VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

December 7, 2023

Ms. Tabitha Davis-Barron, Administrator
Bennington Health & Rehab
2 Blackberry Lane
Bennington, VT 05201-2300

Dear Ms. Davis-Barron:

Enclosed is a copy of your acceptable plans of correction for the recertification survey that was conducted in conjunction with a complaint investigation on **November 1, 2023.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

PamelaMCotaRN
Pamela M. Cota, RN
Licensing Chief

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475027	A. BUILDING _____ B. WING _____	C 11/01/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 11/1/2023. There were no regulatory violations identified.	E 000	This plan of correction was written to follow state and federal guidelines. It is not an admission of noncompliance. However, it is the facility's commitment to demonstrate and maintain compliance.	11/29/23
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey in conjunction with six complaint investigations from 10/30/23 through 11/1/23 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following deficiencies were cited as a result of this survey, as well as a determination of Substandard Quality of Care due to the violation at 483.45(f)(2) - F760.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to determine whether it is clinically appropriate for residents to self-administer medications for 1 of 29 residents (Resident #20). Findings include: Per record review, Resident #20 was admitted to the facility on 9/7/2023 with diagnoses that include congestive heart failure, respiratory failure, and a need for assistance with personal care.	F 554	F554 Specific Corrective Action 1. Resident #20 had a self administration assessment completed for the use of the inhaler on 10/31/2023 . It was determined that the patient can self-administer safely. The patient was instructed in Self-administration, a physician's order was obtained, a locked compartment was provided to secure the medication at bedside, and CP was updated for self administration. 2. An audit of residents wishing to self administer medication was completed to validate the resident had a current self administer of medication evaluation, a method to secure the medication at bedside, a CP to include self administration, and a MD order.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: LNHA

(X6) DATE: 11/24/23

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F 554	Continued From page 1 Per observation of Resident #20's room on 10/30/2023 at 11:00, an Albuterol Inhaler (Albuterol is a medication used to prevent the muscles that line the airways from tightening, resulting in wheezing and coughing], was on the bedside table. Per interview on 10/30/23 at approximately 11:00, Resident # 20 stated that she/he uses the inhaler a few times daily. She/he does not advise the nurses when it is used. Review of the facility policy for Medication Self Administration initiated on 6/1/1996 and reviewed by the facility on 3/1/2022, states the following: Patients who request to self-administer medications will be evaluated for safe and clinically appropriate capability based on the patient's functionality and health condition If it is determined that the patient can self-administer, A physician's order is required, Self-administration and medication self-storage must be care planned, and the patient must be instructed in self-administration, and an evaluation of capability must be performed initially, quarterly, and with any significant change in condition. Further record review revealed that the medical record had no documentation of a physician's order to self- administer, or a capability assessment. The self-administration of the medication is not evident in the care plan. The Medication Administration Record has no documentation that the Resident used the Albuterol Inhaler in the last 30 days. Per interview on 11/1/2023 at aproximately 9:00	F 554	F554 continued.. 3. The facility ensures that patients, who request to self-administer medications, will be evaluated for safe and clinically appropriate capability based on the patient's functionality and health condition If it is determined that the patient can self-administer, A physician's order is required, Self-administration and medication self-storage must be care planned, and the patient must be instructed in self-administration, and an evaluation of capability must be performed initially, quarterly, and with any significant change in condition. Licensed staff will be re-educated to this process. 4. DON/Designee will complete audits of residents requesting to self administer medication to validate a current self administration of medication evaluation was completed, the resident was instructed on use, a MD order was obtained, and a CP was initiated. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then Monthly x 3 months. Results of these audits will be brought to the QAPI Committee for further review and recommendations **Tag F 554 POC accepted on 12/7/23 by S. Freeman/P. Cota**	

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F 554	Continued From page 2 AM, a Licensed Practical Nurse (LPN) stated that she/he does not know when the resident uses the inhaler. Per interview on 11/1/2023 at 10:00 AM with the DON (Director of Nursing), She/he confirmed that a physician's order was not obtained, an assessment was not completed, and the self-medication was not documented in the care plan according to the facility policy.	F 554		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to treat 1 of 29 sampled residents (Resident # 53) with respect and dignity and recognize the resident's individuality. Findings include: Per interview on 10/30/2023 at approximately 11:30 AM with the family of resident #53, a concern was voiced that Resident #53 was called by her/his first name and not her/his middle name as she/he preferred. She/he had requested that their middle name be posted on the room door to alert the staff.	F 557	F557 Specific Corrective Action 1. Resident #53 preferred name was updated on the outside of the door. Her preferred name was added to special instructions , and updated in the plan of care. 2. Residents were interviewed to validate that staff are aware of the residents preferred name. This included validation that the CP, Special instruction section of the chart, and the name outside the resident's door was consistent with the resident's preferred name. 3. The facility treats all residents with respect and dignity and recognize the resident's individuality, inclusive of the resident’s preferred name. The facility staff will be re-educated to this process. 4. The NHA/Designee will complete random interviews to validate the staff are respecting residents by way of using their preferred name. These interviews will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	11/29/23

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F 557	Continued From page 3 Per interview on 10/31/2003 at approximately 10:00 AM an LNA (Licensed Nursing Assistant) stated she/he knew Resident #53 by her/his middle name as it had been told to her several times by family. She/he said the preference should be found in the special instructions area of the medical record. Per record review, Resident #53 was admitted to the facility on 9/22/20223. A discharge summary from the transfer facility has a note under the resident's legal name that states "Prefers to be called [Resident #53's middle name]." Resident #53's care plan does not reflect the preference; the displayed name on her/his room is her/his first and last name. There is no entry under special instructions in the medical record. Per interview on 11/1/2023 at aproximately 3:00 PM, the Director of Nursing confirmed that the care plan should reflect the preference of Resident #53 to be called by her/his middle name, the medical record is not updated to reflect her/his preference, as well as the name on Resident #53's door. She/he confirmed the facility failed to respect the dignity and recognize Resident # 53's individuality.	F 557	**Tag F 557 POC accepted on 12/7/23 by S. Freeman/P. Cota**	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits,	F 583	F583 Specific Corrective Action 1. Resident #253 and Resident #59 personal and medical records are maintained and private to those without authorization to the information.	11/29/23

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F 583	Continued From page 4 and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based upon observation and interview, the facility failed to ensure the right to personal privacy and confidentiality of personal and medical records for 2 residents [Res.#259 and #53] of 29 sampled residents. Findings include: Per observation on 10/31/23 at 8:45 AM during the medication pass on the 3rd floor resident unit, the computer screen on the medication cart was open to a resident name [Res.#259], photograph, medications, and diagnoses. The Staff nurse	F 583	F583 continued.. 2. An audit was completed of the facility to validate residents medical record information is safeguarded and only visible to those with authorization. 3. The facility ensures that residents have a right to personal privacy and confidentiality of his or her personal and medical records. This includes safeguarding of the electronic medical record from those without authorized access to the information. Facility staff will be re-educated to this process. 4. NHA/Designee will complete walking rounds to validate medical and personal records are safeguarded from those without authorization, inclusive of visible medication blister packs and visible computers screens both handheld and affixed to mobile medication carts. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. **Tag F 583 POC accepted on 12/7/23 by S. Freeman/P. Cota**	

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F 583	Continued From page 5 administering medications was away from cart and in resident room #314. Per observation, 2 residents were in proximity of the medication cart with the open resident screen. Additionally, per observation a second medication cart was located against the wall abutting the elevator across from the nurse's station. Visible in the trash container affixed to the side of the medication cart was a medication blister pack with a label listing a resident's name [Res. #53] and medication name. Per observation, 2 residents were in proximity of the medication cart with the blister pack and resident label. An interview was conducted with the Director of Nursing [DON] on 11/1/23 at 1:00 PM. The DON confirmed both the open computer screen and the medication label visible in the trash breached residents' rights to personal privacy and confidentiality of his or her personal and medical records.	F 583		
F 585 SS=F	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	F 585	F585 Specific Corrective Action 1. The events happened in the past and can't be corrected. 2. An audit of grievances for the last 30 days was completed to validate that a written resolution was provided to the resident and/or representative regarding the filed grievance.	11/29/23

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F 585	Continued From page 6 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 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	F 585	F585 continued... 3. The facility ensures 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/ representitives'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. NHA, SS Director, and DON will be re-educated to this process. 4. NHA/Designee will complete audits of grievances to validate that a written resolution was provided to the resident and/or representative. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. **Tag F 585 POC accepted on 12/7/23 by S. Freeman/P. Cota**	

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F 585	Continued From page 7	F 585		

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 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:

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F 585	Continued From page 8	F 585		

Based on staff interview, record review, and review of facility policy, the facility failed to establish a grievance policy that ensures written grievance decisions meet documentation requirements of issuing a written decision that includes the date the decision was issued to all residents. Findings include:

Facility policy titled OPS204 Grievance/Concern, last revised 7/19/23, states that the department manager will "Notify the person filing the grievance of resolution in a timely manner. Provide written resolution for Civil Rights grievances, and upon request for all other grievances, by giving a copy of the Grievance/Concern Form to the patient/representative." The policy does not address the regulatory requirements that all residents, not just those that have Civil Rights grievances, be issued a written decision and that the written decision should include the date the written decision was issued.

4 of 4 grievance forms sampled did not indicate that a written decision, or the date that the decision was issued, was provided to the resident.

Per interview on 11/1/23 at approximately 4:56 PM, the Administrator stated that s/he does not provide a written copy of the grievance decision to residents unless they ask for it and was not aware that s/he had to.

Per interview on 11/1/23 at 4:58 PM the Market Clinical Advisor confirmed that written notices need to be given and dated as given to all residents following resolution of the grievance.

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F 622 F 622 SS=D	Continued From page 9 Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to §	F 622 F 622	F622 Specific Corrective Action 1. Resident #56 was discharged on 10/03/2023 2. All residents have the potential to be affected 3. The facility ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider by the resident's physician. Licensed and administrative staff will be re-educated to this process. 4. NHA/Designee will complete audits of resident records to validate the transfer and/or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider by the resident's physician. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. **Tag F 622 POC accepted on 12/7/23 by S. Freeman/P. Cota**	11/29/23

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F 622	Continued From page 10	F 622		

431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information

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(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on interviews and record review the facility failed to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility without ensuring documentation in the resident's medical record of the danger that failure to transfer or discharge would pose. Additionally, the facility failed to document in the resident's medical record communication with and the provision of required information to the receiving provider by the resident's physician for 1of 2 residents sampled (Resident's # 56) Findings include:

Resident #56 was transferred on 10/3/23 with the intent to be discharged and not readmitted. Resident #56 was admitted from home 16 days prior to being transferred and discharged to the local acute care hospital. Resident #56 was admitted for long-term care with a primary diagnosis of severe vascular dementia with psychotic disturbance. During this brief stay, Resident #56 demonstrated impulsive behaviors including sexual aggression, a severe lack of safety awareness demonstrated by climbing on top of unsteady items of furniture, tireless wandering, and self-injurious head banging.

