Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

November 23, 2022

Ms. Amy Russell, Administrator
Bennington Health & Rehab
2 Blackberry Lane
Bennington, VT 05201-2300

Dear Ms. Russell:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on October 14, 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

Pamela M. Cota, RN
Licensing Chief

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
	475027	A. BUILDING _____ B. WING _____	C 10/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE BENNINGTON, VT 05201

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				11/23/22
E 000	Initial Comments The Division of Licensing and Protection conducted an annual emergency preparedness survey on 10/13/2022. The facility was found to be in substantial compliance with emergency preparedness regulations.	E 000	Please note that the filing of the plan of correction does not constitute admission to any of the alleged violations set forth in this statement of deficiencies. This plan of correction is being filed as evidence of the facility's continued compliance will all applicable laws.	
F 000	INITIAL COMMENTS An unannounced onsite annual rectification survey was conducted in conjunction with six complaint investigations on 10/9/2022 - 10/14/2022. On 10/11/2022, the survey team identified and notified the facility of deficiencies at the Immediate Jeopardy (IJ) level at F726 and F880, related to violations around staff training and infection prevention and control. The IJ was found to be removed on 10/12/2022, prior to the conclusion of the survey. Due to a pattern of harm identified at F686 and F692, substandard quality of care was also identified. The facility is licensed for 91 beds and had a census of 54 at the time of the survey. The regulatory violations identified under 42 CFR Part 483 include:	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550	F 550 Resident #33, LNA who provided care to Resident #33 was re- educated on Residents Rights to include dignity/privacy with care. All Residents have the potential to be affected by this deficient practice. Nursing staff will be reeducated on Residents rights to include dignity/ privacy with care.	

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

MP Vermont 11/4/22

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 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that care was provided to residents in a dignified manner for 1 resident (Resident #33) in a standard survey sample of 35. Findings include: Observation on 10/9/22 at 9:00 PM revealed a Licensed Nursing Assistant (LNA) who entered room #204. The staff member proceeded to the window bed where it was noted the privacy	F 550	Care observation audits will be conducted to ensure staff are maintaining dignity/privacy practices with care. Audits will be conducted weekly X3 then monthly X3 by the Director of Nursing or designee. The results of the audits will be reported and reviewed at the QAPI committee meeting X4 months and evaluated as needed. Oversight will be provided by the DON or designee. F550 POC accepted 11/7/22 sfreemanRN/pmc	11/23/22

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F 550	Continued From page 2 curtain was pulled to approximately 3/4 of the way down towards the foot of the bed. The staff member went behind the partially pulled curtain where the residents bare/naked thighs and a yellow brief was visible on the resident from the doorway of room #204. The staff member was observed pulling the back of the yellow brief down revealing the residents buttocks, and providing incontinence care to Resident #33. Interview on 10/9/22 at 9:10 PM with the LNA revealed she/he was an LNA who was working as emergency relief staff. The LNA stated this was her/his 3rd shift in this facility. The LNA confirmed that she/he was providing peri care to Resident #33 and she/he confirmed that the privacy curtain was not pulled over far enough to ensure privacy for the resident to ensure and maintain his/her dignity.	F 550		
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	F 584	F 584 Laundry Carts and area under the wooden pallet have been cleaned and disinfected. 3rd floor clean utility room has been cleaned & organized. The door has lock has been replaced and a lock added to the medication cabinet. The sign has been updated to include medication. Resident #45's bed is being made daily after care is provided. 2nd Floor hallways have been cleaned of debris. 2nd Floor dining area and	

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F 584	Continued From page 3 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 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to provide residents with a safe, clean, comfortable, and homelike environment, as evidenced by poor performance of Housekeeping, Maintenance, Infection Control and Nursing Services necessary to maintain a sanitary and orderly facility. Findings include: 1. Observation on 10/11/22 at 01:27 PM of the laundry department, contained laundry carts, for the transport of soiled linens. One cart was noted to be unclean with various items of built-up debris such as used gloves, food particles, paper	F 584	kitchenette dirty dishes were removed, exposed food was dis- carded. Refrigerators, freezers, cabinets and microwave were all cleaned and disinfected. Outdated food was discarded. Approved pest devices are in place. Room #201 no longer resides at the facility. Room #205B room personalization has been discussed with the resident. Room #207A no longer resides at the facility. Room #210 room personalization has been discussed with the resident. Room #211B room personalization has been discussed with the resident. Room #212B no longer resides at the facility. Room #204 was cleaned and organized. All Residents have the potential to be affected by this deficient practice. Laundry staff will be educated on routine cleaning & disinfecting of the laundry room and equipment. Licensed Nurses have been educated on the changes to the clean utility/medication storage room. Licensed staff educated on the update to Resident #45 plan of	

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F 584	Continued From page 4 products, a hair tie, a meal ticket, and other unrecognizable particles. There were layers of lint, dust and debris under a wooden pallet that contains large buckets of washing machine chemicals. Interview at the time of observation with a laundry attendant, confirmed the appearance of the dirty laundry cart and dirt/grime build up under the wooden pallet. Another observation of the laundry department and interview with the Infection Control Preventionist (ICP) was conducted the same afternoon on 10/11/22 at 4:15PM. The ICP confirmed that the laundry cart and under the wood pallet near the washing machines were filthy. The ICP confirmed that cleaning visible soiled areas and disinfecting linen carts had not been done and should be to deter pests and prevent the spread of communicable diseases. 2. On 10/11/22 at 08:45AM observation of the 3rd floor unit, revealed a door across from nurse station which is labeled "clean utility" with a key code pad. This same room is also labeled as such on the facility map. This surveyor asked a Licensed Nurse Assistant (LNA) what the door code was. This LNA knew the door code and stated, "it's the same for all other utility rooms" and proceeded to let two surveyors in. Upon entrance, the small room appeared to be a medication storage area rather than a "Clean Utility" room. It contained over the counter medications in a cabinet, a blue plastic tote full of medications on the floor, Lab supplies, syringes with needles (box of 26G x1/2" syringe) in a cabinet, and other supplies. The utility room was filthy with debris on the floor and a dark quarter sized area of sticky substance. The LNA confirmed that the floor was dirty, and that s/he	F 584	care related to bed making. Housekeeping and Dietary staff has been educated on routine cleaning related to common areas and kitchenettes. Dietary staff has been provided education o food storage and refrigerator/freezer cleaning. Environmental Services has been educated on approved pest control devices. Social Services and Recreation has been educated on home-like environment and resident room personalization. Observation audits will be conducted weekly X3 then monthly X3 on the following: Laundry carts and room cleaning. Clean Utility/Med room cleaning, Resident room beds are made, Dining area, refrigerator/freezer cleanliness Food storage Hallway cleanliness, Pest Control, Resident Room personalization. The results of the audits will be reported and reviewed at the QAPI Committee meeting X4 months and evaluated as needed. Oversight will be provided by the Administrator or designee. F584 POC accepted 11/7/22 SFreemanRN/PMC	

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F 584	Continued From page 5 did not "ever really need anything in here". Observation and interview on 10/11/22 at 2:17PM with a housekeeper confirmed that the floor was dirty and s/he "does usually wash the 'clean Utility' floor but has been out for two weeks". This housekeeper revealed that all of 3rd floor is her/his cleaning responsibility. S/he stated that s/he had never had a nurse observe while she cleans the floor to this room and was not aware that s/he should not enter due to it containing medications, but did know the code. Observation of the 3rd floor "Clean Utility" room and Interview on 10/11/22 at 4:45PM with the ICP confirmed that the floor was dirty and that the room was clearly labeled "Clean Utility" outside the door and on the facility map but was being used as a "medication room" which did not contain such items as one would expect to have in a clean utility room. The ICP confirmed that this room had not been cleaned in a while and that only nurses should have access. A day later, on the afternoon of 10/12/22 at 2:30PM, Observation and interview with a Genesis Nurse Consultant confirmed the room was not being used as a "Clean Utility" and the floor was still dirty. 3. Observation on 10/10/22 at 3:10PM of the 3rd floor South unit, room 314 revealed two stripped unmade beds, with resident #45 lying on the bed closest to the window. This resident has dementia and chose the wrong bed to rest on. S/he does not have a room- mate. Both beds have pressure reducing mattresses and are not protected from being soiled. Interview at this time with a Licensed Practical Nurse (LPN) who is familiar	F 584		

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F 584	Continued From page 6 with this resident, stated "We leave the beds unmade in room 314, because the resident is a heavy wetter and goes through all linens constantly, so we make his bed at 7:30PM". Interview with a travel nurse on 10/10/22 at 3:25PM confirmed that there were no sheets on the beds in room 314. Observation on 10/11/22 at 10:30AM revealed both beds were unmade throughout the day. Observation on 10/12/22 at 09:00AM, resident's bed was made and at 1:25PM it was not made. Interview with the Regional Nurse Consultant confirmed that both beds in room 314 were without linens and both beds should be made every day. 4. Observation on 10/9/22 at 8:40 PM of the second floor, revealed a lot of debris in the hallway where resident rooms are located. Interview on 10/9/22 at 8:50 PM with the emergency relief Licensed Practical Nurse (LPN), who confirmed the hallway where resident rooms are located was littered with debris consisting of gloves, pieces of blue plastic that were pieces of the disposable gowns, clear plastic wrappers that are the packaging to protective eyewear, small pieces of paper and dirt. She/he stated that staff have not had time to clean on the unit and to her/his knowledge there are no housekeeping staff at that time available. 5. Observation on 10/9/22 at 9:41 PM of the second floor dining area revealed the following issues in the resident dining area and kitchenette: *tray with dirty dishes and exposed food; *dirty refrigerator and freezer with spills inside on the shelves and on the inside of the door shelves;	F 584		

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F 584	Continued From page 7 *11 pieces of cheese partially wrapped in plastic wrapped, that are curled and dried on one corner of each piece; *cabinet drawers with miscellaneous kitchen disposables (small paper bags, pieces of various sizes of tinfoil, packets of tea, hot cocoa and a binder clip) scattered through the drawer and what appeared to be coffee grounds mixed in with these items; *Another drawer with small plastic disposable lids, some in the plastic protective sleeve and many out of the sleeve and scattered throughout the drawer, an individual package of crackers, and various single serve condiment packets, and what appeared to be coffee grounds mixed in with these items; *dirty microwave; *large metal mouse trap noted under the a utility rack in the kitchenette serving area; *a rat trap located between the refrigerator and the wall of the kitchenette serving area. Observation on 10/10/22 at 8:15 AM revealed the above noted issues identified on 10/9/22 at 9:41 PM were still present. Interview on 10/10/22 at 8:45 AM with the Food Service Director Supervisor, who confirmed the above findings. She/he revealed that some parts of the kitchenettes and serving areas are the responsibility of housekeeping and some by nursing. 6. Observation on 10/10/22 at 9:00 AM revealed resident rooms #201, #205B, #207A, #210, #211B, and #212B were not personalized to the resident, no pictures on the walls, or other items that revealed resident self-expression. Room #204 was very cluttered with clothes that were	F 584		

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F 584	Continued From page 8 draped over furniture, window sills, and other flat surfaces. Interview on 10/10/22 at 10:00 AM with the LPN, who was an emergency staff relief nurse, confirmed that there were rooms that did not contain personal items other than clothes and personal care products - she/he was unsure as to why resident rooms are not personalized.	F 584		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy	F 585	F585 Allegation of abuse was investigated and reported to the state agency. All Residents have the potential to be affected by this deficient practice. Grievances have been reviewed, investigated. Summary of findings and any corrective action taken has been documented as the results of a confirmed or not confirmed grievance. Staff will be educated on the grievance policy. Weekly audits of grievances/ concerns and responses will be conducted by the Administrator or designee weekly X3 then monthly X3.	

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F 585	Continued From page 9 to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by	F 585	The results of the audits will be reported and reviewed in the QAPI committee meeting and evaluated as indicated. Oversight will be provided by the Administrator, F585 POC accepted 11/7/22 SFreemanRN/PMC	

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F 585	Continued From page 10 anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to ensure that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. Findings include:	F 585		

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F 585	Continued From page 11 On 10/14/22 at 1 PM during a review of the facility grievance book it was noted that there were numerous names (2 in January 2022, 2 in April 2022, 3 in July 2022, 2 in September 2022) indicating a grievance had been filed by the named individuals without evidence of investigation or a summary of findings. Among these grievances was one alleging abuse which had not been reported to any State Agency but was investigated as part of the survey. Upon interview with the Administrator, he/she confirmed he/she did not know what happened with the grievances and he/she had no process to monitor these or ensure follow up.	F 585		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(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 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.	F 609	F609 Allegations of abuse for Resident #11 have been investigated and reported to the appropriate state agency. Grievances have been reviewed to ensure any allegations of abuse were reported. Staff was educated on the Abuse prohibition policy and reporting of alleged violations. Weekly audits will be conducted of allegations to ensure allegations of abuse are reported timely weekly X3 then monthly X3 by the Administrator or designee. The results of the audits will be reported and reviewed at the QAPI	

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F 609	Continued From page 12 §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 observation, record review, and staff interview the facility failed to 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 to the appropriate State Agencies for one resident (Resident #11) of two investigated. Findings include: During a review of the facility grievance book a note from Social Services dated 9/7/22 containing information regarding an allegation of sexual abuse from Resident #11 was found. The note appeared to be an initiation of an investigation of the grievance from Resident #11 regarding personal care received from a LNA (Licensed Nursing Assistant) in which he/she complained of the staff "rubbing my chest a little too much for my liking and cleaned my crotch a little too good". There were no conclusions drawn or indication this had been reported to any State Agencies, it was confirmed with the State Division of Licensing and Protection that this incident had not been reported. At approximately 2PM on 10/14/22 the facility Administrator confirmed the allegation had not been reported to any State Agencies.	F 609	Committee meeting monthly X4 and evaluated as indicated. Oversight will be provided by the Administrator or designee. F609 POC accepted 11/7/22 SFreeman RN	

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F 641 F 641 SS=D	Continued From page 13 Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on Observation, interview and record review, it was determined that the facility failed to complete accurate assessments for 2 of 37 residents in a standard survey sample. (Residents #49, and 204) Findings include: 1. Per record review Resident number #49 was admitted to the facility on 9/17/22 with diagnosis of Chronic Obstructive Pulmonary Disease with (Acute) Lower Respiratory Infection, Acute and Chronic Respiratory Failure with Hypoxia, Morbid (Severe) Obesity with Alveolar Hypoventilation, Shortness of Breath, and Dependence on Supplemental Oxygen (Not all inclusive). Review of the Physician orders revealed a signed order for the use of Bi-PAP dated 09/16/22. During interview on 10/12/22 at 2:45 PM the resident stated that s/he is to use a Bi-PAP machine (a Bi- PAP machine is used as a form of non-invasive ventilation (NIV) therapy used to facilitate breathing) while s/he is napping during the day and at night when s/he is sleeping. The resident stated that s/he used this at home and should be using it in the nursing facility. Interview on 10/12/22 at 3PM with the Registered Nurse (RN)/Nurse Practice Educator (NPE) who stated that "the resident refuses to wear the Bi-PAP, it's not even set up and it should just be discontinued" The RN/NPE stated that "the	F 641 F 641	F641 Resident #49 MDS was modified to indicate Bipap use. Resident #204 MDS was modified to include the G-tube in section K0310 part B, G-tube care orders have been obtained and care plan has been developed. House audit conducted to ensure resident's using Bipaps are coded accurately on the MDS and Bipap is working correctly. House audit completed on Residents with G-tubes to ensure Residents with G-tubes are coded correctly on the MDS, have orders for g-tube care and have careplans in place. Education has been provided to MDS staff and those who complete the MDS on the accuracy of MDS coding of section O and K. Education has been completed with licensed staff related to Bipap use and Enteral tube policies. Audits of MDS coding of section O part G, section K0310 part B, treatment orders for G-tubes and Bipap use will be conducted weekly X3 then monthly X3 by MDS or designee.	

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F 641	Continued From page 14 Bi-PAP company and/or a respiratory therapist have not been consulted to do a re-evaluation of the resident's BI-PAP needs in relation to the resident's refusal and complaints of blowing air too hard for her/him to tolerate". Minimum Data Set (MDS) assessment reference date (ARD) 9/23/22 in SECTION O part G. Non-Invasive Mechanical Ventilator (BiPAP/CPAP) is coded "NO" indicating not used prior to this admission to the facility and is coded" NO", indicating not used while a resident. Interview on 10/14/22 at 10:47 AM with the Licensed Practical Nurse (LPN) MDS coordinator, who confirmed the Bi-PAP was not coded correctly on the admission MDS ARD 9/23/22. The LPN/MDS Coordinator confirmed that the BI-PAP should have been coded as being used prior to this admission and currently, while a resident. 2. Per record review Resident # 204 was admitted to the facility on 9/29/22 with medical diagnoses Type 2 Diabetes Mellitus Without Complications, Frontal Lobe and Executive Function Deficit Following Cerebral Infarction, Pressure Ulcer of Sacral Region Stage 2, Dysphagia Oropharyngeal Phase. An admission assessment dated 9/29/22 reflects that the resident was admitted with a G-Tube (a tube that allows for food, fluids, and medication to be given directly to the stomach without swallowing). During interview on 10/12/22 3:00 PM with Registered Nurse (RN) Nurse practice educator (NPE) s/he stated that s/he "has not seen the resident's G tube " and "nursing doesn't do anything with it, it is not used". Record review	F 641	The results of the audits will be reported and reviewed at the QAPI Committee meeting with evaluation as needed X4 months. Oversight will be provided by the MDS coordinator or designee. F641 POC accepted 11/7/22 SFreemanRN/PMC	

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F 641	Continued From page 15 performed with this RN at this time who confirmed that there are no orders for the G-tube site assessment, or care/treatment. The Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 1/5/22 Section K 0310 part B coding indicates there was no G tube in place while not a resident or currently as a resident in this facility. Interview on 10/13/22 12:58 PM with the Licensed Practical Nurse (LPN) MDS coordinator, who confirmed the MDS section K 0310-part B is incorrectly coded and the resident in fact has a G-Tube in place and there are no treatment orders in place for the G- tube and that there is no care being provided for the G-Tube.	F 641		
F 655 SS=E	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.	F 655	F655 Resident #52's care plan has been updated to reflect current mobility, ADL need, Skin prevention, assistive devices, base- line and comprehensive needs. Resident #204's care plan has been updated to reflect current conditions, goals and interventions Resident #37 Diet orders obtained and nutrition care plan has been developed. New Admissions will have base- line care plan development within 48 hours of admission.	

