



AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
<http://www.dail.vermont.gov>
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

August 8, 2011

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

Dear Mr. Cheney:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 29, 2011**. 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,

A handwritten signature in black ink that reads "Pamela M. Cota RN". The signature is written in a cursive style.

Pamela M. Cota, RN
Licensing Chief

PC:jl



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

RECEIVED
Division of
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PRINTED: 07/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ Licensing and Protection	(X3) DATE SURVEY COMPLETED 06/29/2011
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NAME OF PROVIDER OR SUPPLIER MAPLE LANE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 50 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 by the Division of Licensing and Protection from 6/26/11 to 6/29/11. The following regulatory violations were identified.

F 159 SS=B 483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS

F 159

See attached plan of correction 7/29/11

Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.

The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

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

TITLE

(X6) DATE

Frances Chen

Aeln

7/22/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 159	<p>Continued From page 1</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview with one resident in the sample (Resident #24) & staff interviews, the facility failed to ensure that the residents of the facility have ready and reasonable access to their personal funds including weekends. Findings include:</p> <p>Per interview with Resident # 24 during Phase 1 of the survey, s/he reported that s/he could not access their personal funds on the weekends and 'only if s/he asked ahead of time on Fridays.' Per interview on 6/29/11 at 2:40 P.M., with the staff member who was identified by the facility as the person who manages the personal funds account(s) for the residents, s/he confirmed that personal funds were not available to the residents on weekends. S/he stated that residents have access to their money 'Monday through Friday from 7 A.M. to 4:30 P.M.' and that money was not available on weekends because s/he was 'not there on weekends.'</p>	F 159			

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F 159	Continued From page 2	F 159	
F 167 SS=B	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, the facility failed to post survey results in a place readily accessible to all residents and failed to post a notice of their availability. Findings include:</p> <p>Per resident and staff interviews, 2 residents (#4, 48) out of the total sample as well as 2 staff members (that conduct the monthly resident council meetings) were unaware that they could access the state survey results or where they were posted. Per interview on 6/28/11 at 9:45 A.M. Resident # 48, who was identified by staff as being very active in the resident council and s/he routinely attends all the meetings. When s/he was asked by this surveyor where the state survey results were posted and how s/he could access them s/he stated, 'I'm not sure what that is.' Also, 'No, I have never been told about that, I would like to see a copy of that, where is it located?' in</p>	F 167	<p>Please see attached Plan of Correction</p> <p>7/29/11</p>

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F 167	<p>Continued From page 3</p> <p>addition, Resident # 4, who is also very active in the resident council and attends all the meetings. stated, 'I know the State comes in once in a while, but I didn't know there were survey results that we could look or where they are.' She also stated, 'My son would like to see them.'</p> <p>Although the survey results were posted on the wall to the left as you enter the building, the survey findings were posted by a thumb-tack on the wall, too high for wheel-chair bound residents to easily access them. Also there was no notice posted of their availability. A review of the Resident Council Meeting minutes for the last year failed to show any discussion of the state inspection survey results, where they are posted or how residents could access them.</p> <p>Per interview with the upstairs Activities Director on 5/29/11 at 10:30 A.M., who is one of the primary staff members that conducts resident council meetings, s/he confirmed that s/he did 'not know where the state inspection results were, that the residents could access them or where they were located.' In addition, on 5/29/11 at 10:56 A.M., per interview with the Social Services Director, s/he confirmed that s/he did not know where the state inspection results were posted. S/he stated, 'I don't know, I suppose that they are kept in the Administrator's office.'</p>	F 167		
F 226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p>	F 226	<p>Please see attached Plan of Correction</p>	7/29/11

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F 226	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility failed to follow policy and procedures for investigating bruises acquired for 1 applicable resident (Resident #1). Findings include: 1. Per interview on 6/26/11, Resident #1 stated that she had been treated "roughly" by staff during a transfer to the commode, causing bruising and an open area to the buttocks. The resident told this surveyor that two of the younger LNAs (Licensed Nursing Assistants) had done the transfer, and thought they were hurried and not as careful as they should have been. Per review of the nurse's notes, this injury was observed by staff during care on 5/23/11, and was put on the treatment sheet to be monitored daily. The Unit Manager investigated the incident and concluded that the bruise and laceration were caused during a transfer to the commode by mechanical lift when the LNAs did not lower the resident to the center of the commode and had to slide the resident toward the middle of the seat. Per interview on 6/28/11 at 11:15 AM, the Unit Manager stated that the facility's policy was not followed, as an incident report had not been written, there were no written statements by staff involved, no written statement of the resident interview regarding the incident, and no written investigative summary completed.	F 226			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280	Please see attached Plan of Correction	7/29/11	