On 10/2/23 following a display of numerous

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difficult behaviors including head banging, Resident #56 was sent emergently to the local acute care hospital by the facility physician for evaluation of "falls, other change in condition". Resident #56 was returned to the facility with "no significant findings".

On 10/3/23 Resident #56 was again sent emergently to the local acute care hospital with "behavioral symptoms". Per the medical record of 10/3/23 the following entry was placed by the Director of Nursing (DON) "Case Managers from Southern Vermont Medical Center (SVMC) had contacted Genesis Central Admissions Director to discuss the plan for [name]. We had sent a copy of notice of discharge with [name] to SVMC. I had told his/her spouse that we had done so when I notified him/her that we were sending [name] to ER, as well as what the factors were which precipitated the transfer and the discharge."
In a follow-up note on the same day, the DON added "SVMC nurse called to state [name] lab work was good and spouse reported [name] behaviors were typical for him/her and s/he was cleared for return to Bennington Health and Rehab. I advised the ER Nurse that BHR had discharged [name] and all Parties were duly informed (spouse and SVMC ER at the time of transfer, as well as SVMC case managers, additionally, we had emailed the notice of discharge to DAIL [staff name] as well as to Ombudsman Office."

On 11/1/23 at approximately 1:45 PM the facility Administrator, Director of Nursing, and the Market Clinical Advisor were interviewed regarding this occurrence. There was consensus that the intent of the transport on 10/3/23 was to discharge the resident without opportunity for return thus a

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facility-initiated transfer/discharge not originating through a resident's verbal or written request and is not in alignment with the admitting goals for care.
The administrative team confirmed there are no entries in the medical record made by the resident's physician that include:
The specific resident needs the facility could not meet;
The facility efforts to meet those needs; or
The specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility

When asked for copies of the required information provided to the receiving provider by the facility physician which must include a minimum of the following information, the surveyor was advised this information had not been provided in writing.
(A) Contact information of the practitioner responsible for the care of the resident;
(B) Resident representative information including contact information;
(C) Advance Directive information;
(D) All special instructions or precautions for ongoing care, as appropriate;
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.

The administrative team confirmed an inability to produce documentation or other evidence that this information had been provided by the physician as required.

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F 625	Continued From page 14	F 625	F625 Specific Corrective Actions	11/29/23
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)	F 625		

§483.15(d) Notice of bed-hold policy and return-

§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-
(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to provide required notice of the bed-hold policy before transferring a resident to the hospital for 2 of 2 residents sampled (Residents #56 and #309). Findings include:

1. Resident #56 was discharged on 10/03/2023
Resident #309 was discharged on 07/18/2023

2. All resident have the potential to be affected

3. The facility provides required notice of the bed-hold policy before transferring a resident to the hospital. Licensed and administrative staff will be re-educated to this process.

4. NHA/Designee will complete audits of residents who discharge or transfer to the hospital to validate that the appropriate notice of bed-hold policy was provided before transferring a resident. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.

Tag F 625 POC accepted on 12/7/23 by S. Freeman/P. Cota

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F 625	Continued From page 15 1. Resident #56 was transferred without receiving notice of the facility bed-hold policy. Resident #56 was admitted from home 16 days prior to being transferred and discharged to the local acute care hospital. On 10/3/23 Resident #56 was sent emergently to the local acute care hospital with "behavioral symptoms". Per the medical record, a copy of the written discharge notice was sent with the resident and his/her spouse had been notified verbally of the transfer with intent to discharge. On 11/1/23 at 11:30 AM during an interview with the Administrator, Director of Nursing, and Market Clinical Advisor it was confirmed that a bed-hold notice had not been provided. 2. Per record review Resident #309 was admitted to the facility on 7/3/23 and transferred to the hospital on 7/18/23. Further review of the medical record revealed no documentation that Resident #309 was provided a bed-hold notice when transferred. Per interview on 11/1/2023 at approximately 4:45 PM with the Administrator, the Director of Nursing, and the Clinical Marketing Advisor, it was confirmed that the facility failed to provide Resident #309 with a bed-hold notice at the time of, or after transfer to the local hospital on 7/18/2023.	F 625		
F 626 SS=E	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on	F 626	F626 Specific Corrective Action 1. The incident happened in the past can not be corrected 2. All resident have the potential to be affected	11/29/23

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F 626	Continued From page 16 therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to permit a resident to return to the facility after a hospitalization resulting in a facility-initiated discharge for 2 of 2 residents sampled (Residents #56 and #309). Findings include:	F 626	F626 Continued... 3. The facility permits residents to return to the facility after they are hospitalized or placed on therapeutic leave. If the facility determines that a resident, who was transferred with an expectation of returning to the facility, cannot return to the facility because the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident and/or the health of individuals in the facility would otherwise be endangered, the facility follows the process for issuing a written discharge notice. Administrative staff will be re-educated to this process. 4. NHA/Designee will audit discharged resident's records to validate the process for allowing residents to return to the facility was followed. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. **Tag F 626 POC accepted on 12/7/23 by S. Freeman/P. Cota**	

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1. On 10/3/23 Resident #56 was sent emergently and discharged to the local acute care hospital with "behavioral symptoms". Resident #56 was admitted from home 16 days prior to being transferred and discharged to the local acute care hospital. Resident #56 was admitted with a primary diagnosis of severe vascular dementia with psychotic disturbance. During this brief stay, Resident #56 demonstrated impulsive behaviors including sexual aggression, a severe lack of safety awareness demonstrated by climbing on top of unsteady items of furniture, tireless wandering, and self-injurious head banging.

Per the medical record on 10/3/23 the following entry was placed by the Director of Nursing (DON) "Case Managers from Southern Vermont Medical Center (SVMC) had contacted Genesis Central Admissions Director to discuss the plan for [name]. We had sent a copy of notice of discharge with [name] to SVMC. I had told his/her spouse that we had done so when I notified him/her that we were sending [name] to ER, as well as what the factors were which precipitated the transfer and the discharge."
In a follow-up note on the same day, the DON added "SVMC nurse called to state [name] lab work was good and spouse reported [name] behaviors were typical for him/her and s/he was cleared for return to Bennington Health and Rehab. I advised the ER Nurse that BHR had discharged [name] and all Parties were duly informed (spouse and SVMC ER at the time of transfer, as well as SVMC case managers, additionally, we had emailed the notice of discharge to DAIL [staff name] as well as to Ombudsman Office."

On 11/1/23 at approximately 11 AM a document

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without indication of being a formal corporate document was provided to the surveyor by the Market Clinical Advisor. This document dated 10/3/23 identifies the resident and resident representative by name and states "We are transferring [name] to Southwestern Vermont Medical Center because the welfare and the resident's needs cannot be met in the facility as evidenced by:" with a list of behaviors included.

On 11/1/23 at approximately 1:45 PM the facility Administrator, Director of Nursing, and Market Clinical Advisor were interviewed regarding this occurrence. There is consensus that the intent of the transport on 10/3/23 was to discharge the resident without opportunity for return, agreeing that this was a facility-initiated transfer/discharge not originating through a resident's verbal or written request and is not in alignment with the admitting goals for care.

Refer to F622 for additional details regarding violations of transfer/discharge requirements for Resident #56.
2. Per an anonymous complaint submitted to the State Agency on 7/24/23, Resident #309 arrived at the ED (Emergency Department) on 7/18/2023 from Bennington Health and Rehab with a letter in hand that told him/her [Resident #309] the facility would not take her/him back. The complaint information alleged that the facility stated that they would not take the Resident #309 back because [s/he] masturbated and [s/he] grabbed one of their nurses. The Complainant stated that the resident was diagnosed with a UTI (urinary tract infection) upon admission to the hospital and was treated; it was confirmed that s/he does masturbate but has been respectful of others and has not had negative interactions with

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staff. The Complainant reports that Resident #309's medications were reviewed and adjusted and that Resident #309 was assessed and is not a danger to himself/herself or others.

Per interview on 11/1/2023 at 3:00 PM with the Director of Nursing (DON), Administrator, and the Clinical Marketing Advisor, the DON stated she/he had received multiple reports of Resident #309 exhibiting such behaviors as sitting in open doorways watching residents of the opposite sex, inappropriately touching staff of the opposite sex and residents, masturbating in front of staff, requesting entry into residents of opposite sex rooms.

Per the medical record, Resident #309 was admitted to the facility for long-term care in July 2023 with diagnoses of Type II Diabetes, Hemiplegia on the left side due to a stroke, COPD (Chronic Obstructive Pulmonary Disease, a disease of the lungs) and Alcohol and Nicotine Dependence. S/he was discharged to the local hospital on 7/18/2023. Resident #309 was sent to the local hospital for evaluation with the intent to transfer back to the location the resident was admitted from (a non-local hospital) on 7/18/2023. An entry dated 7/18/2023 by the DON states multiple phone calls to the non-local hospital with conflicting information on whether they would receive Resident #309. The final phone call was documented, "I received a second call from another supervisor who was refused admission to the ED (Emergency Department) as well as access to the VA center; I did inform [her/him] that I had clearance from the ER (Emergency Room) doctor as well as admissions and that I was discharging [her/him] with notice to not return to BHR (Bennington Health and

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F 626	Continued From page 20 Rehab) due to being a risk to others, [s/he] agreed that [s/he] could go to [non-local hospital] after medical clearance at SVMC ER (Southwest Medical Center Emergency Room.)" An Emergency Room Report dated 7/18/2023 states that Resident # 309 is being treated for a Urinary Tract Infection and was not exhibiting the behaviors that caused the acute transfer to the local hospital. Additionally, the note indicates that the non-local hospital was contacted and confirmed they do not have an available bed. Per interview on 11/1/23 at approximately 4:45 PM, the facility Administrator, Director of Nursing, and Market Clinical Advisor confirmed that the transport on 7/18/2023 was intended to discharge the resident without opportunity for return. Resident #309 was not reassessed or evaluated by the facility to establish the resident's current condition prior to refusing to allow her/him to return to the facility.	F 626	F636 Specific Corrective Action 1. Resident # 210 Admission MDS was completed on 11/01/2023	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least	F 636	2. An audit of comprehensive MDS assessments completed in the last 30 days was completed to validate assessments were completed timely 3. The facility completes a comprehensive MDS assessment within 14 days of admission. The MDS coordinator, NHA, and DON will be re-educated to this process.	11/29/23

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F 636	Continued From page 21 the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no	F 636	F636 Continued.. 4. NHA/Designee will complete audits to validate comprehensive assessments are completed within 14 days of admission. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. **Tag F 636 POC accepted on 12/7/23 by S. Freeman/P. Cota**	

