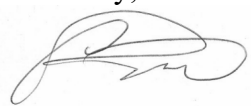
Mr. Rob Bride, Manager
Maplewood Recovery Residence
195 Stratton Road
Rutland, VT 05701

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0614	A. BUILDING: _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD RECOVERY RESIDENCE	195 STRATTON ROAD RUTLAND, 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
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 violations were identified:	R100	Tag R179 Accepted on 8/8/2023 - S. Ross, RN	
R179 SS=E	V. RESIDENT CARE AND HOME SERVICES 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 by:	R179		

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

X Robert A. Brick Manager 8/8/23
Signature Title Date

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R179	Continued From page 1 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 exploitation, respectful and effective interaction with residents, general supervision, and care of residents. This was confirmed by the manager on 7/18/23 at time of finding.	R179		
R266 SS=F	IX. PHYSICAL PLANT 9.1 Environment 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: 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	R266	Tag R266 Accepted on 8/8/2023 - S. Ross, RN	

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R266	Continued From page 2 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 Resident #1was often noncompliant; often showed behaviors such as aggression, paranoia,	R266		

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R266	Continued From page 3 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 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".	R266		
R291 SS=F	IX. PHYSICAL PLANT 9.6 Plumbing	R291	Tag R291 Accepted on 8/8/2023 - S. Ross, RN	

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R291	Continued From page 4 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.	R291	Tag R999 Accepted on 8/8/2023 - S. Ross, RN	
R999 SS=D	MISCELLANEOUS 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	R999		

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R999	Continued From page 5 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: 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.	R999		

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

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R179 SS=E	**V. Resident Care and Home Services** 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 exploitation, respectful and effective interaction with residents, general supervision, and care of residents. This was confirmed by the manager on 7/18/23 at time of finding.	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 basis and review deficiencies in supervision. The manager will review staff compliance with training every two months.	8/14/23
R266 SS=F	**IX. Physical Plant** *9.1 Environment* *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: 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, 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	Procedures were immediately assessed and revised following the identified incident including: 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 it to staff. -Clients 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. 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.	Week of 4/12/21

	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.	8/10/23

	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 SS=F	**IX. PHYSICAL PLANT** *9.6 Plumbing* *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.	Maintenance adjusted the water temperature during the Licensing Visit. Staff will continue to check the water temperature and keep a log, to ensure compliance with regulation. Staff will be expected to contact maintenance if he temperature is over 120 degrees Fahrenheit. The supervisor will check the log weekly to ensure compliance.	7/18/23
R999 SS=D	**MISCELLANEOUS** *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 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:*	Previous audit and corrective action plan are posted next to facility license in building.	7/19/23

	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.		