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.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

November 7, 2023

Ms. Amy Braun, Administrator
Union House Nursing Home
3086 Glover Street
Glover, VT 05839-9701

Dear Ms. Braun:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **October 11, 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,

PamelaMCotaRN
Pamela M. Cota, RN
Licensing Chief

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475036	A. BUILDING _____ B. WING _____	10/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNION HOUSE NURSING HOME	3086 GLOVER STREET GLOVER, VT 05839

(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
E 000	Initial Comments The Division of Licensing and Protection conducted an unannounced, onsite Emergency Preparedness survey in conjunction with the annual recertification survey from 10/8/2023-10/11/2023 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. As a result of this survey, the Facility was determined to be in substantial compliance with these requirements.	E 000		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey from 10/8/2023 through 10/11/2023 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584	1. No residents had any negative effect related to the alleged deficient practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. All identified areas in need of repair identified in the deficiency statement will be repaired. 4. A facility-wide environmental audit will be completed to identify other areas that may need to be repaired and a plan put into place to complete necessary repairs.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

AMY JR | Administrator | 11/2/23

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 584	Continued From page 1 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and record review, the facility failed to ensure a safe, clean, comfortable, and homelike environment was maintained for the residents of the facility. Findings include: A tour of the facility was conducted with the Maintenance Director on 10/11/23 at 8:57 AM. Observations of resident environment issues were confirmed by the Maintenance Director during the facility tour and included: Room 6 & 9- shared bathroom- wood baseboard molding with peeling paint, vinyl wall covering with chipped and curling edges. Areas of the door frame with bare wood or have peeling paint, and	F 584	5. Education will be provided to staff regarding the process for reporting environmental concerns in need of repair. 6. Once the initial identified areas are repaired a weekly environmental audit will be completed by the Administrator and the Maintenance Director to monitor effectiveness of the plan. 7. The results of the environmental audits will be reported to the QAA committee X3 months at which time the committee will determine further frequency of the audits. 8. Corrective action will be completed by 11/11/2023 **Tag F 584 POC accepted on 11/7/23 by H. Fox/P. Cota**	

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F 584	Continued From page 2	F 584		

there are insulated wires without conduit running above the toilet around the door frame. The bathroom mirror has multiple chipped and bare edges.

Room 9- the baseboard radiator beneath the window has bent and detached front panels, exposing bare metal radiator fins.

Room 11- The room's baseboard radiator against the far wall is bent, paint scratched off, and missing the inner panel. There are 3 bare pieces of wood screwed into the wall above the radiator holding a wheel of the resident's bed in place. During the 3 days of the survey, the only chair in the resident room had an overturned table, legs upward, placed on the chair's seat cushion.

Room 14- The room's baseboard radiator beneath the window has bent and detached front panels, exposing the bare metal radiator fins. The windowsill has peeling paint and exposed chipped wood.

Room 15- 2 areas of the room's baseboard radiator have bent and detached front panels, exposing the bare metal radiator fins.

Per interview with staff on the second floor, 5 of 9 rooms on the second floor share a single communal bathroom.
Observations of the communal bathroom on the second floor, conducted with the Maintenance Director on 10/11/23, confirmed the vinyl baseboard molding behind the toilet was detached from the wall and/or resting on the floor. There was no baseboard molding between the wall and the floor on the left side wall next to the sink, and the floor tiles next to the sink had a

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F 584	Continued From page 3	F 584		

large brown stain. An area of floor behind the communal tub contained multiple layers of dust and dirt, along with a dirty cloth wipe. The Maintenance Director confirmed that it appeared not to have been cleaned for an extended period of time.
Metal grab bars located on either side of the toilet were missing bolts that attached them to the wall. When weight was put on the grab bars, the vinyl wall covering flexed outward from the wall. The Maintenance Director stated that the bolts were missing because there was no wall stud behind the vinyl covering to secure and attach them to.

Observations of resident rooms on the facility's first floor, conducted with the Maintenance Director on 10/11/23, included:

Room 122- The room's baseboard radiator is missing the middle panel.