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F 636	Continued From page 22 significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to complete a comprehensive assessment within 14 days of admission for 1 of 29 sampled residents (Resident #210). Findings include: Per record review, Resident #210 was admitted to the facility on 10/13/23. As of 11/1/23, 19 days after their admission, a comprehensive Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) was not completed for Resident #210. Per interview on 11/1/23 at 9:25 AM, the MDS Coordinator confirmed that Resident #210 did not have a complete MDS assessment within 14 days of admission as required.	F 636		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation	F 645	F645 Specific Corrective Action 1.A full PASARR was completed for resident #46 on 10/31/2023 2. An audit of resident records was completed to validate a full PASARR was completed for those residents, meeting criteria including those that exceeded a 30 day stay at the facility.	11/29/23

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F 645	Continued From page 23 performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in	F 645	F645 continued... 3. The facility requires that all admissions have a Preadmission Screening prior to entry into the facility. The facility requires a full PASARR for those individuals with a mental disorder and individuals with intellectual disability if the stay is expected to be >30 days. NHA, Social Services, and DON will be re-educated to this process. 4. NHA/Designee will complete audits to validate residents with a mental disorder and individuals with intellectual disability have a full PASARR completed for stays >30 days. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	

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F 645	Continued From page 24 the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to conduct a Level I "Pre-Admission Screening and Resident Review (PASARR)" for 1 of 29 sampled residents (Resident #46). This failure had the potential for Resident #46 to not receive specialized services. Findings include: Record review reveals that Resident #46 was admitted to the facility on 3/3/23 for rehabilitation related to pain management, cancer, and hip fracture. On admission, Resident #46 had a principal diagnosis of schizophrenia. Review of the electronic medical record "Documents" tab revealed a "State of Vermont Pre-Admission Screening and Resident Review (PASRR): Level I For Mental Illness, Intellectual Disability, or Related Condition" form signed by a physician for an exemption for a short- stay of 30 days or less. There is no date recorded on this screening form but the document tab reveals it	F 645	4. The NHA will follow the OPS300 reporting process and ensure all agencies are notified. **Tag F 645 POC accepted on 12/7/23 by S. Freeman/P. Cota**	

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F 645	Continued From page 25 was entered into the record on 3/6/23. There is no evidence that an updated PASARR was completed in full by the facility once Resident #46 exceeded their less than 30 days stay exemption. Per interview on 10/31/23 at 1:01 PM, the Social Service Director explained that the full PASARR form for Resident #46 was most likely not completed because there had not been social service staff in the facility for approximately six months. The Social Service Director confirmed that a full PASARR was not completed for Resident #46 after they exceeded a 30 day stay at the facility and should have been.	F 645		
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. (E) Social services. (F) PASARR recommendation, if applicable.	F 655	F655 Specific Corrective Action 1. Resident #33 discharged on 11/09/2023. Resident #210 currently has a care plan that addresses vision, depression, and mood. Resident #212 currently has a care plan in place to address dietary including the resident prescribed diet. 2. An audit of resident's baseline care plans were completed to validate care plans are in place that include the minimum healthcare information necessary to properly care for a resident including, but not limited to Initial goals based on admission orders, Physician orders, Dietary orders, Therapy services, Social services, PASRR recommendation, if applicable.	11/29/23

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F 655	Continued From page 26 §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 interview and record review, the facility failed to develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the resident for 3 of 29 sampled residents (Residents #210, #212, and #33). Findings include: 1. Per record review, Resident #210 was admitted to the facility on 10/13/23 for post operative care and antibiotic therapy related to surgical amputation to his/her left toes. An admission nursing assessment dated 10/13/23 reveals that Resident #210 has a history of a mental health disorder and confusion, has moderately impaired vision, has anxiety about	F 655	F655 continued.... 3. The facility developed baseline care plans within 48 hours of a resident's admission and include the minimum healthcare information necessary to properly care for a resident including, but not limited to Initial goals based on admission orders, Physician orders, Dietary orders, Therapy services, Social services, PASRR recommendation, if applicable. Licensed staff/IDT will be re-educated to this process. 4. NHA/Designee will complete audits of resident's records to validate CP are in place with measurable objectives and timetables to meet a patient's medical, nursing, nutrition, and mental and psychosocial needs, inclusive of participation of professionals in disciplines as determined by the resident's needs. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. **Tag F 655 POC accepted on 12/7/23 by S. Freeman/P. Cota**	

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F 655	Continued From page 27	F 655		

their surroundings, and has expressed the desire to leave the facility. A progress note dated 10/15/23 reveals that Resident #210 has expressed sadness or symptoms of depression and experiences loss of interest daily or almost daily. A 10/19/23 Physician assessment reveals that Resident #210 is experiencing a moderate episode of recurrent major depressive order and is prescribed an antidepressant. Per review of Resident #210's care plan, the baseline care plan does not address Resident #210's diagnosis of depression, use of an antidepressant, or impaired vision.

Per interview and observation on 10/30/23 at 1:04 PM, Resident #210 was observed in bed. A folded letter was at the bottom of his/her bed. S/He explained that s/he did not know about the letter because s/he was unable to see it. S/He explained that s/he was unable to read what it stated, and staff had not attempted to communicate the information to him/her. S/He was weepy and expressed that s/he does not want to be at the facility.

Per interview 10/31/23 at 12:50 PM, the Unit Manager indicated that s/he was not aware that Resident #210 had vision problems and was surprised that something had not been triggered to add this issue to his/her care plan.

Per interview on 10/31/23 at approximately 1:30 PM, the Market Clinical Advisor confirmed that Resident #210 did not have a baseline care plan that addressed vision or depression and should have.

Per interview on 11/1/23 at 10:13 AM, the Social Service Director explained that s/he was not

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aware of Resident #210's mood concerns because nursing staff had not relayed that information and confirmed that if s/he was aware of this issue, s/he would have created a care plan.

2. Per record review, Resident #212 was admitted to the facility on 10/20/23 with diagnoses that include end stage renal disease that requires dialysis, diabetes, dysphagia (difficulty swallowing), and malnutrition. Residents with the following diagnoses generally require specific dietary orders that restrict certain foods or are prepared with specific consistencies.

Review of Resident #212's baseline care plan reveals that they were not care planned for nutrition until 10/25/23, five days after admission, and the baseline care plan did not address dietary orders.

Per interview on 11/1/23 at approximately 3:30 PM, the Market Clinical Advisor confirmed that Resident #212 did not have dietary orders or a care plan for dietary orders within 48 hours of admission and should have.

3. Per record review, Resident # 33 was admitted to the facility on 10/18/2023 with diagnoses of Chronic Obstructive Pulmonary Disease, Respiratory failure, Mild cognitive impairment, and Disorientation. A care plan was created for Resident #33 on 10/30/2023. However, there was no documentation in Resident #33's medical record that a baseline care plan had been developed within 48 hours of her/his admission per regulatory requirements.

Per interview on 11/1/2023 at approximately 2:00 PM, the Director of Nursing stated that Resident

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F 655	Continued From page 29 #33's initial care plan was created on 10/30/2023, 12 days after Resident #33 was admitted to the facility. Per interview, on 11/1/2023 at aproximately 2:15 PM, the Clinical Marketing Advisor confirmed that a baseline care plan, due within 48 hours, had not been created for Resident #33 until 10/30/2023, 12 days later.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656	F656 Specific Corrective Action 1. Resident #8 current CP contains personalized interventions from the therapy department. 2. An Audit of residents receiving therapy services was completed to validate the CP contains personalized interventions from the therapy department. 3. The facility developed individual care plans for each patient with participation of professionals in disciplines as determined by the resident's needs. Licensed and rehab staff will be re-educated to this process. 4. NHA/Designee will complete audits of resident's records to validate CP are in place with measurable objectives and timetables to meet a patient's medical, nursing, nutrition, and mental and psychosocial needs, inclusive of participation of professionals in disciplines as determined by the resident's needs. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	11/29/23

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F 656	Continued From page 30 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to create a comprehensive care plan including the participation of professionals in disciplines as determined by the resident's needs for 1 of 29 sampled residents (Resident #8). Findings include: The care plan for Resident #8 does not include evidence of participation of or input from physical or occupational therapists. Per record review Resident #8 was admitted for skilled rehabilitation services from a local acute care hospital following an accident in which they suffered a knee injury. Admission orders for Resident #8 included both physical and occupational therapy evaluations and treatment as recommended. On 9/5/23 Resident #8 was evaluated by the therapy department and a plan	F 656	**Tag F 656 POC accepted on 12/7/23 by S. Freeman/P. Cota**	

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F 656	Continued From page 31 of treatment was created to include physical and occupational therapy five times per week. A review of Resident #8's care plan revealed entries from the nursing department for risk for falls which included transfer assistance and an entry for mobility assistance including "PT/OT screen as indicated" (Physical and Occupational therapies). There is no evidence of interdisciplinary input from the therapy department regarding the skilled rehabilitation services the resident was admitted for. There are no goals or benchmarks regarding skilled physical or occupational therapy. There are no specialized instructions from the therapy departments intended to promote the goal of physical rehabilitation. During interview on October 31, 2023, at 11:45 AM an occupational therapy assistant reviewed the documentation and confirmed that the care plan does not contain personalized interventions from the therapy department for Resident #8, adding that the facility therapy department is short-staffed.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657	F657 Specific Corrective Action 1. Resident #37, #42, #16, #31, #10, #14, #45, #9, and #1 Care plan was revised to include input by the IDT. 2. An audit of resident records was completed to validate the care plan was reviewed and revised quarterly by members of the IDT team including but not limited to the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, and a member of food and nutrition services staff.	11/29/23

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F 657	Continued From page 32 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to review and revise resident's care plans after each assessment and with the required team for 9 of 29 sampled residents (Residents #37, #42, #16, #31, #10, #14, #45, #9, and #1). Findings include: 1. Per record review during an interview on 11/1/23 at 3:43 PM with the Social Service Director the following was revealed regarding care plan meetings: Resident #37 had the following assessment dates: 5/3/23 and 7/19/23. A 5/12/23 care plan meeting note following the 5/3/23 assessment does not indicate that the attending physician, a nurse aide, or a food and nutrition service staff member were in attendance or provided input in the development and revision of the care plan. There is no explanation that participation from Resident #37 was not practicable in their medical	F 657	3. The facility reviews and revises the plan of care at a minimum quarterly and/or with a significant change in condition by members of the IDT team including but not limited to the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, and a member of food and nutrition services staff. The IDT will be re-educated to this process. 4. The NHA/Designee will complete audits to validate the resident's plan of care was reviewed and revised as necessary by the IDT. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. **Tag F 657 POC accepted on 12/7/23 by S. Freeman/P. Cota**	

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record. The Social Service Director reported that Resident #37 had a care plan meeting on 8/3/23 but could not produce documentation of the meeting, or any evidence of who was in attendance.