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F 655	Continued From page 16 (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 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 observation, interview, and record review, it was determined that the facility failed to develop and implement a baseline care plan for 3 of 37 residents in a standard survey sample. (Resident identifiers #37, 52, and 204) Findings include: 1. Observation of Resident #52 revealed that she/he has a right sided BKA (below the knee amputation), and a right legged prosthetic was noted at her/his bedside. Record review revealed that Resident #52 was admitted to the facility	F 655	Education will be provided to the interdisciplinary team on baseline care planning following the Person Centered Care plan policy. Audits will be conducted of baseline careplan development within 48 hours of Admission weekly X3 and monthly X3 by the DON or designee The results of the audits will be reported and reviewed at the QAPI Committee meeting with evaluation as needed monthly X4. Oversight will be provided by the DON or designee. F655 POC accepted 11/7/22 SFreeman RN/PMC	

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F 655	Continued From page 17 from the hospital on 9/30/2022 after a surgical debridement of a stage 4 pressure ulcer on her/his left posterior thigh. Review of the resident's care plan revealed that the resident is not care planned specifically for a pressure ulcer. The resident is care planned for being "at risk for decreased ability to perform ADL's [Activities of Daily Living] however the only intervention is "PT/OT/SP treatment as ordered by physician/mid-level provider" and did not include how care would be provided or the ADL's that the resident would require assistance with. A review of the resident's diagnosis list includes but is not limited to "Pressure Ulcer of Left Hip, Stage 4". The resident does not have a base line care plan specific to her/his mobility needs although the resident's admission assessment dated 9/30/22 at 15:50 hours, revealed that the resident has impaired vision requiring glasses, has broken and/or loosely fitting full or partial dentures, and uses a walker, wheelchair, and a limb prosthesis however these are no baseline care plans for these identified issues. Interview on 10/11/22 at 2:15 PM with an emergency response LPN (Licensed Practical Nurse), confirmed that the resident does have a stage 4 pressure ulcer and the baseline care plan is not specific to a stage 4 pressure ulcer. Interview on 10/13/22 with staff RN/NPE (Registered Nurse/Nurse Practice Educator) revealed that the resident does have a stage 4 pressure ulcer and was admitted with a Wound VAC (vacuum-assisted closure (VAC) is method of decreasing air pressure around a wound to assist in healing). 2. Per record review, Resident # 204 was	F 655		

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F 655	Continued From page 18 admitted to the facility on 9/29/22 with medical diagnoses of Type 2 Diabetes Mellitus Without Complications, Frontal Lobe and Executive Function Deficit Following Cerebral Infarction, Pressure Ulcer of Sacral Region, Stage 2, Dysphagia Oropharyngeal Phase. An admission assessment dated 9/29/22 reflects that the resident was admitted with a G-Tube (a tube used to provide food, fluid, and medications directly to the stomach). Physicians' orders revealed there are no orders for G-Tube care or flushes. a) 10/12/22 3:00 PM Interview with Registered Nurse (RN) Nurse practice educator (NPE) who was working the medication cart at the time of this interview. He/she indicates that he/she "has not seen the resident's G tube, and stated that nursing doesn't do anything with it, it is not used". Record review performed with this RN at this time and date confirms that there are no orders for G-tube site assessment, no flush, and no treatment. The resident's base line care plan was reviewed revealing no care plan in place for the residents existing G-Tube. On 10/13/22 at 10:30 am an LNA confirmed that the resident had a G-Tube and offered to assist the resident, who agreed to allow surveyors to look at her/his dressings. The resident was observed as having a G-tube in place. 10/13/22 12:58 PM Interview with Licensed Practical Nurse (LPN) MDS coordinator confirmed that there isn't treatment for the G-tube in place, and there was not a baseline care plan for the G-Tube. b) On 10/11/22 12:22 PM Observed resident door	F 655		

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F 655	Continued From page 19 was closed, it has a sign on the door that had a star on it. This was confirmed at this time and date by a LNA that the sign was an indication that the resident was a fall risk. The Minimum Data Set (MDS) Assessment Reference date (ARD) 10/5/22 5-day assessment Section Care Area Assessment (CAA) indicates that resident is fall risk and will proceed with care plan. However, there is no fall risk care plan in the baseline care plan that is in place. Interview on 10/14/22 at 12:09 PM with the MDS (Minimum Data Set) Coordinator, (Licensed Practical Nurse) LPN who confirmed that the resident's admission assessment revealed the resident is a fall risk and she/he confirmed there was no fall risk care plan in place on the base line care plan for resident #204. c) Record review revealed a Physician's orders for Santyl External Ointment 250 UNIT/GM (Collagenase) that read: "Apply to Right Groin and coccyx topically everyday shift for wound care cleanse with NS and pat dry, cover with Dry protective dressing AND apply to right groin topically as needed for wound care". Admission assessment dated 9/29/22 indicates Resident was admitted with a Right groin incision dehisced, coccyx open, left, and right buttocks shearing multiple areas. The 5-day admission Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/5/22 Section M part A skin conditions is coded as follows; Resident has a pressure ulcer/ injury a scar over bony prominence or a non-removable dressing/ device, this was coded" NO". Section M	F 655		

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F 655	Continued From page 20 0210 Unhealed pressure ulcers. Does this resident have one or more unhealed pressure ulcers/injuries coded "Yes". (A pressure injury is an area on the skin that has been damaged related to pressure). 10/13/22 12:58 PM interview with Licensed Practical Nurse (LPN) MDS Coordinator confirms that the resident does have a stage 2 pressure ulcer on her coccyx and the base line care plan does not reflect that there is a stage 2 pressure injury. There are no goals, or intervention related to the stage 2 pressure injury to prevent pressure injury from becoming worse. 3. Resident #37 was readmitted to the facility on 8/25/22 after a hospital admission with the following diagnoses: Hemiplegia and Hemiparesis following cerebral infarction affecting left non dominant side, calculus of Gallbladder and Bile Duct without Cholecystitis without obstruction, Paroxysmal Atrial Fibrillation, Cerebral infarction unspecified, Major Depressive Disorder, and Shortness of Breath. Per medical record review resident # 37 does not have a physician order for a diet. Review of Minimum Data Set (MDS) assessment reference date (ADR) 8/17/22 Section G indicates Supervision set up only Care Area Assessment (CAA) yes to proceed with nutrition problem on resident's base line care plan. Further medical record review reveals that the resident does not have a Dietary base line care plan in place. 10/14/22 at 11:54 AM interview with Licensed Practical Nurse (LPN) MDS coordinator confirms at this time that there is no base line dietary care plan in place for resident #37.	F 655		

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F 656 SS=H	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 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	F 656	F 656 Resident #5 care plan and kardex has been reviewed and updated to reflect his current status and care needs. Resident #256 no longer resides at the facility. Resident #204 has had Fall, Nutrition, Pressure Ulcer/Skin care plans reviewed and developed. Resident #37 had a nutrition care plan developed. House audit was conducted on Person Centered comprehensive careplans. Education of the Person-Centered careplan policy has been conducted with the IDT team. Audits of comprehensive care plans will be conducted to ensure a comprehensive individualized care plan has been developed weekly X3 then Monthly X3 by the DON or designee. The results of the audits will be reported and reviewed at the QAPI Committee meeting and evaluated as indicated monthly X4. Over- sight will be provided by the DON or designee. F656 POC accepted 11/7/22 sFreemanRN/PMC	

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F 656	Continued From page 22 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, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan to assure that the resident's care needs were met for 4 of the 37 residents in the survey sample (Residents #5, #256, #204, & #37). Findings include: 1. Per record review Resident #5 has a care plan focus regarding assistance for ADLs [activities of daily living] care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfers, locomotion, and toileting related to dx [diagnosis] of CHF [congestive heart failure] and COPD [chronic obstructive pulmonary disease]. Review of ADL interventions reveal the only ADL that specifies the assistance needed is ambulation. The care plan does not identify the level of staff assistance needed for; bathing, bed mobility, dressing, transfer, toileting, or eating. Resident #5 also has a care plan focus that was initiated on 1/6/2022 and revised on 4/20/2022 that states "Resident may be nutritionally at risk related to [prior] covid recovered, hx [history] of pressure areas, use of mechanically altered diet, use of diuretic therapy, obesity status, diabetes, CHF, recent hospitalization with sig wt [significant weight] change r/t [related to] diuresis' An intervention initiated on 1/6/2022 directs staff to "Record and monitor intakes" and "Record and monitor weights" Another care plan focus initiated on 1/5/2021 of "[Name omitted] has a diagnosis	F 656		

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F 656	Continued From page 23 of diabetes: non-insulin dependent with an intervention initiated on 1/5/2021 of monitor meal consumption each meal." Per review of the licensed nursing assistant documentation for 10/1 - 10/14/22 meal intakes were not consistently monitored per care plan. There were 42 opportunities to document the assistance provided and the percentage of the meal consumed. Of the 42 opportunities, 36 were left blank, not completed. Per interview with a Registered Nurse (RN) on 10/14/2022 at approximately 2:45 PM regarding the above concerns s/he stated that the licensed nursing assistants (LNAs) would find the ADL interventions to include assistance needed for eating on the resident care Kardex. However, while viewing the Kardex the RN confirmed that the care plan and Kardex were not complete, and the care needs were not identified on the resident Kardex or care plan. S/he also confirmed that the LNA documentation was not complete. 2. Per record review Resident # 256 was transferred to the facility from another Genesis facility 5/25/2022 with a discharge summary written on 5/25/2022 that states that her/his skin was intact. During her/his stay at this facility s/he has refused getting out of bed and refused assistance with personal hygiene putting her/him at risk for developing pressure ulcers. A Nursing Evaluation completed on 5/25/2022 indicates that the resident is a high risk for pressure ulcers. Per review of the resident's nursing progress notes, a note written on 8/21/2022 reflects that a Licensed Nursing Assistant informed the Licensed Practical Nurse that the resident was	F 656		

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F 656	Continued From page 24 found to have an open area on her/his left calf. The progress notes states " Area red and draining yellow/green drainage. Resident reports pain in the area 7/10. Scheduled Tylenol administered. Open area measured 4cm L by 1.5 cm W. Information given to {Name omitted RN (Registered Nurse) supervisor to f/u [follow up] with PCP [Primary care Physician] for treatment..." A progress note written on 8/21/2022 reflects that an antibiotic was ordered to treat the "new open area to L (left) medial leg. No ill effects noted." The resident's care plan was reviewed and revealed that there is no care plan focus in place that addresses the high risk of pressure ulcer development and no interventions implemented to decrease or manage the risk or the actual pressure ulcer that developed on 8/21/2022. During an interview with the Executive Director on 10/10/2022 at 9:30 AM when asked if s/he recalled a resident by the name of [name omitted] s/he said yes s/he did. S/he was asked if there had been review of pressure ulcers or injuries to her/his left leg during morning meeting or any type of risk meeting. The ED stated "No, I don't remember anything with her/him like that." The ED was asked if there was any documentation related to the wound. The ED did not provide additional information to this surveyor throughout the survey. 3. Per record review Resident # 204 was admitted to the facility on 9/29/22 with medical diagnoses that include: Type 2 Diabetes Mellitus, Frontal Lobe and Executive Function Deficit Following Cerebral Infarction, Other Reduced Mobility, Pressure Ulcer of Sacral Region, Stage 2, Dysphagia Oropharyngeal Phase. Muscle	F 656		

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F 656	Continued From page 25 Weakness (Generalized) Unspecified Convulsions. a) Observation on 10/11/22 10:00 AM of Resident #204 revealed her/his breakfast tray was placed in front of her/him unsupervised on the over bed table and had been unopened. An attempt to interview Resident #204 revealed s/he was very groggy and lethargic and was not able to participate in the interview. At 12:22 PM revealed Resident #204's room door was closed, and upon the doorframe was a picture of a star. Interview on 10/11/22 at 12:24 PM with Licensed Nursing Assistant (LNA) who confirmed the sign was an indication that the resident was a fall risk, stated she/he was not sure if Resident #204 was an actual fall risk or not. Review of the Minimum Data Set (MDS) with an Assessment Reference date (ARD) 10/5/22, (5-day assessment), Care Area Assessment (CAA) revealed that resident is a fall risk, and the facility will proceed with a fall risk care plan. There was no comprehensive care plan in place for fall risk for Resident #204. The facility fall policy, titled, "NSG215 FALL MANAGEMENT" under Practice Standards, section #2, reads "Implement and document patient-centered interventions according to individual risk factors in the patient's plan of care". Interview on 10/14/22 at 12:09 PM with the MDS Coordinator, Licensed Practical Nurse (LPN) who confirmed the resident's admission assessment revealed the resident is a fall risk, it was triggered on the Care Area Assessment (CAA), and was	F 656		

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F 656	Continued From page 26 indicated to proceed with care plan for fall risk. The LPN MDS Coordinator confirmed there was no fall care plan in place for resident #204. Per record review Resident #204 was admitted to the facility with a G-Tube. Physicians' orders revealed there are no orders for G-Tube care or flushes, Medical Director progress note dated 10/06/22 does revealed that the resident required a G-tube in the hospital due to "severe oropharyngeal dysphagia". A MD progress note dated 10/6/22, revealed the following order for Resident #204: "speech and swallow to follow". Interview on 10/14/22 at 8:30 AM the COTA (Certified Occupational Therapy Assistant) stated that the speech-language pathologists (SLP) was aware of the G-tube and the diagnosis of dysphagia on residents' admission. She/he confirmed that SLP has not screened Resident #204. She/he stated that SLP is only per diem, and s/he was the only therapist in the building on this day. Review of Resident #204's Care Area Assessment (CAA) revealed Nutritional status is triggered as an area where the resident required additional assistance and the facility documented that they would proceed with care plan. There was no evidence of a nutritional care plan for Resident #204. Interview on 10/14/22 at 12:09 PM with the LPN MDS coordinator confirmed that the CAA did trigger for Nutrition and Resident #204 does not have a care plan in place for nutrition that would help to prevent nutritional decline. b) Record review on 10/12/22 04:09 PM revealed	F 656		

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F 656	Continued From page 27 a Physician's orders for Santyl External Ointment 250 UNIT/GM (Collagenase) that read: "Apply to Right Groin and coccyx topically everyday shift for wound care cleanse with normal saline (NS) and pat dry, cover with dry protective dressing AND apply to right groin topically as needed for wound care". Admission assessment dated 9/29/22 revealed resident was admitted with a Right groin incision dehisced, coccyx open, left, and right buttocks shearing multiple areas. Section M 0210 Unhealed pressure ulcers was code as: "Does this resident have one or more unhealed pressure ulcers/injuries" was coded "Yes". The 5-day admission MDS with Assessment Reference Date (ARD) of 10/5/22, the Care Area Assessment (CAA) section revealed the facility documented they would proceed with care plan for Pressure ulcer. Review of the resident's care plans revealed there was no care plan in place for pressure ulcers. Interview on 10/13/22 12:58 PM with the LPN MDS Coordinator confirmed the MDS section M0100 A is coded incorrectly, since the resident does have a stage 2 pressure ulcer on her/his coccyx, and there is no care plan that addresses the resident's stage 2 pressure ulcer. Review of facility policy on 10/14/22, titled "NSG236 Skin Integrity and wound management Policy" stated, "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	F 656		

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F 656	Continued From page 28 assessment and wound evaluation. Staff will continually observe and monitor patients for changes and implement revisions to the plan of care as needed." 4. Per record review Resident #37 was readmitted to the facility after a hospital admission with the following diagnoses: Hemiplegia and Hemiparesis following cerebral infarction affecting left non dominant side, calculus of Gallbladder and Bile Duct without Cholecystitis without obstruction, and Cerebral infarction. Review of Physicians' orders reflects that Resident # 37 does not have a physician order for a diet. The Minimum Data Set (MDS) with an assessment reference date (ADR) of 8/17/22, Section G revealed the resident required Supervision and set up only. The CAA revealed the facility documented they would proceed with a care plan for nutrition for Resident's #37. Review of the resident's care plan revealed that the resident does not have a care plan in place for nutrition with goals and intervention to avoid decline. Interview on 10/14/22 at 11:54 AM with LPN MDS coordinator confirmed the facility documented they would proceed with a dietary care plan, and there is no dietary care plan in place for resident #37.	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.	F 657	F 657 Resident #256 No longer resides at the facility. House audit conducted on care plan timing and revision. Care plans have been revised to reflect residents current conditions.	

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F 657	Continued From page 29 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on and interview and record review the facility failed to ensure that the residents' comprehensive Care plan was revised to reflect the needs of 1 of 37 residents. (Resident #256). Findings include: 1, Per record review Resident # 256 was transferred to the facility from another Genesis facility 5/25/2022 with a discharge summary written on 5/25/2022 that states that her/his skin was intact. During her/his stay at this facility s/he has refused getting out of bed and assistance with personal hygiene putting her/him at risk for developing pressure ulcers. A Nursing Evaluation completed on 5/25/2022 indicates that the	F 657	Education provided to the IDT team on care plan timing and re- vision process. Audits will be conducted on the care plan revision process to ensure care plans are revised to reflect current status and completion on time Weekly X3 then Monthly X3. The results of the audits will be reported and reviewed at the QAPI Committee meeting and evaluated as indicated Monthly X4. Oversight provided by the DON or designee. F657 POC accepted 11/7/22 SFreemanRN/RMC	

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F 657	Continued From page 30 resident is a high risk for pressure ulcers. On 8/21/2022 a Licensed Nursing Assistant informed the Licensed Practical Nurse that the resident was found to have an open area on her/his left calf. The progress notes states " Area red and draining yellow/ green drainage. Resident reports pain in the area 7/10. Scheduled Tylenol administered. Open area measured 4cm L by 1.5 cm W. Information given to {Name omitted} RN (Registered Nurse) supervisor to f/u [follow up] with PCP [Primary care Physician] for treatment..." A progress note written on 8/21/2022 23:16 reflects that an antibiotic was ordered to treat the "new open area to L (left) medial leg. No ill effects noted. The resident's care plan was reviewed and revealed that there is no care plan that addresses the high risk of pressure ulcer development and no interventions implemented to decrease or manage the risk or the actual pressure ulcer that developed on 8/21/2022. Further review of the resident's care plan revealed that no revisions were made after the development of the wound regarding the care needed to manage the wound. During an interview with the Executive Director on 10/10/2022 at 9:30 AM when asked if s/he recalled a resident named [name omitted] and s/he said yes s/he did. S/he was asked if there had been review of pressure ulcers or injuries to her/his left leg during morning meeting or any type of risk meeting. The ED stated "No, I don't remember anything with her/him like that." When asked if s/he did have any documentation related to the wound to provide to this surveyor, the ED did no provide additional information to this surveyor throughout the survey.	F 657		

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F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to conduct and document assessments to accurately reflect the resident's status care and services provided according to accepted standards of clinical practice for two residents (#40 and #54) in a sample size of 37. Findings include: 1. Record review reveals that resident #54 was admitted to the facility on 08/09/22 and died at the facility on 09/05/22 due to acute chronic hypoxic respiratory failure secondary to aspiration pneumonitis and advanced dementia per a practitioner note (09/06/22). This resident had the following diagnoses: Dementia, Delirium, Depression, A-fib, Benign Prostatic Hyperplasia, glaucoma, Hypothyroidism and Dysphagia. This resident contracted COVID-19 virus said to be resolved on 07/14/22 per a practitioner note (08/12/22). This was a resident transferred from another nursing home facility. Further review of the medical record indicates that this resident had a fall on 08/14/22. A nurse note reveals "LNA (Licensed Nurse Assistant) reported hearing loud bang while in the room across the hall from [name omitted], when she entered the room saw pt. laying on the floor next to his bed, this nurse entered the room after	F 658	F 658 Resident #40 returned from the ER on 10/3/22 and continues to be monitored for changes in condition. Resident #54 no longer resides at the facility. Residents with changes in condition have the potential of being affected by the deficient practice. Education has been provided to Licensed staff on Change of Condition Assessment and documentation. Audits will be conducted on change of condition assessments Weekly X3 then Monthly X3 by the DON or designee. The results of the audits will be reported and reviewed at the QAPI Committee meeting with further evaluation if indicated Monthly X 4. Oversight will be provided by the DON or designee. F658 POC accepted 11/7/22 SFreeman RN/PMC	

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F 658	Continued From page 32 being notified by LNA and saw pt. laying on his right side next to his bed, small abrasion noted to top of head, neuro vital signs WNL (within normal limits), VSS [vital signs stable], no indication of fx [fracture] or other injury, floor mats in place, bed in lowest position, assisted back to bed with Hoyer lift and two assist". There is evidence of an initial "change in condition SBAR assessment" completed for this resident, however further documentation related to neurological checks/vital signs could not be found in the medical record as one would expect for a patient with a head injury (noted above-abrasion to top of head). The Neurological status of a resident can change abruptly and suddenly, so ensuring that "neuro checks" usually every hour for at least four hours, then every eight hours for the first 24 hours after a fall is an important nursing assessment. (Post-Fall Care Nursing Algorithm) https://rn-journal.com It was confirmed by the Regional Nurse Consultant on 10/12/22 at 01:30PM that there was no documentation of post fall neurological assessments in resident #54's medical record. 2. Upon record review for Resident #40 on 10/14/22, it was found that this resident had been transferred to the hospital on 10/03/22 due to hypoglycemia (low blood sugar level) with a resulting unresponsive episode per a scanned hospital discharge record from Southwestern Vermont Hospital. There is no evidence that an assessment had been done to reflect an acute change in this resident's condition. Upon the resident's return from the hospital on 10/03/22 there was no assessment to reflect the resident's health status at that time. There were no notes of any kind entered into the EMR progress notes	F 658		

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F 658	Continued From page 33 between the dates of 09/29/22 and 10/05/22. Resident #40 is very medically complex with a diagnosis list that includes: Bladder Cancer, End Stage Renal Disease requiring dialysis, Hypertension, History of MI (heart attack), Coronary Artery Disease, Diabetes, and multiple events in the past of unresponsive episodes and recurrent hypoglycemia. The Director of Nursing Services (DNS) from a sister facility confirmed on 10/14/22 at 2:45 PM that this resident's medical record revealed no medical assessment was entered into the EMR progress notes on 10/03/22 when the resident was transferred to the hospital for an acute change in condition, there was no follow up assessment after the resident returned from the emergency room, and no nursing note was entered into the EMR progress notes regarding this incident. (Refer to cross over tag F842) Reference: Lippincott Manual or Nursing Practice (9th ed). Wolters Kluwer Health/Lippincott Williams & Wilkins, pg. 17.	F 658		
F 686 SS=H	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	F 686	F 686 Resident #5 care plan has been updated to accurately reflect current skin conditions as well as risk factors identified with interventions updated. Dietician has seen the resident and completed a weight loss assessment and care plan has been updated.	

