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

March 27, 2024

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

Dear Ms. Dacosta:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **March 1, 2024.** Please post this document in a prominent place in your facility.

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

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Enclosure

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 03/01/2024

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

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E 000	Initial Comments The Division of Licensing and Protection conducted an onsite, unannounced survey of the facility's emergency preparedness program on 2/27/2024 during a recertification survey. There were no regulatory violations as a result of this survey.	E 000		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and complaint investigation, including reports #22585, #22591, #22495, #22644, #22727, and #22792, from 2/26/2024 through 3/1/2024 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	F 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.	
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 observation, interview, record review, and facility policy, the facility failed to determine whether it is clinically appropriate for residents to self-administer medications for 1 of 34 residents (Resident #49). Findings include: Per facility policy titled "NSG309 Medications Self- Administration," last revised 3/1/22, states "Patients who request to self-administer medications will be evaluated for safe and clinically appropriate capability based on the	F 554	F554 Specific Corrective Action 1. Resident #49 was evaluated for clinical appropriateness to self-administer medications on 03/21/2024. MD orders are currently in place to self administer medications and may keep at bedside. 2. To identify others at risk, interviews will be conducted with residents who request self administration of medications to determine if they are clinically appropriate based on the patient's functionality and health condition. Follow-up self-administration of medication evaluations will be conducted for residents who request to self-administer.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
DaCosta	HA	3/27/2024

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 554	Continued From page 1	F 554	F554 continued..	

patient's functionality and health condition. If it is determined that the patient is able to self-administer:
A physician/advanced practice provider (APP) order is required.
Self-administration and medication storage must be care planned.
When applicable, patient must be provided with a secure, locked area to maintain medications."

Per observation on 2/26/24 at 12:03 PM, Resident # 49 had multiple bottles of pills, in clear sight, on his/her beside table and in his/her nightstand. When asked what the bottles were, s/he explained that they are supplements and showed this surveyor a bottle of elderberry and zinc pills and a bottle of pills that s/he explained were for his/her spouse and roommate (Resident #47), to help with his/her eyesight. S/He explained that facility staff have taken them away in the past but that no one had said anything recently and is glad because they are really important to him/her and s/he doesn't want them to be taken away. S/He stated that s/he does not have a lockbox for the medications.

A 2/27/24 Nurse Practitioner note states, "[S/He] is seen for an acute visit after she was found to have multiple medications and suppliments in [his/her] room by staff. Patient has done this before and [s/he] was spoken to by this writer regarding the concern with these medications being taken without proper documentation. [S/He] reports [s/he] takes tylenol specifically due to having "to wait 2 or more hours." to get tylenol. Some of the medications are not even approved and appear to be random suppliments off of Amazon. Patient takes the time to explain to this writer what each medication is for and this writer

3. The facility assures that residents who demonstrate clinical appropriateness as well as the desire to self-administer medications are given the opportunity to do so. The Nurse Practice Educator (NPE) or designee will educate the licensed nurses on evaluating residents who wish to self-administer medications to determine clinical appropriateness based on functionality and health condition as per policy.

4. The Director of Nursing (DON) or designee will conduct audits of residents to identify those who wish to self-administer medications to determine compliance with the NSG309 Medications Self-Administration policy. This audit will validate the facility staff are following the policy for self-administration of medication evaluation. These audits will be conducted weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly Quality Assurance / Performance Improvement (QAPI) Committee for further review and recommendations.

COMPLIANCE DATE: 04/18/2024.

Tag F 554 POC accepted on 3/27/24 by K. Ruffe/P. Cota

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F 554	Continued From page 2 explains the concerns with these medications again. These include allergy pills, tylenol, B12 complex, physico-omega, liquid cranberry extract and CBD." Record review reveals that s/he has not been assessed to self-administer medications, does not have a care plan to self administer medications, and does not have physician orders for the supplements listed above. Per interview on 2/27/24 at approximately 2:00 PM, The Administrator confirmed that Resident #49 should not have medications at his/her bedside.	F 554		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580	F580 SPECIFIC CORRECTIVE ACTION 1. Residents #22 and #32 have been evaluated by the nurse practitioner (NP) for potential side effects of medications on 02/27/2024. Resident #31(315) has been evaluated by the nurse practitioner (NP) for potential side effects of medications on 03/19/2024. 2. To identify others at risk, audits will be conducted to identify other residents with potential medication side effects to notify the physician or NP for follow-up. 3. The facility assures that residents who demonstrate potential side effects of medications are identified with notification to the physician or NP for follow-up. The NPE or designee will educate the nurses and the interdisciplinary team on identifying changes in behaviors and side effects that must be documented and communicated to the physician or NP for follow-up.	

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F 580	Continued From page 3 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to notify the resident's physician of potential medication side effects for 3 of 34 sampled residents (Resident #31, #32, and #22). Findings include: 1. Record review reveals that Resident #31 has diagnoses that include dementia with agitation, post-traumatic stress disorder, dysphagia (difficulty swallowing), ataxia (poor muscle control	F 580	F580 continued... 4. The DON or designee will conduct rounds of residents to identify those exhibiting new behaviors or potential side effects of medications. This audit will validate that there is documentation in the medical record and notification to the physician or NP for follow-up. These audits will be conducted weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. COMPLIANCE DATE: 04/18/2024. **Tag F 580 POC accepted on 3/27/24 by K. Ruffe/P. Cota**	

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F 580	Continued From page 4	F 580		

that can affect speech), and bipolar. Per review of Resident #31's care plan, s/he "is at risk for complications related to the use of psychotropic drugs. antipsychotic, anti-depressant," revised on 10/27/23, and has the following intervention "Monitor for side effects and consult physician and/or pharmacist as needed," created on 9/18/22.

