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

June 20, 2023

Ms. Holly Wood, Administrator
Berlin Health & Rehab Ctr
98 Hospitality Drive
Barre, VT 05641-5360

Dear Ms. Wood:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **May 24, 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,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475020	A. BUILDING ______ B. WING ______	C 05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERLIN HEALTH & REHAB CTR	98 HOSPITALITY DRIVE BARRE, VT 05641

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The Division of Licensing and Protection conducted an on-site unannounced review of the Emergency Preparedness requirements on 05/23/23. There were no regulatory violations related to emergency preparedness.	E 000	This plan of correction was written to follow state and federal guidelines. It is not an admission of noncompliance. However, it is the facility commitment to demostrate and maintain compliance. Date of Compliance to be 7/7/2023.	
F 000	INITIAL COMMENTS An unannounced onsite recertification survey and staff vaccination review was conducted by the Division of Licensing and Protection from 5/22-2/24/23. During this recertification survey substandard quality of care was identified therefore an extended survey was simultaneously conducted. The following regulatory deficiencies were identified as a result:	F 000		
F 584 SS=F	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584	F584 Specific Corrective Action Type text here 1. The wall molding was fixed and/or replaced in rooms A1, A2, A3, A5, A9, A11, A12, A13, A15, A16, A17, A19, A22, A23, B2, and B4 Furniture, including dressers and side tables, with peeled laminate exteriors, broken door hinges, and/or missing handles are being fixed and/or painted in rooms A2, A3,A4, A10, A11, A12, A13, A15, A16, A17, A18,A19, A20, A21, A22, A23, A25, B3, B4, B5, B7,B8, B9, B10, B12, B13, B14, B15, B16,B18, B19, and B22. Closets with missing doors, loose or missing handles, and/or that were unable to close properly in rooms A1, A2, A3, A4, A5c, A9, A10,A12, A14, A15, A19, A20, A22, A23, B1, B2, B3, B4, B7, B8, B11, B12, B13, B16, B17, B21, B22, and B23 are being fixed and/or replaced. Baseboard heaters with missing panels and large indentations in rooms A10, A14, and A19 are being fixed or replaced. A new bathroom door that was missing in room B18 has been ordered.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Holly Wood
TITLE: LNHA
(X6) DATE: 6·16·23

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 584 Continued From page 1

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observations and staff interview, the facility failed to provide necessary housekeeping and maintenance services to ensure residents have a safe, clean, comfortable, and homelike environment for 2 of 2 open resident units.
Findings include:

Per observation on 5/22/23 from approximately 12:25 PM to 1:45 PM, both nursing units [Units A and B] needed multiple functional and cosmetic repairs, and Unit B's floors were generally messy in several resident rooms and common areas.

1. The wall molding was damaged and/or chipped in rooms A1, A2, A3, A5, A9, A11, A12, A13, A15, A16, A17, A19, A22, A23, B2, and B4.

F 584 Blinds/shades have been ordered/installed for the Resident room windows that had sheets for curtains, or that had no window treatments [blinds or curtains], and/or had ripped blinds in rooms A2, A4, A5, A5c, A6, A13, A15, A16, B3, B4, B5c, B8, B11, B12, B13, B15, and B23.

Electrical outlets overs in rooms A20 and B1 were replaced the day it was identified during survey.

The beds that had loose headboards and/or footboards in rooms A1, A9, B1, B5, B15, and B17 are being fixed or replaced.

The thermostat cover near the Unit B nursing station was replaced at the time of identification.

The Unit B floors that had significant areas of debris, food, dried dirt, and/or sticky substances in the halls, the area around the nursing station, and in rooms B1, B2, B3, B4, B5, B5c, B10, B12, B13, B21, B24, B25 were deep cleaned with the floor machine and are being maintained.

2. An audit of all resident rooms was completed to determine that they are in good repair, safe and clean.

A maintenance team is set to come to the center the week of 6/19/23 to assist in compliance.
A maintenance assistant was hired and set to begin working on 6/26/23.
The center hired 4 houskeeping staff: 1 started 6/13. 2 will start 6/21/23 and the 4th's start date is TBD.

