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

August 3, 2022

Ms. Valerie Cote, Administrator
Barre Gardens Nursing And Rehab Llc
378 Prospect Street
Barre, VT 05641-5421

Dear Ms. Cote:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on June 29, 2022**.** 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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475037	A. BUILDING ______ B. WING ______	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRE GARDENS NURSING AND REHAB LLC	378 PROSPECT STREET BARRE, VT 05641

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E 000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 6/29/22. There were no regulatory violations identified.	E 000		
F 000	INITIAL COMMENTS An unannounced, on-site re-certification survey and staff vaccination requirement review in conjunction with a complaint investigation was conducted by the Division of Licensing and Protection on 6/27/22 through 6/29/22 at Barre Gardens Nursing and Rehabilitaion. There were no regulatory violations related to the complaint. Regarding the recertification survey, the following regulatory violations were identified:	F 000	The filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. This plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law. Results of all listed audits will be brought to the QAPI committee for review and recommendations.	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and record review, the facility failed to ensure one resident [Res. #30] of 13 sampled residents observed during medication administration was assessed to administer medications to themselves. Findings include: An interview was conducted with the Director of Nursing [DON] on 6/28/22 at 1:07 PM. The DON reported the facility's process for self-administration of medications by residents included a screening of the resident by members of various disciplines involved in the resident's	F 554	Resident #30 continues to reside at the facility. Resident #30 was assessed for self-medication administration. All residents at the facility that are not assessed to be independent with self-medications have the potential to be at risk for this alleged deficiency. Current Residents who wish to self-administer medications will be assessed for their ability to do so. A house wide audit will be completed to verify any Residents who wish to be assessed to be independent with self-medications. Self-medication administration education and The Right to Self-administer medications will be provided to LPNs/RNs. Medication pass monitoring will be performed weekly times 4 weeks and then monthly times 2 by the Director of Nursing and/or designee to monitor that no Resident is self-administrating medications unless assessed and able to do so per physician order.	8/2/2022

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

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
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 554	Continued From page 1 care. Depending on the outcome of the interdisciplinary screening, the resident would be approved or denied the opportunity to self-administer medications. Per record review, Res. #30 was admitted to the facility with diagnoses that include Cognitive Communication Deficit, Parkinson's Disease, and Major Depressive Disorder. Per observation on 6/28/22 at 8:55 AM, Res. #30 was lying in their bed in their room. On the right side of the bed, next to the resident's right hand, was a respiratory inhaler labeled 'tiotropium bromide inhalation spray'. Res. #30 was observed picking up the inhaler, holding it in both hands, and releasing the medication into h/her mouth. The resident then placed the inhaler on the bed next to h/herself. Per record review, Physician's Orders for Res. #30 include an order for "Tiotropium Bromide Monohydrate" Aerosol Solution. Under "additional directions" is listed "Administered By: Clinician". A review was conducted of Res. #30's medical record on 6/28/22. Per record review, and confirmed during interview with the facility's DON, there was no documentation of any assessment or interdisciplinary screening regarding Res. #30's ability to identify and self-administer medications. The DON further stated that no current residents were approved to self-administer medications.	F 554	F554 POC accepted 8/2/22 T Dougherty RN/PMM	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 578	Resident #27 continues to reside at the facility and the resident's choices regarding advance directives have been updated in the medical record to reflect the current code status and it can be easily located by staff. All Residents have the potential to be affected by this alleged deficiency.	8/2/2022

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F 578	Continued From page 2 §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that staff follow the established mechanisms for documenting and	F 578	A house wide audit was conducted to verify all Residents have a code status that is easily accessible and that it matched the COLST and care plan. Education regarding Resident Rights to Formulate Advance Directives, Communication and Documentation of Code Status for easy identification will be provided to LPNs/RNs. Code status audits will be conducted by the Administrator and/or designee weekly times 4 weeks and then monthly times 2 months for all new admits. F578 POC accepted 8/2/22 TDougherty RN/PMC	

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F 578	Continued From page 3 communicating residents' choices regarding advanced directives to the interdisciplinary team and to staff responsible for the residents' care for one of 28 sampled residents (Resident #27). Findings include: Per review of Resident #27's medical record on 6/28/22, their code status was not easily identified to this surveyor. The code status was blank on the first page of their record and the physician's orders indicated that a DNR/DNI order was discontinued as of 6/20/22 under advanced directives. The facility policy "Advance Directives" states: "Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record." Per interview on 6/28/22 at 3:40 PM, the Director of Nursing stated that there should be a code status on the first page of the resident's record and a physician order indicating the resident's code status. S/he could not locate these for Resident #27 and confirmed that the code status for this resident was not updated upon readmission from the hospital. S/he stated the floor nurses are responsible for entering the code status into resident's medical record upon readmission, and another staff member should reconcile the new orders, and this was not done.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F 580	Resident #30 continues to reside at the facility. The Resident's physician has now been notified of the missed medications. All Residents have the potential to be at risk by this alleged deficiency.	8/2/2022