Per observations from 2/26/24 through 2/28/24, Resident #31 was seen sitting in his/her wheelchair near the nursing station each morning and afternoon for an hour or more each time. During all observations, Resident #31 was grinding his/her teeth and it was audible in the area surrounding the nursing station.

Per interview 2/27/24 at 2:49 PM with a Licensed Nursing Assistant (LNA), Resident #31 has been grinding his/her teeth for about a week/week and half. This LNA explained that s/he has made nursing staff aware of this. A few minutes later a second LNA also explained that it is a new behavior, "maybe about 10 days," for Resident #31.

Record review reveals that there are no progress notes about Resident #31 grinding his/her teeth or any evidence that the provider was notified or that a provider assessed Resident#31 regarding him/her grinding his/her teeth.

Per interview on 2/27/24 at approximately 4:00 PM, the Psychiatric Nurse Practitioner (NP) stated that s/he has not been made aware of this behavior and should have been. The Nurse Practitioner, who was also present, indicated that s/he was not made aware of this behavior when Resident #31 began grinding his teeth.

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2. Per record review, Resident #22 was admitted to the facility on 11/16/2023 with diagnoses that include dementia, anxiety, and depression. Per review of Resident #22's care plan, s/he "is at risk for complications related to the use of psychotropic drugs Medication: anti-depressant, anti-psychotic, Antianxiety," created 11/17/23, and has the following intervention "Monitor for side effects and consult physician and/or pharmacist as needed," created 11/17/23. A 2/14/24 Psychiatric NP note states "Diagnosis: Unspecified dementia, severe, with other behavioral disturbance Severity: Moderate - Chronic illness with exacerbation - Drug therapy requiring intensive monitoring: anti-psychotic medications."

During an interview with Resident #22 on 2/26/24 at 11:12 AM, the resident had moments during his/her speech where words would be interrupted by a lateral movement at the jaw. This happened multiple times during this interview. The lateral jaw movement was also observed when talking with Resident #22 by the nursing station on 2/27/24 at approximately 9:00 AM. This was observed several other times during the recertification survey.

Per review of Resident #22's medical record, there is no progress note documenting Resident #22's lateral jaw movement or any evidence that a physician had been made aware of this behavior.

Per interview on 2/27/24 at approximately 4:00 PM, the Psychiatric Nurse Practitioner and Nurse Practitioner confirmed that they were unaware that Resident #22 had this behavior and

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F 580	Continued From page 6 confirmed they should have been. 3. Per record review, Resident #32, was admitted to the facility on 3/20/23 with diagnoses that include major depressive disorder and anxiety. Per review of Resident #32's care plan, s/he is at risk for complications related to the use of psychotropic drugs antidepressant, anti-anxiety," created 3/21/23, and has the following intervention "Monitor for side effects and consult physician and/or pharmacist as needed." Per interview on 2/26/24 at 11:04 AM, Resident #32 was in his/her bed grinding his/her teeth. When asked about why s/he was grinding his/her teeth, s/he stated that s/he is not sure why it happens and s/he cannot remember ever talking to a physician about it. A 5/26/23 progress note states, "Note: Patient observed audibly grinding teeth together. Patient states [s/he] is aware [s/he] does it but she cannot stop. Damage and broken teeth not noted by writer. [Patient] denies pain or discomfort. Passing on for possibly [treatment] or plan to prevent damage." There is no evidence in Resident #32's medical record that a provider was notified of this behavior. Per interview on 2/27/24 at approximately 4:00 PM, the Psychiatric Nurse Practitioner and Nurse Practitioner confirmed that they were unaware that Resident #32 had this behavior and confirmed they should have been.	F 580		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and	F 600	F600 Specific Corrective Action	

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F 600	Continued From page 7 Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to protect the residents' right to be free from sexual abuse by a resident for 2 applicable residents (Resident #31 and #38). Findings include: Per record review, Resident #28 was admitted to the facility on 7/28/23 with diagnoses that include chronic pain, epilepsy, depression, and anxiety. Resident #28's care plan states s/he "has the potential to demonstrate verbal behaviors related to: History of verbal outbursts directed toward others (e.g., use of abusive language, pattern of challenging/confrontational verbal behavior), Ineffective coping skills, i.e., poor anger management," revised 2/11/24, with an intervention to "monitor and report any of the following behaviors; verbal outbursts directed toward others (e.g., use of abusive language, pattern of challenging/confrontational verbal behavior), Ineffective coping skills, i.e., poor anger management," revised on 8/8/23.	F 600	F600 continued... 1. Residents #31 (315) and #38 are protected and free from sexual abuse. The psychiatric nurse practitioner is following resident #28, who was last seen on March 13, 2024. 2. To identify others at risk, rounds were made and interviews completed to determine if there were any issues noted of abuse. 3. The facility assures that residents have the right to be free from verbal, mental, sexual, or physical abuse. The NPE or designee will educate all staff on abuse prevention and reporting so incidents can be investigated timely. 4. The Administrator or designee will conduct rounds and interviews to identify abuse. This audit will validate that abuse is reported in a timely manner and that interventions are in place to prevent it. These audits will be conducted weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. COMPLIANCE DATE: 04/18/2024. **Tag F 600 POC accepted on 3/27/24 by K. Ruffe/P. Cota**	

