

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

April 26, 2016

Dr. Catherine Iacuzzi, Manager
Maple Leaf Farm
10 Maple Leaf Road
Underhill, VT 05489-9358

Dear Dr. Iacuzzi:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on April 6, 2016. 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

PRINTED: 04/13/2016
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0519	(X2) MULTIPLE CONSTRUCTION A, BUILDING: _____ B WING: _____	(X3) DATE SURVEY COMPLETED C 04/06/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER
MAPLE LEAF FARM

STREET ADDRESS, CITY, STATE, ZIP CODE
**10 MAPLE LEAF ROAD
UNDERHILL, VT 05489**

(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
T 001	Initial Comments An unannounced on site annual re-licensure survey and self report investigation was conducted by the Division of Licensing and Protection on 04/05/16 - 04/06/16. As the result, the following are Therapeutic Community Residence (TCR) regulatory findings.	T 001		
T 029 SS=E	V.5.6.d Resident Care and Aservices 5.6 Health Care Provider Services 5.6.d All health care providers' orders obtained via telephone shall be countersigned by the health care provider within fifteen (15) days of the date the order was given. This REQUIREMENT is not met as evidenced by: The facility failed to obtain countersigned orders within fifteen days of the date the order was given for 2 of 6 residents reviewed. (Residents #2 & #4) Findings include: 1. Per record review on 04/05/16, Resident #2 was admitted on 02/02/16 and verbal orders were obtained for Nicoderm Patch, Nicorette gum and Citalopram 10 mg. The orders were not countersigned until 04/06/16, greater than 2 months later. 2. Resident #4 was admitted on 03/17/16 and a verbal order was given for Gabapentin 300 mg three times a day for 2 weeks. As of the review date on 04/05/16, the order has not been countersigned by the ordering physician.	T 029	5.6.d All telephone Provider orders will be countersigned within 15 days of the date of the order and documented in the medical record. All current orders will be countersigned and documented. All staff will be trained to use the new Provider order forms. Procedures for the implementation of the new order form are completed by April 21, 2016. All staff training in the procedures for using the new order form are completed by April 21, 2016. A random selection of medical records will be audited monthly for verification of all orders with documented provider signatures. All provider orders will be countersigned and documented in the medical record within 15 days of the date of the order.	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Clayton Thomas

TITLE

QA Director / OP Director

(X6) DATE

4-20-16

STATE FORM

RJZM11

If continuation sheet 1 of 8

T029 - T076 POCs accepted 4/21/16 *scmmw/rlp/mc*

PRINTED: 04/13/2016
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/06/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAPLE LEAF FARM	STREET ADDRESS, CITY, STATE, ZIP CODE 10 MAPLE LEAF ROAD UNDERHILL, VT 05489
---	--

(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
T 029	Continued From page 1	T 029		
T 033 SS=C	<p>V.5.7.c Resident Care and Services</p> <p>5.7 Treatment Plan</p> <p>5.7.c The treatment plan shall contain clear and concise statements of at least the short-term goals the resident will be attempting to achieve, along with a realistic time schedule for their fulfillment or reassessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop, for 4 of 6 Residents, a treatment plan that contained clear and concise statements of at least the short-term goals the resident will be attempting to achieve, along with a realistic time table for their fulfillment or reassessment. (Residents #1, #2, #4 & #5) Findings include:</p> <p>1. Per record review on 04/5/16 - 04/06/16, Residents #1, #2 #4 & #5's treatment plans were not found in the resident's electronic records. The admission dates were noted from February 2016 through March 2016. There are general withdrawal and recovery modalities, however, there are no clear and concise statements to address the specific goals for each resident. Per</p>	T 033	<p>5.7.c All residents will have nursing care plan established to address their primary withdrawal symptoms and a nursing care plan established to address (as needed) any other medical needs. All staff will be advised of the need for nursing care plans. Licensed staff will provide the nursing care plans to be followed. All staff training in the use of nursing care plans will be implemented April 26, 2016</p> <p>Licensed staff training in nursing care planning will be implemented. Nursing Care plans will document the short and longer term goals (as needed) for each resident. Beginning April 26, 2016</p> <p>A random selection of medical records will be audited monthly for the documentation of nursing care plans for withdrawal and other medical issues</p>	

