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

May 30, 2024

Ms. Amy Braun, Administrator
Bel Aire Center
35 Bel-Aire Drive
Newport, VT 05855-4953

Dear Ms. Braun:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **April 24, 2024.** 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
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
	475049	A. BUILDING _____ B. WING _____	C 04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL AIRE CENTER	35 BEL-AIRE DRIVE NEWPORT, VT 05855

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E 000	Initial Comments An unannounced onsite Emergency Preparedness survey was conducted on 04/22/24 through 04/24/24 by the Division of Licensing and Protection. There were no regulatory violations identified.	E 000	This plan of correction was written to follow state and federal guidelines. It is not an admission of noncompliance. However, it is the facility commitment to demonstrate and maintain compliance.	
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey in conjunction with complaint investigations #22749, #22801, and #22958 from 4/22/24 through 4/24/24 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following deficiencies were cited as a result of this survey:	F 000		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact	F 561	F561 Specific Corrective Action 1. Resident #43 is being provided assistance with care in the morning per his/her request in a timely manner. Resident #209 is being assisted with toileting upon his/her request and in a timely manner. Resident # 15 is being assisted with care upon his/her request in a timely manner. 2. Interviews were completed with interviewable residents and/or responsible parties in order to determine the residents preference for completion of ADLS in a timely manner. 3. The facility provides adequate staff in order to meet the resident's physical, mental, and psychosocial needs including meeting the resident's preference for assistance with ADL care in a timely manner. NHA, DNS, and the facility staffing scheduler will be re-educated to this process.	

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

Amy J B | Administrator | 5/24/24

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 561	Continued From page 1 with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide activities of daily living care based on resident preference for 3 of 21 residents sampled (Residents #43, #209, and #15). Findings include: 1. Per record review, Resident #43's care plan reveals the following focus "[Resident #43] is at risk for decreased ability to perform ADL(s) [activities of daily living] in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: CVA [stroke]," created 3/2/2023. Interventions include "Provide resident/patient with extensive assist of 1 for dressing; Provide resident/patient with extensive assist of 2 for transfers using a mechanical lift; Provide resident/patient with extensive assist of 1 for eating." Per observation and interview on 4/23/24 at 8:33 AM, Resident #43 was awake and in bed. S/He stated that s/he would like to be up and in the dining room eating breakfast right now but has to wait until there is enough staff to get him/her up. Per observation at 10:45 AM, staff brought Resident #43 to the dining room for breakfast in his/her wheelchair. Per interview at 11:48 AM, Resident #43 explained that s/he is not able to	F 561	F561 Continued.... 4. DNS/Designee will complete random observations and interviews to validate residents preference for ADL care is completed in a timely manner. These observations/interviews will be weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. Results of these observations/ interviews will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 6/7/2024 **Tag F 561 POC accepted on 5/29/24 by T. Dougherty/P. Cota**	

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F 561	Continued From page 2	F 561		

get out of bed and eat breakfast when s/he wants to because staff are too busy. S/He said that s/he is hungry and by the time s/he eats breakfast, lunch is shortly after. S/He explained this happens almost every day.

2. Per record review, Resident #209's care plan reveals the following focus "[Resident #209] is at risk for decreased ability to perform ADL(s) in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: Limited mobility, L hip fx s/p ORIF [left hip fracture status post open reduction and internal fixation]," created 4/06/2024. Interventions include: Provide resident/patient with extensive assist of 2 for ambulation using a walker, gait belt, and nonskid footwear. Follow with [wheelchair]; Provide resident/patient with extensive assist of 1 with [bedside commode] over toilet; Provide resident/patient with extensive assist of 1 for bathing."

Per observation and interview on 4/23/24 at 8:30 AM, Resident #209 was sitting in his/her chair in his/her room. S/He stated that s/he would like to be up and eating breakfast right now but s/he has to use the bathroom first. S/He explained that the aides know that s/he is waiting to use the bathroom but they are going to come back when they are not as busy. At 9:20 AM, Resident #209 received their breakfast. At 11:57 AM Resident #209 said that s/he never got help using the bathroom this morning. S/He explained that she would like to use the bathroom before s/he eats breakfast in the morning and that never happened because staff did not have enough time. S/He was frustrated that s/he also had to wait so long for breakfast.

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Per interview on 4/23/24 at 8:40 AM, a Registered Nurse explained that it is typical for residents to be waiting in bed for am care and breakfast at this time of day because there are only 2 aides on. The staff try their best to get the residents up when they want to but with only two aides on, some residents have to wait a long time after they ask to get up.

Per interview on 4/24/24 at 3:20 PM the Director of Nursing confirmed that all residents have the right to make their own choices, including when to get out of bed and eat meals.

3. Per record review, Resident # 15's care plan reveals the following focus "[Resident #15] is at risk for decreased ability to perform ADL(s) in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting) related to: weakness, acute renal failure, right great toe amputated; created 05/15/2023. Interventions reveal that Resident # 15 needs assistance with ADL's. Another care area focus states: "While in the facility, [Resident # 15] states that it is important that [s/he] has the opportunity to engage in daily routines that are meaningful relative to their preferences." Intervention includes "I like to get up in the morning between 7am-9am."

During an interview with Resident # 15 on 04/22/2024 approximately 11:30 AM, Resident # 15 states "I have to be removed from my room when the staff care for my roommate. I then wait for my care in the hall outside of the room. I don't get to eat breakfast until 10:00 or 11:00 am which is too late. I would prefer to eat at 7:00 am when I am awake. I have complained to staff, but no one seems to be doing anything about it."

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F 561	Continued From page 4 Per observation and interview at approximately 8:45 am on 4/23/2024 Resident # 15 was outside his/her room, in the wheelchair with a night gown on, open back, and blanket on his/her lap. Resident # 15 stated "I have been up since 7:00 am ready to be bathed and dressed but nobody would assist me in getting up. Now I have to wait in the hall for my turn to take a bath and get dressed. I won't get to today until 10:00 or 11:00 which happens all the time." Per interview with the Social Service Director on 04/23/2024 at approximately 4:00 pm she/he stated they were aware of Resident # 15 concerns related to being moved out of his/her room. The Social Service Director confirmed Resident # 15 has complained several times to her/him about being left in the hall while they move the roommate around. Social Service Director confirmed that there has been no resolution to this issue.	F 561		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve	F 609	F609 Specific Corrective Action 1. The allegation made by resident #14 was reported to DAIL, APS, and the police on 04/24/2024. 2. Interviews were completed with interviewable residents and/or resp. parties to validate any concerns or allegations of abuse have been reported and investigated. This includes reporting to the state licensing agency as required.	