Resident #42 had the following assessment dates: 5/17/23 and 8/2/23. A 6/1/23 care plan meeting note following the 5/17/23 assessment does not indicate that the attending physician, a registered nurse (RN), a nurse aide, or a food and nutrition service staff member were in attendance or provided input in the development and revision of the care plan. There is no explanation that participation from Resident #42's Representative was not practicable in Resident #42's medical record. The Social Service Director reported that Resident #42 had a care plan meeting on 8/17/23 but could not produce documentation of the meeting, or any evidence of who was in attendance.

Resident #16 had the following assessment dates: 5/23/23 and 8/9/23. While there is evidence of a care plan meeting invitation to Resident #16's Representative for a 6/8/23 care plan meeting, there is no evidence that the interdisciplinary team met to review and revise Resident #16's care plan following their 5/23/23 assessment. There is no evidence that the interdisciplinary team met to review and revise Resident #16's care plan following their 8/9/23 assessment.

Resident #31 had the following assessment dates: 4/26/23 and 7/12/23. A 5/11/23 care plan meeting note following the 4/26/23 assessment does not indicate that the attending physician, an RN, a nurse aide, or a food and nutrition service staff member were in attendance or provided input in the development and revision of the care plan. There is no evidence that the

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interdisciplinary team met to review and revise Resident #31's care plan following their 7/12/23 assessment.
Resident #10 had the following assessment dates: 5/10/23 and 7/26/23. A 5/25/23 care plan meeting note following the 4/19/23 assessment does not indicate that a nurse aide or a food and nutrition service staff member were in attendance or provided input in the development and revision of the care plan. There is no explanation that participation from Resident #10 was not practicable in their medical record. The Social Service Director reported that Resident #10 had a care plan meeting on 8/17/23 but could not produce documentation of the meeting, or any evidence of who was in attendance.
Resident #14 had the following assessment dates: 6/21/23 and 8/8/23. The Social Service Director reported that Resident #14 had a care plan meeting on 7/6/23 but could not produce documentation of the meeting, or any evidence of who was in attendance. There is no evidence that the interdisciplinary team met to review and revise Resident #14's care plan following their 8/8/23 assessment.
Resident #45 had the following assessment dates: 6/28/23 and 9/28/23. A 7/13/23 care plan meeting note following the 6/28/23 assessment does not indicate that a nurse aide or a food and nutrition service staff member were in attendance or provided input in the development and revision of the care plan. There is no evidence that the interdisciplinary team met to review and revise Resident #45's care plan following their 9/28/23 assessment. The Social Service Director reported that a care plan meeting was scheduled for 10/25/23 and rescheduled for November 2023 so that Resident #45's Representative could attend.
Resident #9 had the following assessment dates:

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6/20/23, 7/12/23, and 10/12/23. A 6/29/23 care plan meeting note following the 6/20/23 assessment does not indicate that the attending physician, an RN, a nurse aide, or a food and nutrition service staff member were in attendance or provided input in the development and revision of the care plan. Social Service Director reports that Resident #9 had a care plan meeting on 7/23/23 but could not produce documentation of the meeting, or any evidence of who was in attendance. A 11/1/23 care plan meeting note following the 10/12/23 assessment does not indicate that the attending physician, an RN, a nurse aide, or a food and nutrition service staff member were in attendance or provided input in the development and revision of the care plan. Resident #1 had the following assessment dates: 5/3/23, and 7/19/23. A 5/18/23 care plan meeting note following the 5/3/23 assessment does not indicate that the attending physician, an RN, a nurse aide, or a food and nutrition service staff member were in attendance or provided input in the development and revision of the care plan. An 8/3/23 care plan meeting note following the 7/19/23 assessment does not indicate that the attending physician, a nurse aide, or a food and nutrition service staff member were in attendance or provided input in the development and revision of the care plan.

When asked about gaps in care plan meetings, The Social Service Director stated that the facility had been missing a Social Service Director for months prior to their starting work at the facility over the summer. Also, multiple meetings have needed to be rescheduled due to staff illness. S/He confirmed that the meetings listed above did not have attendance from the required interdisciplinary team members.

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F 658 SS=E	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 observation and interview the facility failed to provide services meeting professional standards regarding the use and monitoring of an IV (intravenous line) (Resident #210), and medication administration through a gastrostomy tube (G-tube- a tube that is inserted into the stomach to provide nutritional support in patients with impaired swallowing secondary to various disorders) (Resident #53) for 2 of 29 residents in the sample. Findings include: 1. Per record review, Resident #210 was admitted to the facility on 10/13/23 for post operative care and IV antibiotic therapy related to surgical amputation to his/her left toes. An admission nursing assessment dated 10/13/23 reveals that Resident #210 has a left upper arm PICC line (peripherally inserted central catheter; IV). A 10/26/23 progress note reveals that Resident #210's IV became completely dislodged from their left upper arm. A 10/27/23 skin assessment reveals that Resident #210 has a left lower arm IV line. Review of Resident #210 Medication Administration Record (MAR) reveals physician orders for Ertapenem Sodium (antibiotic) administered intravenously every 24 hours for 28 days, started on 10/14/23, and observation of the IV site every shift, from 10/13/23 through	F 658	F658 Specific Corrective Action 1. Resident # 210 Peripheral IVLine was removed on 10/31/2023. Resident #53 ordered medications are delivered separately through the enteral tube. 2. An audit of residents with orders for IV therapy was completed to validate IV catheters are necessary and are monitored for complications. An audit of residents with enteral tubes used for the delivery of medication was completed to validate medications are administered one at time providing flushing in between each single medication administration. 3. The facility staff maintain IV catheters only when necessary and these IV catheters are monitored for complications. The facility provides medications via enteral tubes that follows the standards to deliver each medication separately. Licensed staff will be re-educated to this process. 4. DON/Designee will complete audits including observations of residents with IV catheters to ensure they are necessary and monitored. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAI Committee for further review and recommendations.	11/29/23

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F 658	Continued From page 37 10/30/23. Review of Resident #210's care plan reveals an intervention to inspect the catheter site every shift. Per observation on 10/30/23 at 3:45 PM, Resident #210 has an IV site on his/her left lower arm dated 10/16/23 and an IV site on his/her upper left arm dated 10/27/23. Per interview on 10/31/23 at 4:30 PM, a Licensed Practical Nurse explained that s/he was unsure why Resident #210 had two IV sites. At 4:31 PM, a Registered Nurse explained that Resident #210 recently had a new IV site placed and thinks that the other IV site was never removed but would have to check. Professional standards indicated that the goal is to remove an IV site as soon as possible to prevent further complications and nurse documentation of IV site monitoring should be complete and accurate. There is no evidence that both IV sites were monitored for complications, instructions in the physician orders as to what IV site was meant to be used for IV antibiotic administration, or a plan was made to remove the unused IV site. Sandra M. Nettina, MSN, ANP-BC, ed. 2019. Lippincott Manual of Nursing Practice - 11th Ed. Philadelphia, PA. Lippincott Williams & Wilkins. 2. On 10/31/23 at 8:26 AM during medication pass observation the surveyor observed a Licensed Practical Nurse (LPN) administer 8 medications simultaneously to Resident #53 via a G-Tube. The LPN was observed putting the 8 individual medications (one medication dose required 3	F 658	F658 Continued... DON/Designee will complete audits including observations of residents with enteral tubes to validate that medication delivered through the enteral tube are provided one at time with flushing noted in between each medication. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. **Tag F 658 POC accepted on 12/7/23 by S. Freeman/P. Cota**	

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individual pills) equaling 10 tablets into a small bag and using a pill crusher crushing the medications together and then mixing them into an unspecified amount of water. Per the LPN "I mix them with water because it tends to clog the tube." When asked if s/he had given this resident medication this way before s/he said they had. The surveyor and the LPN entered the resident's room where the LPN raised the bed but did not elevate the head of the bed, s/he donned gloves without performing hand hygiene, using a piston syringe aspirated stomach contents with scant return. The LPN then using the piston syringe administered 30 cc of water, added the medication/water mixture to the syringe and administered it. The LPN then rinsed the medication residue out of the syringe and followed by flushing the tube with 30cc of water. Following the final instillation of water, the medication cup was noted to have medication residue on the bottom of the cup including yellow powder and small bits of what appeared to be white pills. The cup with medication residue was shown to the LPN who agreed there was medication left over but made no attempt to further administer the residue.

At 9:15 AM the cup with residue was provided to the Market Clinical Advisor who stated the expectation for giving crushed medications via g-tube would be to give them one at a time and agreed the residue in the cup represented partial doses that were not administered. The Market Clinical Advisor was also notified that the head of the bed had not been elevated and returned to the surveyor to confirm it had not been, but s/he had raised it.

A review of the medical orders for Resident #53

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F 658	Continued From page 39 includes an order instructing the nurse to "elevate the head of the bed 60 minutes after medication administration via tube". A review of the facility provided "Specific Medication Administration Procedures" in section IIB13: Enteral Tube Medication Administration under procedures: A.If resident is in bed, elevate head of bed to 30-45 degree angle. C. Wash hands and wear gloves. L. Administer each medication separately, flushing tube with 5 ml of water after each dose. N. Leave head of bed elevated for 30 minutes to prevent aspiration of stomach contents. A literature review regarding the instillation of medication via a G-tube was conducted and in a May 6, 2010 article entitled 'Preventing Errors when Administering Drugs Via an Enteral Feeding Tube" published by the Institute for Safe Medication Practices (ismp.org) it states "Each medication should be administered separately through the feeding tube" noting compatibility between multiple drugs being administered together can be a problem, particularly if two or more drugs are crushed and mixed together before administration. Mixing two or more drugs together ...creates a brand new, unknown entity with an unpredictable mechanism of release and bioavailability (relating to absorption of the medication).	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677	F677 Specific Corrective Action	11/29/23

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F 677	Continued From page 40 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Per observation, interview, and record review, the facility failed to provide showers as needed for 2 of 29 sampled residents (Residents #210 and #212) and failed to provide transfer assistance within a reasonable amount of time for 1 of 29 residents (Resident #212). Findings include: 1. Per record review, Resident #210 was admitted to the facility on 10/13/23 for post operative care and antibiotic therapy related to surgical amputation to his/her left toes. Review of Resident #210's care plan reveals a focus "[Resident #210] requires assistance for ADL [activities of daily living] care related to: Recent illness, fall, hospitalization, etc resulting in fatigue, activity intolerance, confusion, etc. Amputation of toes.," created 10/13/23, with the intervention, "provide resident/patient with limited assist of 1 for bathing," created on 10/13/23. Per observation and interview on 10/30/23 at 1:04 PM, Resident #210 explained that s/he has not been offered a shower since s/he has been here. S/He explained that s/he has been cleaning his/herself up in bed but s/he wants a shower. Resident #210 has dirt underneath all his/her fingernails and his/her hair is greasy. Per review of Licensed Nursing Aide (LNA) documentation, Resident #210 did not have a shower between 10/13/23 through 10/30/23. 2. Per record review, Resident #212 was admitted to the facility on 10/20/23 for management of diabetes, renal disease, and	F 677	F677 continued .... 1.Resident #210 and #212 are receiving showers per their preference Resident #212 is being assisted with transfers per the residents identified need. 2. An audit of resident records was completed to validate residents are receiving showers per their preference and being provided assistance with ADL including transfers per assessment of the residents' needs. 3. The facility offers showers and/or tub baths per the residents preference at a frequency requested by the resident. The facility provides assistance with ADLs as indicated through assessments of the resident required needs. The facility nursing staff will be re-educated to this process. 4. DON/Designee will complete audits of resident ADL documentation to validate that the residents are receiving showers per the residents preference and are receiving assistance for adls as indicated by the residents assessed needs. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	

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weakness. Review of Resident #212's care plan reveals a focus "[Resident #212] requires assistance for ADL care in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: recent illness, fall, hospitalization, etc. resulting in fatigue, activity intolerance, confusion, etc., chronic disease/condition," created on 10/20/23, with the following interventions, "provide [Resident #212] with total assist of 2 for transfers via Hoyer [lift]," created 10/20/23, and "Provide [Resident #212] with extensive assist of 2 for bathing," created on 10/20/23.