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F 580	Continued From page 4 representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement	F 580	LPNs/RNs will be provided education on the medication administration policy, and the Medication Error Policy. Medication Administration Records will be audited to evaluate physician notification for any missed medications by the Director of Nursing and/or designee weekly times 4 weeks and then monthly times 2 months. F580 POC accepted 8/2/22 TDougherty RN/PMC	

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F 580	Continued From page 5 its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to notify a physician related to missed medications for one resident [Res. #30] of 28 sampled residents. Findings include: Per record review, Res. #30 was admitted to the facility with diagnoses that include Dyspnea [Shortness of Breath], dependence on supplemental oxygen, Chronic Obstructive Pulmonary Disease [chronic inflammatory lung disease that causes obstructed airflow from the lungs], and pain and restricted movement of the shoulders. A review was conducted of Res. #30's Medication Administration Record [MAR] for June 2022 on 6/28/22. 1.) Review of Res. #30's MAR for June 2022 revealed orders for 'Symbicort Aerosol ,2 puff inhale orally two times a day related to Chronic Obstructive Pulmonary Disease'. Per review of the MAR, Res. #30 did not receive the ordered Symbicort Aerosol on 6/22, 6/23, 6/24, 6/25, 6/26, 6/27, and 6/28/22. Review of Nurses Notes for Res. #30 dated 6/22/22 record "Previous nurse already called VA for medicine. Still waiting for delivery." Nurses Notes for the next day, 6/23/22 record the resident "was without [h/her] Symbicort inhaler today ...Have requested that [Physician] order it for [h/her] from the VA". Further record review reveals no follow up to the 6/23/22 note regarding the ordered medication not given.	F 580		

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F 580	Continued From page 6 Additionally, Nurses Notes continue recording twice daily that the twice daily ordered medication is either "unavailable" or "not available" for the next 5 days, up through the day of the survey's MAR review on 6/28/22. There is no documentation regarding if the physician received the request, if there was a response, and/or what the response was. 2.) Review of Res. #30's MAR for June 2022 revealed orders for 'Lidocaine Patch 5 %-Apply to shoulders topically in the morning for pain'. Per review of the MAR, Res. #30 did not receive the ordered Lidocaine Patch on 6/21, 6/22, 6/23, 6/24, 6/25, 6/26, and 6/27/22. Review of Nurses Notes for Res. #30 dated 6/22/22 record "No Lidocaine Patch found. Waiting to be delivered." Further record review reveals no notification to the physician that the resident did not receive the ordered medication that day, the previous day, or for the next 5 days. An interview was conducted with the Director of Nursing [DON] on 6/28/22 at 1:15 PM. The DON reported the facility's process regarding medications not administered as ordered includes notifying the provider in order to obtain instructions or new orders to hold the medication, discontinue it, or substitute another medication for the missing or unavailable medication(s). Per record review, and confirmed during interview with the DON, there is no documentation that the physician was notified that the Lidocaine patch was not given as ordered for 7 days total, and that there was no documentation that a "request" was followed up and that the physician was notified that the Symbicort inhaler was not administer as ordered for a total of 7 days as of the survey date of 6/28/22.	F 580		

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F 584	Continued From page 7	F 584		
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 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	F 584	Resident #61 still remains at this facility. That bathroom has had a deep clean. All Residents have the potential to be affected by this alleged deficiency. A deep clean of all bathrooms and bathroom floors will be completed on wing 2. Barre Gardens continues to actively recruit/hire for the housekeeping department. As of 7/18/22, 2 new staff members have been hired and both started orientation on 7/20/22 in the housekeeping department. Education on the daily duties (checklist) will be provided to staff in the housekeeping department. Environmental audits of bathrooms will be performed by the Administrator and/or designee weekly times 4 and then monthly times 2. F584 POC accepted 8/2/22 TDougherty RN/PMC	8/2/2022

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F 584	Continued From page 8 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff and resident interview, the facility failed to ensure each resident has a safe, clean, comfortable, and homelike environment. Findings include: During observations of residents rooms of the long hall on Wing 2 on 6/27/2022 between 10:00 AM- 2:00 PM, the following was revealed: Room 103 feces marks splattered in the toilet, bathroom sink did not appear to have been cleaned, walls are splattered with brown substance, bathroom floor had dirt smudges and small patches of a thicker, brown substance. A lemonade bottle was on the bathroom floor next to the door, and a toothbrush was on the back of the toilet; Room 104 the walls were splattered with a brown substance, and the bathroom floor had spillage and was sticky; Room 105 the bathroom sink was visably dirty and was leaking. The bathroom floor had dark smudges and small pieces of trash and debris; Room 106 the bathroom sink did not appear to have been cleaned, and the bathroom floor had brown spots, dirt smudges, toilet paper, and other debris; Room 107 feces marks were splattered in the toilet. The bathroom sink does not appear to have been cleaned as it was dirty, the bathroom floor had dirt smudges, toilet paper, wrappers, and a pair of eyeglasses were on the floor by the toilet; Room 108 the bathroom sink did not appear to have been cleaned as it was dirty. The bathroom	F 584		

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F 584	Continued From page 9	F 584		

floor had multiple dark spots, appeared to have dried urine around the toilet, and multiple pieces of toilet paper were hanging on the grab bar;
Room 109 the bathroom floor appeared not to have been swept, had multiple dark spots, and liquid, which appeared to be urine around the toilet;
Room 110 feces marks were splattered in the toilet, bathroom sink was visably dirty, bathroom floor had large black lines, multiple spots of dried brown liquid, and unswept debris;
Room 112 the bathroom sink did not appear to have been cleaned and the faucet is covered with hard water stains. The bathroom floor had trash piled in the corner where a trash can might appear and light brown spillage in multiple areas;
Room 113 bathroom sink did not appear to have been cleaned and had a red, sticky substance coating the faucet knob.
All bathroom baseboards were dirty, and the floors had dirt build up around the edges of the room and toilets.