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F 600	Continued From page 8	F 600		

Per a 2/10/24 progress note, Resident #28 was having abnormal behaviors. 2/12/24 behavior notes reveals "At 04:45am resident noted storming up and down the hall and between both units exit seeking, going into another residents room yelling vulgar language, attempted to redirect resident, however resident continue to yell and use profanity toward the staff on the hall." A 2/12/24 Nurse Practitioner (NP) note that s/he is seen for acute behaviors and "Early this morning [s/he] was seen ambulating the hallways, yelling profanities at staff, and going into other residents' rooms." The following day, 2/13/24, the NP wrote, "[S/he] is seen for an acute visit for continued behaviors. This morning it was reported that patient was found in a [gender omitted] resident's room with his/her pants down and was touching himself/herself inappropriately. This weekend [s/he] was also wandering in rooms, yelling at staff (names and racial slurs) and being difficult to redirect. [S/he] was also seen touching another resident's face . . . Based on this escalation and concern for safety of residents and [himself/herself] will send patient to emergency department for further workup." There is no documentation in Resident #28's medical record from the nurse that witnessed Resident #28's inappropriate sexual behavior.

Per interview on 3/1/24 at 10:38 PM, Licensed Nurse #1, the nurse that was working on Resident #28's unit on the 2/12/24-2/13/24 night shift, explained that when s/he came on for his/her shift, there were no new interventions in place for Resident #28's newly increased behavior. S/He explained that while working this shift, Resident #28 had taken their pants down in the middle of the hall a few times. S/He explained that Resident #28 should have been on 1 to 1

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F 600	Continued From page 9 supervision at that point because the resident 's behaviors had increased and s/he was unable to supervise Resident #28 when s/he was providing care for other residents. When asked about Resident #28's sexually inappropriate behaviors, Licensed Nurse #1 explained that around 3 am in the morning s/he was helping another resident when s/he heard the door across the hall close. About 5 minutes later, s/he walked into the hall and heard Resident #38 yell "get out, get out." She opened Resident #38's door and found Resident #28 laying on the floor masturbating. She was unable to determine what Resident #38 or his/her roommate Resident #31 saw, or if either of them were touched by Resident #28. S/He explained that s/he reported this event to the Unit Manager, the Nurse Educator, and Licensed Nurse #2. Per interview on 3/1/24 at 9:35 AM, the Administrator explained that the above event was reported to the team while investigating a separate resident to resident altercation involving Resident #28 but did not investigate it. See F 609 for more information.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609	F609 SPECIFIC CORRECTIVE ACTION 1. Residents #31 (315) and #38 are protected and free from sexual abuse. The psychiatric nurse practitioner is following resident #28, who was last seen on March 13, 2024. This incident was reported on 03/01/2024. 2. To identify others at risk, rounds were made, and interviews were completed to determine if there were any issues noted of abuse and whether these issues were reported in a timely manner.	

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F 609	Continued From page 10 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that allegations involving abuse are reported no later than 2 hours to the Administrator of the facility and the State Survey Agency for 2 applicable residents (Resident #31 and #38). Findings include: Per interview on 3/1/24 at 10:38 PM, Licensed Nurse #1, explained that s/he witnessed Resident #28 masturbating in Resident #31 and #38's room around 3:00 AM on 2/13/23. See F600 for more information. S/He explained that s/he reported this event to the Unit Manager, the Nurse Educator, and Licensed Nurse #2 (Licensed Nurse #1's replacement at change of shift). Per interview on 3/1/24 at 9:10 AM, the Administrator explained that s/he became aware	F 609	F609 Continued.... 3. The facility assures that residents have the right to be free from verbal, mental, sexual, or physical abuse and that abuse is reported within two hours after the allegation is made. The NPE or designee will educate all staff on abuse prevention and reporting so incidents can be investigated in a timely manner and reported to the administrator and other state agency officials within two hours after the allegation is made. 4. The Administrator or designee will conduct rounds and interviews to identify abuse and ensure reporting is completed within two hours to the administrator and state agency officials. This audit will validate that abuse is reported timely with interventions in place to prevent and reported to the administrator and state agency officials within two hours after the allegation is made. These audits will be conducted weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. COMPLIANCE DATE: 04/18/2024 **Tag F 609 POC accepted on 3/27/24 by K. Ruffe/P. Cota**	