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F 686	Continued From page 34 demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to 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 ensure that 5 of 7 residents reviewed for pressure ulcers (Residents #5, 14, 45, 256, and 204) received necessary treatment and services consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. 1. Per record review of three Skin & Wound Evaluations completed on 10/6/2022 reflects that Resident #5 has three inhouse acquired stage 2 pressure ulcers that include a 0.5 cm2 area, 1.0 cm Length, 0.8cm width, 0.2cm depth stage 2 pressure ulcer on her/his coccyx, a 3.0 cm2 area, 3.3cm Length, 1.2 width stage 2 pressure ulcer on her/his right buttock, and a 0.4 cm [squared] area, 1.4cm length, 0.8cm width stage 2 pressure area on her/his left buttock. There is a care plan focus of "[Name omitted] is at risk for skin breakdown related to limited mobility, muscle weakness, and chronic pain. ***Has chronic recurrent MASD (moisture related skin damage inflammation or skin erosion caused by prolonged exposure to a source of moisture such as urine, stool, sweat, wound drainage) areas bilateral buttocks. 5/26/2022 chronic recurrent MASD buttocks wounds are re-open. 9/26/2022 Coccyx newly reopened and 10/6/2022 Coccyx resolved. A care plan goal states [Name	F 686	Resident #14 has a treatment order in place and an incident report has been completed. Resident #256 no longer resides in the facility. Resident #204's MDS has been modified to include stage 2 pressure injury and a care plan has been developed. Treatment is being completed as ordered. Resident #52 Midline IV catheter has been discontinued 10/29/22. Negative Pressure Wound treatment has been changed per physician order. Residents with skin breakdown or alterations have the potential to be affected by the deficient practice. Education will be provided to the Nursing staff regarding Pressure Ulcer prevention with a knowledge check. Education will be provided to Licensed Nursing staff on the Skin Integrity Management policy NSG236.	

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F 686	Continued From page 35 omitted] will not show signs of skin irritation or breakdown through next review period, and 9/12/2022 [Name omitted] continues to have chronic open wounds" revised on 10/10/2022. Interventions include "Daily dressing change to bilateral buttocks, cleanse wounds, place calcium alginate and sure view dressing." and "Treatments as ordered". A Physicians order for cleanse buttocks wounds (MASD) with Wound Cleanser apply calcium alginate to wounds, skin prep surrounding skin and cover with Derma view Transparent Dressing Daily and PRN (as needed) Apply Transparent Dressing so that there are no bridges, gaps, or air spaces. every day shift for MASD AND as needed for dressing soiled or comes off. During observation of incontinence care on 10/9/2022 at approximately 10:00PM Resident #5 was laying on their back in bed, the Licensed Nursing Assistant asked her/him to roll to the left and removed the resident's brief exposing her/his buttocks. There was an open redden wound on both right and left buttocks and a pink and red coccyx, there was no dressing in place. There was no evidence in the brief that there had been a dressing that had fallen off. Per interview with the Licensee Practical Nurse on 10/9/2022 at approximately 10:20 PM s/he was not aware of any wound or treatment ordered. S/he stated that the nurse that s/he relieved may have done a dressing, but s/he did not have it on her/his list. Resident #5 has also experienced a severe (greater than 10%) weight loss of 14.1% over a six-month period that was not identified and/or addressed.	F 686	Audits will be conducted on skin integrity management to include Skin condition identification, Careplan completion, Treatment ordered and completed as ordered, dietary notification, MDS assessment accuracy, Negative Pressure Therapy treatment completion and IV dressing treatment completed as ordered. Weekly X3 then Monthly X3. The results of the audits will be reported and reviewed at the QAPI Committee Meeting Monthly X4 further evaluation if indicated. Oversight will be provided by the DON or designee. F686 POC accepted 11/7/22 Sfreeman RN/PMC	

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F 686	Continued From page 36 On 10/14/22 at 09:27 AM the Registered Dietician (RD) was asked about concerns related to resident #5's weight loss as nutritional status effects the prevention and healing of pressure ulcers. S/he stated that s/he is aware of Resident #5's pressure ulcers and the resident "is on liquid proteins." 2. Per record review Resident #14 developed an in house acquired wound that was identified on 10/10/2022, and experienced a delay in treatment of the wound. A Nursing Evaluation completed on 7/27/2022 identified the resident as being very high risk for pressure ulcer development. On 9/10/2022 an assessment note was written that states "A skin check was performed. the following skin injury/wound(s) were previously identified and were evaluated as follows: MASD-Moisture Associated Skin Damage(s): Location(s): buttocks" A progress note written by a licensed Practical nurse (LPN) on 10/10/2022 at 11:33 PM states "Pt. [resident] coccyx is open and bleeding. There are 2 purple areas with redness all around. [Name omitted], RN (Registered Nurse) came and looked at [her/his] wound. No treatment order at this time. The area was kept clean and dry. Pt. was positioned off the area, from side to side." During observation of incontinence care on 10/12/2022 at 2:20 PM as the licensed nursing assistant (LNA) began to remove resident #14's brief the resident stated "oh, don't hurt my hiney!" as the LNA pulled the brief away from her skin the resident said "ouch, ouch, ouch that hurts!" There was a beefy red open wound noted on the right buttock with no dressing covering it and a patch of thick white paste covering an open area on the left buttock. Per LNA there should be a dressing	F 686		

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F 686	Continued From page 37 over it and the thick white paste was not what should be used on the wounds. When exiting the room, the LNA asked if I would ask the nurse to come to the room to see the wound. Per Licensed Practical Nurse (LPN) there was no treatment ordered but s/he would go and look at it. A progress note written on 10/12/2022 at 16:21 states "Pt [patient] remains alert [with] confusion. Pt noted [with] open areas to left and right buttocks. Area cleansed [with] saline and pat dried. pt. repositioned to l side. communication left [regarding] need for wound care consult/orders." On 10/12/2022 at 2:35 PM during an interview with the RN who was identified in the above note written on 10/10/2022, s/he stated "I think that I had heard something about [the Resident] having a pressure ulcer in morning meeting but I'm not sure." On 10/13/2022 during record review it was noted that there was no evidence of physician notification of the wound, any treatment, or other interventions in place after the identification of the wounds. There had also been no weekly skin checks documented since 9/10/2022. Per interview with the Unit 2 Nurse Manager (UM) on 10/13/2022 at approximately 10:15 AM confirmation was made that there was no treatment in place for the pressure ulcer that had been identified on 10/10/2022. At approximately 11:00 AM the UM informed this surveyor that a skin evaluation had been complete and a physician's order to cleanse the area to coccyx and apply Opti foam was obtained. 3. Per record review Resident # 256 was transferred to the facility from another Genesis facility 5/25/2022 with a discharge summary written on 5/25/2022 that states that her/his skin	F 686		

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F 686	Continued From page 38 was intact. During her/his stay at this facility s/he has refused getting out of bed and assistance with personal hygiene putting her/him at risk for developing pressure ulcers. A Nursing Evaluation completed on 5/25/2022 indicates that the resident is a high risk for pressure ulcers. On 8/21/2022 a Licensed Nursing Assistant informed the Licensed Practical Nurse that the resident was found to have an open area on her/his left calf. The progress notes states "Area red and draining yellow/ green drainage. Resident reports pain in the area 7/10. Scheduled Tylenol administered. Open area measured 4cm L by 1.5 cm W. Information given to {Name omitted} RN (Registered Nurse) supervisor to f/u [follow up] with PCP [Primary care Physician] for treatment..." A progress note written on 8/21/2022 at 23:16 reflects that an antibiotic was ordered to treat the "new open area to L (left) medial leg. No ill effects noted." The resident's care plan was reviewed and revealed that there is no care plan that addresses the high risk of pressure ulcer development and no interventions implemented to decrease or manage the risk or the actual pressure ulcer that developed on 8/21/2022. During an interview with the Executive Director on 10/10/2022 at 9:30 AM when asked if s/he recalled a resident named [name omitted] and s/he said yes s/he did. S/he was asked if there had been review of pressure ulcers or injuries to her/his left leg during morning meeting or any type of risk meeting. The ED stated "No, I don't remember anything with her/him like that." When asked if s/he did have any documentation related to the wound to provide it to this surveyor. The ED did no provide additional information to this surveyor throughout	F 686		

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F 686	Continued From page 39 the survey. 4. A Nurses Note, titled "Admission Note", dated 9/30/2022 at 15:50 revealed, "[proper name omitted] was admitted to 205-B. Arrived by ambulance stretcher information upon admission obtained Patient Chart Reason for admission is Special Treatment Program". An assessment note dated 9/30/2022 at 17:10 revealed, "A new pressure wound Stage 4 presented on admission Location: Left Thigh (Lateral) was assessed today." A Nurses Note dated 9/30/2022 at 17:52 revealed, "...[pronoun omitted] does have a pressure injury noted to left thigh. Resident has an above the knee amputation to right leg. Resident will require wound care to left thigh three days a week on M-W-F [Monday Wednesday Friday] using a wound vac at this time." A Nursing Assessment dated 09/30/2022 at 15:50, page 5 of 15 revealed the residents mental status was "alert", her/his memory was "unimpaired", her/his mood was "sadness/Depression", and her/his affect was "Appropriate". Page 14 of 15 revealed she/he had a skin impairment that was "present" and the site was documented as, "pressure injury noted to left thigh". A "Skin & Wound Evaluation" was noted in the resident medical record that revealed she/he had a pressure ulcer that was a Stage 4 (full thickness skin and tissue loss) and it was present on admission. Wound measures were listed as "Area 32.2 cm2, Length 10.0 cm, Width, 5.0 cm, and Depth was listed as "Not Applicable" and a dressing was noted to be "intact", the "Primary Dressing" was listed as "Negative Pressure Wound Therapy". A Nurses Note, titled "General" dated 10/1/2022 at 05:55, revealed ,"Alert/oriented/Pleasant/Wound VAC intact and running". A Nurses Note, titled, "General", dated 10/11/22 at 13:33 revealed, "...pt is receiving	F 686		

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F 686	Continued From page 40 skilled services for l thigh wound w/ wound vac, wound infx [infection]. .." and "Wound vac in place. [pronoun omitted] continues on iv [intravenous] abx [antibiotic] for wound infx w/ good results." A Nurses Note, titled, "notification note", on 10/12/22 at 5:51 PM, revealed "Primary Chief Complaint: Lines / Tubes / Pump Issues: Wound Vac Issue" and a summary, "Patient currently has a wound VAC and is receiving IV antibiotics. The wound VAC has failed and they are currently awaiting delivery of supplies however [pronoun omitted and incorrect] currently does not have any dressing. Staff is requesting an order for appropriate dressing to be applied." A Nurses Note, titled, "General" on 10/12/2022 at 07:53 revealed, "Slept in long naps\No c/o [complaint] pain during night/Dressing to left thigh intact (l)." A Nurses Note, titled, "General" dated 10/12/2022 at 20:22 revealed, "[physician's name from telehealth contractor services omitted] ordered a more appropriate dressing be applied until the wound vac supplies arrive. The dressing is Maxorb II in wound covered with Optifoam changes q3 [every 3] days and PRN [as needed]." Review of Resident #52's TAR (Treatment Administration Record) for the 10/1/2022 - 10/31/2022 period, revealed the following order: "Negative Pressure Wound Therapy to LLE SET Unit to 125 mmHg specify CONTINUOUSLY Cleanse with (NSS/Wound Cleanser/other) Place black foam into wound. Apply skin prep to intact skin around the wound Cover with occlusive dsg and secure tubing per manufacturer guide every day shift every Mon, Wed, Fri for Debrided Stage IV [4] PU [pressure ulcer] surgically Debrided prior to admission -Start Date- 10/3/2022 0700". Entries for the NPWT dressing change should have been documented on Friday 10/7/22,	F 686		

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F 686	Continued From page 41 Monday 10/10/22, Wednesday 10/12/22, and Friday 10/14/22. The only documentation for the NPWT dressing change was dated on Monday 10/3/22 and Wednesday 10/5/22. The following new order revealed: "apply temporary dressing until wound vac supplies arrive: pack wound with Maxorb II Ag and cover with Optifoam change q3days [every 3 days] and PRN [as needed] every day shift every 3 day(s) for Wound care Discontinue when wound vac supplies arrive. -Start Date- 10/15/2022 0700". Interview on 10/12/22 at approximately 11:30 AM, with RN/NPE, who was working as a floor nurse on this date revealed that the residents dressing failed "last Friday", which would have been 10/7/22. She/he stated that she/he had already called and notified the doctor that the dressing had failed and requested a temporary order for a dressing until the supplies for the residents wound vac were received. Review of the resident MAR (Medication Administration Record) revealed the following order: "Biopatch on Midline, change with weekly and prn dressing changes one time a day every 7 day(s) for IV Care - Start Date- 10/1/2022 0900" This order was noted to be signed off as having been completed on 10/8/22, however, the Biopatch is applied around the Midline IV at the entrance site of the body and was covered by a dressing - the dressing was dated 9/29/22. The following order was also noted on the same MAR: "IV: Change Catheter Site Transparent Dressing. Indicate external catheter length and upper arm circumference (10 cm above antecubital space), Notify practitioner if the external length has changed since last measurement as needed for IV Care -Start Date- 09/30/2022 1706".	F 686		

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F 686	Continued From page 42 Interview on 10/14/22 at approximately 2:30 PM, with Resident #52, who was alert and oriented to person, place, time, and situation. She/he confirmed that her/his wound vac dressing was last changed on "last Friday", 10/7/22. The resident did have a dressing in place to her/his left posterior thigh that was quite saturated and had been leaking onto her/his bed linens. This was confirmed by the travel nurse that accompanied this writer to Resident #52. The resident was also noted to have a midline IV in her/his left upper arm, that was covered by dressing that appeared soiled and was grayish in color and was dated 9/29/22 - Resident #52 confirmed that her/his midline IV dressing was last changed at the hospital, prior to coming to this facility. The travel nurse confirmed that the Midline dressing was dated 9/29/22 and "did not look very clean". The travel nurse stated that for the Biopatch to have been changed, the outer dressing would had to have been removed to access the Biopatch since the Biopatch is placed around the Midline IV, at the entrance where the Midline IV enters the upper arm and the outer dressing is the one that was dated 9/29/22. Therefore, the Biopatch had not been changed since admission to this facility and the outer dressing had not been changed since admission to this facility. 5. Per record review Resident # 204 was admitted to the facility on 9/29/22 with medical diagnoses of Non-ST Elevation (NSTEMI) Myocardial Infarction, Type 2 Diabetes Mellitus Without Complications, Acute Pulmonary Edema, Frontal Lobe and Executive Function Deficit Following Cerebral Infarction, Other Reduced Mobility, Pressure Ulcer of Sacral Region, Stage	F 686		

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F 686	Continued From page 43 2, Dysphasia Oropharyngeal Phase. Muscle Weakness (Generalized) Unspecified Convulsions (Not all inclusive). Record review on 10/12/22 reveals a Physician diagnosis of Pressure Ulcer of Sacral Region, stage 2. Physician orders reflect order for Santyl External Ointment 250 UNIT/GM (Collagenase) Apply to Right Groin and coccyx topically every day shift for wound care cleanse with NS and pat dry, cover with dry protective dressing AND apply to right groin topically as needed for wound care. Unable to find measurements/description of the coccyx wound in the medical record. Review of medication administration record (MAR) reveals Santyl External Ointment 250 UNIT/GM (Collagenase) Apply to Right Groin and coccyx topically everyday shift for wound care cleanse with NS and pat dry, cover with Dry protective dressing and Santyl External Ointment 250 UNIT/GM (Collagenase) Apply to right groin topically as needed for wound care. The above treatment for the month of Oct 2022 There were no nurse initials for the dates of 10/6/22 and 10/7/22, 10/10/22, 10/11/22. Which indicates the treatment was not done on those dates. 10/1/22 was initialed but coded as unknown 10/12/22 was coded see nurse note. Progress notes of 10/12/22 at 1940 (7:40 PM) reflects that the resident refused a number of time and treatment was not administered. The Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 10/5/22 Section M- A skin conditions is coded as follows; Resident has a pressure ulcer/ injury a scar over boney prominence or a non-removable dressing/ device,	F 686		

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F 686	Continued From page 44 this was coded" NO". However there was a pressure ulcer presant at the time of the MDS completetion. Section M 0210 Unhealed pressure ulcers. Does this resident have one or more unhealed pressure ulcers/injuries coded "Yes". Care plan has no problem for a stage 2 pressure ulcer to provide goals, and interventions to encourage heeling or to prevent pressure ulcer from becoming worse. On 10/13/22 at 12:58 PM, interview with Licensed Practical Nurse (LPN) MDS Coordinator confirms that the MDS section M0100 A is coded incorrectly the Nurse confirms that the resident does have a state 2 pressure ulcer on her coccyx and the care plan does not reflect that there is a stage 2 pressure ulcer.	F 686		
F 689 SS=D	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 observation, interview, and record review the facility failed to ensure 1 out of 35 residents sampled were safe from accident hazards (Resident #49). Findings include: Per observation on 10/10/22 at 11:00 AM of resident #49's environment, on the resident's over the bed table there was a container labeled	F 689	F689 Resident #49 Afrin Nasal spray order has been discontinued. Nystatin order in place to apply as needed twice daily. Medications have been removed from the bedside. All Residents have the potential to be affected by this deficient practice. House audit conducted to ensure medications are not left at the bedside for patients who are no assessed to be self-medicating. Education provided to the Licensed staff on not leaving medications at the bedside and delegation of medication	

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F 689	Continued From page 45 Nystatin powder and a container labeled Afrin Nasal spray. Interview on 10/10/22 at 11:10 AM resident #49 confirmed that s/he is unable to take these medications independently, s/he stated the Afrin Spray is for nose bleeds s/he has been experiencing. S/he stated that s/he is still using the nasal spray and that the staff apply the powder to his/her skin. Record review revealed the following order: "Dose check cannot be performed. The unit of measure selected does not match the medispan recommended unit of measure for this medication. Nystatin External Powder 100000 UNIT/GM (Nystatin (Topical)Apply to Skin folds topically as needed for Apply twice daily as needed to skin folds with fungal rash". No order for Afrin spray was found on current physician orders. Review of the October 2022 Medication Administration Record (MAR) revealed the following order: "Afrin Sinus nasal solution 1 unit in both nostrils three times a day for epistasis x 3 days." The start date of this order was 10/6/22 there were 9 administrations of this medication. The stop date of this order was10/9/22, and there is no order in place to have medications at bed side. Interview and MAR review on 10/12/22 1510 with Registered Nurse (RN) specific to leaving Nystatin at the bed side, s/he stated that s/he has the LNA apply when they are doing care. The RN confirmed that Nystatin powder requires an MD order, and LNA's should not be directed to apply this medication. The MAR and Physician orders were reviewed with this RN who confirmed the	F 689	application or administration. Audits will be conducted to ensure medications are not left at the bed side and medication administration or application is not delegated inappropriately Weekly X3 then Monthly X3. The results of the audits will be reported and reviewed at the QAPI Committee Meeting with further evaluation as indicated Monthly X 4. Oversight will be provided by DON or designee. F689 POC accepted 11/7/22 SFreeman RN/PMC	

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F 689	Continued From page 46 Afrin spray was discontinued on 10/9/22. The RN also confirmed that the Afrin nasal spray should not be left at bed side as there is no Physician order to do so.	F 689		
F 692 SS=H	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that 4 of 7 residents in the sample (Resident #9, #5, #18, & #37) recieved adequate assistance, assessment, and monitoring of nutritional status to meet prevent significant weight loss and maintain acceptable parameters of nutritional status.	F 692	F 692 Resident #9 no longer resides in the facility. Resident #5 Order for weights being followed. Feeding assistance addresse in care plan and Kardex Intake documentation is completed. Resident #18 Order for weights is being followed as permitted by Resident. Feeding assistance is addressed on care plan and Kardex. Intake documentation is being completed. Resident #37 Diet order is in place. Intake has been documented and Residents feeding assistance need has been care planned and added to the Kardex. All Residents have the potential to be affected by this deficient practice. House audit conducted of weight orders and completion of obtaining weights as ordered. Intake documentation Nutrition care plans and Kardex eating assistance.	