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F 609	Continued From page 5 abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to ensure that an allegation of staff to resident abuse was reported to the State Licensing Agency as required. Findings include: Per interview on 4/24/24 at approximately 11:30 AM, a Licensed Nursing Assistant stated that a few weeks ago, Resident #14 reported to him/her that the night aide had ripped her necklaces off of him/her and broke them. S/He explained that s/he had reported this to the Director of Nursing (DON). Record review reveals that Resident #14 was assessed on 3/13/2024 to have a BIMS of 14 (brief interview for mental status, indicating cognitive intactness). Per interview on 4/24/24 at 11:52 AM, Resident #14 explained that a couple weeks ago a staff member had ripped off his/her necklaces because "they were mad at me." A review of the investigation of this incident did	F 609	F609 continued... 3. The facility assures that residents have the right to be free from verbal, mental, sexual, or physical abuse and that abuse is reported within two hours after the allegation is made. The NPE or designee will educate all staff on abuse prevention and reporting so incidents can be investigated in a timely manner and reported to the administrator and other state agency officials within two hours after the allegation is made. 4. The Administrator or designee will conduct rounds and interviews to identify abuse and ensure reporting is completed within two hours to the administrator and state agency officials. This audit will validate that abuse is reported timely with interventions in place to prevent it and reported to the administrator and state agency officials within two hours after the allegation is made. These audits will be conducted weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 6/7/24 **Tag F 609 POC accepted on 5/29/24 by T. Dougherty/P. Cota**	

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F 609	Continued From page 6 not include evidence that this allegation of abuse was reported to the State Licensing Agency. Per interview at on 4/24/24 at approximately 2:30 PM, the DON explained that s/he was unaware that s/he was required to report the allegation to the State Licensing Agency but has been educated and understands that s/he should have reported the allegation to the State Licensing Agency.	F 609		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's	F 655	F655 Specific Corrective Action 1. Resident #49 currently has a care plan that includes instructions needed to provide effective and person centered care. Resident #3 discharged on 05/07/2024. 2. An audit of resident's baseline care plans were completed to validate care plans are in place that include the minimum healthcare information necessary to properly care for a resident including, but not limited to Initial goals based on admission orders, Physician orders, Dietary orders, Therapy services, Social services, PASRR recommendation, if applicable. 3. The facility developed baseline care plans within 48 hours of a resident's admission and include the minimum healthcare information necessary to properly care for a resident including, but not limited to Initial goals based on admission orders, Physician orders, Dietary orders, Therapy services, Social services, PASRR recommendation, if applicable. Licensed staff/IDT will be re-educated to this process.	

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F 655	Continued From page 7 admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to develop and implement a baseline care plan within 48 hours of admission that included the instructions needed to provide effective and person-centered care for 2 of 9 residents in the sample (Resident #49 and Resident #3). Findings include: 1. Per record review Resident #49 was admitted to the facility on 1/26/2024 with skin breakdown that required treatment to sacrum and bilateral feet. Resident #49's baseline care plan that was created on 1/26/24, the day of admission, states "Resident at risk for skin breakdown related to CKD (chronic kidney disease], oxygen dependent COPD [Chronic Obstructive Pulmonary Disease]" with a goal of "The resident will not show signs of skin breakdown through review." The base line	F 655	F655 continued... 4. DON/Designee will complete audits of resident's CP to validate that they are in place within 48hrs of admission. These audits will be M-F x 14 days, weekly x 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 6/7/2024 **Tag F 655 POC accepted on 5/29/24 by T. Dougherty/P. Cota**	

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F 655	Continued From page 8	F 655		

care plan does not reflect the actual skin breakdown, nor does it identify interventions needed to care for actual skin breakdown on Resident's sacrum and bilateral feet. On 1/29/2024 Resident #49's care plan was updated to reflect "Resident at risk for skin breakdown related to CKD, oxygen dependent COPD, T2DM [Type 2 Diabetes Mellitus] and has breakdown to sacrum, left lateral and medial foot, left great toe, and right lateral foot."

During an interview on 4/24/2024 at 11:20 the Registered Nurse confirmed that Resident #49's baseline care plan should have identified actual skin breakdown and provided interventions that addressed the care needs related to actual skin breakdown however, it did not.

2. Per record review, Resident #3 was admitted to the facility on 4/2/2024 with diagnoses that include anxiety and depression. A 4/2/2024 nursing note reveals that Resident #3 was admitted for short term rehabilitation related to management of diabetes and dementia.

Review of Resident #3's care plan reveals that the facility did not develop a baseline care plan related to mood and dementia within the first 48 hours of his/her stay. The following care plans were created on 4/23/2024, 21 days after Resident #3 was admitted to the facility: "Resident/patient exhibits or is at risk for distressed/fluctuating mood symptoms related to: dementia...Resident/Patient exhibits or is at risk for limited and/or meaningful engagement related to: Cognitive loss/dementia...Resident/patient has impaired/decline in cognitive function or impaired thought processes related to a condition other than delirium: Dementia (other than Alzheimer's disease)."

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F 655	Continued From page 9 Per interview on 4/24/24 at 3:20 PM, the Director of Nursing confirmed that Resident #3 should have had care plans for mood and dementia in his/her baseline care plan and did not.	F 655		
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 upon observation, interview, and record	F 657	F657 Specific Corrective Action 1. Resident #36, #37, and #47 have intervention added to the plan of care for the prevention of falls. 2. An audit of resident records was completed to validate the plan of care was updated following a fall in an effort to prevent further falls. 3. The facility reviews and revises the plan of care following falls in an effort to prevent further falls. The IDT and Licensed staff will be re-educated to this process. 4. The DNS/Designee will complete audits of residents with falls to validate the plan of care is revised as necessary by the IDT for the prevention of further fall. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 6/7/2024 **Tag F 657 POC accepted on 5/29/24 by T. Dougherty/P. Cota**	

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F 657	Continued From page 10	F 657		

review, the facility failed to review and revise resident Care Plans related to falls for 3 Residents (Res.# 36, #37, and #47) of 28 sampled residents.
Findings include:

1). Per record review, Res. #36 was admitted to the facility with diagnoses that include Alzheimer's Disease, repeated falls, lack of coordination, and abnormalities of gait and mobility. Res. #36 was assessed as "at risk for falls related to a history of falls, poor safety awareness and unsteady gait", and a Care Plan was developed with interventions to prevent falls upon their admission to the facility in 2022. Review of Res. #36's medical record reveals the resident suffering multiple falls while at the facility, with the most recent falls on 2/17/24 and 3/8/24.