Per interview with Resident # 61 on 6/27/22 at 11:07 AM, S/he stated that his/her "bathroom should be cleaned better. It smells really bad, and the floor has dirt specks which have been there since I was admitted."

During the walk through of the long hall of Wing 2 with the Director of Housekeeping on 6/28/22 at 12:15 PM, S/he confirmed that the rooms were not clean and were in need of a deep clean. S/he stated that because the facility is short housekeeping staff, S/he is not able to be on the floors to supervise the housekeeping staff. S/he stated that the facility has not had a full housekeeping staff since S/he started working there and if there were more staff there would be

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F 584	Continued From page 10 a "floor tech" who would be responsible for special cleaning projects, like cleaning the dirty build up and stains on the floor. On 6/29/22 at 1:00 PM, the Administrator confirmed that the facility is short housekeeping staff, and the facility is having a hard time finding anyone to hire.	F 584		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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 rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656	Residents #30 and #23 remain at the facility. Resident #52 has been discharged. Resident #52's care plan to address the pressure ulcer was implemented on 6/29/22. Resident #30 receives medication/oxygen equipment per physician orders and care plan interventions. Resident #23's MD was updated on her weight loss per her care plan intervention. All Residents have the potential to be at risk from this alleged deficiency. Education to LPNs/RNs will be provided regarding Development and Implementation of Resident Comprehensive Care Plans, to include interventions for care of those with pressure ulcers, maintenance of oxygen equipment, notification of physician for medication administration and weight loss. A house wide audit of current residents with pressure ulcers to evaluate development and implementation of the care plan. A house wide audit of current Residents with oxygen concentrators, to evaluate the maintenance interventions are implemented per care plan. A house wide audit of those with missed medications and weight loss will be conducted to evaluate notification of the physician per care	8/2/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475037	A. BUILDING ______ B. WING ______	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRE GARDENS NURSING AND REHAB LLC	378 PROSPECT STREET BARRE, VT 05641

(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
F 656	Continued From page 11 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. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, the facility failed to develop and/or implement a comprehensive care plan for 3 of 28 residents in the sample (Resident #52, #30, and #23). Findings include: 1.) Per record review Resident #52 was admitted to facility on 5/23/22 with a deep tissue injury (pressure ulcer) on his/her right heel. Per review the resident does not have a care plan that addresses the care needs related to an actual pressure ulcer. On 6/29/22 at 10:25 AM, the Director Of Nurses (DNS) and the Facility Administrator stated that Resident #52 should have a care plan to address needs related to an actual pressure ulcer. The DNS and Administrator both confirmed that Resident #52 does not have an actual pressure ulcer care plan. 2.) Per record review, Res. #30 was admitted to the facility with diagnoses that include Dyspnea	F 656	plan. Random audits of the above will be performed by the Director of Nursing and/or designee weekly times 4 weeks and then monthly times 2. F656 POC accepted 8/2/22 TDougherty RN/PMC	

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F 656	Continued From page 12 [Shortness of Breath], dependence on supplemental oxygen, Chronic Obstructive Pulmonary Disease [chronic inflammatory lung disease that causes obstructed airflow from the lungs], and pain and restricted movement of the shoulders. Review of Res. #30's Care Plan reveals interventions that include "Give medications as ordered by physician". A review was conducted of Res. #30's Medication Administration Record [MAR] for June 2022 on 6/28/22. A.) Review of Res. #30's MAR for June 2022 revealed orders for 'Symbicort Aerosol ,2 puff inhale orally two times a day related to Chronic Obstructive Pulmonary Disease'. Per review of the MAR, Res. #30 did not receive the ordered Symbicort Aerosol on 6/22, 6/23, 6/24, 6/25, 6/26, 6/27, and 6/28/22. B.) Review of Res. #30's MAR for June 2022 revealed orders for 'Lidocaine Patch 5 %-Apply to shoulders topically in the morning for pain'. Per review of the MAR, Res. #30 did not receive the ordered Lidocaine Patch on 6/21, 6/22, 6/23, 6/24, 6/25, 6/26, and 6/27/22. C.) Further review of Res. #30's Care Plan reveals interventions that include "Change oxygen supplies and equipment as ordered and as needed". Review of Physician Orders for Res. #30 reveal an order for "Change oxygen tubing, humidification bottle, and clean concentrator filter weekly. Every night shift every Tuesday for Nurse measure." An observation was conducted in Res. #30's room on 6/28/22 at 8:50 AM. Per observation, the oxygen concentrator located at the resident's bedside contained tubing connecting the	F 656		

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F 656	Continued From page 13	F 656		

concentrator to a nasal cannula used to deliver oxygen therapy to the resident. The oxygen tubing had a label attached to it with the date "6/15/22".