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F 692	Continued From page 47 1. Per record review Resident #9 was admitted on 3/17/2022 with diagnoses that include adult failure to thrive and cerebral palsy. An admission weight of 94.5lbs was documented on 3/18/2022. Review of weekly weights documented between 3/18/2022 and the last documented weight on 7/11/2022 the resident had experienced a severe weight loss of 18.1%. There is no evidence of weights being obtained after 7/11/2022. A care plan focus reflects that "[name omitted] may be nutritionally at risk related to severe protein-calorie malnutrition, dysphasia, and adult failure to thrive, low body weight/BMI, use of mechanically altered diet, total dependence for food/fluid intake." Care plan goals include "[name omitted] will consume [greater than]50% at all meals through the next review period." and "Maintain weight of 82.4# with no significant wt [weight] loss thru next review" and "Weight gain would be beneficial for resident, and [name omitted] will consume [greater than] 75% of nutritional supplements daily through next review." A Dietary note written by the previous Registered Dietician on 5/27/2022 at 2:07 PM states "Weight monitoring: reweight obtained and resident current wt 77.9#. This represents a 2.1#/2.6% wt decrease x 30 days and an overall decrease of 6.6#/7.8% since admission in March. [S/He] has nutrition interventions in place currently to promote kcal/protein intake. [Her/His] intakes while variable appear to be at his baseline. Reviewed available advanced directives which indicate an interest in short-term feeding tube. Attempted to have discussion with [Resident] to review that desire however [s/he] is asleep at this	F 692	Education has been provided to nursing staff regarding obtaining and documenting weight process and procedure along with significant weight change management. Education has been conducted with the LNA staff regarding documentation of Intake with all meals consumed. Education has been conducted with the Licensed Staff and Dietician regarding care planning of Nutritional needs and eating support. Audits of resident weights, intake documentation, nutritional care plans and eating support will be conducted Weekly X3 then Monthly X3. The results of the audits will be reported and reviewed at the QAPI Committee Meeting Monthly X 4furtherevaluation as indicated. Oversight will be provided by the DON or designee. F692 POC accepted 11/7/22 SFreeman RN/PM	

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F 692	Continued From page 48 time after eating lunch. Discussed with floor nurse. Left message for social services. Will reattempt to determine if this is still [her/his] desire." There are no further documented dietary notes to indicate follow up on the resident's nutritional status. On 5/27/2022 the Social Service (SS) Director wrote a note stating "Spoke with Dietitian about [resident's] health care wishes for wanting a feeding tube for short time due to weight loss. SS reviewed Advanced Directivities. SS went to speak to resident however resident was fast asleep. SS and Nurse Manager will talk to [her/him] about [her/his] wishes/wants. After that conversation with resident occurs with resident, SS will reach out to [her/his] Health Care proxy and soon to be POA to update. Resident at this time is able to make [her/his] own health care needs, unless [s/he] states [s/he] wants [her/his] Health Care proxy to make the decision for [her/him]." Review of Resident #9's weekly weights documented between 3/18/2022 and 5/27/22 the resident had been experiencing a severe weight loss of 17.57%, not the 7.8% that the dietician had documented. The last documented weight on 7/11/2022 revealed that the resident had been experiencing a severe weight loss of 18.1% over the 4 months residing in the facility. There have been no weights obtained since, and there have been no Dietary notes addressing this severe weight loss or follow up related to the use of a feeding tube documented since 5/27/2022. Per phone interview with the RD on 10/14/22 at 09:27 AM s/he is new to this position since September. S/he stated that if there is an issue	F 692		

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F 692	Continued From page 49 identified related to resident's weights the Unit Managers would reach out to her/him for a consult. reviews weights monthly and if the resident is at risk s/he would review weekly. Confirmed that based on her/his BMI he would be considered at nutritional risk and that there was no documented weight since July 11, 2022. 2. Per record review Resident #5 experienced a severe (greater than 10%) weight loss of 11.7% over a six-month period. Review of the resident's weight record revealed the recorded weight on 4/1/2022 was 248.5 lbs. and on 10/3/2022 the recorded weight was 221lbs, a 27.5 lb. weight loss over 6 months. A care plan focus of "[Name omitted] requires assistance for ADL [activities of daily living] care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfers, locomotion, and toileting related to dx [diagnosis] of CHF [congestive heart failure] and COPD [chronic obstructive pulmonary disease]." However, the only ADL addressed under the care plan interventions is ambulation. The care plan does not identify the level of staff assistance needed for eating. A care plan focus initiated on 1/6/2022 and revised on 4/20/2022 states that "Resident may be nutritionally at risk related to [prior] covid recovered, hx [history] of pressure areas, use of mechanically altered diet, use of diuretic therapy, obesity status, diabetes, CHF, recent hospitalization with sig wt [significant weight] change r/t [related to] diuresis' An intervention initiated on 1/6/2022 directs staff to "Record and monitor intakes" and "Record and monitor weights" Resident #5 also has a care plan focus	F 692		

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F 692	Continued From page 50 initiated on 1/5/2021 of [Name omitted} has a diagnosis of diabetes: non-insulin dependent with an intervention initiated on 1/5/2021 of monitor meal consumption each meal. Per phone interview with the consulting Registered Dietician (RD) on 10/14/22 at 9:35 AM s/he started consulting in September of 2022. When asked if s/he was aware that the resident has had a 11.7% weight loss in six months s/he stated "yes, I was going to do [her/his] quarterly review today." When asked how staff communicated high risk residents or weight concerns to her/him, s/he stated "I gave them a list of weights that I was missing and asked if there were any nutritional risks. There was nothing that they noted as a concern when I sent the email." The RD confirmed that she had not been notified of any concerns related to Resident #5's weight loss or nutritional status. The RD was asked about concerns related to resident #5's pressure ulcers and s/he stated that s/he is aware of pressure ulcer concerns and the resident "is on liquid proteins." Per review of the licensed nursing assistant documentation for 10/1 - 10/14/22 there were 42 opportunities to document the assistance provided and the percentage of the meal consumed. Of the 42 opportunities, 36 were left blank, not completed. Per interview with the MDS (Minimum Data Set) Nurse on 10/14/22 at 2:14 PM the Rehab Director had not been notified of the resident's weight loss and the resident will now be screened by Occupational Therapy. Per interview with a Registered Nurse (RN) on	F 692		

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F 692	Continued From page 51 10/14/2022 at approximately 2:45 PM regarding the above concerns s/he stated that the licensed nursing assistants (LNAs) would find the ADL interventions to include assistance needed for eating on the resident care Kardex. However, while viewing the Kardex the RN confirmed that the care plan and Kardex were not complete, and the care needs were not identified on the resident Kardex or care plan. S/he also confirmed that the LNA documentation was not complete. 3. Per record review Resident #18 was admitted on 4/28/2022. An admission weight on 4/28/2022 was documented as 153.5 Lbs. A physician order states, "Weigh every bath day/shower day every day shift every Thursday (every Thursday) for Health Monitoring AND everyday shift for weight monitoring daily X 3 days until 5/2/2022 23:59." The last weight documented was 150.5Lbs. on 7/26/2022. The resident had experienced a three Lb. weight loss since admission and had not been monitored for additional weight loss or basic nutritional health status since the 7/26/2022 weight. A care plan focus of "Resident may be nutritionally at risk related to recent history of aspiration pneumonia, dementia, bipolar disorder, and hypothyroidism." Care plan goals include "resident will consume >50% of all meals through next review and maintain weight of 154lbs +/- 5 lbs. thru next review." In addition to the nutrition care plan Resident #18 also has a care plan focus of "[name omitted] requires assistance with dressing, personal hygiene, walking, transferring, toileting, changing position in bed, and eating related to: Anxiety, Behavioral symptoms, Change in Cognitive Status, [Pneumonia [spelling	F 692		

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F 692	Continued From page 52 corrected], Recent hospitalization." The documented interventions list eating but do not specify the amount of assistance from staff that the resident needs. Review of LNA documentation for the month of September 2022, revealed that out of 90 meals assistance and percentage of meal consumed were only documented on 24 occasions, and 6 of the 24 documented meals were refused. Review of the October 1-11th 2022 LNA documentation revealed that out of 33 meals assistance and consumption was only documented 4 times. Per interview with the RD on 10/14/2022 at 9:31 AM s/he confirmed that there had been no recent weights documented as ordered for Resident #18. S/he stated that s/he had learned from staff that the resident often refuses to allow weights but did not know if this was the issue and why it is not documented. Also, staff had not made her/him aware that the resident was at nutritionally at risk, or that there were concerns related to meal intake. During interview on 10/14/2022 at 3:30 PM a RN confirmed that the care plan did not identify the residents need for assistance for meals. S/He also confirmed that it was not reflected on the Kardex. 4. Per record review Resident #37 was readmitted to the facility on 8/25/22 after a hospital admission with the following diagnoses: Hemiplegia and Hemiparesis following cerebral infarction affecting left non dominant side , calculus of Gallbladder and Bile Duct without Cholecystitis without obstruction, Paroxysmal Atrial Fibrillation, Cerebral infarction unspecified, Major Depressive Disorder, Recurrent Moderate,	F 692		

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F 692	Continued From page 53 Shortness of Breath, abnormal weight loss. Observation on 10/11/22 at 9:15 AM revealed Resident #37 sitting up on the edge of her/his bed with a breakfast tray in front of her/him unsupervised. Resident declined interview at this time. Record review revealed that resident #37 did not have a physician order for her/his diet. Review of Minimum Data Set (MDS) with an assessment reference date (ADR) of 8/17/22, Section G revealed Supervision set up only. On the Care Area Assessment (CAA), the facility documented that they would proceed with a nutrition care plan. Review of Resident #37's care plans revealed the resident does not have a dietary care plan in place. Interview on 10/14/22 at 11:54 AM with Licensed Practical Nurse (LPN) MDS coordinator who confirmed the MDS CAAs revealed the facility documented they would proceed with developing a dietary care plan. The LPN/MDS Coordinator confirmed that there was no current dietary order in place and there was no dietary care plan in place for resident #37.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences,	F 695	F 695 Resident #23 oxygen concentrator has been cleaned. Oxygen tubing and humidification has been changed, dated and labeled. Resident #27 Floor under bed has been cleaned. Oxygen tubing has been changed, labeled and dated	

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F 695	Continued From page 54 and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to provide oxygen services including the safe handling, humidification, cleaning, storage, and dispensing of oxygen for 2 residents (Resident #23 & Resident #27) of a sample of 4. Observations include: 1. Per record review and obsevation on 10/9/22 Resident #27 was positive for Covid-19 and actively receiving supplemental oxygen through an oxygen concentrator. The oxygen tubing on the concentrator did not have a label to indicate the last time it was changed. The humidifier bottle on the oxygen concentrator was also not labeled as to when it was last changed. Per inspection of the concentrator, it was noted to be sticky on the top with a layer of dust on the flat surfaces. Per interview on 10/9/22 at 10 AM the unit LPN (Licensed Practical Nurse) observed the concentrator and tubing and confirmed the concentrator needed to be cleaned and the tubing should be labeled. 2. Per record review and observation on 10/10/22 Resident #23 was positive for Covid-19 and actively receiving supplemental oxygen through an oxygen concentrator. The oxygen tubing was very long and coiled on the floor under the resident's bed, the floor in the resident room was sticky and there was an accumulation of dust under the bed. The oxygen tubing did not have a label to indicate the last time it was changed. Per interview on 10/10/22 at 1PM the unit LPN confirmed the floor was dirty and the tubing should be labeled.	F 695	Residents using oxygen have the potential to be affected by the deficient practice. Education will be provided to the central supply clerk on replacing oxygen tubing and humidification weekly and labeling/dating items when replaced. Education will be provided to the Maintenance staff regarding cleaning/preventative maintenance of oxygen concentrators. Audits will be conducted to ensure oxygen tubing and humidification has been changed per policy and oxygen concentrators are clean and in good condition Weekly X3 then Monthly X3. The results of the audits will be reported and reviewed at the QAPI Committee Meeting Monthly X4 further evaluation if indicated. Oversight will be provided by the Administrator or designee. F695 POC accepted 11/7/22 SFreeman RN/PM	

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F 725 SS=F	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 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 interviews and record review the facility failed to designate a licensed nurse to serve as a charge nurse on each tour of duty. Findings include: Per interview with the Unit 3 South Licensed Practical Nurse (LPN) on 10/9/2022 at approximately 8:45 PM this was her/his second	F 725	F 725 The Center will provide qualified and appropriate staff supervisor or designated charge nurse to be responsible for supervising Resident related activities. Education has been provided to Nursing staff on the Center staffing plan. Audits will be conducted on sufficient nursing staff to ensure a designated charge nurse is in place. Weekly X3 then Monthly X3. The results of the audits will be reported and reviewed at the QAPI Committee Meeting Monthly X4 with further evaluation as indicated. Oversight provided by the DON or designee. F725 POC accepted 11/7/22 SFreemanRN/pmc	

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F 725	Continued From page 56 day assigned to the facility, and s/he was emergency agency staff. When asked if there was a nursing supervisor or someone in charge in the building s/he stated that s/he did not know. Per interview with the Unit 3 North LPN on 10/9/2022 at approximately 8:50 PM s/he was an agency nurse that has been assigned to the facility and not emergency staff. S/he was informed that the survey team was in the building and asked if we could speak to who was in charge. S/he stated that there was an RN on call and that s/he would text her/him and the Director of Nursing Services to inform them that the survey team was in the building. The LPN confirmed that there was no-one designated as being in charge during the evening shift. During interview with the Unit 2 LPN on 10/9/2022 at 8:45 PM s/he stated that s/he was an emergency response nurse. When informed that the survey team was in the building and asked if there was a nursing supervisor in the building s/he responded "I don't know. I don't think so." Per review of the actual worked schedule for 10/9/22 it was noted that all assigned nurses, with the exception of one Licensed Practical Nurse (LPN) on one unit for one 8-hour shift, were all contract/agency nurses. There was no designation to indicate anyone having been assigned the responsibility of charge nurse. During an interview on 10/11/22 at 11:00 AM with the facility scheduler it was confirmed that no one had been in charge on 10/9/2022.	F 725		
F 726 SS=L	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c)	F 726		

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F 726	Continued From page 57 §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 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 observations, record review and interviews the facility failed to ensure that all nursing staff possess the competencies and skills necessary to protect residents from exposure to COVID-19 during an outbreak by maintaining proper infection control practices, and to provide	F 726	F 726 The covid outbreak has been resolved Resident #52 Midline was discontinued on 10/29/22 without complication. Negative Pressure Wound Therapy continues as ordered All Residents have the potential to be affected by this deficient practice. Education will be provided to staff, including contracted staff, on the implementation of TBP, hand hygiene and proper use of personal protective equipment. Education will be provided to Licensed staff regarding Negative Pressure Wound Therapy and IV Therapy. Contracted staff training and competencies for Negative Pressure Wound Therapy and IV therapy will be provided before taking assignment Audits will be conducted on training and competency completion Weekly X3 then Monthly X3.	

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F 726	Continued From page 58 care to residents based on their individual medical care needs. The lack of staff training and competency in infection prevention and control placed the residents in immediate jeopardy of harm and/or death related to exposure to COVID-19. Findings include: 1. During observation on 10/9/2022 at approximately 9:15 PM a Licensed Nursing Assistant (LNA) assigned to 3 South was observed entering the room of a COVID-19 positive resident (room #316) without applying a gown or gloves. A sign on the door indicated that Transmission Based Precautions should be followed when entering the room to include the donning of a gown and gloves. When asked if the residents in room #316 were Covid positive the LNA stated "I don't know." When directed to the sign on the door that indicated the use of Personal Protective Equipment (PPE), the LNA confirmed that s/he should have used PPE when entering the room. The LNA was asked if anyone from the facility had shown her/him how and when to don PPE s/he stated "No." 2. Per interview with 3 agency LNAs on 10/11/2022 at approximately 9:30 AM they had been assigned to the facility due to the Covid 19 outbreak. They all confirmed that they had not received any training prior to beginning their assignment nor had the facility assessed them for competency in proper use of PPE and hand hygiene. During interview on 10/13/2022 at 10:46 AM the staff educator confirmed that the facility had not provided the emergency staff with training related	F 726	The results of the audits will be reported and reviewed at the QAPI Committee Meeting Monthly X4 with further evaluation if indicated. Oversight will be provided by the DON or Designee. F726 POC accepted 11/7/22 SFreeman RN/PMW	

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F 726	Continued From page 59 to infection control such as proper use of PPE nor were they assessed by the facility for the skills necessary to prevent the spread of COVID-19 prior to their assignment. Review of a list provided by the facility of emergency response staff, there were 15 emergency response staff which included 7 nurses and 8 LNAs scheduled during the current Covid outbreak. Of the 15 emergency responders the there was no evidence that they received training or were assessed for competency related to proper use of PPE and other infection control practices prior to assuming a resident assignment. 3. On 10/12/2022 at 12:00 PM a LNA who was observed entering and exiting a room while wearing the following PPE: a plastic uniform covering gown, gloves, N95 mask and eye protection. They identified themself as agency staff and admitted to not knowing when to wear PPE or how to dispose of it. Per interview with the RN (registered nurse) Staff Educator and the RN Infection Control Preventionist on 10/11/22 at 10:30 AM agency/contract staff were not evaluated or trained prior to assuming an assignment to ensure their competencies and skills to care for the facility's resident population during the current Covid-19 outbreak. Per the Infection Preventionist "aside from getting them computer access we don't even know who they are". Per the Staff Educator who had been working on the unit and was relieved by one agency staff nurse, "I reviewed the medication room location, door codes, personal protection equipment location, I did not review any competencies".	F 726		