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F 609	Continued From page 11 of Resident #28's sexually inappropriate behavior while investigating while investigating a separate resident to resident altercation involving Resident #28. This statement, taken by Licensed Nurse #2 on 2/13/23, states "When I came in this morning to take report form the night nurse, I was told that [Resident #28] was found in another [gender omitted] resident's room masturbating on the floor between the bed and the window. That [gender omitted] patient did not appear to be aware that [s/he] was in the room according to the night nurse." At 9:35 AM, the Administrator stated s/he did not believe the facility investigated or reported this event because they did not believe it to be a reportable event. When asked if a statement was ever taken from the nurse that witnessed this event, s/he did not believe so but would have to check with the Director of Nursing. Per interview on 3/1/24 at 9:40 AM, The DON confirmed that s/he did not interview anyone else about Resident #28's sexually inappropriate behavior. On 3/1/24 at 11:50 AM, the Administrator confirmed that neither the Nurse Educator nor the Unit Manager had reported his event to him/her.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse,	F 610	F610 SPECIFIC CORRECTIVE ACTION 1. Residents #31 (315) and #38 are protected and free from sexual abuse. The psychiatric nurse practitioner is following resident #28, who was last seen on March 13, 2024. This incident was investigated on 03/01/2024. 2. To identify others at risk, rounds were made, and interviews were completed to determine if there were any issues noted of abuse and whether these issues were investigated in a timely manner.	

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F 610	Continued From page 12 neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to initiate and investigate an investigation of an alleged violation of sexual abuse for 2 applicable residents (Resident #31 and #38). Findings include: Per record review of a facility investigation of an allegation of resident to resident physical abuse, a statement taken on 2/13/23 from Licensed Nurse #2 states "When I came in this morning to take report form the night nurse, I was told that [Resident #28] was found in another [gender omitted] resident's room masturbating on the floor between the bed and the window. That [gender omitted] patient did not appear to be aware that [s/he] was in the room according to the night nurse." Per interview on 3/1/24 at 10:38 PM, Licensed Nurse #1 confirmed that s/he found Resident #28 in Resident #31 and #38's room masturbating around 3:00 AM on 2/13/24. S/He explained that while s/he did not know how much Residents #31 or #38 saw of Resident #28's behavior or if Resident #28 had other inappropriate behaviors, s/he is sure that at least Resident #38 was upset and yelling "get out, get out." S/He indicated that	F 610	F610 continued..... 3. The facility assures that residents have the right to be free from verbal, mental, sexual, or physical abuse and that an investigation is completed if there is an allegation of or suspicion of abuse. The NPE or designee will educate all staff on abuse prevention and reporting so that incidents can be investigated promptly. 4. The Administrator or designee will conduct rounds and interviews to identify abuse and ensure an investigation is completed promptly. This audit will validate that an abuse investigation is completed thoroughly and promptly. These audits will be conducted weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. COMPLIANCE DATE: 04/18/2024. **Tag F 610 POC accepted on 3/27/24 by K. Ruffe/P. Cota**	

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F 610	Continued From page 13 no facility staff ever followed up with her about witnessing this event. See F600 for more information. Per interview on 3/1/24 at 9:40 AM, The DON confirmed that s/he did not interview anyone else about Resident #28's sexually inappropriate behavior and did not investigate this event further. On 3/1/24 at 11:50 AM, the Administrator confirmed that there were no nursing notes about this event in Resident #28, #31, or #38's medical record. S/He also confirmed that neither Residents #31 nor #38 were assessed, evaluated, or monitored regarding the event.	F 610		
F 656 SS=E	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).	F 656	F656 SPECIFIC CORRECTIVE ACTION 1. Comprehensive, person-centered care plans have been reviewed, revised, and implemented for Resident #11 to address safety and Resident #52 to address meaningful activities to meet resident needs. Resident #61 was discharged to another center closer to the family on 3/7/2024. 2. To identify others at risk, care plans were reviewed to ensure comprehensive, person centered care plans have been implemented, with revisions made as necessary. 3. The facility assures that residents must have comprehensive, person-centered care plans that are fully implemented to meet resident needs. The NPE or designee will educate the nurses, licensed nursing assistants (LNAs), and the interdisciplinary team on creating and implementing comprehensive, person-centered care plans.	

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F 656	Continued From page 14 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care 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 observation, interview, and record review, the facility failed to create/implement a person-centered care plan for 3 of 34 sampled residents (Residents #61, #11, #52) related to communication for Resident #61, related to safety for Res. #11, and related to activities for Res. #52. Findings include: 1.) Per record review, Resident #61 was admitted to the facility on 11/9/2023 following a five month hospitalization related to stroke and heart complications that resulted in profound neurologic impairment. Per a 11/10/23 Nurse Practitioner	F 656	F656 continued.... 4. The DON or designee will conduct audits of residents to ensure care plans that reflect comprehensive and person-centered care are created and implemented. This audit will validate that comprehensive, person-centered care plans have been created and implemented. These audits will be conducted weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. COMPLIANCE DATE: 04/18/2024. **Tag F 656 POC accepted on 3/27/24 by K. Ruffe/P. Cota**	

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progress note, Resident #61 is non-verbal and does not speak English. Resident #61's admission record factsheet reveals that his/her primary language is Haitian Creole. Per a physician note dated 12/7/23 Resident #61's neurological exam shows that s/he "Smiles when spoken to. Would not blink eyes on command. Known expressive aphasia (a language disorder that affects a person's ability to communicate), have to consider receptive aphasia as well."