Per observation and interview on 10/30/23 at 2:33 PM, Resident #212 was in his/her wheelchair with food on their face and clothes. S/He stated that s/he has not had a shower since they were admitted and would like one but s/he is unable to get help from staff when s/he needs it.

Per observation and interview on 10/31/23 at 9:32 AM, Resident #212 was heard from the hall screaming "hello," over and over again. When asked, Resident #212, who was in bed, said that s/he had been waiting at least 30 minutes for someone to help him/her out of bed. At 10:04 AM, it was brought to staff's attention that Resident #212 had been observed calling for help for over 30 minutes and reported to be waiting even longer to get out of bed. Staff were observed entering Resident #212's room to assist him/her out of bed at 10:05 AM, approximately an hour after Resident #212 reported that s/he first asked for help.

Per observation and interview on 10/31/23 at 3:48 PM, Resident #212 was sitting next to his/her bed in their wheelchair. S/He stated that s/he had

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F 677	Continued From page 42 been waiting a long time for staff to come and get him/her into bed. At 4:06 PM, a Licensed Nursing Aide (LNA) went into Resident #212's room and turned off the call light. This LNA was asked if s/he was going to get Resident #212 into bed. The LNA said yes but s/he had to wait for someone else to help because the resident requires two staff for transfers and the unit is short staffed, so sometimes it takes a while. Per review of Licensed Nursing Aide documentation, Resident #212 did not have a shower between 10/20/23 through 10/30/23. Per interview on 10/31/23 at 4:29 PM, a Registered Nurse confirmed that Residents #210 and #212 had not been put on the unit's showering schedule yet.	F 677		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to provide an ongoing program to support residents designed to meet the interests of and support the physical, mental,	F 679	F679 Specific Corrective Action 1. The residents on the 2nd floor are being provide an ongoing program to support residents that is designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community 2. All resident have the potential to be affected	11/29/23

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and psychosocial well-being of each resident, encouraging both independence and interaction in the community for residents on the second-floor unit. Findings include:

1. Per observation on 10/30/23 between 10:55 AM and 11:10 AM, 4 residents were observed in the common area. A movie is playing on the television but none of the 4 residents are paying attention to the movie. One of the residents, Resident #31 is yelling out phrases about dying and her father. There are no staff present during this time.

Per observation on 10/30/23 between approximately 3:30 PM and 4:30 PM, three residents were sitting around the second-floor nursing station not doing anything while staff assisted other residents with care.

Per observation on 10/31/23 between 9:00 AM and 10:15 AM five residents were sitting around the second-floor nurses' station at 9:20 AM another resident was brought to the nurse's station. The residents were unattended and not engaged in any type of activity.

Between 10/31/23 and 11/1/23, while some activities occurred off the unit, no activities listed on the activities calendar were observed on the unit. Multiple times throughout this time frame, groups of 3 to 6 residents would sit by the nursing station for extended periods of time without any engagement.

2. Resident #42's care plan for activities states, "While in the facility, [Resident #42] states that it is important that [s/he] has the opportunity to engage in daily routines that are meaningful

3. The facility provides an ongoing program to support residents that is designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Recreation staff will be re-educated to this process.

4. NHA/Designee will complete observations of activities provided to residents either one:one or in a group setting to validate the activities provided meet the interest of each resident. These observations will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.

Tag F 679 POC accepted on 12/7/23 by S. Freeman/P. Cota

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relative to [his/her] preference," created on 11/30/22, with interventions to "encourage and facilitate [Resident #42]'s activity preferences," created on 11/30/22, "I would like pet visits and prefer to join the scheduled therapy dogs," created on 11/30/22, and "it is important for me to engage in my favorite activities," created on 11/30/22. There are no interventions that explain what activities are meaningful of his/her favorite in regard to activities, other than pet visits. Review of Resident #42's activity log for October 2023 reveals that Resident #42 participated in only 2 activities in October (pet therapy), other than socially visiting with others. There was no evidence that Resident #42 participated in any additional activities during October.

Resident #31's care plan for activities states, "While in the facility, resident/patient states that it is important that s/he has the opportunity to engage in daily routines that are meaningful relative to their preference," created on 12/12/22, with interventions that include "enjoy listening to music soft music," created on 12/12/22, and "would like pet visits therapy dog visits," created on 12/12/22. Review of Resident #31's activity log for October 2023 reveals that Resident #31 participated in only 3 activities during October, other than watching movies or TV, and socially visiting with others. There was no evidence that Resident #31 attended or refused to attend any music activities or pet therapy visits.

3. Per interview on 10/30/23 at approximately 3:00 PM, a Licensed Nursing Aide (LNA) explained that there was not much going on today for activities since s/he is the only one doing activities and s/he is also scheduled as an LNA for the unit. S/He explained that there is no

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 45	F 679		

Activity Director in the building anymore, as their last day was last week.

Per interview on 10/31/23 at 11:33 AM, an LNA on the second floor stated that there was a lot less going on for activities now because there is not any activity staff.

Per interview on 10/31/23 at 2:43 PM, an LNA stated that there is not much going on for activities on this floor. S/He explained that s/he has a background in dementia care and the limited activities that are available do not engage the resident population.

Per interview on 11/1/23 at 12:52 PM, an LNA working on the second floor stated that since the Activities Director stopped working in the facility last week, nothing has been going on for the residents.

Per interview on 11/1/23 at 11:11 AM with the facility's Activities Director s/he has resigned her/his position. However, s/he will be continuing to complete assessments, care planning, and planning the activity calendar until the facility can recruit a new director. The Center Executive Director (CED) is responsible for overseeing the activities in the building and the staff at this time.

During interview on 11/1/23 at 12:30 PM the CED confirmed that the Activity Director had resigned, and s/he is assisting with assessments, care planning, and the activity calendar until a new Activity Director is recruited.

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F 679	Continued From page 46	F 679		
F 692 SS=D	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 interviews and record review the facility failed to ensure acceptable parameters of nutritional status were monitored for 1 of 29 residents sampled (Resident #8). Findings include: Resident #8 was not weighed per physician orders. Per record review Resident #8 was admitted with diagnoses including diabetes, morbid obesity,	F 692	F692 Specific Corrective Action 1. Resident #8 is being weighed per the MD order 2. An audit of residents medical record was completed to validate weighs are obtained per MD orders 3. The facility monitors nutritional status of each resident inclusive of recording weights in the medical record per the MD order. Licensed staff will be re-educated to this process. 4. DON/Designee will complete audits of resident wgts to validate weights are obtained and recorded per the MD order. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. **Tag F 692 POC accepted on 12/7/23 by S. Freeman/P. Cota**	11/29/23

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F 692	Continued From page 47 hypertension (elevated blood pressure), congestive heart failure (a weakness of the heart muscle resulting in less efficient fluid management), and hyperlipidemia (high cholesterol). A physician order with a start date of 9/2/23 instructs to obtain the weight of Resident #8 "every evening shift for 3 days AND every day shift every Wednesday" without an end date. Further record review reveals one weight recorded on 9/2/23 which is 228#, there is no weight recorded on 9/3 or 9/4. The next 4 Wednesdays' weight is recorded as #228 each time (9/6,13, 20 and 27th). In October there are no weights recorded on the dates due which are 10/4, 11, 18, and 25 or at all. On 10/31/23 at approximately 10 AM the Director of Nursing confirmed the weight of Resident #8 had not been obtained as ordered by the physician.	F 692		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to recognize when a resident experienced pain and ensure that pain management was provided to a resident who required such services for 1 of 29 sampled residents (Resident #7). Findings included:	F 697	F697 Specific Corrective Action 1. Resident #7 is currently receiving her lidocaine patches as ordered and timely 2. Resident #7 is currently receiving her lidocaine patches as ordered and timely	11/29/23

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F 697	Continued From page 48 On 10/30/2023 at approximately 1:40 PM, Resident # 7 was observed sitting by her/his bedside crying. She/he states she/he has "so much pain". She/he reported that she/he gets pain patches in the morning on her/his back and hip, but the staff has been too busy to get them. She/he was told she/he would get them later in the day. Record review indicates Resident # 7 was admitted to the facility on 7/29/2023 for therapy and pain management. Her/his diagnoses include chronic pain and Diabetes. She/he requires assistance with care. Per a review of Resident #7's Medication Administration Record (MAR), there is an order for a Lidocaine External Patch 5% [Lidocaine is a medication that eases pain by numbing the nerves and making them less sensitive to pain] with the following instructions: Apply to the lower back topically one time a day for pain; another order for a Lidocaine External Patch reads: Apply to bilateral hips topically one time a day for pain, apply once daily for twelve hours then remove for 12 hours. Another order dated 9/25/2023 reads: Remove Lidocaine patches to bilateral hips and lower back at bedtime, scheduled for 8:00 PM. Review of the care plan reveals an intervention to medicate resident as ordered for pain and monitor for effectiveness, report to the physician as indicated. Per interview on 10/30/2023 at approximately 1:45 PM with a Licensed Practical Nurse (LPN), she/he stated the pain patches were due to be applied by 9:00 AM, but she was busy and had not gotten to them. She/he said she/he had not noticed Resident # 7 crying and would administer the pain medication immediately.	F 697	F697 continued.. 3. The facility evaluated patients as part of the nursing assessment process for the presence of pain upon admission, quarterly, and with change in condition or change in pain status. Staff will continually observe and monitor patients for comfort and presence of pain and will implement strategies in accordance with professional standards of practice, the patient-centered plan of care, physician orders for pain interventions, and the patient's choices related to pain management. These interventions will be timely to meet the needs of the resident. Licensed staff will be re-educated to this process. 4. DON/Designee will complete audits and observations to validate pain interventions are delivered timely as ordered by the MD and meet the pain relief needs of the patient. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. **Tag F 697 POC accepted on 12/7/23 by S. Freeman/P. Cota**	