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F 726	Continued From page 60 On 10/13/2022 at 10:46 AM during a subsequent interview with the Staff Educator it was further clarified that when nursing staff are obtained through a staffing agency it is the expectation of the facility that all competencies are completed by the staffing agency. When asked to provide facility documentation to review required competencies for agency/contract staff, the facility contacted the staffing agency and obtained evidence of staff self-evaluations and check lists indicating training provided by the staffing agency. 4. Review of the Resident Roster Matrix and the nursing assignment sheet for the second floor, revealed that Resident #52 had a midline IV (Intravenous) for antibiotic administration related to a diagnosis of an infected wound. Review of the residents TAR (Treatment Administration Record) revealed that the resident had an order for a wound vac (a treatment that promotes vacuum-assisted closure of a wound) to her/his left thigh related to a community acquired stage 4 pressure ulcer that was surgically debrided. Interview on 10/10/22 at 10:05 AM with the LPN Rapid Response nurse who stated she had not received any training or competencies specific to the care and medication administration of the Midline IV or the wound vac. Review of Resident #52's 10/1/2022 - 10/31/22 MAR (Medication Administration Record) revealed the following orders: "Biopatch on Midline, change with weekly and prn [as needed] dressing changes one time a day every 7 day(s) for IV Care" with a start date of 10/01/2022 - this	F 726		

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F 726	Continued From page 61 order was signed off as being done on 10/8/22; "Ertapenem Sodium Solution Reconstituted 1 GM [gram] Use 1 gram intravenously one time a day for Infected Wound for 28 Days SASH [saline antibiotic saline heparin] FLUSH via MIDLINE" with a start date of 10/01/2022 - this order was signed off as being done every day from 10/1/22 - 10/13/22; "Heparin Lock Flush Solution 10 UNIT/ML [milliliter] (Heparin Lock Flush) Use 3 ml [milliliter] intravenously two times a day for SASH technique for 28 Days after administration of saline" with a start date of 10/01/2022 - this order was signed off every day from 10/1/22 - 10/13/22 at 1000 hours and every evening from 10/1/22 - 10/5/22 and 10/7/22 - 10/8/22, and 10/10/22 - 10/12/22 at 2100 hours; "IV: Change Midline Needless Connector one time a day every 7 day(s) for IV Care weekly" with a start date of 10/1/2022 at 0900 hour - this order was signed off on 10/8/22 (Monday, 10/1/22 was not signed as being completed); "Normal Saline Flush Solution Use 10 ml Intravenously one time a day for SASH/SAS [saline antibiotic saline] technique after med administration" with a start date of 10/01/2022 at 1000 hour - this order was signed off every day from 10/1/22 - 10/13/22; "Normal Saline Flush Solution Use 10 ml Intravenously one time a day for SASH/SAS technique prior to med administration" with a start date of 10/01/2022 - this order was signed off every day at 0900 hours from 10/1/22 - 10/13/22. Review of Resident #52's 10/1/2022 - 10/31/2022 TAR revealed the following orders: "Negative Pressure Wound Therapy To LLE SET Unit to 125 mmhg [millimeter of mercury] specify CONTINUOUSLY Cleanse with (NSS[Normal Sterile Saline]/Wound Cleanser/other) Place black foam into wound. Apply skin prep to intact	F 726		

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F 726	Continued From page 62 skin around the wound Cover with occlusive dsg [dressing] and secure tubing per manufacturer guide as needed for Surgically Debrided Stage IV [4] PU [pressure ulcer] if NWPT [Negative Wound Pressure Therapy] needs to be turned off for any care, tests/procedures (Bathing, MRI, etc), or for transport; remove dsg entirely, cleanse wound (NSS/Skinintegrity [sic]) and apply hydrogel gauze and secure with ABD [abdominal pad]" with a start date of 09/30/2022 at 1711 hours - this order was indicated as completed on 10/11/22. "Negative Pressure Wound Therapy To LLE SET Unit to 125 mmhg [millimeter of mercury] specify CONTINUOUSLY Cleanse with (NSS[Normal Sterile Saline]/Wound Cleanser/other) Place black foam into wound. Apply skin prep to intact skin around the wound Cover with occlusive dsg and secure tubing per manufacturer guide every day shift every Mon, Wed, Fri for Debrided Stage IV PU prior to admission" - with a start date of 10/03/2022 at 0700 - this order was indicated as completed on Monday 10/3/22 and Wednesday 10/5/22. There was no documentation to represent the the order was implemented/completed on 10/7/22, 10/10/22 or 10/12/22. Interview on 10/14/22 at 10:30 AM with the Infection Control Preventionist (ICP) regarding when and how nurses receive training and competencies to ensure residents are receiving the correct care and treatment of midline IV's and wound vacs. The ICP stated she/he could not find any competencies or policy and procedures regarding trainings for nurses specific to these specialty services. The ICP agreed that nurses are not typically trained to provide care of these specialties unless there was a need in the	F 726		

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F 726	Continued From page 63 building. Since there is a wound vac and a midline in the building, he confirmed that "training should have been provided as well as competencies on those who are providing care to the midline and the wound vac". There has been no training provided to any of the nurses, per the ICP. Interview on 10/14/22 at 1:05 PM with the Market President for Genesis, which is the owner/licensee of the facility, confirmed that there were no trainings or competencies provided to the facility staff or the emergency response staff for midline IV's or wound vacs. A Google search at www.cdc.gov under Infection Control, subtitled: "Guidelines for the prevention of Intravascular Catheter-Related Infections", (2011) under section 1, titled, "Education, training and staffing" revealed the following guidance: '1. Education, Training and Staffing Educate healthcare personnel regarding the indications for intravascular catheter use, proper procedures for the insertion and maintenance of intravascular catheters, and appropriate infection control measures to prevent intravascular catheter-related infections. Periodically assess knowledge of and adherence to guidelines for all personnel involved in the insertion and maintenance of intravascular catheters. Designate only trained personnel who demonstrate competence for the insertion and maintenance of peripheral and central intravascular catheters." F 727 RN 8 Hrs/7 days/Wk, Full Time DON SS=F CFR(s): 483.35(b)(1)-(3)	F 726 F 727	F 727	

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F 727	Continued From page 64 §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Findings include: During a review of the schedule provided by the facility for actual hours worked on 10/9/22 it was noted that all the nurses who worked during the 24 hours were Licensed Practical Nurses (LPN's), there were no Registered Nurses (RN's) working during the timeframe reviewed. In addition to no one having been designated to function as a charge nurse there were no nurses who by licensure (RN's) were able to perform an assessment of residents during the active Covid 19 outbreak being experienced by the facility. Nursing assessment is the gathering of information about a resident's physiological, psychological, sociological, and spiritual status by a licensed Registered Nurse. Accurate assessments are crucial to recognizing critical changes in a resident's status to report to the	F 727	The RN staffing coverage was reviewed with the staffing scheduler to ensure there is at least 8 consecutive hours a day for 7 days a week. Education will be provided to the RN's and scheduler regarding the 8 hours of consecutive RN coverage 7 days a week. Audits will be conducted of the daily schedule to ensure the requirement is met. Weekly X3 then Monthly X3. The results of the audits will be reported and reviewed at the QAPI Committee Meeting Monthly X4 with further evaluation if needed. Oversight will be provided by the DON or designee. F727 POC accepted 11/7/22 SFreemanRN/PMA	

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F 727	Continued From page 65 provider to ensure resident's care needs are met in a timely fashion. The facility staffing coordinator confirmed the accuracy of the schedule and that there were no RN's working during the 24 hours of 10/9/22.	F 727		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756	F 756 Resident #27 Lipid Profile ordered 11/3/22. Oxycodone PRN order reviewed with physician 11/3/22. Pharmacy consultant re-commendations were reviewed to ensure physicians have addressed recommendations. Education will be provided to Licensed Nurses on Pharmacy recommendations, Medication Regimen Review Policy 9.1. Audits will be conducted of Pharmacy Recommendations to ensure completion, Weekly X3 then Monthly X3. The results of the audits will be re-ported and reviewed at the QAPI Committee Meeting Monthly X4 with further evaluation as indicated. Oversight will be provided by the DON or designee. F756 POC accepted 11/7/22 sFreeman RN/mc	

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F 756	Continued From page 66 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to ensure the pharmacist performs a Medication Regimen Review (MRR) reporting any irregularities to the attending physician and the facility's medical director and director of nursing, and that these reports are acted upon. Findings include: Per record review on 9/1/22 following the monthly MRR (a thorough evaluation of the medication regimen of a resident with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) of Resident #27's medication regimen the pharmacist made the following recommendations: 1. Currently receiving Atorvastatin for dyslipidemia (a cholesterol lowering medication for elevated cholesterol levels). Unable to locate recent serum lipid profile in chart recommended 3 months after start then annually thereafter. Please consider ordering. 2. Currently receiving Oxycodone PRN (a narcotic pain reliever taken as needed) without a stop date. Please evaluate duration of therapy. Consider add a stop date of 14 days, if appropriate.	F 756		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 10/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNINGTON HEALTH & REHAB	2 BLACKBERRY LANE BENNINGTON, VT 05201

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F 756	Continued From page 67 During subsequent record review a response from the physician was not located, there was no evidence of the suggested laboratory test or of a stop date being applied to the Oxycodone. Per interview with the Director of Nursing from a sister facility who was providing clinical responses during the survey, the documentation could not be located, and he/she confirmed there was no action taken on these recommendations.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the	F 757	F 757 Resident #40 Order Lispro sliding scale has been reviewed by the attending physician and facility incident report completed for the Administration errors noted. Residents receiving sliding scale insulin have the potential to be affected by this deficient practice. Audit will be conducted on those residents who currently receive sliding scale insulin. Education will be provided to Licensed staff on Insulin Administration to include wrong dose Audits will be conducted on sliding scale insulin orders and Administration Weekly X3 then Monthly X3.	

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F 757	Continued From page 68 facility failed to ensure one applicable resident (Resident #40) was free from unnecessary drugs. Unnecessary drugs include medications administered in excessive doses. Findings include: Per record review, Resident #40 was administered Lispro insulin in excessive doses. This resident had two different sliding scale insulin orders; one to be used if s/he was eating, and one to be used if s/he wasn't eating. Each of the Lispro sliding scale orders in the Electronic Medical Record system (EMR) indicate they are to be administered at the same times of day, except for an 0300 time for administration on the sliding scale for use when s/he would typically not be eating a meal or significant snack. There is also an order in the EMR which is signed by the nurses each shift which reads, "2 different sliding scales based on whether she is having a meal/significant snack or not. Every shift for type 1 DM, be careful to read both scales!" The times the orders appear in the EMR for administration are 0900, 1300, 1800, 2100, and 0300 only on the sliding scale as specified above. Insulin orders were effective as of 07/16/2022 and read as follows: 1) Insulin: Lispro Solution 100 unit/ml: Inject as per sliding scale: if 76 - 100 = 3 units with meals or significant HS Snack including popcorn; 101 - 175 = 4 units with meals or significant HS Snack including popcorn; 176 - 225 = 5 units with meals or significant HS Snack including popcorn; 226 - 275 = 6 units with meals or significant HS Snack including popcorn; 276 - 325 = 7 units with meals or significant HS Snack including popcorn; 326 - 375 = 8 units with meals or significant HS Snack including popcorn; 376+ = 9 units with meals or	F 757	The results of these audits will be reported and reviewed at the QAPI Committee Meeting X4 Months will further evaluation as indicated. Oversight will be provided by the DON or Designee. F757 POC accepted 11/7/22 SFreamanRN/pma	

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F 757	Continued From page 69 significant HS Snack including popcorn, subcutaneously after meals and at bedtime for Diabetes AC Chem Sticks, ** If Not Eating a meal refer to other (this is the exact wording of the order) 2) Insulin: Lispro Solution 100 unit/ml: Inject as per sliding scale: if 76 - 100 = 0 If Not eating a meal or significant Snack; 101 - 175 = 0 If Not eating a meal or significant Snack; 176 - 225 = 0 If Not eating a meal or significant Snack; 226 - 275 = 1 unit If Not eating a meal or significant Snack; 276 - 325 = 2 units If Not eating a meal or significant Snack; 326 - 999 = 3 units If Not eating a meal or significant Snack, subcutaneously five times a day if not eating a meal or significant snack. On the days and times, the insulin was given from both scales at the same time, it is unclear which dose resident #40 should have received. This is due to missing meal intake documentation in the Activities of Daily Living task section of the medical record, but it is clear s/he received both doses erroneously. There was documentation of 100 percent meal intake on 09/13/22 at noon, which resulted in the resident receiving one extra unit of Lispro at that time. Lispro insulin administration errors were made on the following dates, at the specified times, and the total units (u) administered include the number of units given from each scale combined: 09/04/22 at 2100, 7 u were administered, without food 1u would have been the correct dose. 09/08/22 at 2100, 7u were administered, without food 1u would have been the correct dose. 09/09/22 at 0900, 11u were administered, without food 3u would have been the correct dose. 09/13/22 at 1300, 7u were administered, without	F 757		

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F 757	Continued From page 70 food 1u would have been the correct dose. 10/04/22 at 0800 12u were administered, without food 3u would have been the correct dose. 10/08/22 at 0900, 11u were administered, without food 3u would have been the correct dose. 10/12/22 at 1300 9u were administered, without food 2u would have been the correct dose. On 10/14/2022 at 11:45 AM, a Registered Nurse confirmed the medication errors. At 2:45 PM the DNS confirmed there was missing meal documentation which made it unclear as to which dose of Lispro the resident should have received. This resident has a diagnosis of Diabetes and End Stage Renal Disease which requires dialysis. S/he was transferred to the Emergency Room on October 03, 2022, due to hypoglycemia. This was not a date where Lispro insulin had been given in excess, but it is an example of the fragile condition of this resident. Physician documentation in the medical record on October 06, 2022, includes the following statement, " ...60-year-old [gender omitted] with a history of diabetes, ...hyperglycemia (high blood sugar levels), ..., and hypoglycemia (low blood sugar levels) who presented to the ED (emergency department) after being found to have hypoglycemia. [S/he] has had multiple events in the past of unresponsiveness and low blood sugar. S/he does have Type 1 DM (diabetes mellitus)."	F 757		
F 761 SS=F	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	F 761	F 761 The facilities 3rd Floor room labeled clean utility room with a key pad entry has been relabeled to identify medication storage and the lock has been changed to key entry for authorized personnel.	

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F 761	Continued From page 71 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 on surveyor observation and staff interview, the facility failed to adhere to proper labeling and storage of drugs and biologicals. Findings include: 1. On the facility's third floor across from the nursing station is a room labeled "clean utility" with a key code pad used to access the room. On 10/11/22 at 8:45 am, a licensed nurse assistant (LNA) was asked if s/he knew the code to the utility room. This LNA knew the code and stated "it's the same code for all other utility rooms, linen rooms, etc." All staff with knowledge of the key code were able to access this room. The medications and biologicals were not stored in locked compartments to be accessed by	F 761	The 2nd floor clean utility room has been cleaned with stored medication and expired medication removed. Insulin Refrigerators have been locked. Central supply room has been re-viewed for expired medications with expired medications being removed. Omnicell access has been re- viewed All licensed staff have been provided access and a process is in place for new staff access prior to starting on the floor All Residents have the potential to be affected by this deficient practice. Education will be provided to Licensed staff on Medication storage, dating, expiration and Management of controlled substances specific to single dose destruction and Omni- cell access process. Audits will be conducted on Medication Storage to include, expire medications, locked Med storage, Omnicell Access, Insulin Refrigerator locked and Central Supply area locked. Weekly X3	

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F 761	Continued From page 72 authorized personnel only. The following items were found in the utility room: a large blue unsecured tote filled with prescription medications on the floor, over the counter medications were in an unlocked medication cabinet, multiple trays of expired blood draw tubes (vacutainers) were in a cabinet, and there was a box of 26 gauge by ½ inch syringes with needles on the counter near the sink. The counters were cluttered, there was debris and filth on the floor, and a hole in the sheetrock wall. In the lab draw caddy there were also multiple expired vacutainers. On 10/11/ 22, at 8:50 AM an Licensed Practical Nurse (LPN) confirmed the expired vacutainers and confirmed LNA's have access to this room but should not have access where medications are stored. On 10/11/22 at 4:45PM the facility Infection Preventionist (IP) was interviewed and confirmed that the floor was dirty, and the room was clearly labeled "Clean Utility" outside the door and on the facility map but was being used as a "medication room" which did not contain such items as one would expect to have in a clean utility room. S/he confirmed that the vacutainers used for blood draws were expired and only nurses should have access to this room. On 10/12/22 at 2:17 PM a housekeeper was asked if she was able to enter the utility room where medications were stored. The housekeeper knew the code and entered the room. S/he stated, "I do usually wash the floor and clean this area, but I have been out for two weeks." On 10/12/22 at 2:30 PM a Genesis Regional Nurse Consultant confirmed the surveyor's findings and stated, "Only nurses should have access. We will change out the locks, and keys	F 761	then Monthly X3. The results of the audits will be reported and reviewed at the QAPI Committee meeting Monthly X4 with further evaluation if indicated. Oversight provided by the DON or designee. F761 POC accepted 11/2/22 SFreemanRN/PMH	

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F 761	Continued From page 73 will only be given to the nurses." 2. Observation on 10/9/22 at 8:56 PM, a LPN poured medication, which consisted of a Morphine Sulfate 15 mg tablet. The residents orders was for 7.5 mg. The nurse cut the pill in 1/2 with a pill cutter - she/he placed 1/2 of the pill in a medication administration cup and the other 1/2 of the pill in a medication cup which she/he placed inside a larger plastic cup (240 cc cup) and then placed the plastic cup inside the narcotics drawer in the medication cart. Review of the facility policy and procedure titled, "DISPOSAL OF MEDICATIONS AND MEDICATION-RELATED SUPPLIES", subtitle, "1E1: CONTROLLED MEDICATION DISPOSAL", subsection, "Policy, "Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal and state laws and regulations.", subsection, "Procedures", section A, "The director of nursing and the consultant pharmacist are responsible for the facility's compliance with federal and state laws and regulations in the handling of controlled medications. Only authorized licensed nursing and pharmacy personnel have access to controlled medications", section B, "When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It is destroyed in the presence of two licensed nurses, and the disposal is documented on the accountability record on the line representing that dose. The same process applies to the disposal of unused	F 761		

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F 761	Continued From page 74 tablets and unused portions of single dose ampules and doses of controlled substances wasted for any reason." Review on 10/9/22 of the narcotic book for this medication cart revealed that the 1/2 tablet of Morpine Sulfate had been wasted according to nursing standards are care that requires a controlled substance to be wasted in the presence of 2 licensed nurses. Interview on 10/10/22 at approximately 1:00 AM with the relieving/on coming 3 rd shift nurse, who confirmed she/he was a staff LPN. She/he confirmed that the LPN she/he relieved did not present any medications that required wasting. The oncoming staff LPN looked in the medication cart to check and see if perhaps the medication was left in the medication cart somewhere but there was nothing there to be wasted. It is unknown what happened to that 1/2 (7.5 mg) Morphine Sulfate tablet. The 3rd shift staff nurse also confirmed that the above noted refrigerator was an insulin refrigerator and it is supposed to be kept locked as it contains medications. She/he confirmed that upon her/his arrival to the unit for her/his shift that this refrigerator was unlocked. Interview with the above mentioned LPN at approximately 9:05 PM, confirmed that she/he did not lock the medication cart prior to leaving the medication cart and she/he walked away from the medication cart leaving the medication cart out of her/his sight. She/he stated that she/he does not usually leave the medication cart unlocked and unattended. When asked about the eye drops that were left on the top of the medication cart she/he confirmed that she/he had left them on the top of the cart but did not offer a reason why.	F 761		

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F 761	Continued From page 75 The LPN, confirmed that the small refrigerator is the "insulin refrigerator" and that it is "always unlocked" when she/he has been on shift and that she/he doesn't even know if she/he has a key on the medication key ring for the lock on this refrigerator. Review of the facility policy, titled, "MEDICATION STORAGE IN THE FACILITY" "ID 1: STORAGE OF MEDICATIONS", section "Policy", "Medications and biological's are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications." Under subsection, titled, "Procedures" B. "Only licensed nurses, pharmacy personnel, and ethos lawfully authorized to administer medications are allowed access to medications. Medication room, carts, and medication supplies are locked and attended by persons with authorized access." 3. On 10/9/22 at approximately 9:18 PM, the locked Clean Utility on the second floor was observed and noted to consist of several cabinets above, and below the sink. A metal bar with a pad lock was noted across 2 of the upper cabinets and a label that specified back up medications were contained within those cupboards. Just inside the entry door on the counter was a pink basin that contained a bottle of Saline Nasal Spray, Ventolin, a box of Enoxaparin Sodium Injection 40mg/0.4ml, a box of Nicotrol Inhaler 10 mg/cartridge (4 mg delivered), and a 1/2 full quart size see-through plastic (ziplock) bag containing a variety of different colored pills or various shapes and	F 761		