3. Education is being done with staff on entering work orders into TELS as soon as issues are dentified.

4. The Maintenance Director and/or Administrator (or designees) will completed room rounds weekly x4, monthly x3 to ensure rooms are in good repair/clean.

The Maintenance Director and/or Administrator (or designees) eview the work order report weekly x4, monthly x3 to ensure identified issues are being completed on timely or that parts are ordered.

Any concerns/trends identified will be addressed in real time and discussed in QA.

Date of Compliance to be 7/7/2023.

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F 584	Continued From page 2 2. Furniture, including dressers and side tables, had peeled laminate exteriors, broken door hinges, and/or missing handles in rooms: A2, A3, A4, A10, A11, A12, A13, A15, A16, A17, A18, A19, A20, A21, A22, A23, A25, B3, B4, B5, B7, B8, B9, B10, B12, B13, B14, B15, B16, B18, B19, and B22. 3. Closets doors were missing, had loose or missing handles, and/or were unable to close properly in rooms A1, A2, A3, A4, A5c, A9, A10, A12, A14, A15, A19, A20, A22, A23, B1, B2, B3, B4, B7, B8, B11, B12, B13, B16, B17, B21, B22, and B23. 4. Baseboard heaters had missing panels and large indentations in rooms A10, A14, and A19. 5. The bathroom door was missing in room B18. 6. Resident room windows had sheets for curtains, had no window treatments [blinds or curtains], and/or had ripped blinds in rooms A2, A4, A5, A5c, A6, A13, A15, A16, B3, B4, B5c, B8, B11, B12, B13, B15, and B23. . 7. Electrical outlets did not have covers in rooms A20 and B1. 8. Beds had loose headboards and/or footboards in rooms A1, A9, B1, B5, B15, and B17. 9. A thermostat near the Unit B nursing station was missing a cover. 10. Unit B floors had significant areas of debris, food, dried dirt, and/or sticky substances in the halls, the area around the nursing station, and in rooms B1, B2, B3, B4, B5, B5c, B10, B12, B13,	F 584	**Tag F 584 POC accepted on 6/20/23 by H. Fox/P. Cota**	

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F 584	Continued From page 3 B21, B24, B25. On 5/22/2023 at 2:54 PM, the Senior Administrator confirmed the above observations.	F 584		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to revise care plans to	F 657	F657 Specific Corrective Action 1. The careplan was revised for resident #30 to address his/her emotional and psychosocial needs. 2. An audit of all resident Comprehensive Care Plans is being completed by XXXXXXX to ensure their emotional and psychosocial needs are addressed. 3. Education to be completed with all staff responsible for completing/revising Comprehensive Care Plans specific to emotional and psychosocial needs. 4. The Director of Nursing (DON) or designee will conduct weekly audits x4 of 10 random resident/patient care plans to ensure accuracy. Monthly audits x3 will be completed by DON/Designee on 10 random residents to ensure accuracy. Any concerns identified will be addressd immediately and discussed in QA. Date of Compliance to be 7/7/2023. **Tag F 657 POC accepted on 6/20/23 by H. Fox/P. Cota**	

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address emotional and psychosocial needs for 1 of 23 sampled residents (#30). Findings include:

Per record Review, Resident #30 was admitted to the facility on 2/2/2022 and has diagnoses that include major depressive disorder, insomnia, anorexia, mild cognitive impairment, and difficulty in walking. Resident #30's Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) dated 5/11/2023 reveals in a mood interview that s/he had trouble falling or staying asleep, or sleeping too much, and feeling tired or having little energy nearly every day.

On 5/22/2023, Resident #30 was observed dressed, and curled up in bed. S/he was weepy and stated that s/he was having a hard time because her/his roommate was not nice and wouldn't say hi to her/him.