PRINTED: 04/19/2016
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/08/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAPLE LEAF FARM	STREET ADDRESS, CITY, STATE, ZIP CODE 10 MAPLE LEAF ROAD UNDERHILL, VT 05489
---	--

(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
T 033	Continued From page 2 Interview with the Clinical Manager on 04/05/16 at 3:41 PM stated that the Case Managers create the treatment plans and "they might have them in hard copy, although they might not be available". S/he confirmed that the expectation would be that treatment plans have clear individual steps but were not found in the resident's records.	T 033		
T 044 SS=D	V.5.8.g.1.2.3.4.5.6. Resident Care and Services 5.8 Medication Management 5.8.g Residences must establish procedures for documentation sufficient to indicate to the health care provider, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the residence; (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; (5) For residents receiving psychoactive medications, a record of monitoring for side	T 044	5.8.g The medical record will document Residents requesting as needed medication for symptom relief and will document the effectiveness of the medication ordered and provided. All staff will be advised of the need to document the request for as needed medication and the documentation of the effectiveness of the medication. All staff training about the use of as needed medication and the effectiveness of the medications frequently requested by April 27, 2016. A random selection of medical records will be audited for documentation of the request for as needed medication and documentation of the effectiveness of the medication. All medical records will show documented evidence that all as needed medications ordered and administered also note the effectiveness of the medication.	

PRINTED: 04/13/2016
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/06/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAPLE LEAF FARM	STREET ADDRESS, CITY, STATE, ZIP CODE 10 MAPLE LEAF ROAD UNDERHILL, VT 05489
---	--

(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
T 044	<p>Continued From page 3</p> <p>effects; and</p> <p>(8) All incidents of medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the TCR failed to assure there is documentation of appropriate regimen and PRN medication's effect for 1 of the 6 residents in the sample. (Residents #1) Findings include:</p> <p>1. Resident #1 was admitted on 03/28/16 for bi-polar and poly-substance abuse. The physician ordered on admission Hydroxyzine 25 mg as needed (PRN) every 4 hours for anxiety and Clonidine 0.1mg as needed for withdrawal symptoms. The medications were given on 04/01/16, however, there was no documentation as to the effectiveness of the medication. In addition, on 04/01/16 an order for Seroquel 25-50 mg was given. The physician evaluation note stated a trial of the mood stabilizer would be considered and to titrate to effect and adverse reaction[sedation]. Staff wrote the order as Seroquel 25 - 50 mg at bedtime. Per the MAR [medication administration record] 50 mg was given on 04/02/16. A staff progress note demonstrates that the resident was very sedated that night and into the next day. Per interview on 04/06/16 at 1:10 PM the Director of Nursing (DON) stated that staff will write by 'default', meaning, if the medication didn't work there would be a note and 'we can assume if the resident didn't come back [to the nursing station] they're o.k.' When asked how staff know which dose should be given when there is a range, the DON stated it should be more clear, which didn't</p>	T 044		

PRINTED: 04/13/2016
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/06/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAPLE LEAF FARM	STREET ADDRESS, CITY, STATE, ZIP CODE 10 MAPLE LEAF ROAD UNDERHILL, VT 05489
---	--

(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)	(X6) COMPLETE DATE
T 044	Continued From page 4 happen. The DON confirmed the lack of documentation for proper reglmen and the effectiveness of PRN medications.	T 044		
T 052 SS=C	V.5.9.b.1.2.3.4.5.6.7 Resident Care and Services 5.9 Staff Services 5.9.b. The residence 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, hand washing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents	T 062	5.9b Upon hire and annually all staff will receive training to meet requirements set forth by all accrediting agencies. This process will initiate at hire, each month every staff member will be required to complete an online training that will be assigned by their supervisor and each direct service staff member will also receive documented training during supervision sessions. These details will be monitored bi-weekly by the QA director. The QA director will submit a written summary to the Executive director monthly, illustrating the findings of the bi-weekly audit. This will all be active and ready for review by 5/01/2016	

