

Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

November 11, 2015

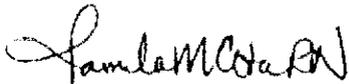
Mr. Francis Cheney, Administrator
Maple Lane Nursing Home
60 Maple Lane
Barton, VT 05822-9494

Dear Mr. Cheney:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 16, 2015**. 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
Licensing Chief



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 476042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/16/2015
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NAME OF PROVIDER OR SUPPLIER MAPLE LANE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 60 MAPLE LANE BARTON, VT 05822
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(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
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F 000 INITIAL COMMENTS

F 000

An unannounced onsite recertification survey was conducted on 9/14- 9/16/15 by the Division of Licensing & Protection. The following regulatory deficiencies were identified as a result of the survey:

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

F 280

Please see attached plans of correction.

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on record review, staff and resident interview, the facility failed to ensure that a resident with the capability to participate in planning care was invited to the care plan meeting for 2 of 17 residents sampled (Resident

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

TITLE
Administrator

(X6) DATE
10/15/2015

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 11/04/2015
FORM APPROVED
OMB NO. 0938-0391

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F 280	<p>Continued From page 1 #44, #52). Findings include:</p> <p>1. Per interview on 9/14/15, Resident #44 answered the resident interview question "No" regarding involvement in their care and treatment. The resident stated that they were not invited to the care plan meeting and did not participate in the process. Per review of the Social Service notes and the care plan meeting sign-in sheet, there was no evidence that suggested s/he was asked to attend the care plan meeting. Per interview on 9/15/15 at 10:46 AM, the Director of Social Services (DSS) confirmed that the resident was not invited to attend the care plan meeting, however the family was involved. Per the DSS, the resident is cognitively intact enough to participate in the care planning process, however was not consulted about attending the meeting.</p> <p>2. Per resident interview on 9/14/15, Resident #52 stated that they were not involved in decisions about their care, and did not attend the care plan meetings, nor were they invited to attend them. Per review of the social service notes and care plan attendance sign-in sheet, there was no evidence that suggested the resident was invited to attend the care plan meeting or participated in any way. Per interview on 9/15/15 at 10:45 AM, the DSS confirmed that although family members were notified regarding the care plan meeting, Resident #52 was not consulted to see if they would like to attend themselves to be a part of the care plan development process.</p>	F 280		
F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of</p>	F 431		

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F 431	<p>Continued From page 2</p> <p>a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that all medications were labeled in accordance with accepted professional principles for expiration dates for 3 resident's</p>	F 431	

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F 431	Continued From page 3 medications (Resident #13, #24, and #66). Findings include: 1. Per observation on 9/14/15 at 7:25 AM, the medication cart on the upstairs west wing contained insulins that were in use for residents. Per observation, the opened vial of Levemir Insulin in use for Resident # 24 had no date written on the vial or box to indicate when it had been opened to indicate when it needed to be discarded per the pharmacy recommendation. Also at this time a Humalog Insulin pen which was opened and in use for Resident #13 was found to have no date written on it to indicate when it was opened. Per interview on 9/14/15 at 7:35 AM, the nurse administering medications confirmed that these two insulins were not labeled with the date that they were opened. 2. Per observation on 9/15/15 at 2:35 PM, the downstairs unit medication cart was observed to have a Lantus insulin pen prescribed and in use for Resident #66 that did not have the date written on it to indicate when it had been opened. Per interview on 9/15/15 at 2:40 PM, the nurse administering medications confirmed that the insulin pen was unlabeled with the date it was opened. Per a reference sheet published by the American Society of Consultant Pharmacists, the recommended discard dates for insulin vials and pens are as follows: Lantus Insulin- 28 days, Levemir- 42 days, and Humalog - 28 days, after opening.	F 431			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441			

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F 441	<p>Continued From page 4</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <ol style="list-style-type: none"> (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. <p>(b) Preventing Spread of Infection</p> <ol style="list-style-type: none"> (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 441		

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F 441	<p>Continued From page 5</p> <p>Based on observation and staff interview, the facility failed to ensure that infection control practices were followed for the disposal of soiled linens for 1 of 17 residents sampled (Resident #44). Findings include:</p> <p>Per observation on 9/14/15 at 7:05 AM, by the bed of Resident #44, there was a soiled bedpad lying on the carpet, and next to it a visibly soiled and wet washcloth was seen lying directly on the carpet. Per interview on 9/14/15 at 7:10 AM, the LNA working on that wing confirmed that they had completed incontinence care on Resident #44 and had placed the wet pad and soiled washcloth directly on the carpeted floor.</p>	F 441	
F 514 SS#D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to maintain clinical records that were complete and accurate</p>	F 514	
(X5) COMPLETION DATE			

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F 514	<p>Continued From page 6</p> <p>regarding documentation for 1 of 3 residents with an identified nutrition risk. Findings include:</p> <p>Per staff interview and record review, the facility failed to maintain complete and accurate documentation to establish that physician orders for nutritional supplements were followed for a resident identified as having a significant weight loss and nutritional risk. The lack of documentation made it difficult to determine whether or how frequently the resident was receiving or refusing the supplements and whether other nutritional strategies should be implemented for the weight loss.</p> <p>Per 9/15/15 medical record review, the Unit Coordinator (UC) documented on 6/3/15 that Resident #28 was steadily losing weight and had lost a total of 12 pounds since admission 5 weeks ago. The resident was reported to receive health shakes with each meal which s/he did not take consistently. The physician was notified and on 6/3/15 signed an order adding 'Banana Flip' drinks two times per day and to continue Health Shakes (both high calorie supplements) with every meal. Per review of the resident's weekly weights, the resident weighed 148.4 pounds on 4/22/15 and his/her weight dropped to 132.6 pounds on 9/11/15.</p> <p>Per interviews with nursing staff, the facility tracks supplement intake on a meal percentage sheet and staff LNA's (Licensed Nursing Assistants) enter the amounts of the supplement consumed. Per review, for the month of June, there was documentation that Resident #28 consumed a health shake supplement on 4 of 90 opportunities and refused the supplement one time; for July, documentation supported that the resident took</p>	F 514	