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F 697	Continued From page 49 Per interview on 10/31/2023 at aproximately 10:00 AM, the Director of Nursing, confirmed that Resident # 7 was not provided pain management as per the order. She/he confirmed that the Lidocaine patches were not applied at 8:00 AM per the physician's order; she/he also confirmed that the physician was not notified that the medication was administered over 5 hours past due. She/he also confirmed Resident #7 was not monitored for pain and was not administered her/his pain medication until this surveyor made the staff aware of her/his distress five hours later.	F 697		
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by:	F 712	F712 Specific Corrective Action 1. Residents #9 had a current regulatory visit completed by the NP on 10/05/2023 Resident #31 had a current regulatory visit completed by the MD on 11/08/2023 Resident #16 had a current regulatory visit completed by the MD on 11/08/2023 Resident #37 had a current regulatory visit completed by the MD on 10/30/2023 Resident #46 had a current regulatory visit completed by the MD on 09-08-23 Resident #1 had a current regulatory visit completed by the MD on 11/01/2023 Resident #10 had a current regulatory visit completed by the MD on 11/08/2023 Resident #14 had a current regulatory visit completed by the NP on 10/06/2023 Resident #45 had a current regulatory visit completed by the NP on 09/29/2023 Resident #42 had a current regulatory visit completed by the NP on 09/29/2023	11/29/23

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F 712	Continued From page 50 Based on staff interview and record review, the facility failed to ensure that required physician visits occurred every 30 days for the first 90 days after admission and at least 60 days thereafter for 10 of 29 sampled residents (Residents #9, #31, #16, #37, #46, #1, #10, #14, #45, and #42). Findings include: Per record review, the following residents did not have documentation of all regulatory physician visits from 1/1/2023 through 10/31/23: Resident #9 was admitted to the facility on 4/12/22. Resident #9 did not have the required regulatory physician visits for March 2023 or August 2023. Resident #31 was admitted to the facility on 5/15/22. Resident #31 did not have the required regulatory physician visit for August 2023. Resident #16 was admitted to the facility on 3/25/23. Resident #16 did not have the required regulatory physician visit for May 2023. Resident #37 was admitted to the facility on 9/17/22. Resident #37 did not have the required regulatory physician visits for April 2023 or August 2023. Resident #46 was admitted to the facility on 3/3/2023. Resident #46 did not have the required regulatory physician visits for April 2023, May 2023, or August 2023. Resident #1 was admitted to the facility on 2/2/22. Resident #1 did not have the required regulatory physician visits for January 2023, March 2023, or July 2023. Resident #10 was admitted to the facility on 9/7/22. Resident #10 did not have the required regulatory physician visits for August 2023. Resident #14 was admitted to the facility on 12/23/21. Resident #14 did not have the required regulatory physician visits for January 2023,	F 712	F712 Continued... 2. An audit of physician visits was completed to validate required physician visits occurred every 30 days for the first 90 days after admission and at least 60 days thereafter. This includes that after the initial visit by the MD, visits may alternate between the physician and a physician assistant or nurse practitioner. 3. The facility ensures that required physician visits occurred every 30 days for the first 90 days after admission and at least 60 days thereafter. This includes that after the initial visit by the MD, visits may alternate between the physician and a physician assistant or nurse practitioner. Medical staff, DON, and NHA will be re-educated to this process. 4. NHA/Designee will complete audits of required physician visits to validate the process is followed timely. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	

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F 712	Continued From page 51 March 2023, or August 2023. Resident #45 was admitted to the facility on 1/17/23. Resident #45 did not have the required regulatory physician visits for January 2023, March 2023, May 2023, or September 2023. Resident #42 was admitted to the facility on 8/19/22. Resident #42 did not have the required regulatory physician visits for January 2023, March 2023, or September 2023. Per interview on 11/1/23 at 2:28 PM, the Market Clinical Advisor confirmed the above residents did not have evidence of required regulatory physician visits in their medical records for the above dates.	F 712	**Tag F 712 POC accepted on 12/7/23 by S. Freeman/P. Cota**	
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	F 725	F725 Specific Corrective Action 1. The facility currently has staffing patterns in place, based on census and acuity, that are sufficient to assure patient safety and attain or maintain the highest practicable physical,mental, and psychosocial well-being of each patient. This includes a PPD of 2.0 for LNA and an overall nursing PPD of 3.0 at a minimum. 2. All residents have the potential to be affected	11/29/23

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F 725	Continued From page 52 (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 observation, resident and staff interviews, and record review, the facility failed to ensure there are a sufficient number of skilled licensed nurses, nurse aides, and other nursing personnel to provide care and respond to each resident's basic needs and individual needs as required by the resident's diagnoses, medical condition, or plan of care impacting all residents of the facility. Findings include: 1. Review of facility direct care staff schedules and PPD (direct care staff to resident ratios) for September and October 2023 reveals that the facility failed to maintain required minimum staffing levels to allow for 2.0 hours of direct care per resident per day (PPD) on a weekly average by Licensed Nursing Assistants (LNAs) for 7 of the 8 sampled weeks in September and October 2023 and failed to maintain required minimum staffing levels to allow for 3.0 hours of direct care per resident per day (PPD) on a weekly average, including nursing care, personal care, and restorative nursing care for 4 of 8 sampled weeks in September and October 2023. Per interview on 11/1/23 at 8:37 AM, the Nursing Scheduler stated that the facility has been short staffed due to the lack of staff available to be scheduled and fill in when staff members call out of work. S/He confirmed that the direct care PPD	F 725	F725 continued. 3. The facility ensures they have sufficient nursing staff, including nurse aides in accordance with state and f ederal regulations, with the appropriate competencies and skills sets to provide nursing and related services to assure patient safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each patient. Facility NHA and nursing leadership will be re-educated to this process. 4. NHA/Designee will validate that the facility has sufficient nursing staff to meet the needs of the facility this includes at a minimum of a PPD of 2.0 for nurses aides and an overall nursing PPD of 3.0. These audits will be daily x 30 days, weekly x 4 weeks, then bi weekly x 2 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. **Tag F 725 POC accepted on 12/7/23 by S. Freeman/P. Cota**	

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F 725	Continued From page 53	F 725		

as referenced above did not meet the 2.0 and 3.0 hour requirements for the weeks reviewed.

Per review of the Facility Assessment dated 1/20/23, the percentage of residents that require a one person assist for activities of daily living (ADL) is 76.5% and 55.7 % for residents that require a two person assist for ADLS. The facility determined the staffing needs to meet the care requirements of the resident population is based on meeting or exceeding the minimum PPD requirements.

2. Per interview on 10/30/23 at 1:19 PM, Resident #37 explained that sometimes s/he has to wait hours to get changed because s/he has been told that staff are not allowed to help with care while meals are being served and sometimes s/he has to sit in urine so long that it starts to puddle. S/He stated that over the weekend it took over an hour for staff to answer his/her call light and help him/her. His/Her oxygen tubing had fallen onto the floor and it gave him/her a lot of anxiety because s/he is unable to get out of bed without staff assistance.

Per observation on 10/31/23 at 9:32 AM, 8 call lights were going off at the same time on the third floor. There were no Licensed Nursing Aide staff present in the hallway. Resident. #212 was heard in the hall screaming "hello," over and over again. When asked, Resident #212, who was in bed, said that s/he had been waiting at least 30 minutes for someone to help him/her out of bed.

On 10/31/23 at 9:45 AM, an LNA indicated that there was not enough staff to handle the needs of the residents and s/he can't do it all. S/He explained that it is typical for the facility to be

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F 725	Continued From page 54 short staffed. S/He stated that last week s/he was the only aide on the 2 floor unit for the day and evening shift for almost a week. On 10/31/23 at 9:58 AM, the Unit Manager explained that having 8 active call lights at same time is typical because the unit has a lot of needs. The care is non-stop all day long. On 10/31/23 at 10:04 AM, it was brought to staff's attention that Resident #212 had been observed screaming for help for over 30 minutes and reported to be waiting even longer to get out of bed. Staff were observed entering Resident #212's room to assist him/her out of bed at 10:05 AM, approximately an hour after Resident #212 reported that s/he first asked for help. On 10/31/23 at 10:05 AM, 6 call lights were still active on the third floor. Per observation and interview on 10/31/23 at 3:48 PM, Resident #212 was sitting next to his/her bed in his wheelchair. S/He stated that s/he had been waiting a long time for staff to come and get him/her into bed. At 4:06 PM, a Licensed Nursing Aide (LNA) went into Resident #212's room and turned off the call light. This LNA was asked if s/he was going to get Resident #212 into bed. The LNA said yes but s/he had to wait for someone else to help because the resident requires two staff for transfers and the unit is short staffed, so sometimes it takes a while.	F 725		
F 742 SS=D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure	F 742	F742 Specific Corrective Action	11/29/23

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F 742	Continued From page 55 that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to develop an individualized care plan that addresses the assessed emotional and psychosocial needs of the resident and failed to provide services that address the assessed needs of the resident for 1 of 29 residents (Resident #210). Findings include: Per record review, Resident #210 was admitted to the facility on 10/13/23 for post operative care and antibiotic therapy related to surgical amputation to his/her left toes. An admission nursing assessment dated 10/13/23 reveals that Resident #210 has a history of a mental health disorder and confusion, has anxiety about their surroundings, and has expressed the desire to leave the facility. A progress note dated 10/15/23 reveals that Resident #210 has expressed sadness or symptoms of depression and experiences loss of interest daily or almost daily. A 10/19/23 Physician assessment reveals that Resident #210 is experiencing a moderate episode of recurrent major depressive order and is prescribed citalopram (an antidepressant). Per review of Resident #210's care plan, the baseline care plan does not address Resident #210's diagnosis of depression or use of an antidepressant.	F 742	F742 continued... 1. Resident #210 has a current care plan to address her dx of depression and use of antidepressant medication. Resident #210 had an order for referral for psychiatrist telemed on 10/26/23. Resident refused to be seen by psychiatry, this refusal was documented. 2. An audit of residents with mental disorder or psychosocial adjustment difficulty was completed to validate the plan of care addressing the resident psychosocial needs including the use of psychotropic medication and that the resident is offered services by way of a psychiatrist. 3. The facility ensures that residents who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. Unit managers, DON, NHA and social services will be re-educated to this process. 4. DON/Designee will complete audits to validate those residents who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being.	