Per nursing notes dated 2/17/24, Res. #36 was "found on bedroom floor next to the door laying on [h/her] side". A "Change in Condition" form for the resident was completed regarding the fall, noting that the resident's "Primary Care Provider responded with the following feedback: follow fall protocol". Review of the facility's 'Falls Management' policy [revision date 3/15/24] includes "Implement and document patient-centered interventions according to individual risk factors in the patient's plan of care." Review of the resident's Care Plan after the fall on 2/17/24 revealed no new interventions added to prevent future falls.

Further review of Res.#36's medical record reveals on 3/8/24 Res. #36 suffered another fall, resulting in a "contusion" and "facial bruising". Nursing notes after the fall record the resident 'has a history of mental health disorders, falls,

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F 657	Continued From page 11	F 657	Type text here	

impulsiveness, wandering, anxiety about surroundings, and left and right leg extremity weakness'. Review of the resident's Care Plan after the fall on 3/8/24 revealed no new interventions added to prevent future falls.

2). Per record review, Res. #37 was admitted to the facility with diagnoses that include Alzheimer's Disease, dementia, psychotic disturbances, and fractures of the right arm, right femur [leg], and right pubis [hip]. Res. #37 was assessed as "at risk for falls related to a history of falls, impaired mobility, and unsteady gait", and a Care Plan was developed with interventions to prevent falls upon their admission to the facility in 2022.

Review of Res. #37's medical record reveals the resident suffering multiple falls while at the facility, including 3 falls in 3 weeks, from 3/13/24 to 4/3/24. Per review of Res.#37's medical record, a "Change in Condition" note dated 3/13/24 records "Resident found on floor on [h/her] right side between [h/her] bed and [h/her] recliner chair...Resident hoyered [mechanical lift] off the floor onto [h/her] bed." On 3/25/24, a "Change in Condition" note for Res.#37 records "Resident found to be sitting upright on floor at bedside. States [s/he] was trying to get into bed and slid down to floor." On 4/3/24, Nursing notes document Res.#37 "was laying on right side of body, on the floor, directly by bed ...Assisted from floor to wheelchair with 2 person assist".

Review of the resident's Care Plan after 3 consecutive falls on 3/13, 3/25, & 4/3/24 revealed no new interventions added to prevent future falls.

An interview was conducted with the facility's

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Director of Nursing [DON] and the Corporate Compliance Director on 4/24/24 at 10:56 AM. The DON and the Corporate Compliance Director confirmed that after multiple falls, the care plans for both Res.#36 and #37 were not updated with new interventions to prevent future falls, resulting in both residents suffering additional falls, including Res. #36 who suffered a contusion and facial bruising.

3. Per record review, Resident # 47 was admitted to the facility on 08/11/2023 and has diagnoses that include history of falls, lumbar spine fracture and orthostatic hypotension (low blood pressure drops when standing). Resident # 47 has the following care plan initiated on 08/11/2023 which states "resident at risk for falls related to impaired mobility, lumber fracture, stroke with left sided weakness." Interventions include "toilet after meals, offer resident to go to the bathroom every 2-3 hours, obtain resident input and anticipate needs to prevent future falls, provide verbal cues for safety, place walking device within reach to enable use of walker, and place the call bell within reach."

Per record review from 08/11/2023 through 4/22/2024, Resident # 47 had 22 documented falls. Resident # 47's care plan was revised only 4 of the 22 times after a fall.

Per facility policy "Falls Management" last revised 03/24/2024 states "patients experiencing a fall will receive appropriate care and post fall interventions will be implemented. The purpose is to identify risk for falls, minimize the risk of recurrence of falls, and to ensure patient centered care plan is reviewed and revised."

Per interview with a Licensed Nursing Assistant

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F 657	Continued From page 13 (LNA) familiar with Resident # 47's care on 4/23/2024 at approximately 2:30 pm, he/she stated that they were concerned that there isn't enough staff to keep Resident # 47 from falling. The LNA stated that often Resident # 47 has falls multiple times a day, and there are not enough interventions including adequate supervision to prevent falls and keep Resident # 47 safe.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide treatment and care to an existing non-pressure-related injury in accordance with professional standards of practice and the person-centered care plan consistent with the facility policy for 1 of 6 residents (Resident # 11). Findings Include: Per record review, Resident #11 was admitted to the facility on 3/28/24 with the following diagnoses: Acute osteomyelitis (infection in the bone) of left ankle and foot, acquired absence of left great toe (amputation), Type 2 Diabetes, and peripheral artery disease (PAD), (the narrowing or blockage of the vessels that carry blood from the heart to the legs.)	F 684	F684 Specific Corrective Action 1. Resident # 11 discharged to home on 05/09/2024. 2. An audit of residents with pressure and non pressure related injuries was completed to validate treatments are provided in accordance with professional standards of practice and per the MD and/or consulting MD orders 3. The facility provides residents with pressure injuries and non pressure related injuries with necessary treatment in accordance with professional standards of practice and per the MD order. Licensed staff will be re-educated to this process. 4. The DNS/Designee will complete observations of treatments for pressure injuries and non-pressure related injuries to validate treatments are provided with professional standards of practice and per the MD order. These observations will be weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. The results of these observations will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 6/7/2024	

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F 684	Continued From page 14 Per record review, a care plan entry was dated 3/28/24 with an intervention of "weekly wound assessment to include measurements and description of wound status." Per record review, a skin assessment dated 4/5/24 and 4/12/2024 states, "Left foot, surgical toe amputation. Dressing C/D/I [clean/dry/intact]." Per record review, a skin assessment dated 4/19/2024 has a note entry: "Left foot, surgical toe amputation. Great toe sutures have dehisced [partial or total separation of previously approximated wound edges due to failure of proper wound healing], and great toe is currently open." Per record review, a clinical office note from the attending surgeon dated 4/23/24 indicates dead tissue was removed from the wound to expose the bone, "given [his/her] diabetes and PAD, [s/he] will have difficulty healing this wound and may ultimately need a BKA [below the knee amputation]." Facility policy titled NSG236 Skin Integrity and Wound Management, last reviewed 2/1/23, states: "A comprehensive initial and ongoing nursing assessment of intrinsic and extrinsic factors that influence skin health, skin/wound impairment, and the ability of a wound to heal will be performed. The plan of care for the patient will be reflective of assessment findings from the comprehensive patient assessment and wound evaluation. Staff will continually observe and monitor patients for changes and implement revisions to the plan of care as needed." Practice Standards include: "6 A licensed nurse will: 6.4 Perform and document skin inspection on	F 684	**Tag F 684 POC accepted on 5/29/24 by T. Dougherty/P. Cota**	