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F 761	Continued From page 76 sizes. Interview on 10/9/22 at approximately 9:25 PM with the LPN on the second floor regarding the locked Clean Utility room and the pink basin full of medications, she/he stated that these were expired medications that were there to be destroyed. Interview on 10/9/22 at approximately 9:30 PM with a LNA regarding the Clean Utility and if she/he knew the code to enter this room, she/he provided the correct code to access this Clean Utility room. When asked how she/he knew the code and if she/he ever goes in this locked room, she/he stated that she/he doesn't usually go in the Clean Utility but the access code to all locked doors is the same throughout the facility. 4. Observation on 10/10/22 at 12:45 PM revealed a Central Supply room on the first floor. The door to this supply room was fully opened and accessible to unauthorized individuals and there were no staff present in the room at the time of this observation. This room contained the facility's stock medications/Over-The-Counters (OTC's) and the liquid supplements. There were 26 individual containers of Glucerna that were expired on Sept 2022. Interview on 10/10/22 at 12:58 PM with the RN/ Infection Control Preventionist (ICP) who confirmed the above findings and stated the Central Supply room needs to be kept locked to prevent unauthorized individual access. The ICP also confirmed that there were 26 individual servings of Glucerna that were expired on Sept 2022.	F 761		

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F 761	Continued From page 77 5. Interview on 10/10/22 at approximately 4:15 PM with a second floor, [temporary agency] Licensed Practical Nurse (LPN) regarding access to emergency medications and access to a pixus type device revealed that she/he did not have access to this medication system. She/he stated that none of the Emergency Response staff have access to the pixus type system. She/he explained that she/he would need to find someone in the building that actually has access in order to get medications out of this system. When asked if there was ever a time she/he needed to get med's from this system and there was no one in the building to get the medications for patient needs - she/he confirmed that this has happened. When asked for further details and who the resident was - she/he stated it was a couple weeks ago, it was for a pain medication and there were only travelers in the building. She/he stated that the resident was a male and she/he did not remember his name. She/he said that the resident was angry because he couldn't get his pain addressed so he left the facility Against Medical Advice (AMA). Interview with a second [temporary agency] Registered Nurse (RN) confirmed that she/he also did not have access to the pixus type medication system. When asked what she/he would do if there was no one in the building who could gain access to this system in the building at a time of need, she/he stated she/he would start looking for phone numbers to find someone to call. When asked if she/he received any orientation to this facility specific to emergency numbers and a phone tree for who to call for certain situations/needs she/he stated nothing like that was provided. Interview on 10/11/22 at approximately 11:30 AM	F 761		

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F 761	Continued From page 78 with the Market President and the Regional Nurse Consultant regarding access to Emergency Medications in the pixus type system, specific to access rights to travelers and the Emergency Response nurses. The Regional Nurse Consultant stated that she/he does not give access to travelers or the Emergency Response nurses only to staff nurses. When asked how these medications are accessed for residents who need them when there is not a staff nurse in the building, she/he explained that there is always a nurse available to access these medications and phone numbers are available to call someone with access in an emergent situation. 6. Observation on 10/12/22 at approximately 10:30 AM on the second floor revealed the Nurse Practice Educator (NPE)/RN (Registered Nurse) who was working at the medication cart and providing medications to residents. She/he was observed leaving the medication cart with a cup of liquid and a small cup of pills, she/he entered a resident room, leaving the medication cart in the unlocked position. Interview with the above mentioned RN at approximately 8:40 AM, confirmed that she/he did not lock the medication cart prior to leaving the medication cart and the medication cart was out of her/his line of sight.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812	F 812 No Residents were negatively affected by the alleged deficient practice.	

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F 812	Continued From page 79 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on Observation and interview, it was determined that the facility failed to ensure safe food and beverage storing, preparing, distribution, and serving in accordance with professional standards for food service safety. Per observation on 10/9/22 at 11:53 PM the survey team did a walkthrough of the facility's main kitchen with the ICP (Infection Control Preventionist), the following issues were observed: a.) Ice scoop was inside the ice machine with the handle of the scoop exposed to the ice. b.) A box of "Instant Food Thickener" was observed in an open plastic bag and set inside a box that was labeled by the manufacturer as the contained food product. c.) The commercial blender was dirty with crumbs and debris around the blender motor and on the table the equipment was sitting on. d.) The food puree machine pitcher was cracked all the way around the bottom of the container	F 812	All Residents have the potential to be affected by the deficient practice. Identified areas that require cleaning have been cleaned. Food storage areas identified have been cleaned with appropriate food storage. Maintenance Director has addressed the pest control issue and out- side pest control vendor is routinely used. Education will be provided to the dietary staff on kitchen sanitation, food storage, cleaning schedules. Education has been provided to the Maintenance Director related to Pest Management. Audits will be conducted on kitchen sanitation, food storage, and pest management Weekly X3 the Monthly X3. The results of the audits will be reported and reviewed in the QAPI Committee Meeting Monthly X4 with further evaluation if indicated. Oversight will be provided by the Administrator or designee. F812 POC accepted 11/7/22 SFreeman RN/DNCC	

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F 812	Continued From page 80 just above where the blades are located inside the pitcher. e.) An air conditioner was observed in one of the windows across from the table where the mixer, puree machine and various other equipment for food prep were stored. The air conditioner was noted to have a thick and sticky substance on the front grill where the cool air comes out of the conditioner and into the environment. Within this thick and sticky substance was noted some hair, dust, and insects. In front of the air conditioner was a spray can of non-stick spray that was without the cover, and beside that spray can of non-stick spray was a second can of the same product, also without a cap. f.) An opened box of cornstarch was noted on the counter next to the air conditioner, in front of three, 4-inch binders - 1 labeled "Breakfast", 1 labeled "Lunch", and 1 labeled "Dinner"; g.) On a 3-tiered utility rack, it was noted the top and middle rack housed bulk spices of which 18 plastic containers of spices were on the top rack, of which 6 were open to the environment. h.) A commercial sized mixer was noted on a table and was covered with a black trash bag. Upon removing the black trash bag to view the mixer, it was noted to be dirty - the wire guard, the mixing bowl, and underneath the mixer above where the mixing bowl would sit were all spattered with dried material, as was the table the mixer sat on. i.) A commercial can opener was attached to a table and was noted to have a thick sticky red substance on the blade of the can opener and the bracket that holds the removable can opener had a thick black and yellow sticky substance with/containing what appeared to be a hair. j.) A large refrigerator was observed and upon opening the doors, a full container/pitcher with a	F 812		

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F 812	Continued From page 81 light-yellow liquid inside, revealed a tag and upon the tag was written "Orange - Use by 9/16". A full second container/pitcher was noted with a tangerine-colored liquid inside and there was no tag or markings to reveal the contents or an expiration/use by date on the container. k.) A steam table with 3 separate sections were noted to be full of hot dirty water. l.) A sideboard attached to the steam table was visibly dirty with a white greasy substance. m.) In the corner of the kitchen, behind the 2nd entrance/exit door was a sticky mouse trap that was covered with various sizes of black spots. Upon closer inspection these black spots were ants, spiders, flies (large and small), and various other insects and dirt. To the left of the sticky trap was a large mousetrap. n.) In front of the above-mentioned sticky trap was a substance that was dark brown with variations of brown, yellow, black, and red. This substance appeared wet and was noted to be sitting in an area that was wet with a clear grayish color that extended from the sticky trap and mouse trap and encompassed this unidentified brown object. The object could not be identified. This was shown to the ICP person who stated that she/he did not know what this brown object was as "I'm not a biologist but I can tell you that's not mouse [droppings] or rat [droppings]". o.) The grout in the kitchen was noted to be black and crusty over most parts of the floor. p.) A large commercial utility rack revealed stacked square and round plastic containers and there were moisture/water droplets between the layers of stacked containers. q.) A second large commercial utility rack revealed stacked square metal containers and there were moisture/water droplets between the layers of stacked containers.	F 812		

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F 812	Continued From page 82 r.) A steam machine was noted to be wet inside on the sides and top of the machine. s.) Under the oven/stove was a thick sticky and greasy substance black in color, that extended under a utility rack and a light-yellow substance was noted dripping down the front of the stove on the oven door and was pooling on the lip at the bottom of the stove/oven. t.) The inside of the oven was noted to have a large thick pool of black and red gel like substance on the inside base of the oven. At the time of the kitchen walk-through, the ICP was present for the entire walk-through, and as issues presented, they were shown and confirmed by the ICP person. The ICP confirmed that it is the expectation that the dietary staff clean the kitchen prior to leaving for the night, especially when managing an identified issue with rodents. (see F925) Observation on 10/10/22 at 8:45 AM in the kitchen revealed a staff member in the dish room with her/his mask under her/his chin. Interview with this staff person regarding her/his role in the kitchen, she/he pulled her/his mask up under her/his nose. The Food Service Director (FSD) and her/his supervisor were present at the time of this observation and interview with the staff, and when ask if the staff member was wearing her/his mask/PPE (Personal Protective Equipment) correctly, the Food Service Director Supervisor confirmed she/he was not and she/he spoke to the staff member telling her/him that she/he needed to wear her/his mask correctly. The staff member at that time pulled her/his mask up over her/his nose demonstrating appropriate PPE use at that time. A walk-through of the kitchen with the Food Service Director and her/his supervisor,	F 812		

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F 812	Continued From page 83 the above findings from 10/9/22 were discussed and confirmed by the FSD's supervisor. She/he stated that she/he had already cleaned the equipment, and the air conditioner and would be scraped along with the grease under the stove and extending areas. She/he stated that a pressure washer would be the best way to keep the floors clean, but the facility does not allow for pressure washers in their kitchens. During this walk-through the utility racks where the square metal pans, and the round and square plastic containers were observed were found to again/still be wet inside between the containers and pans. The FSD Supervisor confirmed that this is not sanitary and is a breeding ground for organisms. The mouse traps were observed and the FSD and FSD Supervisor confirmed that there are mice in the facility. When asked about whether they had seen any rats, they confirmed that they had in the past and plastic tubs were purchased to store and protect food from rodents. Several plastic tub lids were noted to have large holes that appeared to have teeth marks. When asked about these holes and quetionable teeth marks both staff responded that the rats had chewed through the covers and some of the heavy-duty storage tubs. A mouse trap was observed in the dry storage area under a commercial utility rack along with a square black box. When asked what this box was, the FSD Supervisor picked it up and looked it over and said she/he didn't really know but said she/he would get the maintenance man to help figure it out. At approximately 9:15 AM a maintenance staff person came to the dry storage area and explained that the black box was a "bait box" for rats and confirmed that the facility has had an issue with rats and a professional company had been involved but now the maintenance	F 812		

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F 812	Continued From page 84 department was responsible for checking the traps. A walk-through with the FSD and her/his supervisor continued and the unidentified brown item/substance that had been noted the evening before was observed in the same place. When asked what the item was, neither the FSD or her/his supervisor could identify the item but the supervisor stated the kitchen floor is swept and washed every night. The FSD put on a glove and picked up the unidentified item/substance and said she/he thought it was "a piece of petrified sausage".	F 812		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842	F 842 Resident #54 no longer resides at the facility. All Residents have the potential to be affected by the deficient practice. Education will be provided to Licensed and LNA staff on charting and documentation Policy OPS402 to include E-Interact. Education will be provided to Licensed staff on evaluation after a fall specific to Neurological Evaluation. Audits will be conducted to ensure completion of LNA documentation, Interact completion and Neurological Evaluation completion Weekly X3 then	

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F 842	Continued From page 85 records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and	F 842	Monthly X3. The results of the audits will be reported and reviewed at the QAPI Committee Meeting Monthly X4 further evaluation if indicated. Oversight will be provided by the DON or designee. F842 POC accepted 11/7/22 SFreeman RN/PM	

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F 842	Continued From page 86 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on review of information, the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards for 5 residents (#14, #18, #5, #54, #40) in a sample size of 37. Findings include: 1. Per record review Resident #14's Licensed Nursing Assistant (LNA) documentation of care needs provided such as bathing, dressing, bed mobility, toileting, assistance needed and percentage of meal consumed during the month of September revealed documentation was completed on only 8 day shifts, 11 night shifts and there was no documentation completed on evening shift throughout the entire month. LNA documentation for October 1 - October 14th had multiple spaces that were not completed. Day shift documentation for all care areas was completed on 3 shifts between 10/1- 10/14, there was no documentation completed on evening shift, and night shift documentation of all care areas was only 5 shifts. 2. Per record review Resident #18 LNA documentation of care needs provided such as bathing, dressing, bed mobility, toileting, assistance needed and percentage of meal consumed during the month of September revealed documentation was completed on only 10 day shifts, 11 night shifts and there was no documentation completed on evening shift throughout the entire month. LNA documentation for October 1 - October 14th	F 842		

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F 842	Continued From page 87 had multiple spaces that were not completed. Day shift documentation for all care areas was completed on 2 shifts between 10/1- 10/14, there was no documentation completed on evening shift, and night shift documentation of all care areas was only 4 shifts. 3. Per record review Resident #5's LNA documentation of care needs provided such as bathing, dressing, bed mobility, toileting, assistance needed, and percentage of meal consumed from October 1 - October 14th has multiple spaces that were not completed. Day shift documentation for all care areas was completed on 3 shifts between 10/1- 10/14, there was no documentation completed on evening shift, and night shift documentation of all care areas was only 5 shifts. During interview on 10/14/2022 at 2:30 PM with the Infection Control Preventionist [ICP] regarding the lack of LNA documentation, particularly the evening shift, while reviewing the LNA documentation flow sheet the ICP confirmed that the LNAs had failed to document care provided. S/he stated that all staff including agency LNAs, and emergency staff have access to the electronic health record, and they can and should be documenting the care provided. 4. Upon record review on 10/14/22 Resident #40 did not have accurate meal documentation recorded in the Activities of Daily Living (ADL) task section of the electronic medical record (EMR). This information is part of a complete medical record and in this case was also needed because Resident #40 had insulin orders that required dosing based on meal intake. In reviewing the ADL records for September and	F 842		

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F 842	Continued From page 88 October of 2022, there are multiple blank boxes for meal recording. There was other required ADL information missing in the EMR such as: dressing, transfers, bed mobility, personal hygiene, etc. On this same date at 2:45 PM an Registered Nurse (RN) confirmed there was missing ADL documentation to include meal documentation required for complete medical records and insulin administration. 5. Upon record review for Resident #40 on 10/14/22, it was found that this resident had been transferred to the hospital on October 03, 2022 due to hypoglycemia. This information was found on a hospital discharge record from Southwestern Vermont Hospital which was scanned into the EMR. No medical assessment was entered into the EMR progress notes on that date indicating an acute change in this resident's condition requiring a hospital transfer, and no medical assessment or other entry was found in the EMR progress notes of the resident's return from the hospital. There was an Interact hospital transfer form found scanned into the medical record. This is a form used for hospital transfers and includes data such as pertinent medical history, acute changes in a resident's medical status that requires transfer to the hospital at that time and the most recent vital signs, etc. The Interact hospital transfer form was not filled out with accurate or organized information. The date of transfer was entered as 09/01/22, but it also included medical information dated 10/03/22. The form could not be utilized to gather information for either October or September reliably as it was filled out inaccurately. Upon interview on 10/14/22 at 2:45 PM with the Genesis Regional Nurse Consultant and an RN	F 842		

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F 842	Continued From page 89 acknowledged the 2 different dates of information on the same Interact form. The only other information found in the EMR related to this transfer was a scanned in fax form to the provider stating, "Resident had unresponsive episode accompanied by low BS (blood sugar level). We would like a PRN (as needed) Glucagon (Glucagon is a medication used to increase blood sugar levels quickly) IM shot (an injection into the muscle) when she is unable to take the gel po (by mouth)." 6. Record review reveals that resident #54 was admitted to the facility on 08/09/22 and died at the facility on 09/05/22 due to acute chronic hypoxic respiratory failure secondary to aspiration pneumonitis and advanced dementia per a practitioner note (09/06/22). This resident had the following diagnoses: Dementia, Delirium, Depression, A-fib, Benign Prostatic Hyperplasia, glaucoma, Hypothyroidism and Dysphagia. This resident contracted COVID-19 virus said to be resolved on 07/14/22 per a practitioner note (08/12/22). This was a resident transferred from another nursing home facility. Further review of the medical record indicates that this resident had a fall on 08/14/22. A nurse note reveals "LNA (Licensed Nurse Assistant) reported hearing loud bang while in the room across the hall from [name omitted], when [s/he] entered the room saw pt. laying on the floor next to his bed, this nurse entered the room after being notified by LNA and saw pt. laying on [her/his] right side next to [her/his] bed, small abrasion noted to top of head, neuro vital signs WNL, VSS, no indication of fx or other injury, floor mats in place, bed in lowest position, assisted back to bed with Hoyer lift and two assist". There	F 842		

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F 842	Continued From page 90 is evidence of an initial "change in condition SBAR assessment" complete for this resident, however further documentation related to neurological checks/vital signs could not be found in the medical record as one would expect for a patient with a head injury (noted above-abrasion to top of head). The Neurological status of a resident can change abruptly and suddenly, so ensuring that "neuro checks" usually every hour for at least four hours, then every eight hours for the first 24 hours after a fall is an important nursing assessment. (Post-Fall Care Nursing Algorithm) https://rn-journal.com) It was confirmed by the Regional Nurse Consultant on 10/12/22 at 01:30PM that there was no documentation of post fall neurological assessments in resident #54s medical record. (Refer also to F658)	F 842		
F 880 SS=L	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. §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,	F 880	F 880 Sanitizer dispensers have been changed and are filled with sanitizer product. Linen was removed from the floor. Resident #52 Mid Line has been discontinued without complications Laundry and trash bins are covered. Shower rooms have been cleaned and broken tiles replaced. Mattress and linen removed.	

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F 880	Continued From page 91 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 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	F 880	Clean Utility rooms have been cleaned and storage organized. Medication storage signage has been added and the key number pad lock has been removed and replaced with a key lock entry with only authorized staff use. 2nd Floor kitchenette and dining area has been cleaned. Steam table and all other equipment has been cleaned. The kitchen and all equipment have been cleaned. Food stored improperly has been discarded. Mouse traps have been replaced with pest bait boxes. Laundry room/carts have been cleaned and disinfected. Mattress from Room #205 has been removed and discarded. All identified kitchen issues have been corrected. All Residents have the potential to be affected by the deficient practice.	