An interview was conducted with the Director of Nursing [DON] on 6/28/22 at 1:15 PM.
Per record review, and confirmed during interview with the DON,
The DON confirmed that physician orders and Care Plan interventions included "Change oxygen tubing, humidification bottle, and clean concentrator filter weekly" and "Change oxygen tubing as ordered". The DON confirmed that Res. #30's oxygen tubing should have been changed on 6/21/22, and the tubing labeled with that date, but was not.

3) Per record review, Res. #23 was admitted to the facility with diagnoses that include Dysphagia [difficulty in swallowing food or liquid] Gastro-Esophageal Reflux Disease, Protein-Calorie Malnutrition, and dementia.
Review of Res. #23's Care Plan reveals the resident was identified as having a 'nutritional problem or potential nutritional problem related to dysphagia' and 'may be nutritionally at risk related to dementia'. Care Plan interventions for Res. #23 include "Observe for/record/report to Physician as needed signs and symptoms of malnutrition: significant weight loss: 3lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months.
Review of Res. #23's medical record on 6/29/22 reveal the resident's recorded weights as:
On 4/6/22: 104.1 lbs.
On 5/6/22: 96.5 lbs.
A loss of weight of 7.3% in 1 month. [Significant weight loss].

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F 656	Continued From page 14 On 3/25/22: 106.4 lbs. On 6/6/22: 96 lbs. A loss of weight of 9.77% in 3 months [Significant weight loss]. On 1/4/22: 110 lbs. On 6/6/22: 96 lbs. A loss of weight of 12.73% in 6 months [Significant weight loss]. Care Plan notes dated 5/11/22 record "Nursing reports that [Res. #23] is alert and oriented with confusion, needing maximum assist with activities of daily living and transfers. Dietary reports that [Res. #23] ... Current weight: 97 lbs. Significant weight loss x1 month, x3 months, x6 months." Further review of Res. #23's medical record revealed no documentation that Res. #23's Physician was notified of the resident's significant weight loss after weights taken on 5/6/22 and 6/6/22 demonstrated significant losses after 1 month, 3 months, and 6 months. Per record review and confirmed during interview with the Director of Nursing [DON] on 6/28/22 at 1:15 PM, Res. #23 demonstrated significant weight losses at 1, 3, and 6 month intervals, which the care plan noted as a sign and symptom of malnutrition. The DON confirmed that there was no documentation that the Physician was contacted per the Care Plan intervention regarding significant weight loss.	F 656		
F 657 SS=D	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	F 657	Resident #37 continues to reside at the facility. Resident #37's care plan has been updated to reflect the current status. Residents who have skin integrity issues have the potential to be affected by this alleged deficiency. Education regarding updating wound care plans and assessments to reflect the current status will be provided to LPNs/RNs.	8/2/2022

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F 657	Continued From page 15 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 observations, interview and record review, the facility failed to ensure that a care plan was revised to reflect the most current presentation regarding 1 of 28 residents (Resident #37) related to pressure ulcers. Findings include: Review of a care plan for resident #37, indicates "Actual impairment to skin integrity r/t stage II to right hip/butt, Date Initiated: 05/06/2022". There is a nurses note (5/6/2022-15:10) that states "Stage II to right hip/buttock without signs of infection. Very superficial with full epithelial tissue noted, sloughing from blister noted. Surrounding tissue remains intact. WCTM protective dressing in	F 657	A house wide audit of current wound care plans to evaluate updates to reflect current status and the corresponding assessments will be performed by the Director of Nursing and/or designee. Random audits of wound care plans and assessments will be performed by the Director of Nursing and/or designee weekly times 4 and then monthly times 2. F657 PoC accepted 8/2/22 TDougherty RN/PMC	

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F 657	Continued From page 16 place. Discussed with PT/OT about repositioning tactic with [Res. #37] since return from hospital. The area appears to be an area of friction r/t brief, due to location and appearance of the blister. [Res. #37] able to pull herself forward in the chair, shift her buttocks side to side, and scoot back. Staff education provided to encourage her to do this throughout the day." Further review suggests there are weekly Nurse Practitioner assessments of venous ulcers to the right malleolus and lower leg, but not of the stage II pressure ulcer on the right hip. On 06/29/22 at 10:46 AM, interview with the Unit Licensed Practical Nurse (LPN) and Nurse Practitioner and observation of the resident's right hip, reveals that the pressure ulcer had resolved. The LPN confirmed that no assessments were complete after discovery of the pressure ulcer (unknown date) and the care plan was not updated to reflect the date of the resolved pressure ulcer.	F 657		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to	F 686	Resident #52 no longer resides at the facility. All Residents with wounds who follow with the wound care consultant are at potential risk from this alleged deficiency. Education regarding timely implementation of wound consultant orders will be provided to LPNs/RNs. A house wide audit of current wound care consultant notes will be performed by the Director of Nursing and/or designee.	8/2/2022