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F 684	Continued From page 15 all newly admitted /readmitted patients weekly thereafter and with any change in condition. 6.5 complete wound evaluation upon admission /readmission, new in-house acquired weekly and with unanticipated decline in wounds. 6.6 Perform daily monitoring of wounds or dressings for the presence of complications or declines. 6.6.1.4 Signs of decline in wound status. 6.6.1.4.1 If unanticipated decline in the wound, surrounding tissue, or new or increased wound-associated pain, complete a wound re-evaluation, change in condition." Per an interview on 4/23/24 at approximately 1:30 PM with the facility's wound care nurse, s/he stated that the facility does not assess surgical wounds on admission, and the responsibility of documenting the condition of the wound falls to the nurse changing the dressings. S/he stated s/he did not assess the wound until the skin check dated 4/19/2024 when the wound was assessed to have necrotic (dead tissue) in it. S/he had not assessed the wound since 4/19/2023 and has not followed facility policy 6.6, "perform daily monitoring of wounds or dressings for the presence of complications or declines." Per record review, Resident # 11's care plan has no documentation of revisions to reflect the 4/19/24 assessment of necrotic tissue in the wound. Per an interview on 4/24/24 at approximately 11:15 AM with the Director of Nursing, s/he confirmed that the facility failed to perform an initial wound assessment after the resident was admitted to the facility as per the facility's policy.	F 684		

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F 684	Continued From page 16 Additionally, the facility failed to assess and document the status of the wound weekly, as the resident's care plan indicated. There is no evidence that the wound was assessed during dressing changes in the medical record until 4/19/2024; s/he confirmed that there was no evidence of documentation of the condition of the wound from 4/19/2024 until 4/23/2024 when the surgeon removed the dead tissue from the wound. S/he also confirmed that the facility failed to revise Resident #11's care plan after the assessment on 4/19/2024. Rosen, R. D. 2023, (November 3). National Library of Medicine (NLM). National Institute of Health. https://www.nih.gov/about-nih/what-we-do/hih-almanac/national-library-medicine-nlm Accessed 30 April 2024 Streed,J.(2023,July 5).PAD: The other arterial disease-mayo clinic news network. Mayo Clinic.https://newsnetwork.mayoclinic.org/discussion/pad-the-other-arterial-disease/ Accessed 30 April 2024 Momodu, I. I. (2023, May 31). Osteomyelitis. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK532250/#:~:text=Osteomyelitis%20is%20a%20serious%20infection,bloodstream%2C%20fractures%2C%20or%20surgery. Accessed 30 April 2024	F 684		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management.	F 697	F697 Specific Corrective Action 1. Resident #3 discharged on 05/07/2024.	

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F 697	Continued From page 17 The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, and the comprehensive person-centered care plan for 1 of 21 sampled residents (Resident #3). Findings include: Per record review, Resident #3 was admitted to the facility on 4/2/2024 for rehabilitation services following repeated falls at home. Resident #3's care plan reveals "Resident exhibits or is at risk for alterations in comfort related to advanced age, [history] of falls," created 4/02/2024 with interventions that include "Evaluate pain characteristics: quality, severity, location, precipitating/relieving Factors," created on 4/2/24 and "Monitor for pain. Attempt non-pharmacologic interventions to alleviate pain and document effectiveness," created on 4/16/24. Review of Resident #3's Medication Administration Record (MAR) reveals that following physician orders for as needed (PRN) pain medications were administered: "Acetaminophen Oral Tablet 500 MG (Acetaminophen) Give 2 tablet by mouth every 8 hours as needed for pain TID as needed -Start Date- 04/02/2024," administered on 4/16/24, 4/18/24, 4/19/24, and 4/23/24; and "Lidoderm Patch 5 % (Lidocaine) Apply to back topically as needed for back pain daily as needed -Start Date-	F 697	F697 continued... 2. An audit of residents receiving prn pain medication was completed to validate non-pharmacological interventions for pain relief are attempted and documented prior to attempting to give prn pain medications. 3. The facility staff will implement strategies in accordance with professional standards of practice, the patient-centered plan of care, and the patient's choices related to pain management. This includes documentation of non pharmacological interventions attempted prior to attempting prn pain medication. Licensed staff will be re-educated to this process. 4. DNS/Designee will complete audits of resident records to validate non pharmacological interventions are attempted and documented prior to the attempting prn pain medication. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. The results of these observations will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 6/7/2024 **Tag F 697 POC accepted on 5/29/24 by T. Dougherty/P. Cota**	

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F 697	Continued From page 18 04/10/2024," administered on 4/17/24. In addition to the above medications, Resident #3's MAR reveals the following order "Non-Pharmacological Intervention(s) used before PRN Pain Medication. Record Non-Pharm intervention in Supplementary Documentation. Document Effectiveness. If pain continues follow providers direction which may include pain medication. as needed -Start Date- 04/02/2024." The MAR does not show documentation that non-pharmacological interventions were used prior to the administration of the above PRN medications. A review of pain assessments in both the MAR and under "vitals", Resident #3's pain is documented as being 0 for the entirety of their stay. There is no pain assessment indicating the use of the above PRN pain medications. Per interview on 4/24/24 at 3:58 PM, the Director of Nursing confirmed that if Resident #3 was receiving PRN medications, there would need to be both an indication for the need based on a pain assessment and documentation that non-pharmacological interventions were attempted before and there was not.	F 697		
F 699 SS=E	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 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.	F 699	F699 Specific Corrective Action 1. The care plan for Residents #26 has been updated to reflect the past history of trauma, accounting for the resident's experience to mitigate or eliminate triggers that may cause re-traumatization. 2. To identify others at risk, interviewable residents and family members of non-interviewable residents were interviewed about a history of trauma along with triggers and needs. Any new information regarding the history of trauma was added to the documentation and comprehensive care plan.	