Resident #30's care plan reveals the following focus: "[Resident #30] is at risk for distressed/fluctuating mood," created on 9/30/2022. The only intervention for this care area is "observe for worsening signs/symptoms of existing psychiatric disorder (e.g. mania, hypomania, frequent mood changes, etc.) Notify physician/advanced Practice Practitioner as needed," created on 2/21/2023.

On 5/23/2023 at 2:27 PM, the Social Service Director stated that Resident #30's care plan for depression should include at least 3 interventions and there was only one. S/He stated there were additional interventions to address Resident #30's emotional needs in prior care plans but they were removed, and s/he is not sure why.

On 5/24/2023 at approximately 1:00 PM, the

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F 657	Continued From page 5 Market Clinical Lead confirmed that Resident #72's care plan should include more than one intervention related to depression.	F 657		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences.	F 660	F660 Specific Corrective Action 1. Resident #72 had a discharge planning meeting with resident and resident representative on 6/2/2023 and 6/8/2023. A follow up meeting will be scheduled for the week of 6/19/2023. Resident #72's discharge goals have been updated in his/her plan of care. 2. An audit of residents that are expected to discharge was completed to ensure their discharge goals are documented in their plan of care. 3. Education was provided regarding discharge goal documentation to the Social Services Director on 6/15/23 including the Sr Social Services Director, Administrator and DON. 4. Social Services or designee will conduct weekly audits x4, monthly x3 to ensure resident discharge goals are updated in care plans for those planning on discharging. Any concerns identified will be addressed immediately and discussed in QA. Date of Compliance to be 7/7/2023. **Tag F 660 POC accepted on 6/20/23 by H. Fox/P. Cota**	

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F 660	Continued From page 6 (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's	F 660		

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discharge or transfer.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and facility policy review, the facility failed to address discharge goals in the plan of care for 1 of 23 sampled residents (Residents #72). Findings include:

Record review reveals that Resident #72 was admitted to the facility on 4/6/23 with diagnoses that include cellulitis of scrotum, lower extremity edema, and urinary retention. A progress note dated 4/10/2023 reveals that Resident #72's stay is expected to be short term. Resident #72's care plan does not reveal a focus or goal of care for discharge.

On 5/22/2023 at 3:40 PM, Resident #72 stated that s/he wants to be discharged. S/He said that s/he has done everything s/he needs to do to go home with rehab, but they won't let him/her leave because of the catheter.

On 5/23/2023 at 2:27 PM, the Social Service Director stated that s/he was unsure when Resident #72 would be able to discharge. S/He stated that Resident #72 should have a discharge care plan and confirmed that s/he did not.

Facility policy titled OPS406 Discharge Planning Process, revised on 11/15/22, reveals on page 1, "Discharge planning will begin upon admission and be completed as part of the Person-Centered Care Plan process." Page 3 reveals "Discharge Plan Documentation UDA [user defined assessment] will begin as early as admission and no later than seven days prior to patient discharge.

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F 660	Continued From page 8 On 5/24/2023 at approximately 1:00 PM, the Market Clinical Lead confirmed that Resident #72 did not have a care plan in place for discharge.	F 660		
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 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to provide the necessary and preferred services to maintain good personal hygiene for 3 of 23 sampled residents (Residents #12, #27 and #19). Findings include: 1. Resident #12 is an 86-year-old-person with diagnoses to include chronic obstructive pulmonary disease, diabetes type II and cerebral infarct (stroke). During the resident interview on 5/22/23 at approx. 10 am, Resident #12 stated "I never get a shower even though I ask". Resident #12's care plan was reviewed and noted to contain the nursing diagnosis self-care performance deficit related to easily fatigued, physical limitations and is dependent for bathing. The resident bathing schedule was reviewed, it is noted that Resident #12 is scheduled for bathing Friday PM. The bathing documentation was reviewed for the past 30 days with the following dates checked indicating a bed bath/sponge were provided on 4/24, 25, 28 x2, 30 and 5/8, 10, 12, 15, 17, 19 and 22. Of these dates, 2 fall on a Friday. During an interview with a Licensed Nursing Assistant who stated s/he was familiar	F 677	F677 Specific Corrective Action 1. Residents #12, #19 and #27 are currently being offered showers by their preference. 2. An audit of resident shower preferences is being completed and updated. 3. Education is being completed with direct care staff regarding following patient preference in regards to bathing. 4. The Director of Nursing (DON)/designee will conduct weekly audits x4, monthly x3 to ensure resident showers are being completed to the reside[nt] preference. Date of Compliance to be 7/7/2023. **Tag F 677 POC accepted on 6/20/23 by H. Fox/P. Cota**	