PRINTED: 04/13/2016
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0519	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/06/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAPLE LEAF FARM	STREET ADDRESS, CITY, STATE, ZIP CODE 10 MAPLE LEAF ROAD UNDERHILL, VT 05489
---	--

(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
--------------------	--	---------------	---	--------------------

T 052	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Therapeutic Care Residence (TCR) failed to assure all direct care staff were provided 12 hours of training on a yearly basis and before providing direct care to residents. Findings include: Per review on 04/06/16 of training records for 4 of 6 direct care staff, who have been employed greater than 1 year, the required 12 hours of annual training had not been documented as being completed. Two of two newly hired direct care staff did not receive the all the required trainings. In addition, review of the education modules shows the Abuse/Neglect trainings were not specific to reporting timelines for Vermont's statutes. This was confirmed on the afternoon of 04/06/16 with the Operations Director.	T 052		
-------	--	-------	--	--

T 062 SS=B	V.5.10.b.4 Resident Care and Services 6.10 Records/Reports 6.10.b.4 The results of the criminal record and abuse registry checks for all staff. This REQUIREMENT is not met as evidenced by: Based on record review and interview the TCR failed to maintain and have on site the results of the criminal record and abuse registry checks for all staff. This has the potential to effect all residents. Findings include: 1. On 04/05/16 at 2:45 PM, the nurse surveyor requested information regarding employee background checks. The Operations Director	T 062	5.10.b.4 Effective immediately, all employee background checks are pulled prior to hire and annually regardless of their hire date. This will be the standard for any staff member providing services on site. The HR director will notify the first Monday of May, the executive director will verify with the HR director that all have been updated.	
---------------	--	-------	---	--

PRINTED: 04/13/2016
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/08/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MAPLE LEAF FARM	STREET ADDRESS, CITY, STATE, ZIP CODE 10 MAPLE LEAF ROAD UNDERHILL, VT 06489
---	--

(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
--------------------	--	---------------	---	--------------------

T 062	Continued From page 6 stated that background checks for (outside) Agency workers are not on site and handled by the Agency themselves and stated "because they're not our employee they're the Agency's employee". A telephone call to the Agency later in the afternoon, demonstrated that the Agency employee's background check was completed 06/22/12, although hired to work for the TCR in December 2015. The Operations Director on 04/08/16 at 10:00 AM confirmed that the TCR did not have the current required personnel files maintained on site.	T 062		
T 079 SS=D	V.5.16.a Resident Care and Services 5.16 Reporting of Abuse, Neglect or Exploitation 5.16.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be contacted by calling toll-free 1-800-564-1612. Reports must be made to APS within forty-eight (48) hours of learning of the suspected, reported or alleged incident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the TCR failed to report to Adult Protective Services (APS) within 48 hours of learning of alleged abuse for 1 applicable resident. (Resident #6) Findings include: 1. Per record review and confirmed by the TCR Director during interview on 04/05/16 at 1:20 PM, former Resident #6 had alleged employee abuse	T 079	5.16 Effective immediately, all reports of abuse and/or neglect will be filed within 48hours of the alleged incident. The Executive director will communicate with the operations director that an incident has been reported and both the operations director and the executive director will review and report.	

PRINTED: 04/13/2016
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0519	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/06/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER MAPLE LEAF FARM	STREET ADDRESS, CITY, STATE, ZIP CODE 10 MAPLE LEAF ROAD UNDERHILL, VT 05489
---	--

(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
T 078	Continued From page 7 on Saturday 08/08/15 at 5 am. Although required to file the report with APS within 48 hours of being aware of the allegation, the TCR filed a report on 08/21/15, 13 days after the allegation was made. The client reported that a staff member entered [resident's] room, the staff grabbed [his/her] arm and it hurt. The TCR conducted their internal investigation however failed to report the allegation of abuse to APS within the required time frame. The failure to make a timely report was confirmed with the TCR Director.	T 078		