Room 104- both windowsills, including one over the resident's bed, have cracked and flaking paint.

Room 125- windowsill with cracked and flaking paint.

A ceiling fan within reach of residents on the first-floor hallway has an exposed and empty light bulb socket. The Maintenance Director stated that the fan 'should be removed'.

Per interview with the facility's Maintenance Director on 10/11/23 at 8:57 AM, the Director stated that "anybody can make a maintenance request" regarding resident rooms, conditions, or equipment in the building. The Director reported that request forms are available at the nurse's

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F 584	Continued From page 4 stations and are collected daily. The Director stated that Maintenance conducts room checks weekly, and that radiator issues "happen all the time". The Director confirmed there were no Maintenance requests regarding any of the observed conditions listed above, Maintenance had not identified the issues, and that there were no repairs scheduled to address the issues. The Maintenance Director stated, "I am waiting for someone to tell me to do it."	F 584		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656	1. Residents #13 & #15 had no negative effects as a result of the alleged sufficient practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. Residents #13 & #15 have had care plans based on the diagnosis and medication use. 4. All other residents will be reviewed to ensure comprehensive care plans are developed to address individual needs based on diagnosis and medication use. 5. Education will be provided to staff responsible for developing comprehensive care plans for residents.	

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F 656	Continued From page 5 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to develop a comprehensive care plan that is individualized and meets the needs identified for each resident based on the diagnosis and medications prescribed for 2 of 20 residents sampled (Resident's #13& #15). Findings include: 1. Resident #13 was admitted to the facility in April 2023 with diagnoses including acute respiratory failure with hypoxia (deprivation of adequate oxygen supply), chronic heart failure, major depressive disorder, and diabetes type II. Medications include insulin orders: "Novolog FlexPen 100 unit/milliliter solution use sliding scale three times per day (sliding scale dose is based on the results of current blood sugar level) and Lantus SoloStar 100 units/milliliter inject 40 units".	F 656	6. Weekly audits will be completed by the Director of Nursing to monitor the effectiveness and continued compliance with the plan. 7. Results of the audits will be reported to the QAA Committee X3 months at which time the committee will determine further frequency of the audits. 8. Corrective action will be completed by 11/11/2023 **Tag F 656 POC accepted on 11/7/23 by H. Fox/P. Cota**	

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F 656	Continued From page 6	F 656		

A review of the resident care plan reveals the diagnosis of diabetes, and the use of insulin is not included as a focus area. Diabetes and the use of insulin can result in unstable blood sugar levels that may cause hypoglycemia (low blood sugar) or hyperglycemia (elevated blood sugar) both of which present with signs and symptoms that should be monitored for. These may include extreme thirst, confusion, drowsiness, or even coma in the case of hypoglycemia and headache, confusion, and racing pulse in the case of hyperglycemia. If noted these symptoms require a prompt response which should be delineated in the care plan.

On 10/10/23 at 2 PM the Director of Nursing confirmed that diabetes and the use of insulin were not included in the care plan.

2. Per record review, Resident #15's medical diagnosis includes Major Depression. Review of Resident #15's physician orders reveals that Resident #15 is currently receiving the following psychotropic medications; Abilify (Abilify is an antipsychotic medication. that works by changing the actions of chemicals in the brain. It is used to treat psychotic conditions including schizophrenia and bipolar disorder), Bupropion (Bupropion is a psychotropic medication used to treat depression) and Fluoxetine (Fluoxetine is a psychotropic medication used to treat depression).

Review of Resident #15's care plan reveals that there is no care plan in place for psychotropic medications.

During an interview on 10/11/23 at 10:59 A.M. the Minimum Data Set Coordinator (MDS) Confirmed that the care plan is not in place for psychotropic medications.