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with Resident #12, s/he stated Resident #12 uses the shower chair and seemed to enjoy having a shower and was not sure why the Resident has not received a shower in the past month. Resident #12 was again interviewed following the record review on 5/23/23 regarding bed or sponge baths and stated, "I don't get any bath I just get cleaned up when my diaper (brief) is changed".

2. Resident #27 is a 66-year-old-person with diagnoses to include chronic obstructive pulmonary disease, congestive heart failure, diabetes type II, and a persistent fungal infection beneath the breasts and abdominal fold. During the resident interview on 5/22/23 at approximately 10:45 AM Resident #27 complained that s/he has "not had a shower for over a month even though I'm scheduled to have one Friday mornings". Resident #27's care plan was reviewed and noted to contain the nursing diagnosis of activities of daily living self-care performance deficit related to activity intolerance, impaired balance, and limited mobility, it is noted that Resident #27 is scheduled for bathing Friday morning. The bathing documentation was reviewed for the past 30 days with the following dates checked, indicating a bed bath/sponge bath were provided on 4/25, 28, 30, 5/2, 4, 8, 17 and 22. Of these dates, one is a Friday. Resident #27 was interviewed following the record review on 5/23/22 to ascertain what bathing care was provided on these dates s/he replied that s/he is independent in his/her room and does not receive bed or sponge baths but has provided his/her own bathing with a washcloth.

3. Resident #19 is a 68-year-old-person with diagnosis to include multiple sclerosis and

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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 677	Continued From page 10 muscle weakness. During the resident interview on 5/22/23 at approximately 1 PM, Resident #19 complained that s/he is supposed to have a shower on Mondays, keeps notes and states last shower was on 4/17/23 and before that was 4/3/23. Resident #19 states "I really miss having a shower". Resident #19's care plan was reviewed and noted to have the nursing diagnosis of requires assistance/is dependent for ADL (activities of daily living) care related to: limited mobility, incontinence, MS (multiple sclerosis) it is further noted in the care plan that the resident is incontinent of both bowel and bladder, Resident #19 is scheduled for bathing on Monday PM. The bathing documentation was reviewed for the past 30 days with the following dates checked, indicating a bed bath/sponge bath were provided on 4/24, 5/8, 5/15 and 5/22. On 5/23/22 at approximately 3:30 PM during an interview with a Regional Clinical RN s/he confirmed the documentation regarding these residents indicates showers or tub baths were not provided.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684	F684 Specific Corrective Action 1. Resident #64 discharged from the center on 6/14/2023. 2. An audit of all residents identified as being at risk for pressure ulcers and skin breakdown is being completed to ensure skin checks are being done. 3. Education is being provided to direct care staff in regards to identifying those residents at risk for skin breakdown and pressure ulcers and completing skin assessments. 4. The DON/Designee will conduct weekly audits x4, monthly x3 to ensure skin assessments are being completed. Results will be discussed in QA. Date of Compliance to be 7/7/2023.	