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F 686	Continued From page 17 promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection and prevent new ulcers from developing for 1 of 28 residents (Resident #52). Findings include: Facility staff failed to implement a treatment order for Resident # 52's pressure ulcer. A 6/15/22 Wound Nurse progress note states " Right heel pressure wound measurements 1.2 cm x 0.7 cm x 0 cm. no drainage. closed by scab. Instructions cleanse area pat dry Apply adhesive foam border dressing change every 3 days and as needed -pressure relief off loading -facility pressure ulcer prevention protocol -heel offloading per facility protocol -optimize nutrition -plan of care discussed with staff ". A 6/22/22 Wound Nurse consult note states " Right heel pressure wound measurements 1 cm x 0.5 cm x 0.3 cm. drainage light serosanguinous. 60% slough 40% derm shallow circular wound. Instruction Cleanse area and pat dry apply Manuka honey and cover with adhesive foam border dressing change every 3 days and as needed ". Per the Treatment Administration Record (TAR), the treatment to right heel pressure wound Manuka honey was discontinued on 6/15/22, with no evidence of treatment reinstated as per	F 686	Random audits of the weekly wound care consultant notes and orders will be performed by the Director of Nursing and/or designee weekly times 4 and monthly times 2. Wound care consultant has been given access and permission to enter her own orders into the Resident's chart with a standing order that we may follow the recommendations from the wound consultant. F686 POC accepted 8/2/22 TDougherty RN / PMu	

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F 686	Continued From page 18 Wound Nurse consult recommendations of 6/22/22. The current treatment noted on the TAR is Right heel pressure ulcer wash with wound cleanser or Normal Saline apply adhesive foam boarder dressing change every 3 days and as needed. On 6/29/22 at 10:25 AM, the Director of Nurses (DON) and the Facility Administrator both agreed that the resident's right heel treatment order should have been changed to the Wound Nurse consultant's most recent recommendation. Both DON and Administrator confirmed that the treatment order was not updated and that Resident # 52 was, to date, not receiving the current treatment recommended by the Wound Nurse consultant.	F 686		
F 689 SS=E	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 observations, staff interviews, and record review, the facility failed to implement individualized, resident-centered interventions, including adequate supervision, and wandering management devices, to prevent accidents related to falls, wandering, and choking for three of 28 sampled residents (#27, #36, and #48).	F 689	Residents # 27, #36 and #48 continue to reside at the facility. Resident # 27 receives assistance to use toilet. Resident #36 receives supervision during meals. Resident #48's wander guard/secure care device is now attached to his walker and to his wheelchair. Residents who have safety risks/care planned interventions for assist or supervision, per their plan of care are at potential risk from this alleged deficiency. Education to LPNs/RNs/LNAs will be provided regarding assistance with toileting and meal supervision per care plan. Education to LPNs/RNs/LNAs will be provided on secure care placement. A house wide audit of Residents with secure care/wander guard orders will be conducted by	8/2/2022

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F 689	Continued From page 19 Findings include: 1. Per record review, Resident #27 has diagnosis that include repeated falls and his/her care plan states that S/he is at high risk for falls. Per Resident #27's care plan dated 5/23/22, Resident Assessment and Care Screening (MDS) dated 4/4/22 and Kardex report (nursing aide bedside report) dated 6/28/22, S/her requires one staff participation to use toilet. Per observation on 06/27/22 at 11:05 AM, Resident #27 was on the toilet in his/her bathroom unsupervised. This surveyor then saw the resident leave the bathroom without any assistive devices unsupervised. Per interview on 6/28/222 at 11:21 AM, a Licensed Practical Nurse (LPN) stated that "it is not acceptable for [Resident #27] to be toileting alone." On 6/29/22 at 1:00 PM, the Administrator (ADM) and Director of Nursing (DON) confirmed that Resident #27 requires one staff participation to use toilet and staff should be assisting him/her. 2. Per record review, Resident #36's care plan indicates that S/he aspirates easily and has difficulty swallowing. Resident #36's care plan, dietary order, and meal slip state that this resident requires supervision while eating. Per observation on 6/27/2022 at 10:37 AM, 6/27/2022 at 1:05 PM, and 6/29/22 at 9:09 AM, Resident #36 was observed eating in bed with no supervision. Per interview on 6/27/22 at 10:51 AM, a Licensed Nurse Aide (LNA) confirmed that S/he should be supervised while S/he eats.	F 689	the Director of Nursing and/or designee to evaluate placement of such devices per physician order. Random audits of resident assistance, supervision during meals, and secure care devices and its placement will be conducted by the Director of nursing and/or designee weekly times 4 weeks and monthly times 2 to monitor such care plans or physician orders. F689 POC accepted 8/2/22 TDougherty RN / PMC	