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F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to revise a comprehensive care plan for 2 of 20 Residents sampled (Residents #13 & #25) to include interventions that address Resident #13's impaired vision and request for large print reading material, and invite/educate Resident #25 regarding care plan meetings.	F 657	1. Resident #13's care plan has been revised to include the preference and need for large print reading materials. 2. Resident #15 has had another care plan meeting scheduled and she/he has been invited to attend. 3. Residents residing in the facility to have the potential to be affected by the alleged deficient practice. 4. Education will be provided to staff responsible for care plan revisions and care plan meetings regarding the requirements. 5. Documentation of care plan invitations and attendance will be included in progress notes with each care plan meeting. 6. Weekly audits will be conducted by the Social Worker regarding care plan meetings and invitations. 7. Weekly audits will be conducted by the Director of Nursing or a designee regarding care plan revisions.	

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F 657	Continued From page 8 1.Resident #13 was admitted in April 2023 with diagnoses including hypoxia (the deprivation of adequate oxygen supply), chronic heart failure, major depressive disorder, and type 2 diabetes. During an interview with Resident #13 on 10/9/23 at approximately 9 AM Resident #13 mentioned having requested large-print reading materials but having only rarely received such materials. They stated they enjoyed reading but could not indulge in this pastime due to poor eyesight. A review of section B (hearing, speech, vision) of the Minimum Data Set (a system used to assess each Resident for numerous uses including care planning purposes) dated 7/28/23 notes Resident 13's vision is assessed to be "highly impaired-object identification in question but eyes appear to follow objects". Under Activities in the care plan for Resident #13, the goal of "I will try to attend at least 1-3 activity sessions a week of my liking." Followed by "The activity staff will supply me with a daily newsletter that has a list of the scheduled activity sessions though out the day. The staff may need to remind me of the time of the scheduled activity session." On 10/10/23 at approximately 3:30 PM the Activities Director acknowledged Resident #13 prefers large print reading material and that there is no indication of such in the care plan. When asked how this information would be communicated to other staff they responded "just by verbal". 2. Per interview on 10/09/2023 at 12:48 p.m., Resident #25 reveals that s/he has not been invited to a care plan meeting and does not know what a care plan meeting is. Per record review, there is no documentation to support that Resident #25 had been invited to or attended a care plan meeting. There is also no documentation that supports that Resident #25's	F 657	8. Reports of the audits will be reported to the QAA committee X3 months to monitor effectiveness of the plan at which time the committee will determine further frequency of the audits. 9. Corrective action will be completed by 11/11/2023 **Tag F 657 POC accepted on 11/7/23 by H. Fox/P. Cota**	

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F 657	Continued From page 9 participation is determined not practicable. Per physician progress note of 09/26/23 resident is oriented x 2 to person and place. Per review of the facility policy titled Interdisciplinary Care Plan Conference policy #Q3 section Purpose /Policy statement # 4 "Residents are invited to participate and if they grant permission, other family members (or the responsible party) are invited and documented in their resident's care plan." Per the interview on 10/11/2023 at 8:30 a.m. the Social Services Director confirmed that he/she has not documented Resident #25's invitation and/or attendance to care plan meetings.	F 657		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to implement appropriate interventions and provide adequate supervision to prevent accidents and injuries for 1 of 8 sampled residents (Resident #5). Findings include: Resident #5 was admitted to the facility in May 2023 with diagnoses including heart failure, chronic kidney disease stage 3, major depressive disorder, and chronic obstructive pulmonary disease (a lung disease). A review of the	F 689	1. Resident #5's care plan has been updated to reflect accurate fall risk factors and appropriate interventions to assist in the prevention of falls and an updated fall risk assessment has been completed. 2. Residents with risk factors for falls have the potential to be affected by the alleged deficient practice. 3. Other residents with fall risk factors requiring staff intervention have been reviewed and care plans updated as needed to ensure they reflect accurate risk factors and appropriate interventions.	