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F 880	Continued From page 92 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, interviews, and review of documentation, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of COVID-19 and other communicable diseases and infections. The deficient practices related to lack of infection control measures specifically to source control and containment led to the determination that the residents who resided in the facility were in immediate jeopardy of harm and/or death. At the time that immediate jeopardy was called on 10/11/2022, review of the facility provided list of residents who had tested as COVID-19 positive since the beginning of the facility outbreak that began on 10/1/2022, there were 30 COVID-19 positive residents residing throughout the facility. During the outbreak, there had been three residents who died while COVID-19 positive. Findings include: 1. Per record review Resident # 7 was found by facility staff to be unresponsive on 10/5/2022 and was transferred to the local Emergency	F 880	Education will be provided to staff on the implementation of TBP, Hand Hygiene and proper use of Personal Protective Equipment including donning and doffing. Education will be provided to dietary staff regarding kitchen sanitation procedures. Education will be provided to the Laundry/Housekeeping staff on Environmental cleaning procedures. Audits will be conducted to include TBP, Hand Hygiene, and donning and doffing of PPE. Weekly X3 then Monthly X3. Audits will be conducted of Environmental cleanliness, kitchen sanitation/cleanliness and Laundry room cleaning and disinfection Weekly X3 then Monthly X3. The results of the audits will be reported and reviewed at the QAPI Committee Meeting Monthly X4 further evaluation is indicated. Oversight will be provided by the Administrator or designee. F880 POC accepted 11/7/22 SFreeman RN/PMA	

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F 880	Continued From page 93 Department. Review of the hospital Emergency Department Report written on 10/5/2022 revealed that the admitting diagnoses were acute hypoxic respiratory failure, shock, and COVID-19. Review of Resident #7's Vermont Certificate of Death states that the primary cause of death was COVID-19 infection. 2. Per observations made during the initial tour of the third floor (Unit 3 North and South) on 10/9/2022 at 8:45 PM, the 3 South Licensed Practical Nurse (LPN) was observed in the hall preparing medications for administration without eye protection. When asked how many of the residents on the South unit were positive for COVID-19 s/he stated, "I think three" However, there were 11 confirmed COVID-19 positive residents in her/his care. 3. On 10/9/2022 at approximately 9:15 PM a Licensed Nursing Assistant (LNA) assigned to 3 South was observed entering two COVID-19 positive resident's room (#316) without the required personal protective equipment (PPE), a gown or gloves. A sign on the door indicated that Transmission Based Precautions should be followed when entering the room of a COVID-19 positive resident to include the donning of a gown and gloves. When asked if the residents in room #316 were Covid positive the LNA stated "I don't know." When directed to the sign on the door that indicated the use or PPE, the LNA confirmed that s/he should have used PPE when entering the room. The LNA was asked if anyone from the facility had shown her/him how and when to don PPE s/he stated "No." On 10/9/2022 at approximately 9:20 PM the Director of Nursing (DNS) entered the facility.	F 880		

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F 880	Continued From page 94 When approached by this surveyor s/he stated that s/he had not been feeling well and that s/he was going to take a COVID test. When this surveyor returned the DNS stated that she was positive for COVID and that s/he was trying to contact the Executive Director. The DNS remained in the facility in her/his office. S/he was there when the surveyors exited the facility at approximately 1:00AM. On 10/9/2022 at approximately 9:45 PM the Infection Control Preventionist (ICP) was informed of the infection control concerns related to the use of PPE (personal protective equipment) and the potential spread of COVID-19 that had been identified. S/He was asked if it was the expectation that staff wear a face shield or goggles as PPE when on the unit the ICP stated "yes, it is." At approximately 10:15 s/he was seen on the unit talking with staff. 4. On 10/9/2022 at 10:20 PM an agency LNA assigned to the 3rd North and South Unit was observed exiting a room of a COVID-19 positive resident (room #323), without removing the gown and gloves that s/he had been wearing in the room. The LNA walked down the hall with the contaminated gown and gloves from the COVID-19 positive room, to retrieve incontinence care products. S/he then returned walking back into the resident's room. When asked if s/he should have removed the gown and gloves and washed her hands when s/he exited the room s/he confirmed that s/he should have. 5. Review of the facility list of residents who were Covid-19 positive, provided by the ICP on 10/9/2022, revealed that 7 of the 12 residents residing on the 2nd floor (2 North) were	F 880		

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F 880	Continued From page 95 COVID-19 positive, and one additional resident was currently admitted to the hospital with COVID-19. Of the 19 residents on the 3rd floor North Hall, 12 of them were COVID-19 positive. On the 3rd floor South Hall there were 20 residents total with 11 that were COVID-19 positive. On 10/10/2022 at 9:34 AM during interview with the facility Executive Director s/he confirmed the above COVID-19 cases and provided documentation (the facility "Heat list" On 10/11/2022 the list was updated to reflect two new COVID-19 positive residents on 2nd floor Unit 2). When informed of the multiple concerns identified throughout the facility on 10/9/2022, s/he stated "we are in the middle of a COVID outbreak, and we have travelers and emergency staff working. Things were getting better until this outbreak happened." 6. Per observation on 10/10/22 at 12:15 PM, a LNA was seen in a resident's room (#317) delivering a lunch tray to a COVID-19 positive resident without wearing the required gown and gloves. Upon leaving the room, s/he did not perform any hand sanitization. Signage was posted on the wall outside the room indicating that Transmission-Based Precautions (TBP) were to be followed and that required Personal Protective Equipment (PPE) was to be worn prior to entering the room. When asked why s/he failed to wear the required PPE or wash hands or perform any hand sanitizing, s/he stated, "I just didn't think about it, I'm agency." 7. The sanitizer mechanism located on the wall unit outside of room #311, on the left side of the North Hall, was empty and did not contain any	F 880		

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F 880	Continued From page 96 hand cleaning product. Room #312, a room which required the use of PPE for transition-based precautions, did not contain any hand sanitizer, and there was no receptacle available to place soiled PPE in prior to exiting the room, thus causing staff to exit the room and remove their gown in the receptacle in the hall, increasing the risk of spread. The missing sanitizer and receptacles were confirmed by housekeeping at the time they were found to need replacing. 8. Observation on 10/10/22 at 12:30 PM revealed an LNA in the resident hallway outside of room #212, wearing an N95 mask with the top elastic strap laying across the top of mask on her/his nose. At the time of this observation, the LNA was observed walking by the ICP, who acknowledged the LNA and failed to correct her/his inappropriate use of PPE. Interview on 10/10/22 at 12:55 PM with the ICP regarding the observation noted above. The ICP confirmed that the LNA was not wearing her/his PPE correctly, as the top elastic strap should be placed around her/his head as per the manufacturer's recommendations for use. 9. During observation on Unit 3 South on 10/11/2022 at 9:20AM an agency LNA was observed entering a Covid positive resident's room (#317) without the required person protective equipment (PPE) on, other than a face shield. When s/he exited the room s/he was asked if the resident in that room was positive for COVID-19 and if the resident was on precautions s/he stated "yes, I should have put on a gown before I went in there."	F 880		

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F 880	Continued From page 97 10. During observation on Unit 3 South on 10/11/22 at 11:00 AM a LNA was seen entering a room (#324) of two COVID-19 positive residents without a protective gown and gloves and set up a meal tray for the resident. Upon exit of the room this surveyor asked the LNA if the residents in the room were positive for COVID or if they no longer required use of PPE, the LNA confirmed that they were COVID-19 positive, and s/he should have had it on. 11. Per observation on 10/12/22 at 12:00 PM an LNA entered a resident room on a COVID-19 positive unit on the third floor to respond to a call light. The facility was amid a Covid 19 outbreak and following transmission-based precautions to include all staff wearing N-95 masks and eye covering. When entering a resident room designated as having residents with Covid-19 by a sign at the door the additional infection control measure included donning a disposable plastic gown to protect clothing and protect residents from cross contamination. The LNA approached the room already dressed in PPE to include plastic clothes covering gown, gloves, an N-95 mask and a face shield, upon entering the room the LNA handled the call bell to turn it off, put his/her hand on the resident's arm and exited the room without removing the PPE or sanitizing his/her hands. The LNA confirmed he/she was unsure of when to Donn or doff his/her PPE. 12. Per observation on 10/12/2022 at 12:10 PM a trash receptacle inside room #303 designated as having Covid-19 positive residents was observed to be overflowing with disposable PPE with soiled linens on the floor next to it. This practice increases non-infected residents' risk of exposure to COVID-19. The unit LPN confirmed used PPE	F 880		

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F 880	Continued From page 98 and linens did not belong on the floor. 13. Per observation at 10/12/2022 12:15 PM on the third floor in the empty resident dining area 2 LNA's were observed standing near the food service area having a conversation without wearing masks or eye protection, when questioned both LNA's confirmed they should be wearing N-95's and eye protection. On 10/12/2022 at approximately 12:50 PM the Regional Nurse Consultant confirmed that the staff should be wearing masks and eye protection when on the Unit. 14. Observation on 10/12/22 at 1:34 PM an LNA was observed coming out of resident room #213 which housed a resident who was COVID-19 positive. The LNA leaned out over the door threshold with a tray of dishes and attempted to flag down a staff member to come take the tray. Another LNA came and took the tray without gloves on and placed the tray inside the tray cart. She/he did not perform hand hygiene and immediately proceeded to room #211, where she/he was observed going into this room and no hand hygiene was performed before entering. Room #211 does not house a COVID-19 positive resident at the time of this observation. The same LNA was observed coming out of room #211 with a tray that contained dishes, paper towels were observed as a barrier between the tray and her/his hands. She/he took the tray to the tray cart, placed the tray inside the cart and proceeded to the kitchenette entrance door where she/he entered the lock code on the code pad, opened the door to the kitchenette and entered. She/he did not perform hand hygiene between putting the tray from room #211 into the tray cart and entering the lock code on the kitchenette	F 880		

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F 880	Continued From page 99 door. Interview on 10/12/22 at 1:38 PM with this above noted LNA, regarding the differences in her/his practice of picking up trays from a COVID-19 positive room vs. the non-COVID-19 positive room. She/he said it was not clear what she/he was supposed to be doing at that point. She/he stated that she/he had received some additional training regarding infection control practices, but it was quick and not entirely clear what the process is supposed to be for tray pick up. 15. On 10/13/22 at 9:40 AM a laundry person was noted putting a gown on and going into room #211 (not designated a covid positive room). She/he was interviewed on 10/13/22 at 9:42 AM regarding her/his practice of wearing a disposable gown into a non-covid room and she/he stated that the gowns and gloves are required in rooms that have signs on the doors. When asked if room #211 had a sign on the door and she/he didn't know. Room #211 did not have a sign indicating the room was a precaution room. At 9:52 AM on 10/13/22 this same laundry staff was observed going into a COVID-19 positive resident's room (#213) with a few hangers of laundry and entered the room without a disposable gown or gloves. There was a sign outside room #213 indicating the requirement for the use of PPE. Interview with the laundry staff who confirmed that she/he should be wearing a disposable gown and gloves to enter any room that is indicated by a sign that the room is a precaution room. The laundry staff member did not see any sign - the sign was pointed out to the laundry staff, as well as the orange sign that was inside the door on the left side of the wall indicating the need to wear PPE, she/he stated	F 880		

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F 880	Continued From page 100 that she/he "was used to the sign being a little higher" and that she/he did not see it. 16. Interview on 10/13/22 at 1:20 PM with the ICP regarding the training and competency of staff related to infection control and COVID-19 prevention, revealed that "Genesis employees" must do their annual mandatory educational training on the "Vital Learn Electronic System". The ICP can run reports for tracking and states "I do spot checks for extra training when we have unit managers." The ICP "keeps records of education but not always." If agency staff are hired, when they come through the door, the ICP reviews their agency packet to see what's needed. Per the ICP "We lag on this.". Audits are conducted in the housekeeping/laundry department on a weekly basis. Observations of meal service are conducted weekly to observe hand hygiene, gloving, and wearing proper personal protective equipment (PPE) during delivery of meal trays to COVID positive rooms and dietary staff serving behind the line. Observations are done in the kitchen monthly to observe preparation of food, and cleanliness of kitchen. The ICP states "audits have not been done in a while since we came back to Genesis [this occurred in July]" and no evidence related to the above was provided. On 10/14/22 at 09:21 AM a list of examples of training/audits (minus the mandatory annual education which another nurse educator works on) was given to the ICP. This list included items such as cleansing of equipment (glucometer, mechanical lift, wheelchairs, et.), hand hygiene, COVID education, reporting breaches of the integrity of equipment. There is no documented evidence of audits related to infection control. The	F 880		

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F 880	Continued From page 101 ICPs response at 11:52 AM when asked for the above information regarding any audits/education was "No, I don't have any of this." Additional findings of non-compliance related to infection control that were identified during the survey include: 1. Observation in room #205, on 10/13/22 at 10:45 AM of Resident #52's midline IV was place in her/his left upper arm. A dressing was observed over the midline IV that was grayish in color and appeared dirty - the dressing was dated 9/29/22. Interview on 10/13/22 at 10:45 AM with the resident, who is A&Ox3 and stated that this dressing is the dressing that was put on at the hospital prior to her/his admission to this facility. This was reviewed with the nurse, who confirmed she/he was part of the emergency response team and was an LVN (Licensed Vocational Nurse). She/he confirmed that Resident #52's dressing appeared dirty, and she/he also confirmed the date on the dressing as being 9/29/22 and that this resident was admitted to this facility on 9/30/2022. 2. Observation on 10/9/22 at 8:40 PM of the second floor (Unit 2) revealed a long hallway with an open nurses station in the middle. The portion of hall to the left of the nurses station housed 12 residents, 7 of these residents were Covid-19 positive. One additional COVID-19 positive resident was currently admitted to the hospital. The portion of the hallway to the right of the nurses station was empty of residents. The hallway that was housing residents was observed to have a lot of debris on the floor, consisting of	F 880		

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F 880	Continued From page 102 gloves, clear plastic wrappers, small pieces of paper, and long pieces of thin blue plastic, as well as dirt/sand. To the right side of the resident's hallway were 2 uncovered bins, 1 contained what appeared to be dirty gloves, and the other appeared to be empty. Interview on 10/9/22 at 8:35 PM with an LNA, who stated one bin is for trash and the other bin she/he believed was for linens. She/he stated, "I do not know if they should be covered, this is only my third shift here and I don't know the policy for having the bins covered or uncovered." Interview on 10/9/22 at 8:50 PM with the nurse on duty who identified her/himself as an emergency response nurse, confirmed the hallway where resident rooms are located was littered with debris that consisted of gloves, pieces of blue plastic that she/he identified as pieces of the disposable gowns that are used to go into the rooms of residents who are on precautions due to a covid positive status, clear plastic wrappers, she/he identified as the packaging to protective eyewear, small pieces of paper and dirt. She/he stated that staff have not had time to clean on the unit and to her/his knowledge there are no housekeeping staff available. When asked about the uncovered bins in the resident's hallway, she/he stated they were for dirty linens and disposable items and thought they "probably should be covered and labeled," she/he did not know the facility policy regarding bins in the hallway. 3. Observation on 10/9/22 at 9:08 PM of the tub/shower/whirlpool room revealed a shower area that was separated from a second shower area and a whirlpool tub area. Upon entering the tub/shower/whirlpool room to the left is a shower	F 880		

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F 880	Continued From page 103 area that was noted to be dirty, the floor had many broken tiles, some missing pieces of tile, most of the grout that was between the remaining tiles was gray, black, or yellow in color, there was a washcloth that was draped over the shower bar at the right side of the shower wall. The washcloth appeared dirty, it was gray in color, it was hard/crusty and formed to the shower bar. To the right of the entrance door, across from the first shower area (refereinced above) was a bariatric sized tub chair and upon it was an unfolded towel hanging off the left side of the shower chair. To the left of the tub/shower/whirlpool room, to the right of the first shower area was a second shower area that revealed a PVC (polyvinyl chloride) pipe shower bed with thick plastic foam covered mattress that was in disrepair. The headrest of the plastic foam covered mattress revealed 3 slits and a piece of clear plastic tape that exposed the foam mattress. Upon touch of the foam mattress, it was noted to be moist and with a little applied pressure a clear liquid oozed out of the foam mattress. On the floor of this second shower area was a gray plastic strap that is used to secure residents in the tub chair for transport and use of the whirlpool tub. To the right of this second shower area was a covered plastic bin and atop of the cover was a neatly folded johnnie that had some pieces of white plastic type material that resembled drier sheets, and 2 face masks around and on top of the johnnie. Interview on 10/9/22 at 9:30 PM with the emergency response nurse, who confirmed that the shower room was a mess, had several infection control issues as noted above, and that s/he would leave a note for the oncoming shift nurse to address these identified concerns.	F 880		

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F 880	Continued From page 104 Interview on 10/9/22 at 1:00 AM with a facility staff nurse who had relieved the emergency response nurse, who stated she/he was not aware the equipment was in disrepair but confirmed the slits in the plastic covering of the mattress which exposed the foam mattress. She/he also confirmed that the tub/shower/whirlpool room was dirty, tiles were broken or missing. 4. Observation on 10/9/22 at 9:15 PM of the Clean Utility room revealed a small room that was dirty, the floor had empty syringe wrappers, a covered blood draw needle, trash can with what appeared to be a dried bouquet of flowers that was holding the cover of the trash can open, a box of N95 masks open to and laying on its side on a dusty metal shelf, 4 glass jars, 1 labeled BANDAGES and contained cotton balls and was covered with a metal cover, 1 labeled GAUZE that was empty and was covered with a metal cover, a second glass jar that was labeled GAUZE that was full of 2x2 gauze squares and was not covered , and 1 labeled APPLICATORS that was full of tongue depressor sticks, that was not covered. 5. Observation on 10/9/22 at 9:30 of the 2nd floor kitchenette and dining area revealed a full trash can, dishes with food on trays, a refrigerator with dirty shelves and inside doors, a large mouse trap under a commercial utility shelving unit, a rat trap between the kitchenette wall and the refrigerator of the serving area, dried food on counters, doors, and the microwave. The bottom part of the doorway and floor into the kitchenette had a thick black substance that was also present in the spaces between the wood floor at the doorway.	F 880		

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F 880	Continued From page 105 The 3 compartments in the steam table each had dirty water in them with what appeared to be food particles and debris. 6. Observation on 10/9/22 at 11:53 PM the survey team did a walkthrough of the facility's main kitchen with the ICP, the following issues were observed: a.) Ice scoop was inside the ice machine with the handle of the scoop exposed to the ice. b.) A box of "Instant Food Thickener" was observed in an open plastic bag and set inside a box that was labeled by the manufacturer as the contained food product. c.) The commercial blender was dirty with crumbs and debris around the blender motor and on the table the equipment was sitting on d.) The food puree machine pitcher was cracked all the way around the bottom of the container just above where the blades are located inside the pitcher e.) An air conditioner was observed in one of the windows across from the table where the mixer, puree machine and various other equipment for food prep were stored. The air conditioner was noted to have a thick and sticky substance on the front grill where the cool air comes out of the conditioner and into the environment. Within this thick and sticky substance was noted some hair, dust, and insects. In front of the air conditioner was a spray can of non-stick spray that was without the cover, and beside that spray can of non-stick spray was a second can of the same product, also without a cap. f.) An opened box of cornstarch was noted on the counter next to the air conditioner, in front of three, 4-inch binders - 1 labeled "Breakfast", 1 labeled "Lunch", and 1 labeled "Dinner"	F 880		

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F 880	Continued From page 106 g.) On a 3-tiered utility rack, it was noted the top and middle rack housed 18 plastic containers of spices on the top rack of which 6 were open to the environment h.) A commercial sized mixer was noted on a table and was covered with a black trash bag. Upon removing the black trash bag to view the mixer, it was noted to be dirty - the wire guard, the mixing bowl, and underneath the mixer above where the mixing bowl would sit were all spattered with dried material, as was the table the mixer sat on. i.) A commercial can opener was attached to a table and was noted to have a thick sticky red substance on the blade of the can opener and the bracket that holds the removable can opener had a thick black and yellow sticky substance with what appeared to be hair. j.) A large refrigerator was observed and upon opening the doors, a full container/pitcher with a light-yellow liquid inside, revealed a tag and upon the tag was written "Orange - Use by 9/16". A full second container/pitcher was noted with a tangerine-colored liquid inside and there was no tag on the container. k.) A steam table with 3 separate sections were noted to be full of hot dirty water l.) A sideboard attached to the steam table was visibly dirty with a white greasy substance m.) In the corner of the kitchen, behind the 2nd entrance/exit door was a sticky mouse trap that was covered with various sizes of black spots. Upon closer inspection these black spots were ants, spiders, flies (large and small), and various other insects and dirt. To the left of the sticky trap was a large mousetrap. n.) In front of the above-mentioned sticky trap was a substance that was dark brown with variations of brown, yellow, black, and red. This	F 880		