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F 699	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to identify a resident's past history of trauma, and/or triggers which may cause re-traumatization for 2 applicable residents (Residents #26 and #11). Findings include: 1. Record review reveals that Resident #26 was admitted to the facility on 7/29/22 and has diagnoses that include mood disorder, major depressive disorder, and delusional disorder. Per review of Resident #26's physician orders, Resident #26 is taking Olanzapine, an antipsychotic medication, for post traumatic stress disorder (PTSD). Nurse Practitioner notes from 3/28/24, 4/3/24, and 4/11/24 reveal in the list of medications reviewed and updated that Resident #26 is taking "OLANZapine Oral Tablet 5 MG (Olanzapine) Give 5 mg by mouth two times a day for PTSD." Per review of Resident #26's care plan, neither PTSD or trauma is addressed as a care plan focus or within care plan interventions. Per interview on 4/24/24 at 9:55 AM, a Licensed Nursing Assistant (LNA) explained that Resident #26 sometimes has flashbacks from being in the service. The LNA said s/he didn't think s/he was care planned for this. Per interview on 4/24/24 at 1:38 PM, the Nurse Practitioner explained s/he recently attempted a gradual dose reduction for Resident #26's Olanzapine but was not successful because s/he received reports that Resident #26 was having aggressive behaviors and flashbacks. A social service assessment used to screen for	F 699	F699 continued.. 3. The facility assures that trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences to eliminate or mitigate triggers that may cause retraumatization. The NPE or designee will educate the nurses and social services on the evaluation of trauma and ensure a comprehensive, person-centered care plan is in place to eliminate or mitigate triggers for anyone with a history of trauma. 4. The DON or designee will review documentation and care plans to ensure trauma survivors have a comprehensive, person-centered care plan that addresses preferences to eliminate or mitigate triggers. This audit will validate that trauma-informed care is addressed in the care plan for trauma survivors. These audits will be conducted weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of compliance 6/7/2024 **Tag F 699 POC accepted on 5/29/24 by T. Dougherty/P. Cota**	

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PTSD was completed 7/19/23. The assessment coded Resident #26 as negative for trauma. The screening tool used is a two question assessment that asks the resident if they have experienced any consequences from trauma in the past month. It does not ask the resident if they have experienced trauma at any point in their past.

Per interview on 4/23/24 4:02 PM, the Social Service Director explained that s/he was not aware that Resident #26 had a history of PTSD. S/He confirmed that the only screening that s/he did for trauma was to ask the two questions above. S/He explained that there are no other screening tools that s/he uses to assess for trauma.

2.) Per interview on 4/22/24 at approximately 1:40 PM, Resident #11 revealed that s/he has post-traumatic stress disorder PTSD. S/he is a Marine with a history of live combat. S/he states sudden loud noises and loud male voices all trigger him/her causing panic and a need to hide.

Per record review, Resident #11 was admitted to the facility on 3/28/24 with diagnoses of Major Depressive Disorder and Traumatic Stress Disorder. A care plan with a date of 4/10/24 indicates an entry: "Resident /Patient reports past experience of trauma as evidenced by PTSD, with an intervention of "Encourage Resident/Patient to identify personal trauma and triggers and take steps to eliminate/minimize." Resident #11 has no triggers identified in his/her medical record or care plan.

Per the record review, a social service assessment used to screen for PTSD was completed on 4/3/24; the assessment coded

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F 699	Continued From page 21 Resident #11 as positive for trauma. The screening tool used is a two-question assessment that asks the residents if they have experienced any consequences from trauma in the past month. It does not ask the resident if they have experienced trauma at any point in their past. Per interview on 4/24/24 at approximately 2:30 PM, the Director of Social Services confirmed that the only screening that s/he used for trauma was to ask the two questions above. S/he confirmed there are no other screening tools s/he uses. S/he reveals that she/he learns of a resident's PTSD by their medical record or the two-question assessment.	F 699		
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). §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	F 725	F725 Specific Corrective Action 1. The facility currently has staffing patterns in place, based on census and acuity, that are sufficient to assure patient safety and attain or maintain the highest practicable physical,mental, and psychosocial well-being of each patient. This includes the ability to meet the plan of care of each resident. This includes a PPD of 2.0 for LNA and an overall nursing PPD of 3.0 at a minimum. 2. All residents have the potential to be affected 3. The facility ensures they have sufficient nursing staff, including nurse aides in accordance with state and federal regulations, with the appropriate competencies and skills sets to provide nursing and related services to assure patient safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each patient. Facility NHA and nursing leadership will be re-educated to this process.	

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F 725	Continued From page 22 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 upon interview and record review, the facility failed to provide sufficient nursing staff related to resident care and treatment for Res.#20, #36, #8, #51and #209 of 28 sampled residents. Findings include: 1.) Review of Res.#20's Care Plan reveals the resident is assessed as "at risk for decreased ability to perform Activities of Daily Living [ADLs] in bed mobility, transfer, and toileting related to impaired mobility and generalized weakness". Interventions to be provided by staff include "Provide resident with extensive assist of 1 for toileting. Ambulate into bathroom with rolling walker and extensive assist of 1 with gait belt." The Care Plan also assessed the resident as at risk for falls and at risk for skin breakdown related to incontinence. An interview was conducted with Res.#20 on 4/22/24 at 4:53 PM. Res.#20 stated that "staff have been 'wonderful' but sometimes I have to wait and wait. Once in a while I couldn't wait any longer, and I was embarrassed" [wet myself]. "I was told I have to wait for staff for assistance- with transfers to the bedside commode". Per observation, a notice next to Res.#20's bedside instructs the resident to wait for staff before toileting.	F 725	F725 continued.. 4. NHA/Designee will validate that the facility has sufficient nursing staff to meet the needs of the facility, this includes at a minimum of a PPD of 2.0 for nurses aides and an overall nursing PPD of 3.0. These audits will be daily x 30 days, weekly x 4 weeks, then bi weekly x 2 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 6/7/2024 **Tag F 725 POC accepted on 5/29/24 by T. Dougherty/P. Cota**	

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2.) Review of Res.#36's Care Plan reveals the resident is assessed as "at risk for decreased ability to perform Activities of Daily Living [ADLs] in bed mobility, transfer, and toileting related to altered mental status". Interventions to be provided by staff include "Provide resident with extensive assist of 2 for toileting." The Care Plan also assessed the resident as at risk for falls related to a history of falls, poor safety awareness and unsteady gait, and at risk for skin breakdown related to incontinence. An interview was conducted with Res.#20 on 4/22/24 at 1:26 PM. Res.#26 stated sometimes s/he "have to wait and wait and wait" and sometimes "you can't wait any longer" [soil him/herself]. Res.#36 said, "then you need even more help and you are still waiting".