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F 689	Continued From page 10 Minimum Data Set (MDS ; an assessment tool used to gather information relevant to care plan development among other uses) dated 7/23/23 reveals in Section B regarding hearing/speech and vision, vision is assessed as highly impaired-object identification in question, but eyes appear to follow objects. Resident #5 has a current Brief Interview for Mental Status (BIMS) score of 13 (this score reflects cognitive function and ranges from 1-15 with lower scores indicating a higher level of impairment). A record review reveals the following physician documentation dated 10/3/23 ... "Resident has had 4 falls since last seen. [His/her] falls are mostly unwitnessed and occur in [his/her] room with the oxygen off! [He/she] is commonly found sitting on [his/her] buttocks. Has had some scrapes from the falls but no significant injuries." Records indicate the falls referenced in the physician's note occurred on 8/20/23, 9/7/23, 9/9/23, 9/10/23. A progress note dated 10/4/23, the day following the physician's visit, reveals that Resident #5 "was observed face down in lying position by the closet door with [his/her] walker beside [him/her]. The resident was assessed and stated that [he/she] hit [his/her] head and [his/her] left arm and shoulder and that it was hurting really bad. Resident was noted to have a skin tear to left elbow." Resident #5 was sent emergently to the local emergency department where he/she spent several hours and was found to have a distal radius and ulnar styloid fracture of the left forearm (a break of both bones in the forearm) requiring splinting. Resident #5's care plan was reviewed and noted	F 689	4. Education will be provided to staff regarding fall risk factors, appropriate interventions, and the required frequency of fall risk assessments. 5. Weekly audits will be completed by the Director of Nursing or a designee to monitor effectiveness of the plan. 6. The results of the audits will be reported to the QAA committee X3 months at which time the committee will determine further frequency of the audits. 7. Corrective action will be completed by 11/11/2023 **Tag F 689 POC accepted on 11/7/23 by H. Fox/P. Cota**	

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F 689	Continued From page 11	F 689		

to contain the nursing diagnosis "Fall risk related to unsteady gait, chronic obstructive pulmonary disease, peripheral vascular disease [limited blood flow to extremities], hearing impaired, glaucoma, wears [bilateral] hearing aids." This care plan entry was created 4/20/23 with a review date of 5/19/23. Beneath the entry is an additional notation stating "[Resident #5]'s family reports that [he/she] is legally blind and has an unsteady gait." The Interventions included and intended to be a response to the risk of falls, include three that are written notices intended to be read and understood, which, based on the MDS visual assessment as well as the family report of legal blindness are unrealistic and proved to be ineffective: 1. "Place a sign on walker to remind me to call for assistance before I ambulate by myself". 2. "Put stop sign on oxygen tank to help deter turning oxygen settings". 3. "Visual aide in room to remind [patient] to call for assistance before ambulating". There was no evidence that the Resident's ability to read the signs was assessed. There is also an intervention of "every 15-minute safety checks to ensure {resident name} is safe and ask if he/she is needing anything".

On 10/10/23 at approximately 3:45 PM the Licensed Practical Nurse (LPN) MDS coordinator provided a fall assessment for Resident #5 with a completion date of 5/4/23 and a next due date of 8/2/23, this assessment had a total score of 10 labeled HIGH. The LPN confirmed no other fall assessments had been done. The facility policy entitled Falls and Fall Risk, Managing with a revision date of March 2018 was reviewed. There is no reference to the fall risk assessment or how to use the scores determined by the assessment.

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	475036	A. BUILDING _____ B. WING _____	10/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNION HOUSE NURSING HOME	3086 GLOVER STREET GLOVER, VT 05839

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F 689	Continued From page 12 On 10/11/23 at approximately 10:30 AM the Director of Nursing (DON) was interviewed regarding Resident #5 and their care plan interventions related to falls. The DON stated he/she had updated the care plan following the most recent fall by adding "visual aide in room to remind pt to call for assistance before ambulating," and "will refer to PT [physical therapy] for evaluation related to frequent falls and generalized weakness [status post] recent illness." The DON was not certain if a therapy evaluation had been completed and the care plan did not reflect any new interventions from a physical therapy screen or assessment. The DON also stated he/she was unaware that Resident #5 had impaired vision and had missed noticing that on the care plan, and did not know if Resident #5 was on 15-minute checks. Following this conversation , the surveyor and DON went to the medication nurse to request the 15-minute check sheet to verify the 15-minute checks were being completed per the care plan. The nurse advised there were no residents on 15-minute checks. The DON was able to locate check sheets that had been done every 30 minutes (although the care plan called for 15-minute checks) between 9/10/23-9/28/23 and appeared to have been discontinued without any explanation prior to the 10/4/23 fall with injury resulting.	F 689		
F 699 SS=G	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with	F 699		