Per observations made during the recertification survey between 2/26/24 and 2/28/24 Resident #61 did not seem to have established a method to communicate with this surveyor or any staff member. On 2/26/24 at 12:40 PM, Resident #61 was in bed and did not show any audible response to this surveyor's presence. While this surveyor was unable to get either verbal or physical responses to questions, Resident #61 did make eye contact with this surveyor and tears fell from his/her eyes. At 12:51 PM, a Licensed Nursing Assistant (LNA), who entered Resident #61's room, explained that Resident #61 doesn't understand English but can understand French. The LNA explained that s/he speaks to the resident in English and does not use interpretive services. The LNA indicated that Resident #61 does not understand him/her but Resident #61 does react to his/her voice by looking at him/her and sometimes smiling and s/he can identify if Resident #61 has physical pain or discomfort. Resident #61's head and eyes tracked the LNA as s/he spoke and moved around the resident's bed. When this LNA spoke directly to Resident #61, s/he smiled at the LNA. During a medication administration on 2/27/24 at approximately 11:30 AM, Resident #61 was observed tracking the nurse, the LNA assisting with repositioning, and

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this surveyor's voice throughout the medication administration. Resident #61 was not observed to be out of bed at all on 2/26/24 or 2/27/24 and did not observe any recreational or social visits with Resident #61 on these days. Resident #61 was observed sitting by the nursing station in his/her wheelchair on 2/28/24 for a couple hours but did not see any activities being held in the common area or any staff or other residents interact with Resident #61 in any social or recreational way.

Per phone interview on 2/28/24 at 1:46 PM, Resident #61's Representative explained that Resident #61 had only been in America for a short time before being hospitalized, speaks Creole, and does not understand French or English. S/He has told this to the facility many times and is unsure what they are doing to help him/her communicate. S/He was told that the facility tried to use an interpreter in therapy once over video and it was not successful. S/He explained that s/he would expect that because Resident #61 is not familiar with that type of technology. S/He expressed concern that Resident #61 does not understand what happened to him/her, where s/he is, and why s/he does not have any visitors. S/He has been trying to get Resident #61 transferred to a nursing facility in the town where his/her family lives since December. The Representative believes that if Resident #61 can have visitors that speak to him/her in Creole, the visitors can see how much Resident #61 understands of his/her situation, find out what Resident #61 needs, and see if the visitors can help staff learn how to communicate with Resident #61 better. S/He expressed concern that Resident #61 is not happy and is possibly depressed due to language barriers and lack of visitors, of whom can speak Creole.

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Record review reveals that Resident #61 has the following care plan, "[Resident #61] has impaired communication as evidenced by aphasia r/t [related to] anoxic brain injury [injury caused from lack of oxygen]," created 11/09/2023. While this care plan focus acknowledges his/her impaired communication, the interventions created are based on the resident understanding English and do not address that Resident #61 only understands Creole. Other care plans related to Resident #61's psychosocial health that have communication components are as follows, "Resident is at risk for or is experiencing adjustment issues related to: Loss of social support network as a result of moving into the center, Coping with decline in overall health status, including functional decline," created 1/11/2024, and "Resident/Patient exhibits or is at risk for limited and/or meaningful engagement related to: Cognitive deficits due to traumatic brain injury (TBI)," created 1/16/2024. Interventions for these care plans do not address that Resident #61 does not understand English or that s/he only understands Creole.

Record review reveals a speech therapy note dated 12/21/23 explaining that an evaluation of expression and comprehension was completed and it was determined that Resident #61 rarely/never understands others. The note explains that the evaluation was completed with the language line (a remote translator service). The note also reveals that the Nurse Manager reported to the SLP (Speech Language Pathologist) that Resident #61 has "no eye tracking ability and appears to have no cognitive response to stimuli. . . [Resident #61's Representative] requested another SLP attempt

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to engage the patient at another date." There is no evidence in Resident #61's medical record that there was a follow up SLP reevaluation based on Resident's observed ability and reported ability by staff to track voices and smile at staff or evidence that a reevaluation was conducted using an alternative translation method (such as an in-person translator).

Per interview on 2/27/24 at 12:54 PM, the Social Service Specialist (SSS) explained that it was the responsibility of nursing staff to ensure that communication needs were addressed in care plans and interventions.

Per interview on 2/28/24 at approximately 3:30 PM, the Market Clinical Lead stated that the Social Service department was responsible for updating the care plans to address communication needs and confirmed that Resident #61's care plan did not contain sufficient, person-centered interventions to meet his/her communication needs.

2.) Per record review, Res.#11 was admitted to the facility on 10/9/19 with diagnoses that include 'Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right dominant side' [complete paralysis and partial weakness after a stroke affecting the right side of the body].
Per review of Progress Notes for Res.#11, on 11/5/23, Res.#11 was "evaluated for a blister after burn from coffee spillage on left inner thigh area. Blister is now broken, 2 by 2 centimeters and patient is in burning pain."
Res.#11's Care Plan identified the resident as "requires assistance/is dependent for Activities of Daily Living care related to: generalized weakness, impaired mobility". After the blistering