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F 684	Continued From page 11 Based on staff interview and record review, the facility failed to provide treatment and care in accordance with professional standards of practice and the person-centered care plan regarding skin care for one of 21 sampled Residents (Resident #64). Findings include: Per record review, Resident #64 was identified as being at risk for pressure ulcers and skin breakdown in Resident #64's care plan as well as in the admission MDS assessment from 4/21/2023. As of 5/22/2023, there was no evidence that Resident #64's skin had been assessed by anyone at the facility since their admission on 4/14/2023. Per interview on 5/24/2023 at approximately 3:15 PM, the Director of Nursing confirmed that Resident #64's skin had not been assessed since they were admitted to the facility.	F 684	**Tag F 684 POC accepted on 6/20/23 by H. Fox/P. Cota**	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced	F 686	F686 Specific Corrective Action 1. Resident #51 discharged from the center on 5/23/2023 2. A skin sweep was completed to validate areas idenitified have treatment orders written and followed. 3. Education is being completed with licensed nursing staff regarding care and services related tp treatment of pressure ulcers. 4. The DON/designee will complete audits weekly x4, monthly x3of 8 residents to evaluate their skin status, confirmation that anything present has been appropriately identified and treatments are being followed. Any concerns will be addressed immediately and discussed in QA. Date of Compliance to be 7/7/2023.	

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F 686	Continued From page 12	F 686	**Tag F 686 POC accepted on 6/20/23 by H. Fox/P. Cota**	

by:
Based on interviews, and record reviews the facility failed to ensure that 1 of 26 residents in the applicable sample (Resident # 51) received the necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing.
Findings include:

A physician's order form dated 05/15/23 has the following order: Pressure foam dressing referral to podiatry Wound Registered Nurse until follow-up with podiatry Notify TEH (Third Eye Health) if develops fever or expanding redness from the wound.

A skin check assessment dated 05/17/ 2023 states left heel is discolored, superficial, and open. RN applied a heel protector for additional protection.

A review of the Electronic Medical Record (EMR) on does not reflect a dressing change order for a heel ulcer. A review of the resident's care plan does not reflect a revision for a new pressure ulcer.

A provider note dated 05/23/2023 indicates findings of a necrotic, draining heel ulcer, temperature of 101.2, and a diagnosis of Sepsis (A serious condition resulting from the presence of harmful microorganisms in the blood or other tissues and the body's response to their presence, potentially leading to the malfunctioning of various organs, shock, and death).

Per record review, Resident # 51 was transferred

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F 686	Continued From page 13 to the hospital on 05/23/2023 for evaluation of a temperature of 101.2 and a pain level of 6. A review of a nurse's note dated 05/23/22 indicates provider was contacted and apprised of the condition of resident # 51 with an order to transfer immediately to the emergency room for urgent labs, fluids, antibiotics, and a surgical evaluation of the foot. During an interview on 05/24/2023 at approximately 8:30 am with the Clinical Marketing lead and the Licensed Practical Nurse (LPN) who took the original order for the dressing change, the Clinical Marketing lead confirmed that there was no physician order for the heel wound in the EMR, there was no documentation of dressing changes in the EMR, and the resident's heel wound was not addressed in the care plan. The Clinical Marketing lead also confirmed that the original order did not contain a dressing change frequency and there should have been further follow-up with the provider.	F 686		
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	F 692	F692 Specific Corrective Action 1. Resident #64 discharged from the center on 6/14/2023. 2. An audit of all resident wieghts will be completed by the DON/Designee and re-weighed if needed and documented. Any Concerns will be discussed with nursing, dietician and/or provider as needed. 3. Education to licensed staff will be completed regarding obtaining resident weights and re-weights and documentation. 4. The DON/designee will conduct weekly audits x4, monthly x3 to ensure wights are being completed, documented and re-weighed if required. Any concerns will be escalated to DON, dietician and/or provider as needed and discussed in QA. Date of Compliance to be 7/7/2023pe text here	

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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 staff interview and record review, the facility failed to ensure residents maintain acceptable parameters of nutritional status, such as normal body weight, for one of 21 sampled residents (Resident #64). Findings include:

Per record review, Resident #64 was admitted to the facility on 4/14/2023. A weight of 180 pounds was entered into the record on 4/18/2023. A weight of 180 pounds was entered into the record as well on 4/25/2023. On 5/3/2023, a weight of 160.6 pounds was entered into the record. This is a 10.61% loss from the original weight over approximately one week. The facility Dietitian entered a note on 5/5/2023 that reads, "[Resident #64] is triggering for a sig weight loss of 20 pounds since admission; will monitor for re-weight to assess weight trend. [They are] at risk for weight loss related to variable meal response. Will monitor and follow up as needed." Another weight was entered that same day for Resident #64. This weight was 163.2 pounds, which confirms a significant weight loss of 9.22%. There are no other assessments in Resident #64's record from the Dietitian.