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F 742	Continued From page 56 Per interview and observation on 10/30/23 at 1:04 PM, Resident #210 was observed in bed. S/He was weepy and expressed that s/he does not want to be at the facility. On 10/31/23 at 9:42 AM, Resident #210 was teary and expressed that staff do not seem interested in what s/he needs. On 10/31/23 at approximately 4:20 PM, Resident #210 indicated that s/he was sad and wanted to go home. A provider communication log located at the unit nursing station reveals that nursing staff informed the provider staff that Resident #210 was depressed on 10/17/23 and requested a psych consult for Resident #210 on 10/24/23 because s/he was weepy and is communicating that s/he is feeling depressed. Per review of Resident #210's medical record, there was no evidence that s/he had a psychological consult. Per interview on 11/1/23 at 10:13 AM, the Social Service Director explained that s/he was not aware of Resident #210's mood concerns because nursing staff have not relayed that information and confirmed that if s/he was aware of this issue, s/he would have created a care plan. Per interview on 10/31/23 at approximately 1:30 PM, the Market Clinical Advisor confirmed that Resident #210 did not have a baseline care plan that addressed depression and should have.	F 742	F742 Continued.. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendation **Tag F 742 POC accepted on 12/7/23 by S. Freeman/P. Cota**	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its-	F 759	F759 Specific Corrective Action	11/29/23

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F 759	Continued From page 57 §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations and record review the facility failed to maintain a medication error rate of less than 5%. Findings include: Between 10/30 and 11/1/23 41 medications were observed being administered with 8 of those medications being given in contrast to facility policy, professional standards, and a prescriber's order resulting in an error rate of 19.5%. On 19/31/23 at 8:26 AM during medication pass observation the surveyor observed a Licensed Practical Nurse (LPN) administer 8 medications simultaneously to Resident #53 via a gastrostomy tube (G-tube) is a tube that is inserted into the stomach to provide nutritional support in patients with impaired swallowing secondary to various disorders). The medications given were: Hyoscyamine 0.125 mg 1 tablet - used for Parkinson's disease. Amlodipine 10mg 1 tablet- used for elevated blood pressure. Multiple Vitamin 1 tablet- used for health maintenance. Vitamin D 1 tablet- used for health maintenance. Citalopram 20 mg 1 tablet- used to treat depression. Eliquis 5 mg 1 tablet- used to avoid blood clots. Prednisone 20 mg 3 tablets- steroid medication Solifenacin 5 mg 1 tablet - used to treat overactive bladder.	F 759	F759 Continued.. 1. Resident #53 is having their medications Administer each one separately, flushing tube with 15 ml of water after each dose. The LPN was provided education on 10/31/2023 2. An audit was completed and education provided to licensed staff to validate medication ordered through an enteral tube is completed one medication at time flushing with 15 mls of water between each medication ordered 3. The facility provides medication as ordered through an enteral tube by first rising the HOB to a 30-45 degree angle, washing hands and donning gloves, administer each medication separately, flushing tube with 15 ml of water after each dose, and leaving the head of bed elevated for 30 minutes to prevent aspiration of stomach contents. Licensed staff will be educated and competencies completed to validate this process. 4. DON/Designee will complete observation of medication pass including medications given via enteral tube to validate this process is followed. These observations will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	

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F 759	Continued From page 58	F 759	**Tag F 759 POC accepted on 12/7/23 by S. Freeman/P. Cota**	

The LPN was observed putting the 8 individual medications (one medication dose required 3 individual pills) equaling 10 tablets into a small bag and using a pill crusher crushing the medications together and then mixing them into an unspecified amount of water. Per the LPN "I mix them with water because it tends to clog the tube." When asked if s/he had given this resident medication this way before s/he said they had. The surveyor and the LPN entered the resident's room where the LPN raised the bed but did not elevate the head of the bed, s/he donned gloves without performing hand hygiene, using a piston syringe s/he aspirated stomach contents with scant return. The LPN then using the piston syringe administered 30 cc of water added the medication/water mixture to the syringe and administered it. The LPN then rinsed the medication residue out of the syringe and followed by flushing the tube with 30cc of water. Following the final instillation of water, the medication cup was noted to have medication residue on the bottom of the cup including yellow powder and small bits of what appeared to be white pills. The cup with medication residue was shown to the LPN who agreed there was medication left over but made no attempt to further administer the residue.

A review of the medical orders for Resident #53 includes an order instructing the nurse to "elevate the head of the bed 60 minutes after medication administration via tube".

A review of the facility provided "Specific Medication Administration Procedures" in section IIB13: Enteral Tube Medication Administration under procedures:
A. If resident is in bed, elevate head of bed to

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F 759	Continued From page 59 30-45 degree angle. C. Wash hands and wear gloves. L. Administer each medication separately, flushing tube with 5 ml of water after each dose. N. Leave head of bed elevated for 30 minutes to prevent aspiration of stomach contents. At 9:15 AM the cup with residue was provided to the Market Clinical Advisor who stated the expectation for giving crushed medications via g-tube would be to give them one at a time and agreed the residue in the cup represented partial doses that were not administered. The Market Clinical Advisor was also notified that the head of the bed had not been elevated and returned to the surveyor to confirm it had not been, but s/he had raised it. As these medications were given in a manner that disregards the potential incompatibility between them when mixed and given as one* and in contrast to the facility procedure and the prescribers order to "elevate the head of the bed 60 minutes after medication administration via tube" they are each considered having been given in error. *Reference: Preventing Errors when Administering Drugs Via an Enteral Feeding Tube (May 6, 2010) Institute for Safe medication Practices Retrieved from http://www.ismp.org	F 759		
F 760 SS=H	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced	F 760	F760 Specific Corrective Action	11/29/23

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F 760	Continued From page 60 by: Based on observation, interview, and record review the facility failed to ensure that 2 of 29 residents in the sample were free from significant medication errors related to the administration of a medication prescribed for seizure management (Resident #1), and an antithrombotic (treatment and prevention of blood clots) medication (Resident #9). 1. Per observation of the lunch meal on 10/30/2023 at 11:45 AM Resident #1 was sitting in a specialized wheelchair eating her/his meal. S/he was observed with her/his arms raised above her/his head with a scared facial expression and drool coming from her/his mouth. This surveyor asked her/him if they were alright, and s/he stated in a barely audible voice "can you help me?" The nurse who was assisting another resident with their meal was alerted, and after speaking to Resident #1 they took her/him to their room. When the nurse came back into the dining area s/he stated that the resident was sick. At 5:20 PM Resident #1 was still in her/his room. S/he stated that s/he still did not feel good. Per record review Resident #1 has received clonazepam 1 MG by mouth three times a day for seizure management since 11/9/2020. A physician's order with a start date of 9/25/23 states clonazepam 1 MG by mouth three times a day for seizure management. Review of Resident #1's medication administration record (MAR) for the month of October 2023 revealed that clonazepam is to be administered at 9:00 AM, 1:00 PM, and 9:00 PM. The MAR also revealed that clonazepam was not administered per order on 10/28/23 at 9:00 AM through 10/30/23 at 9:00 PM, missing 9 doses. According to the American	F 760	F760 continued... 1. Resident #1 is receiving ordered clonazepam and is free from nausea and vomiting Resident #9 is receiving pradaxa and is free from signs and symptoms of stroke 2. An audit was completed of resident MAR to validate medications are provided and administered as ordered and/or MD is notified of medications not available 3. The facility has the following procedure in place when medications ordered are not available, including when not available in the emergency medication Pixus System: The nurse will evaluate the patient for adverse effects, report immediately to the Director of Nursing, notify physician/ advanced practice provider, patient, and responsible party, obtain orders, if indicated, initiate orders, if any, and monitor the patient. Licensed staff will be re-educated to this process.	

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F 760	Continued From page 61 Addiction Center "Clonazepam should not be stopped suddenly or without direct supervision and guidance of a medical professional." and "Withdrawal from clonazepam can be dangerous and even life threatening." Progress notes written between 10/28 - 10/30 reflect that the medication was not available and had not been delivered from the pharmacy. There was no documented evidence that the physician was notified at the time of any of the omissions. A summary to the physician written on 10/30/23 at 3:05 PM states that the resident was experiencing nausea and/or vomiting. Per interview with the Unit Manager (UM) on 10/31/23 at 3:01 PM the nurse who was responsible for medication administration should have checked the Pyxis (an automated medication dispensing machine that is used to provide storage of commonly prescribed medications) to see if the clonazepam was available. If the medication was not available in the Pyxis, the nurse then should have called the on-call provider to inform them that the medication was not available and inquire about any alternative orders. The UM agreed that based on the symptoms that Resident #1 had been exhibiting on 10/30/23 s/he may be experiencing withdrawal from the missed medication. Review of the facility's policy titled NSG306 Medication Errors: A medication error is defined as a discrepancy between what the physician/advanced practice provider ordered and what the resident/patient received. Types of errors include; medication omission..." The facility Medication Error procedure states: 1. Evaluate the patient for adverse effects. 2. Report immediately to the Director of Nursing	F 760	F760 continued... 4. DON/Designee will complete audits, observation, and interviews to validate that the omission of medication process is followed. These audits, observations, and interviews will be daily x 30 days, weekly x 4 weeks, then bi weekly x 2 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. **Tag F 760 POC accepted on 12/7/23 by S. Freeman/P. Cota**	

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F 760	Continued From page 62	F 760		

or designee.
3. Notify physician/advanced practice provider, patient, and responsible party. Obtain orders, if indicated.
4. Initiate orders, if any.
5. Monitor the patient....

On 10/31/23 at 5:15 PM while observing the Pyxis machine on the 2 North Unit the medication nurse stated that s/he did have access to the Pyxis however, she was unable to do so because s/he had never used it. S/he went to get the UM who provided a list of medications that are available in the Pyxis. The UM confirmed that clonazepam was on the list as being available.

A physician's progress note dated 11/1/23 states that Resident #1 "had an episode last weekend as [s/he] went without clonazepam for several doses due to system issues. [S/he] had fatigue, altered mental status over the weekend in concurrence to that event. [/S/he] is feeling better today with no complaints."

Per interview on 11/1/23 at 12:58 PM with the UM the physician had a phone conversation with Resident #1 this morning. The physician gave no new orders and instructed the UM to continue to monitor for further symptoms of withdrawal from the clonazepam.