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burn from the coffee spill, the intervention "Ensure resident is provided with coffee cup with secured lid" was added to the Care Plan to prevent future burns.
Per observation on 2/26/24, Res.#11 was observed eating dinner in their room. On their dinner tray was a cup of coffee with no lid. There was no lid visible on the tray or table.
Per observation on 2/27/24 and on 2/28/24, Res.#11 was again served hot coffee without a secured lid.
An interview was conducted with the facility's Corporate Clinical Specialist on 2/28/24 at 9:02 AM. The Corporate Clinical Specialist confirmed the resident had a history of burns from spilled coffee and due to their stroke was at risk for future burns during meals. The Corporate Clinical Specialist confirmed Res. #11's Care Plan included the intervention to provide a secured lid to the resident's coffee to prevent burns, and that the intervention was not being followed.
At 9:24 AM on 2/28/24, the Corporate Clinical Specialist reported that lids had been available for the resident's coffee but had not been used.
3.) Per record review, Resident #52 has a diagnosis of severe dementia with agitation. Resident #52 has a care plan for "risk for decreased socialization and interactions due to diagnosis of Dementia" with interventions that include "initiate participation in leisure events of choice weekly, 1 to 1 visits as indicated, [Resident #52] enjoys reading, watching TV, and visiting with friends, invite to activities daily and assist with transportation as needed, provide magazines, books, materials." Per review of the facility's activities participation log, Resident #52 is not documented as having attended a group activity, having received a 1 to 1 visit, or having been provided with activities supplies in the last 2

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F 656	Continued From page 20 months. Per initial unit observation on 2/26/24 at approximately 11:00 AM, Resident #52 was overheard yelling "Help! Help! Is anyone there? Does anybody work here?" while resting in their bed. Resident #52's distress was quickly relieved by conversation with this surveyor, and a calm, pleasant conversation ensued. Resident #52 was laying in their bed with a top sheet over their legs. There were no other items within reach of the Resident. The TV was off and the room was dark. Some reading materials were stacked on the nightstand well out of Resident #52's reach. Resident #52 was observed wringing the top sheet with their hands continuously. Resident #52 was observed in this same way many times over the course of the day on 2/26/24. Resident #52 was not observed to be taken outside of their room to be with other residents or provided any distracting or stimulating activities. Per observation on 2/27/24 at approximately 11:00 AM, Resident #52 was again observed to be laying in bed with the lights off with no engaging or stimulating activity materials of any kind. Resident #52 was observed in the same position at approximately 3:00 PM, calling out for help. Per interview on 2/27/24 at approximately 12:00 PM, the Activities Director confirmed that care plan interventions related to activities were not being implemented by the facility for Resident #52.	F 656		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix)	F 660	F660 Specific Corrective Action	

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F 660	Continued From page 21 §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. (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	F 660	F660 continued.... 1. Resident #61 was discharged to another center closer to the family on 3/7/2024. 2. To identify others at risk, the discharge goals of all residents have been reviewed to determine if anyone wishes to be discharged and to ensure the care plan is updated with discharge plans. 3. The facility assures residents that discharge plans are addressed within the care plan and discharge planning for those wishing to be discharged. The NPE or designee will educate the nurses and the interdisciplinary team on ensuring the care plans are updated with discharge goals and discharge planning for those residents who wish to be discharged. 4. The DON or designee will conduct audits of residents of resident discharge goals to ensure care plan updates and discharge planning for those who wish to be discharged. This audit will validate that the care plans have been updated and discharge planning has been completed for those residents who want to be discharged. These audits will be conducted weekly x 4 weeks, biweekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. COMPLIANCE DATE: 04/18/2024. **Tag F 660 POC accepted on 3/27/24 by K. Ruffe/P. Cota**	

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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 discharge or transfer.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and facility policy review, the facility failed to address discharge goals in the plan of care and create a discharge plan in a timely manner for a

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resident whose representative had expressed a desire to transfer to another facility as soon as possible for 1 of 3 sampled residents reviewed for discharge (Resident #61). Based on Resident #61's severe neurological impairment and inability to communicate, and using the reasonable person concept, the resident has the potential for more than minimal psychosocial harm including anxiety, isolation, distress, and depressed mood due to not being able to see family. Findings include:

Per record review, Resident #61 was admitted to the facility on 11/9/2023 following a five month hospitalization related to stroke and heart complications that resulted in profound neurologic impairment. Per a 11/10/23 Nurse Practitioner progress note, Resident #61 is non-verbal and does not speak English. Resident #61's Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) dated 2/8/24 reveals that s/he is completely dependent on staff for all activities of daily living (ADLs) and transfers and receives 100% of nutrition via tube feed. Per a physician note dated 12/7/23, Resident #61 does not have noted movement in his/her upper or lower extremities and a neurological exam shows that s/he "Smiles when spoken to. Would not blink eyes on command. Known expressive aphasia (a language disorder that affects a person's ability to communicate), have to consider receptive aphasia as well."