Per review of Resident #64's orders, an order was placed on 4/14/2023 that states "weigh every

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F 692	Continued From page 15 day shift every Friday for 4 weeks." This order ended on 5/19/2023. At the time of record review on 5/22/2023, there was no active order for obtaining Resident #64's weight. Per interview on 5/24/2023 at approximately 3:15 PM, the Director of Nursing confirmed that they could not provide evidence of any additional follow up pertaining to Resident #64's significant weight loss after 5/5/2023, nor were there any current orders to obtain Resident #64's weight.	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 interview, observation, and record review, the facility failed to ensure pain was managed, providing adequate pain control for one resident of the 23 included in the sample (Resident #378). Findings include: Per the Record review resident #378 was admitted on 05/18/2023 for the following reason (s): "Therapy Status post a fall, Pain Management pelvis fracture" Resident #378 has a history of CVA, Dementia, Falls, S/he is expected to have a stay of 7-14 days. An adult child has POA (Power of Attorney) and indicates Resident #378 has some dementia, with a request that staff speaks with her whenever possible.	F 697	F697 Specific Corrective Action 1. Resident #378 discharged from the center on 5/24/2023 Type text here 2. An audit of those residents on pain management program is being completed to validate resident pain is managed by both verbal feedback and/or facial/body language. 3. Education is being completed with licensed nursing staff regarding pain management for residents. 4.DON/Designee will conduct weekly audits x4, monthly x3 on 8 residents to ensure pain is being managed. Any concerns identified will be escalated to the DON addressed immediately and discussed in QA. Date of Compliance to be 7/7/2023 **Tag F 697 POC accepted on 6/20/23 by H. Fox/P. Cota**	

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An interview with a family member on 05/22/2023 at approximately 10:30 indicates resident #378 has only had minimal therapy since admission due to pain. S/he states s/he has requested to "use caution with anything stronger than Tylenol" as it makes Resident #378 sleepy. S/he expresses frustration with the nursing staff specifically regarding pain medication to facilitate resident #378's participation in therapies. S/he states she has asked them to coordinate adequate pain medication prior to therapy. The POA indicates she specifically asks nursing to give a scheduled dose of Tylenol and to add Methocarbamol (A medication used to decrease muscle spasms and decrease pain) prior to scheduled therapy. S/he states the nursing staff asks about pain when s/he is resting in bed. S/he is more comfortable at rest and says s/he has no pain. They do not medicate residents adequately prior to therapy because of this. S/he states therapy has been stopped as it hurts the resident too much to move.

A review of the electronic medical record shows an order for a scheduled Tylenol 500mg every 6 hours, Tramadol HCL 50 mg every 12 hours as needed for pain, and Methocarbamol750 mg every 6 hours as needed for muscle spasms. A record review of the Physical Therapy (PT) Evaluation dated 05/19/23 indicates resident # 378 has pain that interferes with/limits functional activity. Pain is communicated via non-verbal methods. Resident says "ouch", demonstrates guarding left extremity movement, and cries during bed mobility tasks on evaluation.

A record review of the Occupational Therapy (OT) Evaluation dated 05/22/2023 states a high pain