3.) Review of Res.#8's Care Plan reveals the resident is assessed as "at risk for decreased ability to perform Activities of Daily Living [ADLs] in bed mobility, transfer, and toileting related to a history of a left leg fracture and altered mental status". Interventions to be provided by staff include "Provide resident with supervision of 1 for toileting". The Care Plan also assessed the resident as at risk for falls related to a impaired mobility and impaired cognition and to "monitor and assist with toileting". An interview was conducted with Res.#8 on 4/22/24 at 11:55 AM. Res.#8 stated they have "to wait a long time for staff to respond to the call bell at night. Two times no one came. I ended up peeing in my pants. It's degrading".

4.) The following observations were made during dinner service on 4/22/24. At 4:11 PM, there were 13 residents in the dining room waiting for dinner. Dinner started to be plated at 4:30 PM and a few

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more residents were brought into the dining area. At 4:39 PM, Resident #51 was sitting at the dining table with food in from of him/her. A Licensed Practical Nurse (LPN) approached him/her and said that they need him/her for a minute because s/he hadn't had his/her sugars done yet. The nurse brought Resident #51 back to the unit. Staff approached Resident #35 at 4:43 PM, Resident #25 at 4:45 PM, and Resident #36 at 4:56 PM, all during dinner service because they had not had their blood sugars checked before eating the meal.

Per interview on 4/22/24 at 5:01 PM, this LPN explained that s/he has at least 7 blood sugars to check before dinner and was unable to check the above residents because s/he was busy with another resident. S/He explained that staffing is low and there are resident safety concerns because of it, like not being able to get to all the residents in time to do their blood sugars as one example.

5.) Per observation on B hall on 4/23/24 from 8:30 AM through 8:45 AM, most residents are in their rooms in their beds or in their chairs. Most residents are not dressed.

Per observation on 4/23/24 at 8:30 AM, Resident #209 was sitting in his/her chair in his/her room. S/He stated that s/he would like to be up and eating breakfast right now but s/he has to use the bathroom first. S/He explained that the aides know that s/he is waiting to use the bathroom but they are going to come back when they are not as busy. At 8:36 AM, Resident #15, who is in the hall in a johnny, stated that s/he will probably have to wait until 10:00 AM now to get dressed because of how busy staff are.

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F 725	Continued From page 25 Per interview on 4/23/24 at 8:40 AM, a Registered Nurse explained that it is typical for residents to be waiting in bed for am care and breakfast at this time of day because there are only 2 aides on. The staff try their best to get the residents up when they want to but with only two aides on, some residents have to wait a long time after they ask to get up. Per interview on 4/23/24 at 2:23 PM with two Licensed Nursing Assistants (LNAs), one LNA stated that there are not enough staff to meet the needs of the residents. This LNA explained that there are not enough staff to get residents up in the morning and to the dining room at the time they want to eat, monitor residents that are at risk for falls, get to residents to help them to the bathroom before they soil themselves, and help residents with eating. The second LNA confirmed the above information.	F 725		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services 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). §483.35(a)(3) The facility must ensure that	F 726	F726 Specific Corrective Action 1. Licensed nurses and licensed nursing assistants identified have had competency skill set documentation reviewed and competencies completed to meet the needs of the facility resident population per the facility assessment. 2. To identify others at risk, The facility staff education files were reviewed to validate the skill sets and competencies are in place to meet the needs of the facility resident population per the facility assessment.	

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F 726	Continued From page 26 licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that 4 of 5 sampled licensed nursing assistants (LNAs) and 4 of 5 nurses were assessed for competency in the skills required to care for the resident needs based on resident care plans. Findings include: Review of 5 LNA training and competency files revealed the following: * 2 LNA files had no evidence of competency evaluation. * 1 LNA file had no evidence of competency since 2022. * 1 LNA file had only hand hygiene and personal protective equipment (PPE) competencies completed on 5/9/2024. There was no evidence in their file of any other resident care competency evaluations. Review of 4 staff nurse's training and competency	F 726	F726 Continued... 3. The facility assures licensed nurses and licensed nursing assistants are assessed for their competency and skill sets to provide care and respond to each resident's individualized needs based on the facility assessment. The NPE or designee will educate the management and leadership team members on the requirements for competency and skill sets to be completed before working with residents, yearly thereafter, and any new skill sets identified through the facility assessment. 4. DNS/designee will conduct audits of staff members to ensure all competencies are completed before working with residents. This audit will validate that the competencies are completed before the new licensed nurse and licensed nursing assistants work with residents. These audits will be conducted weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 6/7/2024 **Tag F 726 POC accepted on 5/29/24 by T. Dougherty/P. Cota**	

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F 726	Continued From page 27 file revealed the following: * 2 nurse files had no evidence of competency evaluation since 2022. * 1 nurse file had evidence of a Medication Pass and an IV (intra venous) therapy competency dates 7/10/23 only. There was no evidence that the nurse had been assessed for competencies related to other skills since 3/28/22. Per review of the designated wound care nurse's training and competency file there is no evidence that wound care competency evaluations have been completed since 2020. During an interview on 4/24/24 at 9:35 AM the Market Clinical Lead confirmed that nursing competencies have not been completed per regulation. During an interview on 4/24/24 at 11:30 AM the Market Operations Advisor confirmed that nursing staff have not been assessed for competency as required by regulation. The Market Operations Advisor also confirmed that the designated wound care nurse has not been assessed for competency since 2020.	F 726		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	F 758	F758 Specific Corrective Actions 1. Resident #3 discharged on 05/07/2024. Resident #6,26,36,and 47 are currently being monitored for behaviors and side effects related to the use of the psychotropic medications.	