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F 514	<p>Continued From page 7</p> <p>the supplement on 5 of 93 opportunities and refused the supplement two times; in August, s/he took the supplement on 6 of 93 opportunities and in September, documentation supported that the resident took the supplement one time through September 15th.</p> <p>On 9/15/15 at 10:07 AM, LNA #1 reported that LNAs are supposed to document the percentage of meals that residents consume, but are not documenting whether residents drink their health shakes or refuse them unless their nurse specifically asks for documentation or if a resident is losing weight. S/he reported that Resident #28 gets health shakes with his/her meals and is encouraged to drink them. On 9/16/15 at 10:39 AM, LNA #2 reported that it is difficult to document whether Resident #28 drinks his/her health shakes as the resident sometimes takes them back to his/her room and has been caught dumping them in the sink or toilet. S/he reported that no one is consistent about documenting whether the shakes are consumed and floating or new staff aren't always aware of what needs documentation.</p> <p>On 9/16/15 at 9:39, the UC confirmed the physician orders above for nutritional supplements and confirmed that there was a lack of documentation of whether the resident was consuming or refusing the shakes; s/he confirmed that the lack of documentation made it difficult to determine if the physician orders are being followed or whether other nutritional strategies might have been called for, though the residents weight had recently stabilized.</p>	F 514		

**Maple Lane Nursing Home
Plan of Correction
Survey 9/16/2015**

F280 Right to Participate in Planning of Care

1) To address the Resident's #44 and 55 lack of involvement in their recent Care Plan development our Social Service Director will review these resident's current Plan of Care with them if desired by the residents.

2) All other resident's of the facility that have not been judged incompetent by the State of Vermont have the potential to be affected by this deficient practice. All residents of the facility who are able to participate in the Care Planning process will be identified. Our Social Service Director will review their Plan of Care with each identified resident if so desired.

3) In the future all resident's of the facility that are able to participate in the Care Planning process will be invited to all Care Plan Meeting by our Social Service Director. A formal tracking form will be instituted to record this process which will include details of resident participation.

4) Out Quality Assurance Committee will monitor the effectiveness our corrective action. The participation tracking form will be submitted to the Administrator on a monthly basis for review, finding will be reported to the Quality Assurance Committee.

Frank Cheney, Administrator is responsible for the correction of this deficiency.

Completion Date: 10/26/15

F280 POC accepted 11/10/15 Pmcoturn

F431 Store Drugs & Biologicals

All residents of the facility receiving Insulin have the potential to be affected by this deficient practice. Our Plan of Correction includes:

1) The DNS has examined all currently opened Insulin vials and pens to ensure that the date they were opened is identifiable and that they are not past the recommended discard date.

2) An in-service will be held for all Professional Nursing personnel on October 22, 2015 to review facility policy relative to the labeling and discarding of Insulin vial and pens. Rhonda Smith, DNS will be delivering this educational program.

3) Professional Nursing personnel will now verify proper dating of Insulin during our established controlled drug count system.

4) Unit Coordinators will view all open Insulin vials and pens on a weekly basis to ensure ongoing compliance with facility policy. Findings will be reported to our QA Committee for an overview.

Rhonda Smith, DNS is responsible for the correction of this deficiency.

Correction Date: 10/26/15

F431 POC accepted 11/10/15 pmcatarn

F441 Infection Control

All residents of the facility have the potential of being affected by this deficient practice. Corrective action includes:

1) The staff member caring for resident #44 has been counseled regarding importance of the following proper IC policy and procedure.

2) An infection control in-service for all facility staff was held on 10/8/15. Frank Cheney, Administrator and Claire Bishop, RN/IC Nurse conducted the educational event. Topics included General IC policy, Blood borne Pathogens policy, Infectious diseases, Modes of transmitting, Isolation procedures, Hand washing and handling of soiled linen.

3) An IC in-service will be held for all Professional staff on 10/22/15. Rhonda Smith, DNS and Frank Cheney, Administrator will deliver this in-service. Topics will include monitoring LNA staff and supervisory responsibilities of staff nursing positions.

4) The existing IC observation reviews will increase from monthly to weekly.

Our Quality Assurance Committee will monitor the effectiveness of this corrective action by reviewing weekly observation reviews. Reviews will be completed by our IC Nurse.

Rhonda Smith, DNS is responsible for the correction of this deficiency.

Correction Date: 10/26/15

F441 POC accepted 11/10/15 pmcatarn

F514 Resident Records

Documentation of Dietary Supplements is done by our LNA positions. Recording of this information has always occurred on our daily meal percentage sheets. This documentation has not been kept as part of our permanent records and thus has been

shredded at the end of each day. Accordingly evidence of supplements administration was not available during our recent survey. This documentation will now be kept as part of the permanent resident's record. The effectiveness of this corrective action will be monitored by our RN Unit Coordinator positions on a weekly basis. Findings will be reported to our Quality Assurance Committee.

Rhonda Smith, DNS will be responsible for the correction of this deficiency.

Correction Date: 10/26/15

F514 POC accepted 11/10/15 pncetarn