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F 697	Continued From page 17 level, pain assessment indicates resident # 378 has pain that interferes /limits functional activity, bed mobility, stand-to-sit, and any activity with prolonged pressure to the backside such as standing, and walking. Pain Intensity is 8/10, with intermittent frequency in the location of the pelvic area. The pain is relieved by rest and made worse by movement. An interview with the unit manager on 05/23/2023 at approximately 1:30 pm was conducted, where the unit manager indicated the process of communication between therapies and nursing was to discuss what was needed from nursing after therapy evaluations. The unit manager does not recall discussing Resident #378 with therapy but agrees that therapy would have discussed pain levels with nursing. An interview on 05/23/2023 at approximately 2:00 pm with a treating Physical Therapist indicated that resident #378 could not complete the initial evaluation for Physical Therapy due to pain levels. The therapist verified s/he spoke with nursing regarding such. However, no plan was initiated to ensure that the resident received proper pain management prior to therapy visits. An interview on 05/23/2023 at approximately 2:15 PM with another treating physical therapist (PT) indicated therapy was stopped for the day on 05/19/23 due to pain levels. S/he verified speaking with the nursing staff regarding pain levels. An interview on 05/23/2023 with a treating occupational therapist (OT) indicated the initial OT assessment of resident #378 was shorter than normal due to pain levels. The OT indicated	F 697		

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F 697	Continued From page 18 nursing was updated regarding pain levels. S/he was told by a nurse "Resident is not due for Tylenol and family won't let us give anything else". An interview on 05/23/2023 at approximately 3:30 with the Nurse Practitioner (NP) and the clinical marketing manager indicated that the NP had evaluated resident #378 twice since admission. The NP verified that s/he did not discuss with either the resident or nursing the need to pre-medicate the resident to alleviate pain and allow for participation in therapy. During an interview on 05/23/2023 at approximately 3:45 PM the clinical marketing manager confirmed Resident #378 did not receive adequate pain control, which prevented her/him from participating in prescribed therapy.	F 697		
F 808 SS=E	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 by: Based on observations and interviews, the facility failed to assure that residents received foods in the appropriate form as prescribed by a licensed dietician and approved by the physician for 2 of 23 residents sampled (Residents #31, and #63). Findings include:	F 808	F808 Specific Corrective Action 1. The diet tickets for Residents #31 and #63 were updated by the dietician to read "extra sauces, gravy and/or condiments for moisture" 2. An audit of all residents that require moisture was completed by dietician and the diet tickets were updated to say "extra sauces, gravy and/or condiments for moisture. 3. Education is being completed with dietary staff and direct care staff to ensure moisture is added by means of extra sauces, gravy and/or condiments when noted on a resident's diet slip. 4. DON /designee and/or dietician/designee will conduct weekly audits x4, monthly x3 of residents needing extra moisture on their food and ensure their ticket is update. Any issues will be escalated to the DON/Dietician and corrected and discussed in QA. Date of Compliance to be 7/7/2023	

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F 808	Continued From page 19	F 808	**Tag F 808 POC accepted on 6/20/23 by H. Fox/P. Cota**	

1. On 5/22/23 at 1:04 PM during lunch service in the dining room on 'A unit', lunch tray tickets were randomly compared to the tray contents. Resident #31's tray ticket was noted to say "soft foods with added moisture"and the tray contained a plate with a sandwich made of 2 slices of white bread, a chicken breast and 2 whole slices of bacon. When the LPN was asked if this was appropriate s/he responded "s/he would never be able to eat this" and removed the tray. Resident #31 is a 92-year-old-person with a BIMS score of 0 indicating impaired cognition and diagnosis including vascular dementia. His/her diet order dated 11/4/20 is for regular diet, regular texture, thin consistency, extra sauce, gravy, condiments.

2. During the same period of observation, Resident #63's tray ticket was noted to say "extra moisture" the tray also contained the aforementioned chicken club sandwich with a packet of mayonnaise on the tray. Resident #63 is a 67-year-old-person with diagnosis including acute/chronic respiratory failure with hypoxia (lack of oxygen), other signs and symptoms involving cognitive function and awareness. His/her diet order dated 11/4/20 is for regular diet, regular texture, extra sauce, gravy, condiments.

On 5/24/23 at 10:15 AM the Regional Dietician was interviewed regarding the expectation of the provision of extra moisture as ordered. Per the dietician extra sauce, gravy or condiments is intended to assist the resident with chewing/swallowing and as "some residents don't or can't apply condiments" when they are served in a sealed packet on the tray, the food should be served with the extra moisture applied.