2. Per record review Resident #9 has a diagnosis of Atrial Fibrillation (afib, an irregular, often rapid heart rate that commonly causes poor blood flow increasing the risk of blood clots). Physician's orders reflect an order for Pradaxa 150 MG orally two times a day for afib. Review of Resident #9's Medication Administration Record revealed that the morning dose of Pradaxa was not

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F 760	Continued From page 63 administered on 9/5/2023 and 9/11/2023. Electronic Medication Administration Record Progress Notes dated 9/5/2023 and 9/11/2023 state that the Pradaxa is "on order from pharmacy." According to the American Heart Association missing doses of Pradaxa "may increase your risk of stroke." There is no evidence in the record that the physician was notified of the missed doses or contacted for alternative orders. During an interview on 11/1/23 at 1:04 PM the Unit Manager confirmed that Resident #9 did not receive the Pradaxa as ordered on 9/5/23 and 9/11/23 and that the nurse should have notified the physician of the missing doses. References: American Addiction Center, Clonazepam Withdrawal Symptoms, Timeline & Detox Treatment, americanaddictioncenters.org American Heart Association, A Patient's Guide to Taking Dabigatran Etexilate (Pradaxa), ahajournals.org	F 760		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced	F 808	F808 Specific Corrective Action 1. Resident #8 is receiving foods that meet the requirement of the prescribed therapeutic diet. 2. An audit of resident prescribed diets was conducted to validate the prescribed diet is currently being followed.	11/29/23

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F 808	Continued From page 64 by: Based on observations, interviews, and record review the facility failed to provide a therapeutic diet as ordered for 1 of 29 residents sampled (Resident #8). Findings include: Resident # 8 was not provided with the therapeutic diet as ordered. Resident #8 was admitted with diagnoses including diabetes, morbid obesity, hypertension, congestive heart failure, and hyperlipidemia (high cholesterol). The diet order placed as active on 9/12/23 created by the facility's registered dietician and signed by the nurse practitioner was noted to be a consistent carbohydrate diet (a diet intended to keep blood sugar levels stable), regular texture NO high processed breakfast foods, low sodium heart healthy. On 10/30/23 at 12:10 PM during an interview with Resident #8 his/her lunch tray was served with the following components noted: kielbasa and sauerkraut, scalloped potatoes, mixed vegetables, a roll, and a brownie (there were no condiments included). The lunch ticket on the tray included Resident #8's name confirming this was the correct lunch tray for this resident, the ticket listed the diet as a 2-gram sodium diet with NO salt packet, bacon, sausage, processed meats, tomato sauce, fried foods. Resident #8 stated "I always get things I don't think I should have" when asked about the tray contents. On 10/31/23 at 9:30 AM the registered dietician was interviewed regarding the diet order versus the diet being provided. The registered dietician confirmed the active order to be correct. When asked if the diet provided for lunch yesterday met the parameters of either a consistent carb diet or	F 808	F808 continued... 3. Within the dietary department the menu is written for a regular/ liberalized diet and is extended for therapeutic diets. Dietary staff will be re-educated to the extended spreadsheets to meet the needs of the therapeutic diets. 4.RD/Designee will conduct observations of meals served to residents to validate the meal served meets the prescribed diet. These observations will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. **Tag F 808 POC accepted on 12/7/23 by S. Freeman/P. Cota**	

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F 808	Continued From page 65 the 2-gram sodium diet listed on the diet ticket, the registered dietician confirmed this lunch tray did not meet the parameters of either diet.	F 808		
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide specialized rehabilitative services as ordered for 1 of 29 residents sampled (Resident #8). Findings include: Resident #8 did not receive skilled physical therapy 12 out of 35 opportunities during a 7-week period. Resident #8 was admitted for skilled rehabilitation services from a local acute care hospital following	F 825	F825 Specific Corrective Action 1.Resident #8 is receiving therapy per the order 2. An audit of resident's records was completed to validate the residents are receiving therapy per the number of times specified in the therapy order. 3. The facility provides therapy services to those residents whose evaluation indicates the need and the number of times the therapy should be delivered in a weekly period. Rehab staff will be re-educated to this process. 4. NHA/Designee will audit resident records to validate that rehab services are being offered and/or delivered per the resident physician order. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	11/29/23

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F 825	Continued From page 66 an accident in which they suffered a knee injury. Admission orders for Resident #8 included both physical and occupational therapy evaluations and treatment as recommended. On 9/11/23, Resident# 8 was evaluated by the physical therapy department and a plan of treatment was created to include physical therapy five times per week. A review of the Service Log Matrix on which documentation of the minutes per day of therapy are recorded revealed that in the 7 weeks since Resident #8 began to receive physical therapy s/he should have received treatment 35 times. However, the Service Log Matrix from September 5-October 30 reveals s/he received therapy 20 times with 15 sessions being missed. Of these 15 missed opportunities, the resident is coded to have refused twice and been sick for one day leaving 12 unaccounted for missed opportunities. During interview on October 31, 2023, at 11:45 AM an occupational therapy assistant reviewed the documentation and confirmed the missed therapy opportunities adding that the facility therapy department is short-staffed.	F 825	**Tag F 825 POC accepted on 12/7/23 by S. Freeman/P. Cota**	
F 880 SS=E	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.	F 880	F880 Specific Corrective Action 1. Resident #1 is free from infection LPN observed is no longer employed at the facility 2. All residents have the potential to be affected by the practice.	11/29/23

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F 880	Continued From page 67 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 880	3. The facility Cleans and disinfects meters before and after use with EPA approved disinfectant, following manufacturer's instructions. Licensed staff will be re-educated to this process. Adherence to hand hygiene practices is maintained by all Center personnel. This includes handwashing with soap and water when hands are visibly soiled and after exposure to known or suspected Clostridium difficile or infectious diahrrea (e.g norovirus) and the use of alcohol based hand rubs for routine decontamination in clinical situations per the Centers for Disease Control and prevention (CDC),when hands are not visibly dirty, alcohol based hand sanitizers are the preferred method for hand hygiene. Facility staff will be re-educated to this process. 4.DON/Designee will complete observations and rounds to validate the process for cleaning glucometers is followed and hand hygiene is performed as indicated. These observations will be daily x 30 days, weekly x 4 weeks, then bi weekly x 2 months. Results of these audits will be brought to the monthly QAPI Committee for further review and Recomendations	

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F 880	Continued From page 68 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure standard precautions were followed to prevent the spread of infection related to hand hygiene and equipment cleaning. On 10/31/2023 at approximately 8:55 AM on the third floor, the Licensed Practice Nurse (LPN) was observed administering medications. She/he administered a nebulizer treatment to Resident #1, assisting the resident to put on an Oxygen mask, then was observed returning to the medication cart, preparing medications for the next resident without performing hand hygiene. She/he was observed donning gloves to administer an Insulin pen, removing the gloves, and returning to the medication cart to continue setting up medications without performing hand hygiene on two occasions during the medication pass. Per a review of the Hand Hygiene policy, it read,	F 880	**Tag F 880 POC accepted on 12/7/23 by S. Freeman/P. Cota**	

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F 880	Continued From page 69	F 880		

"Perform hand hygiene before resident care, before an aseptic procedure, after any contact with blood or other body fluids, even if gloves are worn, after patient /resident care, after contact with patient/resident's environment." The policy has an effective date of 12/15/ 01 and a review date of 5/1/2023.

Per Interview on 10/31/2023 at 10:00 AM, the LPN confirmed s/he did not sanitize her/his hands after donning and doffing gloves or after contact with a resident and the resident's environment.

Per observation on 10/31/2023 at approximately 12:00 PM, the LPN was observed checking the blood glucose of a resident using a glucometer, which utilizes a sample of blood to obtain a blood glucose reading. She/he returned to the medication cart without cleaning the machine and did not sanitize her/his hands before and after using the device.

Per interview on 10/31/2023 at 12:10 PM, she/he stated that s/he "thought [s/he] should wipe the glucometer down with alcohol." She/he confirmed that the device is used for more than one resident. The LPN confirmed she/he did not clean the glucometer per the facility policy, and she/he did not sanitize her/his hands before and after donning and doffing gloves.

Per the facility policy, "the device should be cleaned and disinfected with Sani Cloth Bleach Disposable wipes after every use."

The Centers for Disease Control (CDC) indicates the following:
"If blood glucose meters must be shared, the device should be cleaned and disinfected after

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F 880	Continued From page 70 every use, per the manufacturer's instructions, to prevent carry-over of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected, then it should not be shared." https;//www.cdc.gov/injectionsafety/blood-glucose-monitoring.html Per interview on 10/31/2023 at approximately 12:30 PM with the clinical marketing advisor, she/he confirmed that the LPN failed to adhere to infection control policies related to hand hygiene and cleaning and sanitization of glucometers.	F 880		

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S320 SS=F	7.13 (d)(1) QUALITY OF CARE - STAFFING LEVELS 7.13 (d)(1) The facility shall maintain staffing levels adequate to meet resident needs. 1. At a minimum, nursing homes must provide: i. no fewer than three (3) hours of direct care per resident per day, on a weekly average, including nursing care, personal care and restorative nursing care, but not including administration or supervision of staff; and ii. of the three hours of direct care, no fewer than two (2) hours per resident per day must be assigned to provide standard LNA care (such as personal care, assistance with ambulation, feeding, etc.) performed by LNAs or equivalent staff and not including meal preparation, physical therapy or the activities program. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to maintain required minimum staffing levels to allow for 2.0 hours of direct care per resident per day (PPD) on a weekly average by Licensed Nursing Assistants (LNAs) for 7 of the 8 sampled weeks and failed to maintain required minimum staffing levels to allow for 3.0 hours of direct care per resident per day (PPD) on a weekly average, including nursing care, personal care, and restorative nursing care for 4 of 8 sampled weeks. Findings include: Per review of the daily nursing PPD hours, the average direct care PPD by LNA staff was below the required 2 hours per day minimum during the following weeks in September and October 2023:	S320	S320 Specific Corrective Action 1. The facility currently has staffing patterns in place, based on census and acuity, that are sufficient to assure patient safety and attain or maintain the highest practicable physical,mental, and psychosocial well-being of each patient. This includes a PPD of 2.0 for LNA and an overall nursing PPD of 3.0 at a minimum. 2. All residents have the potential to be affected 3. The facility ensures they have sufficient nursing staff, including nurse aides in accordance with state and federal regulations, with the appropriate competencies and skills sets to provide nursing and related services to assure patient safety and attain or maintain the highest practicable physical,mental, and psychosocial well-being of each patient. Facility NHA and nursing leadership will be re-educated to this process.	11/29/23

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CED — (X6) DATE: 11/24/23

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S320	Continued From page 1 9/6/23- 9/12/23 = 1.92 9/20/23- 9/26/23 = 1.62 9/27/23- 10/3/23 = 1.61 10/4/23- 10/10/23 = 1.69 10/11/23- 10/17/23 = 1.77 10/18/23- 10/24/23 = 1.66 10/25/23- 10/31/23 = 1.98 Per review of the daily nursing PPD hours, the average direct care PPD by direct care staff, including nursing care, personal care, and restorative nursing care, was below the required 3 hours per day minimum during the following weeks in September and October 2023: 9/20/23- 9/26/23 = 2.8 9/27/23- 10/3/23 = 2.81 10/4/23- 10/10/23 = 2.88 10/18/23- 10/24/23 = 2.93 Per interview on 11/1/23 at 8:37 AM, the Nursing Scheduler stated that the facility has been short staffed due to the lack of staff available to be scheduled and fill in when staff members call out of work. S/He confirmed that the direct care PPD as referenced above did not meet the 2.0 and 3.0 hour requirements for the weeks reviewed.	S320	4. NHA/Designee will validate that the facility has sufficient nursing staff to meet the needs of the facility this includes at a minimum of a PPD of 2.0 for nurses aides and an overall nursing PPD of 3.0. These audits will be daily x 30 days, weekly x 4 weeks, then bi weekly x 2 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. **Tag S 320 POC accepted on 12/7/23 by S. Freeman/P. Cota**	