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F 689	Continued From page 20 On 6/29/22 at 1:00 PM, the Administrator (ADM) and Director of Nursing (DON) confirmed that Resident #33 requires supervision while eating. 3. Per record review, Resident #48's care plan indicates that S/he is an elopement risk. Interventions reflects the use of a wander guard and to check the placement of it each shift. Physician orders are for "Wanderguard applied to walker: Monitor placement every shift." Per observation on 6/29/22 at 10:30 AM, Resident #48 was seen walking in the hall using a walker. There was not a wander guard on the walker. This surveyor observed the wander guard placed on Resident #48's wheelchair. Per interview on 6/28/222 at 11:21 AM, a LPN stated that this resident should have a wander guard on their walker in addition to their wheelchair because S/he uses the walker more. On 6/29/22 at 1:00 PM, the ADM and DON) confirmed that Resident #44 should have a wander guard on his/her walker.	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).	F 725	Residents #36, #27, #62, and #s 33, 42 and 61 continue to reside at the facility. The facility continues to actively recruit/hire for new direct hire staff, as well as for agency contracted staff. Staffing will be audited by the Administrator and/or designee to evaluate sufficient nursing staff and related services are sufficient to maintain the highest practicable physical, mental, and psychosocial well-being of each resident weekly times 4 and then monthly times 2.	8/2/2022

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F 725	Continued From page 21 §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to ensure that there was sufficient nursing staff and related services to maintain the highest practicable physical, mental and psychosocial well-being of each resident. Findings include: 1. Review of Licensed Nursing Assistant (LNA) Assignment Sheets provided to the surveyor on 6/27/22, revealed that there are 40 residents on Wing 2. There are assignment sheets written for 5, 4, or 3 LNAs on shift. The residents on Wing 2 require the following staff assistance; 9 residents require a mechanical lift for transfers (2 staff members must assist with the use of a mechanical lift). 5 other residents require 2 staff assist for transfers without mechanical lift. 20 residents require the assistance or supervision	F 725	Education to LPNs/RNs/LNAs will be provided re: following care plan interventions r/t toileting assist and meal supervision. Education to LPNs/RNs will be provided on medication administration as well as the medication errors policy. Education to LPNs/RNs/LNAs will be provided regarding expectations of completion of resident morning care routines, toileting assistance, and meal supervision. Random audits will be performed by the Director of Nursing and/or designee weekly times 4 and then monthly times 2 to monitor for completion of resident morning care routines, toileting assistance, and meal supervision. per the care plan Random audits of medication pass times will be performed by the Director of Nursing and/or designee weekly times 4 and then monthly times 2. F725 POC accepted 8/2/22 TDougherty RN / PM	

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F 725	Continued From page 22 of 1 staff member. 12 residents require assistance of 2 staff for Activities of Daily Living (ADLs) and 25 require assistance of 1 staff member. 27 of the 40 residents are incontinent of bowel and/or bladder and require assistance with toileting and/or incontinence care. During interview on 6/27/22 at 10:06 AM, a Licensed Practical Nurse (LPN) stated that the unit was short staffed. S/he confirmed that there were only three Licensed Nurse Aides on for the day shift to care for forty residents and they should have four or five LNAs on. 2. During observation 6/27/2022 at 10:37 AM, 6/27/2022 at 1:05 PM, and 6/29/22 at 9:09 AM, Resident #36 was observed eating in bed with no supervision. A meal slip that was located on the meal tray stated that the resident should be "supervised for all meals for pacing." During interview on 6/29/22 at 11:21 an LPN stated that resident #36 might have been eating in bed and not in the dining room because there were not enough staff to get her/him out of bed. On 6/29/22 at 1:00 PM, the Administrator and Director of Nursing confirmed that the resident should have been supervised. 3. Per observation on 06/27/22 at 11:05 AM, Resident #27 was seen sitting on the toilet in his/her bathroom unsupervised. Resident #27's care plan states that S/he requires one staff participation to use the toilet. On 6/29/22 at 1:00 PM, the Administrator and Director of Nursing confirmed that the resident	F 725		

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F 725	Continued From page 23 should have been supervised. 5. During observation and resident interview on 6/27/22 at 12:20 PM, Resident #62 was lying in bed with a hospital gown on. S/he stated that there is not enough staff, especially in the mornings. S/he stated that when S/he asks to get out of bed, staff say that S/he will have to wait because there is not enough staff, and that is why S/he is not out of bed yet. 6. Per observations and staff interview, four medications were administered over an hour late for three residents (Residents #33, #42, #61) on 6/28/22 and 6/29/22 according to physician orders. On 6/27/22 at 1:15 PM the LPN administering these medications stated that there are too many residents and not enough staff to be able to administer the medications on time because "it is too crazy."	F 725		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure that medication error rates were not 5% or greater as evidenced by 4 out of 13 residents (#30, #33, #42, #61) being administered medications that were not given according to their prescribed orders. Findings Include:	F 759	Residents #s 30, 33, 42 and 61 continue to reside at the facility. All Residents have the potential to be at risk from this alleged deficiency. Education to all LPNs/RNs will be provided education on the medication administration policy as well as the self-medication administration policy. Medication pass random audits will be performed by the Director of Nursing and/or designee weekly times 4 and then monthly times 2. F759 POC accepted 8/2/22 TDougherty RN / PMM	8/2/2022