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F 758	Continued From page 28 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	F 758	F758 continued... 2. An audit of residents receiving psychotropic was completed to validate that staff are monitored for behaviors and side effects related to the use of these psychotropic medications. 3. The facility validates that medications used to treat behaviors have a clinical indication and are monitored for efficiency, risk, benefits, and harm or adverse consequences. The facility documents the behaviors in the medical record and licensed staff monitor for side effects of psychotropic medications. Licensed staff and LNAs will be re-educated to this process. 4. DNS/Designee will complete audits to validate staff are recording behaviors and monitoring for s/s of side effects related to psychotropic medication use. These audits will be conducted weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 6/7/2024 **Tag F 758 POC accepted on 5/29/24 by T. Dougherty/P. Cota**	

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F 758	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that residents who use psychotropic drugs are accurately monitored for behaviors and/or side effects for 5 of 5 sampled residents (Residents #3, #26, #36, #6 and #47). Findings include: Bel-Aire policy titled "Psychotropic Medication Use," last revised 10/24/2022, states "all medications used to treat behaviors must have a clinical indication and be used in the lowest possible dose to achieve the desired therapeutic effect. All medications used to treat behaviors should be monitored for efficacy, risks, benefits and harm or adverse consequences." Facility policy also states staff should monitor the resident's behavior triggers, episodes and symptoms and document in the medical record. 1. Per record review, Resident #26 on 7/29/22 and has diagnoses that include mood disorder, major depressive disorder, and delusional disorder. Resident #26 has the following care plan focus "[Resident #26] is at risk for complications related to the use of psychotropic drugs," revised 4/21/24. Interventions include "Complete behavior monitoring flow sheet. . . Monitor for continued need of medication as related to behavior and mood." Resident #26's Medication Administration Record (MAR) reveals the following physician orders for psychotropic medications: "OLANZapine Oral Tablet 5 MG (Olanzapine) Give 5 mg by mouth in the afternoon for PTSD [post traumatic stress disorder], psychosis GDR [gradual dose reduction] on 3/5/24 -Start Date- 03/06/2024 through- 04/11/2024 . . . OLANZapine Oral Tablet	F 758		

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5 MG (Olanzapine) Give 5 mg by mouth two times a day for PTSD, psychosis GDR on 3/5/24 failed -Start Date- 04/11/2024." There is no documentation of behavior monitoring in the MAR.

Per interview on 4/24/24 at 11:30 AM, a Licensed Practical Nurse explained that Resident #26 has behaviors daily and s/he is typically angry, yelling, refusing care, and aggressive with staff.

While Resident #26's behaviors are monitored by the licensed nursing assistants (LNAs), they are not accurately monitored by the LNAs. Per review of the behavior flow sheets for March 2024 and April 2024, Resident #26 is documented to have behaviors only 3 times from March 1, 2024 through April 23, 2024. This behavior monitoring sheet does not reflect actual behaviors as per the LPN above.

Per interview on 4/24/24 at 9:57 AM, the Market Clinical Lead confirmed that behavior monitoring for Resident #26 was not being completed by the licensed nursing staff, rather it was being done by the LNAs.

2. Per record review, Resident #3 was admitted to the facility on 4/2/2024 and has diagnoses that include anxiety and depression. Resident #3 has the following care plan focus "Resident is at risk for complications related to the use of psychotropic drugs Medication: antidepressant, antianxiety," created 4/2/24. Interventions include "Monitor for side effects and consult physician and/or pharmacist as needed." Resident #3's MAR reveals the following physician orders for psychotropic medications: "clonazePAM Oral Tablet 0.5 MG(Clonazepam) Give 1 tablet by

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mouth at bedtime for anxiety -Start Date- 04/03/2024. . . Sertraline HCl Tablet 50 MG Give 1 tablet by mouth one time a day for Depression -Start Date- 04/03/2024." Monitoring for psychotropic medication side effects was not added to the MAR until 4/24/24.

Per interview on 4/24/24 at 9:57 AM, the Market Clinical Lead confirmed that side effect monitoring was added to Resident #3's MAR today (4/24/24).

3. Per record review, Resident #36 was admitted to the facility on 2/10/2022 and has diagnoses that include major depressive disorder. Resident #36 has the following care plan focus "[Resident #36] is at risk for complications related to the use of psychotropic drugs antidepressant," created 2/10/2022. Interventions include "Monitor for side effects and consult physician and/or pharmacist as needed." Resident #3's MAR reveals the following physician orders for psychotropic medications: "DULoxetine HCl Capsule Delayed Release Particles 60 MG Give 1 capsule by mouth one time a day for depression -Start Date- 12/15/2022." Monitoring for psychotropic medication side effects was not added to the MAR until 4/24/24.

Per interview on 4/24/24 at 9:57 AM, the Market Clinical Lead confirmed that side effect monitoring was added to Resident #36's MAR today (4/24/24).

4. Per record review, Resident #6 was admitted to the facility on 09/11/2020 and has diagnoses of delusions and agoraphobia. Per record review Resident #6 has the following care plan initiated 09/11/2020 which states "Resident at risk for

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complications related to the use of psychotropic drugs." Interventions include "complete behavior monitoring, monitor for continued need of medication as related to behavior and mood, monitor for side effects, and consult physician and or pharmacist as needed." Resident #6's MAR reveals the following physician orders for psychotropic medications "Risperidone 1 milligram by mouth two times a day." There is no documentation of behavior monitoring in the MAR.

Per interview on 4/24/24 at 11:16 AM, a Licensed Practical Nurse (LPN) explained that Resident #6 has behaviors almost daily as s/he is typically having hallucinations. While Resident #6's behaviors are monitored by the licensed nursing assistants (LNAs), they are not accurately monitored by the LNAs. Per record review, behavior flow sheets, completed by the LNAs, did not start until 3/5/24 and in March 2024 and April 2024, Resident #6 is documented to have behaviors only 10 times from March 5, 2024, through April 23, 2024. This behavior monitoring sheet does not reflect actual behaviors as per the LPN above.

Per interview on 4/24/24 at 9:57 AM, the Market Clinical Lead confirmed that behavior monitoring for Resident #6 was not being completed by the licensed nursing staff, rather it was being done by the LNAs.