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F 280	<p>Continued From page 5</p> <p>incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to assure that care plans were revised to reflect the current status of 2 of 17 residents in the Stage 2 sample (Residents #1, #19). Findings include:</p> <p>1. Per interview on 6/26/11, Resident #1 stated that s/he was injured during a transfer to the commode, causing bruising and an open area to the buttocks. Per review of the nurse's notes, this injury was observed by staff during care on 5/23/11, put on the treatment sheet to be monitored daily, and per interview, the Unit Manager investigated the incident and concluded that the bruise and laceration were caused during a transfer to the commode by hooyer lift when the</p>	F 280		

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F 280	<p>Continued From page 6</p> <p>LNAs (Licensed Nursing Assistants) did not lower the resident to the center of the commode and had to slide the resident toward the middle of the seat. Per review of the resident's care plan, there was no documentation of the potential for injury if the resident was not centered properly during toileting. Per interview on 6/28/11 at 3:55 PM, the Unit Manager stated that the care plan was not updated to alert staff to the problem regarding the transfer of the resident to the commode, to make sure that they centered the resident over the middle of the seat to prevent further injury.</p> <p>2. Per record review on 6/28/11. Resident #19 is cognitively impaired and not interviewable. The resident requires assist with hygiene and bathing and is unable participate, and often combative to staff while they are providing this care. On 2/26/11, the nurses notes stated that the resident had bruises to the top of both hands. On 5/17/11, the resident was noted to have a skin tear after attempting to scratch the staff person providing care and accidentally scratched their own hand. On 6/16/11, the nurse noted a bruise to the resident's left inner leg, and again the cause was attributed to combative behavior during care. Per interview on 6/29/11, The Unit Manager (UM) stated that the resident was one of three residents on a list to be washed and dressed by the night shift early in the morning before the day shift came on. The UM noticed that it was on the night shift when the injuries took place, and decided to change the time of care to be later in the morning when there are more staff available so two LNAs could perform the task instead of one, and see if sleeping later made a difference. After the time of care was changed to later in the morning, the resident became much less</p>	F 280		

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F 280	Continued From page 7 resistant and combative, and the Unit Manager concluded that the resident did not like getting up early and that was contributing to the resistance. Per interview on 6/29/11 at 3:55 PM, the UM confirmed that the resident's care plan was not updated to address the change in time of care to better suit the resident's likes, and possibly decrease the potential for further injury from combative behaviors.	F 280		
F 371 SS=F	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to label, date, and monitor food so it is used by its use-by date or discarded in 2 of 2 resident snack refrigerators, the kitchen's silver upright refrigerator, and the kitchen's white upright refrigerator with separate freezer compartment. Additionally, the facility failed to show evidence of monitoring of dishwasher temperatures for a period of 5 days from June 21-26, 2011. Findings include: 1. During the initial kitchen tour at 4:30 PM on 6/26/11, the kitchen's large silver refrigerator	F 371	See attached POC.	

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F 371	<p>Continued From page 8</p> <p>contained a ham product which was out of its original container and wrapped in undated, clear plastic wrap. At 4:38 PM on 6/26/11, the dietary staff B confirmed that the kitchen's large silver refrigerator contained a ham product which was out of its original container and wrapped in undated, clear plastic wrap.</p> <p>2. During the initial kitchen tour at 4:30 PM on 6/26/11, the freezer compartment of the white, single door refrigerator freezer contained 3 hot dogs in their original wrapper which was unsealed, and several apparent pancakes wrapped in wax paper and not dated. At 4:40 PM on 6/27/11 the dietary staff B confirmed that the freezer compartment of the white refrigerator contained an unsealed package of 3 hot dogs and undated, wax paper wrapped pancakes.</p> <p>3. During the initial kitchen tour at 4:30 PM on 6/26/11, the temperature log for the facility's dishwasher was found to lack entries for the wash and rinse temperatures from lunch on June 21, 2011 through lunch on June 26, 2011. At 4:40 PM on 6/26/11, the dietary staff B confirmed that the dishwasher temperature logs for wash and rinse cycles were blank from lunch on June 21, 2011 through lunch on June 26, 2011. During an interview on 6/27/11 at 2:55 PM, the Food Service Director stated that s/he had not noticed the blank dishwasher temperature log used for monitoring wash and rinse cycles from lunch on June 21 through lunch on June 26, 2011.</p> <p>4. Per observation of the Downstairs Special Needs Unit (SNU) snack refrigerator and confirmed during an interview with the Medication Nurse on 6/28/11 at 10:06 AM, the following</p>	F 371			