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F 759	Continued From page 24 Observation of 42 opportunities for medication administration were observed by three surveyors. Six medications were given in error, making the error rate 14.29%. 1. Per observation on 6/28/22 at 8:55 AM, Res. #30 was lying in their bed in their room. On the right side of the bed, next to the resident's right hand, was a respiratory inhaler labeled 'tiotropium bromide inhalation spray'. Res. #30 was observed picking up the inhaler, holding it in both hands, and releasing the medication into h/her mouth. The resident then placed the inhaler on the bed next to h/herself. Per record review, Physician's Orders for Res. #30 include an order for "Tiotropium Bromide Monohydrate" Aerosol Solution. Under "additional directions" is listed "Administered By: Clinician". An interview was conducted with the Director of Nursing [DON] on 6/29/22. The DON confirmed that Res. #30's respiratory inhaler should have been administered by a nurse or other qualified clinician but was not. 2. Medication pass was observed for Resident #33 on 6/28/22 at 1:15 PM. While the Licensed Practical Nurse (LPN) prepared medications, observation of his/her computer screen showed Resident #33's name in red. The LPN administered one tablet of Calcium 600+D3 Tablet 600-400 MG-UNIT (Calcium Carb-Cholecalciferol), rOPINIRole HCl [medication used to treat Parkinson's Disease] Tablet 0.25 MG, 1 tablet, and a Multi-Day Tablet (Multiple Vitamin), 1 tablet. At the time of this observation the LPN confirmed that residents shown in red are past due for their medications. Per record review Resident #33's Medical	F 759		

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F 759	Continued From page 25	F 759		

Continued From page 25

Administration Record (MAR) and physician orders the three medications were ordered to be given at 8:00 AM, confirming that the medications were administered over five hours late.

3. Medication pass was observed for Resident #61 on 6/28/22 at 1:29 PM. Observation of this LPN's computer screen showed this resident's name in red. The LPN administered one Magnesium Lactate Tablet Extended Release 84 MG (7MEQ). Per review of Resident #61's MAR and physician orders the medication was ordered to be administered at 12:00 PM. During the above observation, this LPN confirmed that Resident #61's medication was being administered late. S/he stated that "there are too many residents and not enough staff and can't administer the medications before lunch because it is too crazy."

4. Medication pass was observed for Resident #42 on 6/29/22 at 9:11 am. Observation of this LPN's computer screen showed this resident's name in red. Per review of Resident #42's MAR and physician orders following the observation of medication administration, the two overdue medications were ordered as follows: "Carbidopa-Levodopa [a drug used to treat Parkinson's Disease] Tablet 25-100 MG Give 3.5 tablet via G-Tube, due at 8 am; Acetaminophen Extra Strength Tablet 500 MG (Acetaminophen) Give 2 tablet; due at 8 am," confirming that the medication was administered over one hour late.

Review of the Medication Administration policy and procedure, titled, "Administering Medications" revealed the following: Page 1 "Policy Interpretation and Implementation 3. Medications must be administered in accordance with the orders, including any required time frame. 4.

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F 759	Continued From page 26 Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified."	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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. This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and record review, the facility failed to ensure medications were properly stored for one resident [Res. #30] of 13 sampled residents observed during medication administration.	F 761	Resident #30 continues to reside at the facility, and medications are stored per state and federal laws. All Residents have the potential to be at risk for this alleged deficiency. Education to LPNs/RNs will be provided on the storage of drugs per state and federal regulations. Random medication storage audits will be performed to evaluate storage of drugs by the Director of Nursing and/or designee weekly times 4 and then monthly times 2. F761 POC accepted 8/2/22 TDoughertyRN/PMC	8/2/2022

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F 761	Continued From page 27 Findings include: Per observation on 6/28/22 at 8:55 AM, Res. #30 was lying in their bed in their room. On the right side of the bed, next to the resident's right hand, was a respiratory inhaler labeled 'tiotropium bromide inhalation spray'. An interview was conducted with the Director of Nursing [DON] on 6/28/22 at 1:07 PM. The DON stated that no medications should be stored in a resident's room or bedside, and that no current residents were approved to self-administer medications and would have medications at their bedside.	F 761		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record review, the facility failed to ensure food is prepared in a form designed to meet individual needs for 1 of 28 sampled residents (Resident #36). Findings include: Per record review Resident #36 has a physician order for a CCHO (consistent carbohydrate) diet, Dysphagia (difficulty swallowing) Advanced texture, thin consistency. Add moisture to meat. Regular solid texture for snacks. The resident's care plan indicates that S/he aspirates easily and has difficulty swallowing. Resident #36's care plan and meal slip state that this resident's diet is dysphagia advanced. A late entry care plan note	F 805	Resident #36 continues to reside at this facility, and meals are prepared according to physician's order for modified diet. Residents on a modified diet have the potential to be at risk for this alleged deficiency. Education will be provided to the dietary manager and dietary staff regarding preparing modified diets for residents per physician orders. Education regarding serving modified diets per the resident's physician order and supervision per the care plan will be provided to LPNs/RNs/LNAs. Education will be provided to LPNs/RNs/LNAs and Activities staff by the Speech Therapist on diet consistencies. A random audit of food served to Residents with modified diets to evaluate correspondence to physician orders and supervision per care plan will be performed by the Director of Nursing and/or designee weekly times 4 and then	7/29/2022