Per phone interview on 2/28/24 at 1:46 PM, Resident #61's Representative explained that s/he and Resident #61's family are not able to visit Resident #61 regularly because of where the facility is located. S/He explained that Resident #61 had only been in America for a short time

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before being hospitalized. Because s/he has not been able to visit s/he is not sure if Resident #61 understands what happened to him/her, where s/he is, and why s/he does not have any visitors. The Representative explained that Resident #61 speaks Creole and does not understand French or English. S/He has told this to the facility many times and is unsure what they are doing to help him/her communicate. S/He expressed concern that Resident #61 is not happy, possibly depressed, and believe s/he would have a better chance of getting the care that s/he needs and being happier if s/he was at a facility where s/he could have frequent visitors that knew him/her and could communicate with him/her in a language that s/he understood. The Representative's thought was, if Resident #61's family were able to visit, they could explain to him/her in Creole what his/her situation is, they would be able to participate in helping staff understand the best way to care for him/her, and Resident #61 would not be lonely because s/he could have visitors. S/he has been trying to get Resident #61 transferred to a nursing facility in the town where his/her family. S/He explained that s/he made this request with the facility in December. S/he explained that s/he has tried to follow up with the facility, including the Administrator, multiple times about transferring Resident #61 to Burlington but no one has gotten back to him/her with next steps and s/he feels like s/he is on his/her own to try to get Resident #61 transferred.

Facility policy titled OPS406 Discharge Planning Process, revised on 11/15/22, states, "The Center must develop and implement an effective discharge planning process that focuses on the patient's/resident's (hereinafter "patient")

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discharge goals. . . Discharge planning will begin upon admission and be completed as part of the Person-Centered Care Plan process. . .
1. The interprofessional care team will use the discharge planning process to:
1.1 Identify discharge needs and develop a discharge plan to meet those needs;
1.2 Include regular evaluation of patients to identify changes that require modification of the discharge plan; the discharge plan must be updated to reflect these changes;
1.8.3 Centers must update a patient's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities."

A 12/29/23 care plan meeting note states, "Their [Resident #61's Representative] desire is to have the patient moved to a facility in Burlington." The Administrator-in-Training was in attendance at this meeting.
Record review shows that Resident #61's care plan was not revised after 12/29/23 to reflect Resident #61's Representative's goal to transfer to a different skilled nursing facility. There was no evidence of a discharge plan to prepare to meet this request nor any documentation that this request had been followed up on by any facility staff member, including social service staff.

Per interview on 2/28/24 at 3:44 PM, the Social Service Specialist (SSS) explained that in December, Resident #61's Representative had brought the request to transfer Resident #61 to a different nursing facility in the same city that his/her family lived so Resident #61 could have more visitations with his/her family. The SSS explained that s/he was not aware of the status of

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F 660	Continued From page 26 this request because s/he had not followed up on it and was unable to produce evidence that a referral to this other facility was started. S/He explained that both the Administrator-in-Training and the Administrator were supposed to follow through with the family about the request. The SSS confirmed that the care plan was not revised to reflect the discharge goals and there was no other discharge plan in place that evaluated the resident's discharge needs and discharge plan. Per interview on 2/28/24 at approximately 5:00 PM, the Market Clinical Lead confirmed Resident #61's Representative's discharge goals had not been addressed by the facility.	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 observation, interviews, and record review, the facility failed to ensure that residents who are unable to carry out activities of daily living receive the necessary services to maintain wellbeing as evidenced by staff not getting one of 34 sampled residents out of bed (Resident #52) and to maintain good hygiene as evidenced by excessively long fingernails for 3 of 34 sampled residents (Residents #47, #61, and #54). Findings include: 1. Per initial unit observation on 2/26/24 at approximately 11:00 AM, Resident #52 was overheard yelling "Help! Help! Is anyone there? Does anybody work here?" while resting in their	F 677	F677 SPECIFIC CORRECTIVE ACTION 1. Activities of daily living (ADLs) are being carried out for the following residents: • Resident #52 to be out of the room • Resident #47 for personal hygiene for nail care – nails were cut on 03/01/2024 • Resident #54 for personal hygiene for nail care – nails were cut on 03/01/2024. Resident #61 was discharged to another center closer to the family on 3/7/2024. 2. To identify others at risk, rounds were made to determine that residents can leave their rooms as desired and that nail care is being performed. 3. The facility assures residents who cannot carry out their ADLs receive the necessary services to maintain their well-being. The NPE or designee will educate the nurses and the LNAs on all aspects of ADLs to ensure ADL care assistance is being provided and documented.	

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bed. Resident #52 was observed in this same way many times over the course of the day on 2/26/24. Resident #52 was not observed to be taken outside of their room.

Per interview on 2/26/24 at approximately 11:30 AM, an LNA (licensed nursing assistant) stated that they have worked at the facility for 11 weeks and have never once seen Resident #52 leave their room and is always yelling out. At the same time, an LPN who works with Resident #52 said that Resident #52 cannot tolerate being upright in a chair due to a painful sore on their hip and not being able to offload that hip in a chair.

Per observation on 2/27/24 at approximately 11:00 AM, Resident #52 was again observed to be lying in bed with the lights off. Resident #52 was observed in the same position at approximately 3:00 PM, calling out for help.

Per review of Resident #52's wound care documentation, Resident #52 had a new stage 2 pressure ulcer on the right hip that was discovered on 8/30/23. The record also states that the pressure ulcer was resolved on 2/1/24. Per Resident #52's ADL (activities of daily living) care plan, Resident #52 is listed as dependent for wheelchair mobility with bilateral leg rests. The ADL care plan does not list Resident #52 as bed bound. Resident #52's activities care plan also states that Resident #52 should be invited to activities daily and should be assisted with transportation as needed.