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F 371	Continued From page 9 items were observed in the refrigerator: a) one full bowl of soup was not dated as to when it was placed in the snack refrigerator and was not labeled with a resident's name, b) approximately 1/2 bowl of jelly, which was not in the original container, was dated 3/13 (no year) and was not labeled with a resident's name. 5. Per observation of the Upstairs East and West resident snack refrigerator and confirmed during an interview with the Director of Nursing (DNS) on 6/28/11 at 10:32 AM, the following items were observed in the refrigerator: a) one full bowl of jelly, which was not in the original container, was dated 6/22/11 and not labeled with a resident's name, b) approximately 1/8th full serving pitcher of apple juice, which was not in the original container, was dated 6/24/11, c) approximately 1/2 bottle of Vitamin Water was not dated as to when opened/placed in the refrigerator. In addition, per interview with the DNS on 6/28/11 at 10:28 AM, food in the snack refrigerator outdates in 72 hours, the expectation is for staff to check the snack refrigerators daily, discard outdated food, but there is no written Facility policy concerning checking for and discarding outdated food in the snack refrigerators.	F 371		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by:	F 502	See attached POC	

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F 502	Continued From page 10 Based upon observation and interview, the facility failed to provide quality laboratory services by not discarding expired blood drawing equipment in one of two medication storage rooms. Findings include: Per observation and confirmed during an interview with the downstairs Special Needs Unit (SNU) Medication Nurse on 6/28/11 at 10:06 AM, the following items were in the medication storage room available for use: a) four purple top blood drawing tubes with an expiration date of January 2011; and b) # 47 Butterfly Venisystems (used to draw blood) with expiration dates of April 2006.	F 502			

**Maple Lane Nursing Home
Plan of Correction
Survey 6/29/11**

F159 Personal Funds

A locked cash box system has been established in the facility. This cash fund will be locked in our Nurses cart and will enable our nurses to release resident funds when needed 24 hours a day. An in-service presented by Frank Cheney, Administrator will be held on 7/26/11 for all Professional Nursing staff to ensure proper understanding of this adjustment. Additionally a resident council meeting has been scheduled on 7/25/11 to inform our residents of the availability of their personal funds and how to access them. Our quality assurance program will monitor the effectiveness of our Plan of Correction. Our Social Service Supervisor will conduct resident interviews on a weekly basis for 4 weeks to ensure that access to their funds is available 24 hours a day. Findings will be reported to our QA Committee.

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

Completion Date 7/29/11

F159 POC Accepted 8/18/11 K Campos RN / P. Mcota RN

F167 Survey Results

The facility will upgrade our process of postings Federal or State survey results. The labeling height and number of posting will be addressed to make them more readily available to our residents. A resident council meeting will be held on 7/25/11 to go over current survey results, inform our residents of their right to have access to these results and how to do so. Additionally an in-service will be held on 7/26/11 to ensure proper staff understanding of this process. Lastly survey results will be added to the resident council agenda at a minimum on a BI annual basis.

Our quality Assurance program will monitor the effectiveness of our corrective action. Our Social Service Director will conduct resident interviews on a weekly basis for 4 weeks on a sampling of residents. These interviews will be designed to identify if our residents are knowledgeable regarding the availability of the facilities survey results. Findings will be reported to our QA Committee.