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F 699	Continued From page 13 professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on resident representative and staff interviews and record review, the facility failed to create and implement an individualized person-centered plan to render trauma-informed care to a resident with a personal history of trauma, related to witnessing a relative drown, for 1 of 20 residents sampled (Resident #30). Findings include: Record review reveals that Resident #30 was admitted in April 2021 with diagnoses including Alzheimer's disease, muscle weakness, and major depressive disorder. On 10/9/23 at approximately 12:20 PM, Resident #30's Representative noted that at times Resident #30 does not appear to have been bathed and at other times they receive reports that Resident #30 has assaultive behaviors that occur during bathing. Resident #30's Representative detailed a past traumatic event during which Resident #30 was witness to a family member drowning and has had a "terror of water" ever since. Per the Representative, this traumatic event was discussed with the Social Services Director during a care planning meeting. During a review of the care plan for Resident #30 an entry for activities of daily living is noted to include the requirement of 1-2 staff for bathing assistance however there is no mention of triggers related to water-induced trauma, strategies, approaches, or staff response to resultant behaviors. A review of the bathing record for Resident #30 between 9/1-10/9/23 reveals during the 6 week period	F 699	1. Resident #30's care plan has been updated to ensure the history of trauma, triggers, and appropriate interventions are in place to minimize potential trauma. 2. Residents with a history of trauma have the potential to be affected by the alleged deficient practice. 3. Education has been provided to staff regarding trauma informed care and to staff responsible to ensure an effective trauma informed care plan is in place for potentially affected residents. 4. Other residents in the facility have been assessed for trauma and appropriate care plans have been put in place for those found to have potential trauma induced triggers. 5. Weekly audits will be conducted by the Director of Nursing or the designee to monitor effectiveness of the plan and ensure care plan interventions are appropriate.	

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F 699	Continued From page 14 Resident #30 received 3 tub baths. Per interview on 10/9/23 at 10:37 AM, the Social Services Director confirmed that s/he was made aware of Resident #30's history of trauma during an 8/31/23 a care planning meeting but was unsure of how that could be incorporated into the care plan. On 10/10/23 at 11:30 AM the Director of Nursing confirmed that resident-centered individualized information related to trauma-informed care was not in the care plan. On 10/10/23 at 1:30 PM a Licensed Nursing Assistant (LNA) described the bathing process for Resident #30 as "horrible" and stated that when they lower the resident into the water "[s/he] screams and hits, [s/he] screams like you're killing [him/her]," and "I don't know if it's the water or what it is but we have to do it we can't have [him/her] stinking." Resident #30 was interviewed by the surveyor on 10/10/23 at approximately noon, Resident #30 demonstrated cognitive impairment and appeared unable to comprehend questions therefore was unable to describe any potential psycho-social outcomes related to his/her bathing experience. However, employing the reasonable person concept which allows determination of the severity of the psycho-social outcome or potential outcome the deficiency may have on a reasonable person in the resident's position it is clear that if one had a "terror of water" as Resident #30 has the experience of being lowered into the water despite "screaming" like one is being "killed" represents psychosocial harm.	F 699	6. Results of the audits will be reported to the QAA committee X3 months at which time the committee will determine further frequency of the audits. 7. Corrective action will be completed by 11/11/2023 **Tag F 699 POC accepted on 11/7/23 by H. Fox/P. Cota**	