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			monthly times 2.	
F 805	Continued From page 28 written on 06/28/22 at 11:24 AM, dated 5/25/2022 1:33 PM states "Dietary reports that [resident] does maintain a CCHO/dysphagia advanced w ground meat/thin liquids. Weekly weight order. Adequate po intake: 75-100%. Eats independently with supervision - requires assist at times." During observation on 6/29/2022 at 8:30 am, Resident #36 was seen in bed unsupervised with his/her meal tray which contained a whole sausage patty. The facility's "Dysphagia Diets Overview" revised on 10/15/2018 on page 4 under dysphagia advanced, it is stated that residents can have sausage patties if they are diced. Per interview with an LPN on 6/29/22 at 11:21 AM, Resident #36 should not be served a whole sausage patty because S/he is on a dysphagia advanced diet. During interview with the Administrator on 6/29/22 at 3:40 PM, S/he confirmed that residents on a dysphagia advanced diet can have diced sausage patties but not whole sausage patties.	F 805	F805 POC accepted T. Daugherty RN/PM 8/2/22	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880	Resident #369 was discharged. The infection control precautions were corrected prior to discharge. All Residents have the potential to be affected by this alleged deficiency. Education regarding transmission-based precautions, and hand hygiene will be provided to nursing home staff. Random infection control audits, focusing on (if any) covid precautions and hand hygiene, will be performed by the Director of Nursing and/or designee weekly times 4 and then monthly times 2.	8/2/2022

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F 880	Continued From page 29 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880	F880 POC accepted 8/2/22 TDougherty RN/PM	

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F 880	Continued From page 30	F 880		

contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observations and staff interview the facility failed to ensure proper transmission based precautions and hand hygiene procedures were followed for 1 applicable resident (Resident #369). Findings include:

The following breaches in infection control were noted in room 154. This room has a contact precautions sign on the door indicating staff are to don gown and gloves prior to entering the room:
1. 10:58 AM Staff observed entering room 154 without donning gown or gloves.
2. 11:12 AM Staff observed entering room 154 to clean without donning gown or gloves.
3. 12:30 PM Staff observed serving resident lunch in the room without donning gown or gloves. Staff squirted sanitizer into his/her hands while carrying potentially soiled gloves, carried the gloves to the end of the hall and disposed of

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F 880	Continued From page 31 them in a bin near the nurse station. Per interview with the Director Of Nurses (DNS) on 6/27/22 at 12:32 PM. Resident number #369 is a new admission and is on Covid precautions until 6/28/22. The DNS confirmed that staff should be gowning and gloving prior to entering the room.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 883	Residents #s 48, 12, 2, and 49 continue to reside at the facility. Residents #48 and #12 will be offered the pneumococcal vaccine. Residents that have not had their pneumococcal vaccine and/or those current during flu season have the potential to be affected by this alleged deficiency. The education regarding Resident's flu vaccine and pneumonia vaccine will be documented/scanned into the Resident's records. The medical records clerk and Admissions department will be provided education on uploading/scanning the flu and pneumonia vaccine consents into the Resident records. New Admission process developed to ensure the pneumonia vaccine education and flu vaccine education (during flu season) will be provided upon admission. Residents/representatives will be educated on the benefits and potential side effects of the pneumonia vaccine and of the flu vaccine (during flu season).	8/2/2022

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F 883	Continued From page 32 §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and medical record review, the facility failed to ensure that 3 of 5 applicable residents (#48, #12, #2) received education regarding the benefits and potential side effects of the Influenza vaccination; and 2 of the 5 residents were not offered the pneumococcal vaccine (Residents #48 and #12). Findings include: 1. Per medical record review for residents #48, #12, #2 the records did not have evidence that Influenza education and/or informed consent was	F 883	Education regarding informed consent/education and offering of the pneumonia vaccine and flu vaccine (during flu season) will be provided to LPNs/RNs and the Admissions department. A house wide audit of all current Resident records will be performed to evaluate the need for pneumococcal vaccine by the Director of Nursing and/or designee. Will offer the vaccine and education to those that are in need of the vaccine. Random audits of newly admitted Residents will be conducted by the Director of Nursing and/or designee to evaluate the need for pneumococcal vaccine weekly times 4 and monthly times 2. F883 POC accepted 8/2/22 TDougherty RN/PMC	

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F 883	Continued From page 33 given to the residents and/or their representative(s). On 06/29/22 at 11:00 AM the Facility Administrator confirms that residents receiving Influenza Vaccinations need education/informed consent when receiving the Influenza vaccine. The Facility Administrator also confirms that residents #49, # 12, #2 did not have informed consents for Influenza vaccine on administration. 2. Per record review, there is no evidence that residents #48 and #12 were offered the Pneumococcal Vaccination. Also, there is no evidence that residents #48 and #12 received pneumococcal vaccines prior to admission to the facility. On 6/29/22 at 11:00 AM the Facility Administrator confirmed that residents #48 and #12 were not offered Pneumococcal vaccine and that there is no documentation that residents #48 and #12 received Pneumococcal vaccination prior to the facility admission.	F 883		