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

Completion Date 7/29/11

F167 POC Accepted 8/18/11 K Campos RN / P. Mcota RN

F226 Abuse

F226

- 1) The Plan of Care of resident #1 has been reviewed and updated to reflect the findings of our Unit Managers investigation into the incident. Staff that care directly for resident #1 have been counseled regarding proper transfer techniques. All residents of the facility who need assist with transfers are potentially affected by our deficient practice. Our DNS will provide in-service education for all LNAS regarding proper Hoyer lift technique and potential hazards during transfer.
- 2) In order to ensure that the deficient do not recur we will:
 - a) Review and upgrade our incident report policy and procedure to provide more specific direction for our Nurses in this area
 - b) An in-service will be held on 7/26/11 for all Nurses. Ellen Niles, DNS will deliver the education with topics to include, Incident reporting policy and procedure, proper Nursing "Follow Thru" of accidents/injuries and Incident report investigation.
- 3) Our Quality Assurance Program will monitor the effectiveness of our Plan of Correction. Our Nursing Unit Managers will conduct chart audit type review on a sampling of residents on a weekly basis for 4 weeks focusing on identification of events that per policy should initiate incident reports. Once identified we will verify that an Incident report was initiated and investigated were necessary. Findings will be reported to our QA Committee.

Ellen Niles, DNS will be responsible for the correction of this deficient practice.

Completion Date 7/29/11

F226 POC Accepted 8/8/11 K. Campos RN / P. McArthur

F280 Care Planning

- 1) The Plans of Care for residents #1 and #19 have been reviewed and updated to reflect the current status of these residents. These adjustments have been communicated to our staff responsible for the care of residents #1 and #19.
- 2) In order to identify all other residents of the facility who have the potential to be affected by our deficient practice nursing staff will review all resident care plans who exhibit combativeness during care and the ADL section of all residents. These care plans will be updated where appropriate to accurately reflect the current status of each resident.
- 3) In order to ensure that the deficient practice does not recur an in-service will be held on 7/26/11 for all professional staff responsible for the timely adjustment of care plans. The agenda will include timely care planning adjustment, communication of care plan changes, an overview of care plan process, purpose and philosophy.
- 4) Our Quality Assurance program will monitor the ongoing effectiveness of our Plan of Correction. In order to ensure compliance a sampling of resident care plans will be reviewed on a weekly basis for 6 weeks by our DNS to determine if they accurately reflect the resident's status. Findings will be reported to our QA Committee and Administrator.

Ellen Niles, DNS will be responsible for the correction of this deficiency.

Completion Date 7/29/11

F280 POC Accepted 8/8/11 K. Campos RN / P. Motar RN

F502 Administration

- 1) All resident of our SNU Unit who may require Laboratory service are potentially affected by the deficient practice. All nursing storage areas in our SNU have been cleaned out and reorganized with all outdated material being disposed of.
- 2) In order to ensure the deficient practice does not recur:
 - a) Responsibility for this storage area will now be handled by our Central Supply Coordinator and not by multiple staff members.
 - b) Central Supply Coordinator will inspect supply areas on a weekly basis when stocking occurs to address out dated items.
 - c) An in-service will be held on 7/26/11 for all Nurses. Ellen Niles, DNS will deliver education focusing on proper stocking techniques, supply procurement and out dated items.
- 3) Our Quality Assurance program will monitor the effectiveness of our Plan of Correction. We will inspect our nursing storage on a weekly basis to ensure that out of date items are discarded and not used. Report of findings will be provided to our QA Committee.

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

Completion Date 7/29/11

F502 POC Accepted 8/8/11 K. Campos RN / P. Motar RN

F371 Food Storage

All residents of the facility have the potential of being affected by the deficient practice. In order to ensure that the deficient practice does not recur we will accomplish the following:

- 1) Development of a detailed policy and procedure to address the proper storage of food based on acceptable industry standards.
- 2) Our existing "duty" checklist will be upgraded to allow for more specific direction and assignment of dishwasher temperature monitoring.
- 3) An in-service for all Dietary staff will be held on 6/26/11. Education will be delivered by our Dietary Supervisor. Topics will include food storage guidelines, food storage policy and procedure, handling food/sanitary conditions and appliance (dishwasher, refrigerator, freezer etc...) temperature range and monitoring protocol.

Our Quality Assurance program will monitor the effectiveness of our Plan of Correction. Our Dietary Supervisor will conduct observation reviews of this area of concern on a

weekly basis for 6 weeks to ensure that proper labeling are adhered to, dating of stored food, dishwashing temperature. Findings will be reported to our QA Committee.

Frank Cheney will be responsible for the correction of this deficiency.

Completion Date 7/29/11

F371 POC Accepted 8/8/11 K. Campos RN / P. Meota RN