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F 727	Continued From page 15	F 727		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to ensure it used the services of a Registered Nurse for at least 8 consecutive hours a day, 7 days a week for 52 days from April 1st, 2023, to Oct. 1st, 2023. Findings include: A review was conducted of the facility's staffing schedules from April 1st, 2023, to Oct. 1st, 2023 regarding nursing care provided to the facility's residents. Review of the staffing schedule for April 2023 revealed 10 days with no RN scheduled [4/3, 4/6, 4/10, 4/14, 4/17, 4/20, 4/24, 4/25, 4/26, 4/27]. May 2023 included 6 days with no RN coverage [5/8, 5/21, 5/22, 5/27, 5/28, 5/29], June 2023 included 3 days [6/10, 6/11, 6/28] and July 2023, 7 days [7/4, 7/5, 7/6, 7/15, 7/16, 7/20, 7/29]. August 2023 documented 15 days without RN coverage, including 5 consecutive days [8/1, 8/5, 8/8, 8/10 thru 8/14, 8/17, 8/18, 8/22, 8/26, 8/27, 8/30, 8/31] and	F 727	1. No residents were negatively affected by the alleged deficient practice. 2. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 3. Facility administration is aware of the requirement to have 8 consecutive hours of RN coverage per day. 4. The facility nursing schedule has been reviewed and revised to ensure the requirement is met. 5. The Administrator of the facility will monitor for compliance daily. 6. The QAA committee will receive reports regarding the compliance of the RN hours X3 months, at which time the committee will determine further reporting requirements. 7. Corrective action will be completed by 11/11/2023 **Tag F 727 POC accepted on 11/7/23 by H. Fox/P. Cota**	

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F 727	Continued From page 16 September thru October 1st, 2023, included 11 days with no RN scheduled [9/2, 9/3, 9/8, 9/9, 9/10, 9/12, 9/14, 9/22, 9/23, 9/24, 10/1]. An interview was conducted with the facility's Administrator [ADM] and Director of Nursing [DON] on 10/11/23 at 11:27 AM. The ADM and DON both confirmed that the facility had no Registered Nurse scheduled or present in the building for a minimum of 8 hours daily as required by regulation on the 52 dates listed above.	F 727		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified	F 756	1. Resident #25 had no negative effects related to the alleged deficient practice and the pharmacist recommendation has been addressed with the provider. 2. Residents that receive medication and have recommendations made by the consultant pharmacist may have the potential to be affected by the alleged deficient practice. 3. Education has been provided to nursing staff regarding the requirements for stop dates to be included in orders for as needed psychotropic medication.	

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F 756	Continued From page 17 irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff Interview and record review the facility failed to follow Pharmacist's recommendations concerning a stop date for psychotropic medication for 1 of 5 residents sampled (Resident #25). Findings include: Per record review Resident #25 has diagnoses that include Major depressive disorder and nightmares. Review of Resident #25's physician orders reveals a current order for Clonazepam 0.5 milligrams (mg) by mouth every 6 hours as needed (PRN) for agitation. (Clonazepam is used as a treatment for panic attacks, insomnia, and symptoms related to chronic anxiety and anxiety disorders). A Consultant Pharmacist Medication Regime review dated 9/1/2023 to 9/17/2023 states "attn [attention] Nursing this consult is repeated from July and August as I cannot locate that it had been addressed....in response to my consult from last month. The physician authorized to extend the following order by 90 days; Clonazepam 0.5 mg every 6 hours as needed, please update the order in the Electronic Medication Record (EMR) to have an end date of	F 756	4. Weekly audits will be conducted by the Director of Nursing or a designee to monitor effectiveness of the plan. 5. Results of the audits will be reported to the QAA committee X3 months at which time the committee will determine further frequency of the audits. 6. Corrective action will be completed by 11/11/2023 **Tag F 756 POC accepted on 11/7/23 by H. Fox/P. Cota**	

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F 756	Continued From page 18 9/25/23." During interview on 10/10/2023 at 12:12 p.m. the Minimum Data Set (MDS) Coordinator confirmed that there is no documentation that the as-needed Clonazepam has had a stop date added to the order. He/she also confirms that there should be a stop date for this as-needed medication and the Consultant Pharmacist Medication Regime Review was not followed.	F 756		