5. Per record review Resident #47 was admitted to the facility on 8/11/2023 with a diagnosis of depression. Per record review Resident #47 has the following care plan initiated 8/11/2023 which states "Resident at risk for complications related to the use of psychotropic drugs." Interventions

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F 758	Continued From page 33 include "complete behavior monitoring, gradual dose reduction, monitor for continued need of medication as related to behavior and mood, monitor for side effects, and consult physician and or pharmacist as needed." Resident #47's MAR reveals the following physician orders for psychotropic medications "Paroxetine 30 mg by mouth twice a day for depression, start date 03/24/2024." There is no documentation of behavior monitoring in the MAR and monitoring for psychotropic medication side effects was not added to the MAR until 4/24/24. Per interview on 4/24/24 at 11:16 AM, a Licensed Practical Nurse (LPN) explained that Resident #47 is typically sad daily and s/he is frequently having hallucinations. While Resident #47's behaviors are monitored by the licensed nursing assistants (LNAs), they are not accurately monitored by the LNAs. Per record review, behavior flow sheets, completed by the LNAs, did not start until 4/6/24 and in April 2024, Resident #47 is documented to have behaviors only 9 times from April 6, 2024, through April 23, 2024. This behavior monitoring sheet does not reflect actual behaviors as per the LPN above. Per interview on 4/24/24 at 9:57 AM, the Market Clinical Lead confirmed that behavior monitoring for Resident #47 was not being completed by the licensed nursing staff, rather it was being done by the LNAs and confirmed that side effect monitoring was added to Resident #47's MAR today (4/24/24).	F 758		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 34 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. §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	F 880	F880 Specific Corrective Action 1. Resident #26, 17, 37, 36 have been placed on enhanced barrier precautions. Resident #19 deceased on 04/25/2024 2. An audit of residents with wounds and/or indwelling medical devices was completed to validate that residents have enhanced barrier precautions in place. 3. The facility implements an infection control program that is designed to help prevent the development and transmission of communicable diseases and infection related to enhanced barrier precautions and resident at risk. Licensed staff will be reeducated to this process including the nursing leadership team. 4. DNS/Designee will complete rounds on residents with wounds and/or indwelling medical devices, who may be at risk for infection to validate enhanced barrier precautions are in place. These rounds will be weekly x 4, bi-weekly x 4 weeks, then monthly x 3 months. The results of these observations will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 6/7/2024 **Tag F 880 POC accepted on 5/29/24 by T. Dougherty/P. Cota**	

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	475049	A. BUILDING _____ B. WING _____	C 04/24/2024

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F 880	Continued From page 35 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 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 upon observation, interview, and record review, the facility failed to implement an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections related to "Enhanced Barrier Precautions" (EBP) and residents identified as at risk. Findings include: 1.) Per the Centers for Disease Control and Prevention: "Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that	F 880		

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F 880	Continued From page 36	F 880		

employs targeted gown and glove use during high contact resident care activities. EBP may be indicated for residents with ... wounds or indwelling medical devices" and "Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care." (https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html.)

Per observation on 4/22/24 at 11:30 AM, there were no residents on Enhanced Barrier Precautions (EBP) on any of the facility's resident units. Per observation, interview, and record review, it was revealed that Residents #26, #51, #17, #37, #36, #19, all were identified as having either "wounds or indwelling medical devices" which indicated that EBP should be implemented. Per interview on 4/22/24, staff were unaware of any requirement for Enhanced Barrier Precautions for the above listed residents and were not observed using PPE during direct care on the residents.

Per observation on 4/23/24 at 8:00 AM, resident rooms #12, #13, #15, #17, #18, and #21 had EBP signs on the doors that were not on the doors the previous day. Per interview on 4/23/24 at approximately 8:10 AM, a Licensed Nursing Assistant explained that the signs were on doors of residents with wounds or catheters and they were just put there last night.

Per interview on 4/23/24 at 9:05 AM, the Infection Preventionist confirmed that the signs were not up yesterday; the facility had put up the signs and started education with the staff regarding the precautions last night.

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F 880	Continued From page 37 Per interview with the facility's Infection Preventionist on 4/23/24 at 2:30 PM, Enhanced Barrier Precautions [EBP] including signage, staff education, placement of PPE, and resident notification were conducted after the survey team arrived on-site on the morning of 4/22/24. The Infection Preventionist confirmed that EBP should have been in place for any residents having either wounds or indwelling medical devices but was not. The Infection Preventionist stated signage, education, and notification was conducted "in the afternoon" of 4/22/24.	F 880		

Division of Licensing and Protection

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S320 SS=F	7.13 (d)(1) QUALITY OF CARE - STAFFING LEVELS 7.13 (d)(1) The facility shall maintain staffing levels adequate to meet resident needs. 1. At a minimum, nursing homes must provide: i. no fewer than three (3) hours of direct care per resident per day, on a weekly average, including nursing care, personal care and restorative nursing care, but not including administration or supervision of staff; and ii. of the three hours of direct care, no fewer than two (2) hours per resident per day must be assigned to provide standard LNA care (such as personal care, assistance with ambulation, feeding, etc.) performed by LNAs or equivalent staff and not including meal preparation, physical therapy or the activities program. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to maintain required minimum staffing levels to allow for 2.0 hours of direct care per resident per day (PPD) on a weekly average by Licensed Nursing Assistants (LNAs) for 8 of the 11 sampled weeks. Findings include: Per review of the daily nursing PPD hours, the average direct care PPD by LNA staff was below the required 2 hours per day minimum during the following weeks in February, March, and April 2024: 2/1/24 - 2/7/24 = 1.9 2/15/24 - 2/21/24 = 1.9	S320	S320 Specific Corrective Action 1. The facility is currently staffing to,at a minimum, of 2.0 LNA PPD and 1.0 Nurse PPD for a total PPD of 3.0 at a minimum. 2. All resident have the potential to be affected 3. The facility ensures they have sufficient nursing staff, including nurse aides in accordance with state regulations, to ensure patient needs are met in regards to daily personal care, assistance with ambulation.feeding etc. Facility NHA, Scheduling and Payroll Manager, and Nursing Leadership will be re-educated to this process. 4.NHA/Designee will validate that the facility has sufficient nursing staff to meet the needs of the facility this includes at a minimum of a PPD of 2.0 for nurses aides and an overall nursing PPD of 3.0. These audits will be daily x 30 days, weekly x 4 weeks, then bi weekly x 2 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of compliance 6/7/2024 **Tag S320 POC accepted on 5/29/24 by T. Dougherty/P. Cota**	

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S320	Continued From page 1 2/22/24 - 2/28/24 = 1.7 3/8/24 - 3/14/24 = 1.7 3/15/24 - 3/21/24 = 1.6 3/22/24 - 3/28/24 = 1.9 4/1/24 - 4/7/24 = 1.8 4/8/24 - 4/14/24 = 1.8 Per interview on 4/24/24 at 9:35 AM, the Clinical Market Lead confirmed that the PPD was under the 2.0 LNA hours per regulatory requirement.	S320		