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F 880	Continued From page 107 substance appeared wet and was noted to be sitting in an area that was wet with a clear grayish color that extended from the sticky trap and mouse trap and encompassed this unidentified brown object. The object could not be identified. This was shown to the ICP person who stated that she/he did not know what this brown object was as "I'm not a biologist but I can tell you that's not mouse shit or rat shit". o.) The grout in the kitchen was noted to be black and crusty over most parts of the floor. p.) A large commercial utility rack revealed stacked square and round plastic containers and there were moisture/water droplets between the layers of stacked containers. q.) A second large commercial utility rack revealed stacked square metal containers and there were moisture/water droplets between the layers of stacked containers. r.) A steam machine was noted to be wet inside on the sides and top of the machine. s.) Under the oven/stove was a thick sticky and greasy substance black in color, that extended under a utility rack and a light-yellow substance was noted dripping down the front of the stove on the oven door and was pooling on the lip at the bottom of the stove/oven. t.) The inside of the oven was noted to have a large thick pool of black and red gel like substance on the inside base of the oven. At the time of the kitchen walk-through, the ICP was present for the entire walk-through, and as issues presented, they were shown and confirmed by the ICP person. The ICP confirmed that it is the expectation that the dietary staff clean the kitchen prior to leaving for the night, especially when managing an identified issue with rodents.	F 880		

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F 880	Continued From page 108 7. Observation on 10/10/22 at 8:45 AM in the kitchen revealed a staff member in the dish room with her/his mask under her/his chin. Interview with this staff person regarding her/his role was in the kitchen, she/he pulled her/his mask up under her/his nose. The Food Service Director (FSD) and her/his supervisor were present at the time of this observation and interview with the staff, and when ask if the staff member was wearing her/his mask/PPE (Personal Protective Equipment) correctly, the Food Service Director Supervisor confirmed she/he was not and she/he spoke to the staff member telling her/him that she/he needed to wear her/his mask correctly. The staff member at that time pulled her/his mask up over her/his nose demonstrating appropriate PPE use at that time. A walk-through of the kitchen with the Food Service Director and her/his supervisor, the above findings from 10/9/22 were discussed and confirmed by the FSD's supervisor. 8. Observation on 10/10/22 at 12:33 PM it was noted that a tray with dishes, utensils, and napkins were placed on top of the infection control cart outside of room 211. This was brought to the attention of the Infection Control Preventionist (ICP) on 10/10/22 at 1:32 PM. The ICP confirmed the tray atop the infection control cart and stated that nothing should be placed on top of the infection control carts as these carts are considered a clean surface. 9. On 10/11/22 at 08:45AM observation of the 3rd floor unit, revealed a door across from nurse station which is labeled "clean utility" with a key code pad. This same room is also labeled as such on the facility map. This surveyor asked a	F 880		

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F 880	Continued From page 109 Licensed Nurse Assistant (LNA) what the door code was. This LNA knew the door code and stated, "it's the same for all other utility rooms" and proceeded to let two surveyors in. Upon entrance, the small room appeared to be a medication storage area rather than a "Clean Utility" room. It contained over the counter medications in a cabinet, a blue plastic tote full of medications on the floor, Lab supplies, syringes with needles (box of 26G x1/2" syringe) in a cabinet, and other supplies. The utility room was filthy with debris on the floor and a dark quarter sized area of sticky substance. The LNA confirmed that the floor was dirty, and that s/he did not "ever really need anything in here". 10. Observation on 10/11/22 at 01:27 PM of the laundry department, contains laundry carts, for the transport of soiled linens. One cart was noted to be unclean with various items of built-up debris such as used gloves, food particles, paper products, a hair tie, a meal ticket, and other unrecognizable particles. There were layers of lint, dust and debris under a wooden pallet that contains large buckets of washing machine chemicals. Interview at the time of observation with a laundry attendant, confirmed the appearance of the dirty laundry cart and dirt/grime build up under the wooden pallet. Another observation of the laundry department and interview with the Infection Control Preventionist (ICP) was conducted the same afternoon on 10/11/22 at 4:15PM. The ICP confirmed that the laundry cart and under the wood pallet near the washing machines were filthy. The ICP confirmed that cleaning visible soiled areas and disinfecting linen carts had not been done.	F 880		

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F 880	Continued From page 110 Observation and interview on 10/11/22 at 2:17PM with a housekeeper confirmed that the floor was dirty and s/he "does usually wash the "clean Utility" floor but has been out for two weeks". This housekeeper revealed that all of 3rd floor is her/his cleaning responsibility. S/he stated that s/he "had never had a nurse observe while [s/he] cleans the floor to this room and was not aware that [s/he] should not enter due to it containing medications but did know the code". 11. Observation of the 3rd floor "Clean Utility" room and Interview on 10/11/22 at 4:45PM with the ICP confirmed that the floor was dirty and that the room was clearly labeled "Clean Utility" outside the door and on the facility map but was being used as a "medication room" which did not contain such items as one would expect to have in a clean utility room. For example, Linens. The ICP confirmed that this room had not been cleaned in a while and that only nurses should have access. A day later, on the afternoon of 10/12/22 at 2:30PM, Observation and interview with a Genesis Nurse Consultant confirmed the room was not being used as a "Clean Utility" and indeed did not contain linens as one would expect, and the floor was still dirty. 12. Observation on 10/13/22 upon exiting room #205 at 10:58 AM, it was noted that the mattress on the bed next to the door in room #205 had been stripped of linens leaving just the mattress and at the foot of the mattress there was an area of approximately 2-foot diameter that showed significant wear to the fabric covering the mattress. This area was where the manufacturer	F 880		

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F 880	Continued From page 111 had stamped on the mattress the name of the company, mattress type and various other unreadable information - most of this manufacturer stamp was gone. The integrity of the mattress is poor and unable to be cleaned adequately. The nurse, who was exiting the room at the same time confirmed the appearance of this mattress and she/he stated that the mattress was not usable and needed to be replaced. This was brought to the attention of the Clinical Quality Consultant and the Market President on 10/13/22 at approximately 11:15 AM.	F 880		
F 888 SS=F	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents,	F 888	F 888 The 16 TLC contracted staff are no longer working at the facility. All Residents have the potential to be affected by this deficient practice. Education will be provided to the Nursing Administration team on the Universal Covid 19 vaccination policy. Audits will be conducted on new hires to ensure they have a completed primary vaccination series. Weekly X3 then Monthly X3. The results of the audits will be reported and reviewed at the QAPI Committee Meeting Monthly X4 further evaluation if indicated. Oversight will be	

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F 888	Continued From page 112 under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this	F 888	provided by the Administrator or designee. F888 POC accepted 11/7/22 SFreeman RN/PMC	

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F 888	Continued From page 113 section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the	F 888		

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F 888	Continued From page 114 CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on interview and review of records, the facility failed to verify and ensure staff are fully vaccinated when using emergency, temporary staff. Per review of the facilities staff vaccination policy IC604 COVID-19 Vaccination dated 11/15/21, the National Healthcare Safety Network (NHSN) website, 3 different employee vaccine lists and other documentation revealed discrepancies with the facilities staff vaccination status. Per interview with the Infection Control Preventionist on 10/13/22 01:20 PM, "There are 2 unvaccinated staff with exemptions. Now that we are Genesis again, these two staff are grandfathered in, but any Genesis employee must be vaccinated upon hire."	F 888		

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F 888	Continued From page 115 The Facility provided a list of TLC nursing contracted emergency staff that consists of a combination of 16 Licensed Nurses Assistants (LNA's) and Nurses, and a copy of an Email to the agency, dated 10/13/22 time stamped 10:25AM, requesting vaccination verification for the 16 individuals on the list. Upon entrance to the facility, the evening of day one of survey (Sunday Oct 9th), according to the facilities actual working schedule "Genesis Daily Placement Sheet" there were a handful TLC staff working. The TLC nursing schedule sent via email from the agency dated 10/13/22 time stamped 2:37PM, reveals that these 16-nursing staff were scheduled as of 10/4/22. The ICP and a Regional Nurse Consultant confirmed that staff vaccination status was not provided on 10/10/2022 as requested, or again on 10/12/22, and that a list was provided on day 5 (10/13/22) at 1:00PM of survey. This list did not include agency staff. It was confirmed on this day, that the facility did not have staff vaccinations status for 16 TLC nursing staff "prior" to their working in the building. A new updated list was provided on day 6 of the survey (10/14/22).	F 888		
F 908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure all patient care equipment was maintained in safe operating condition.	F 908	F 908 The shower/tub room has been cleaned and tile floor has been repaired. The PVC shower bed in disrepair has been removed. Identified kitchen issues in need of cleaning or repair have been corrected.	

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F 908	Continued From page 116 1.) Observation on 10/9/22 at 9:08 PM of the tub/shower/whirlpool room revealed a shower area that was separated from a second shower area and a whirlpool tub area. Upon entering the tub/shower/whirlpool room to the left is a shower area that was noted to be dirty, the floor had many broken tiles, some missing pieces of tile, most of the grout that was between the remaining tiles was gray, black, or yellow in color. To the left of the tub/shower/whirlpool room, to the right of the first shower area was a second shower area that revealed a PVC (polyvinyl chloride) pipe shower bed with thick plastic foam covered mattress that was in disrepair. The headrest of the plastic foam covered mattress revealed 3 slits and a piece of clear plastic tape that exposed the foam mattress. Upon touch of the foam mattress, it was noted to be moist and with a little applied pressure a clear liquid oozed out of the foam mattress. Interview on 10/9/22 at 9:30 PM with the emergency response nurse, who confirmed that the shower room was a mess, had several issues as noted above, and that s/he would leave a note for the oncoming shift nurse to address these identified concerns. Interview on 10/9/22 at 1:00 AM with a facility staff nurse who had relieved the emergency response nurse, who stated she/he was not aware the equipment was in disrepair but confirmed the slits in the plastic covering of the mattress which exposed the foam mattress. She/he also confirmed that the tub/shower/whirlpool room was dirty, tiles were broken or missing. 2.) Observation on 10/9/22 at 11:53 PM the	F 908	All Residents have the potential to be affected by the deficient practice. Education will be provided to the Maintenance Director and Maintenance staff on routine maintenance. Education will be provided to the dietary staff on policy HCSG027, regarding food service equipment will be cleaned, sanitized and in working order. Audits will be conducted on the Environment to include preventative/routine maintenance Weekly X3 then Monthly X3. Audits will be conducted on kitchen sanitation, equipment cleanliness and equipment in working order Weekly X3 then Monthly X3. The results of the audits will be reported and reviewed at the QAPI Committee Meeting Monthly X4 further evaluation if indicated. Oversight will be provided by the Administrator or designee. F908 POC accepted 11/7/22 SFreeman RN/PMA	

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F 908	Continued From page 117 survey team did a walkthrough of the facility's main kitchen with the ICP (Infection Control Preventionist), the following issues were observed and confirmed by the ICP person at the time of these observations: a.) The food puree machine pitcher was cracked all the way around the bottom of the container just above where the blades are located inside the pitcher. b.) The food puree machine pitcher was cracked all the way around the bottom of the container just above where the blades are located inside the pitcher. c.) An air conditioner was observed in one of the windows across from the table where the mixer, puree machine and various other equipment for food prep were stored. The air conditioner was noted to have a thick and sticky substance on the front grill where the cool air comes out of the conditioner and into the environment. Within this thick and sticky substance was noted some hair, dust, and insects. d.) Several plastic tub lids were noted to have large holes that appeared to have teeth marks. When asked about these holes and quetionable teeth marks in the identified lids, the Food Service Director (FSD) and her/his supervisor responded that the rats had chewed through the covers of some of the heavy-duty storage tubs where dry goods/foods are being kept since the mice and rat issue started. Observation on 10/10/22 at 8:45 AM of the kitchen with the FSD and her/his supervisor. A walk-through of the kitchen occurred and revealed the above findings from the evening of 10/9/22 to continue to be identified issues.	F 908		

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F 908	Continued From page 118 Interview on 10/10/22 at approximately 9:45 AM with the FSD and her/his supervisor, both confirmed the above findings.	F 908		
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain an effective pest control program that ensures the facility is free of pests and rodents. Findings include: Tour on 10/9/22 at approximately 8:35 PM of the second floor, revealed a small room behind the nurses station that revealed a clipboard hanging on the wall to the left of the room entrance. The clipboard contained a form that was titled, "TRAP CHECK DATE LOG 2022" with the following information documented: "8/15/22 small rat over cooler; 8/16/22 med rat diet office; 10/3/22 checked traps all; 10/10/22 checked traps all; 9/7/22 check all; 9/16/22 check all; 9/23/22 check all; 9/30/22 check all" The third floor Pest Log had one entry on 9/19/2022 that stated "RT (Rat) Caught in trap in ceiling at nursing station."	F 925	F 925 The facility is contracted with a pest control vendor for appropriate ongoing services. All Residents have the potential to be affected by the deficient practice. Education will be provided to staff regarding environmental cleaning and proper food storage. Education will be provided to the Maintenance staff on Infection Control policy 1.5 specific to Pest control. Education will be provided to the dietary staff on HCSG policy 029 for pest control. Education will be provided to the nursing staff on reporting pest management issues in the TELs system. Audits will be conducted on environmental cleanliness, pest control process and pest control monitoring and use of TELs to report pest control issues.	

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F 925	Continued From page 119 The above referenced form was not in chronological order and was documented as is written above. Observation on 10/9/22 at 9:41 PM of the second floor dining area revealed the following issues in the resident dining area and kitchenette: *tray with dirty dishes and exposed food; *dirty refrigerator and freezer with spills inside on the shelves and on the inside of the door shelves; *11 pieces of cheese partially wrapped in plastic wrapped, that are curled and dried on one corner of each piece; *cabinet drawers with miscellaneous kitchen disposables (small paper bags, pieces of various sizes of tinfoil, packets of tea, hot cocoa and a binder clip) scattered through the drawer and what appeared to be coffee grounds mixed in with these items. *Another drawer with small plastic disposable lids, some in the plastic protective sleeve and many out of the sleeve and scattered throughout the drawer, an individual package of crackers, and various single serve condiment packets, and what appeared to be coffee grounds mixed in with these items. *dirty microwave; *large metal mouse trap noted under the a utility rack in the kitchenette serving area; *a rat trap located between the refrigerator and the wall of the kitchenette serving area. Observation on 10/10/22 at 8:15 AM revealed the above noted issues identified on 10/9/22 at 9:41 PM were still present. Interview on 10/10/22 at 8:45 AM with the Food	F 925	Weekly X3 then Monthly X3. The results of the audits will be reported and reviewed at the QAPI Committee Meeting Monthly X4 further evaluation if needed. Oversight will be provided by Administrator or designee. F925 POC accepted 11/7/22 SFreeman RN/PMC	

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F 925	Continued From page 120 Service Director (FSD) and FSD's Supervisor, who confirmed the above findings. They stated that some parts of the kitchenettes and serving areas are the responsibility of housekeeping and some by nursing. Observation on 10/10/22 at approximately 8:50 AM during a kitchen walk-through/kitchen tour with the FSD and her/his supervisor revealed numerous food sources for pests and rodents. In the corner of the kitchen, behind the 2nd entrance/exit door at opened to the first floor hallway, was a sticky mouse trap that was covered with various sizes of black spots. Upon closer inspection these black spots were ants, spiders, flies (large and small), and various other insects and dirt. To the left of the sticky trap was a large metal mousetrap. In front of the above-mentioned sticky trap was a substance that was dark brown with variations of brown, yellow, black, and red. This substance appeared wet and was noted to be sitting in an area that was wet with a clear grayish color that extended from the sticky trap and mouse trap and encompassed this unidentified brown object. The object could not be identified on 10/9/22 by the survey team or the accompanying Infection Control Preventionist (ICP). The FDS put on a glove and picked up the unidentified item/substance and said she/he thought it was "a piece of petrified sausage". The mouse traps were observed and the FSD and FSD Supervisor confirmed that there are mice in the facility. When asked about whether they had seen any rats, they confirmed that they had in the past and plastic tubs were purchased to store and protect food from rodents. Several plastic tub lids were noted to have large holes	F 925		

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F 925	Continued From page 121 that appeared to have teeth marks. When asked about these holes and questionable teeth marks both staff responded that the rats had chewed through the covers and some of the heavy-duty storage tubs. A mouse trap was observed in the dry storage area under a commercial utility rack along with a square black box. When asked what this box was, the FSD Supervisor picked it up and looked it over and said she/he didn't really know but said she/he would get the maintenance man to help figure it out. At approximately 9:15 AM a maintenance staff person came to the dry storage area and explained that the black box was a "bait box" for rats and confirmed that the facility has had an issue with rats and a professional company had been involved but now the maintenance department was responsible for checking the traps. The maintenance staff was asked if she/he had actually seen rats in the building and she/he responded with, "yes". When asked when the last time was that she/he saw a rat in the building and where she/he saw the rat, she/he stated, "last month we caught a large one in the rat trap in the ceiling above the second floor nurses station." She/he was asked to explain the "bait box" and how that works. She/he stated that the maintenance department does not have access to the bait boxes but that [pest control company name] had placed these boxes throughout the inside and outside of the facility and that they were the only ones who could open these boxes to refill them with bait for the rats. When asked how often the pest control company checks these traps, the maintenance person stated that she/he believed it was several times a week but that they hadn't been there since some time this past August due to a disagreement between the pest control company and the facility "something to do with payment".	F 925		

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F 925	Continued From page 122 Interview on 10/10/22 at approximately 11:15 AM with the Director Of Maintenance confirmed that there are many mouse and rat traps throughout the building and outside the building. She/he explained that there was a disagreement between the facility and the pest control company regarding an outstanding bill. She/he explained that she/he believed the $6,000 bill was from the previous management and that the new management was trying to work out the particulars regarding the past due amount. Copies of pest control reports revealed that the pest control company was last in the building providing services in August of 2022. Further interview with the facility Administrator on 10/14/22 at 10:24 AM who confirmed that "the [name of pest control company] came in yesterday". She/he explained that there was an issue with payment and that is why [name of pest control company] has not been providing services to the facility since this past August - she/he stated that she/he paid them with her/his personal credit card and a new contract was in process.	F 925		
F 943 SS=F	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.	F 943	F 943 The 15 Emergency response contracted staff are no longer working at the facility. All Residents have the potential to be affected by the deficient practice.	

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F 943	Continued From page 123 §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to provide training to all staff that at a minimum educates staff to include agency/contract staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property. Findings include: While investigating an allegation of abuse, staff training records specific to abuse, neglect, exploitation, and misappropriation of resident property were requested and reviewed. The Staff Educator and Infection Preventionist were interviewed on 10/11/22 at 1030 AM, it was revealed that the facility uses agency staffing to fill projected vacancies and emergency temporary agency staffing during the current Covid-19 outbreak. When questioned regarding the qualifications and competencies of the emergency staff the Infection Preventionist replied "aside from getting them computer access we don't even know who they are". Records regarding training for the agency staff were obtained by the facility from the agency per surveyor's request, the records provided included self-assessments and contained various check lists of education related to competencies without evidence of measurable patterns of knowledge related to abuse, neglect, exploitation, or misappropriation of resident property.	F 943	Education will be provided to staff on Abuse Prohibition policy OPS300 with a post test. Audits will be conducted on Abuse training with newly hired or contracted staff to ensure staff have received Abuse training. Weekly X3 then Monthly X3. The results of the audits will be reported and reviewed at the QAPI Committee Meeting Monthly X4 further evaluation if indicated. Oversight will be provided by the Administrator or designee. F943 POC accepted 11/7/22 SFreemanRN/PMC	

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F 943	Continued From page 124 Per review of a list of emergency response staff provided by the facility, there were 15 emergency response staff which included 7 nurses and 8 Licensed Nursing Assistants (LNAs) scheduled during the current Covid outbreak. Of the 15 emergency responders there was no evidence that the facility provided training or were assessed for competency related to abuse prevention or response prior to assuming a resident assignment. During an interview on 10/13/2022 at 10:46 AM the staff educator confirmed that the 15 emergency responders did not receive training, nor were they assessed for competencies related to abuse.	F 943		