Per interview on 2/27/24 at approximately 3:00 PM, the facility's Nurse Practitioner stated that they were aware that Resident #52 was not able to get out of bed due to not tolerating being up in

4. The DON or designee will round to identify ADLs being carried out per the care plan. This audit will validate that ADL care is being completed per the care plan. These audits will be conducted weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.

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the chair, and that this was a result of the right hip pressure ulcer. They confirmed that they had not been made aware that this pressure ulcer has since resolved.

Per interview on 2/27/24 at approximately 5:00 PM, the LPN who documented that the pressure ulcer was resolved confirmed that they had observed that the pressure ulcer was completely healed, but did not know whether the area still caused Resident #52 pain that prevents them from getting out of bed into a chair.

Per interview on 2/27/24 at approximately 5:15 PM, the Clinical Market Advisor confirmed that the facility had not reevaluated Resident #52's ability to leave their room after their pressure ulcer had resolved on 2/1/24.

2. Per record review, Resident #47's care plan, created 5/29/23, reveals that s/he requires extensive assistance for personal hygiene. Per observation on 2/26/24 at 12:03 PM, Resident #47's nails were long, brittle, jagged, and dirty.

Per record review, Resident #61's care plan, created 11/9/23, reveals that s/he is completely dependent for all care. Per observation on 2/26/24 at 12:40 PM, Resident #61's nails were long and brittle.

Per record review, Resident #54's Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) dated 2/12/24 reveals that s/he requires partial assistance for activities of daily living (ADLs). Per observation on 2/28/24 at 9:10 AM, Resident #54's nails were long, brittle, and dirty.

On 2/28/24 at 11:05 AM the Market Clinical

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F 677	Continued From page 29 Advisor observed Residents #47, # 61, and #54's fingernails with this surveyor and confirmed that their nails were long, brittle, dirty, and needed to be cut.	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, interview, and record review, the facility failed to provide a program to support residents in their choice of group, individual, and independent activities to meet the interests of and support the well-being of each resident as evidenced by a lack of engaging activities both in and out of resident rooms for 5 of sampled 34 residents (Residents #52, #61, #22, #28, and #20). Findings include: 1. Per initial unit observation on 2/26/24 at approximately 11:00 AM, Resident #52 was overheard yelling "Help! Help! Is anyone there? Does anybody work here?" while resting in their bed. Resident #52's distress was quickly relieved by conversation with this surveyor, and a calm, pleasant conversation ensued. Resident #52 was laying in their bed with a top sheet over their legs.	F 679	F679 SPECIFIC CORRECTIVE ACTION 1. Activities/recreation is being provided to support residents in their choice of group, individual, and independent activities to meet the interests of and support the well-being of Residents #20, #22, #28, and #52. Care plans were updated to address individual preferences and engagement needs. Resident #61 was discharged to another center closer to the family on 3/7/2024. 2. To identify others at risk, interviews were conducted to discuss preferences for interviewable residents to ensure their individualized preferences were addressed in their care plan. Families were interviewed for those residents who could not be interviewed to provide a person-centered care plan was in place for activities/recreation. 3. The facility assures that activities/recreation are provided to support residents in their choice of group, individual, and independent activities to meet their interests and support their well-being. The NPE or designee will educate the activities department regarding activities/recreation to support residents in their choice of group, individual, and independent activities to meet their interests and support their well-being.	

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There were no other items within reach of the Resident. The TV was off and the room was dark. Some reading materials were stacked on the nightstand well out of Resident #52's reach. Resident #52 was observed wringing the top sheet with their hands continuously. Resident #52 was observed in this same way many times over the course of the day on 2/26/24. Resident #52 was not observed to be taken outside of their room to be with other residents or provided any distracting or stimulating activities in their room.

Per interview on 2/26/24 at approximately 11:30 AM, an LNA (licensed nursing assistant) stated that they have worked at the facility for 11 weeks and have never once seen Resident #52 leave their room and is always yelling out. At the same time, an LPN who works with Resident #52 said that Resident #52 cannot tolerate being upright in a chair, so they do not leave their room. Neither were aware of what Resident #52 enjoys doing.

Per observation on 2/27/24 at approximately 11:00 AM, Resident #52 was again observed to be laying in bed with the lights off and no engaging or stimulating activity materials of any kind. Resident #52 was observed in the same position at approximately 3:00 PM, calling out for help.

Per record review, Resident #52 has a diagnosis of severe dementia with agitation. Resident #52 has a care plan for "risk for decreased socialization and interactions due to diagnosis of Dementia" with interventions that include "initiate participation in leisure events of choice weekly, 1 to 1 visits as indicated, [Resident #52] enjoys reading, watching TV, and visiting with friends, invite to activities daily and assist with

4. The Administrator or designee will conduct rounds to identify activities/recreation programs to support residents in their choice of group, individual, and independent activities to meet their interests and support their well-being. This audit will validate that activities/recreation are provided based on each resident's individualized care plan. These audits will be conducted weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.

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transportation as needed, provide magazines, books, materials." Per review of the facility's activities participation log, Resident #52 is not documented as having attended a group activity, having received a 1 to 1 visit, or having been provided with activities supplies in the last 2 months.

Per interview on 2/27/24 at approximately 11:35 AM, an independent quality consultant hired by the facility stated that they are currently working with the facility on a project to improve the activities programming for Residents on the memory care unit (where Resident #52 resides). They stated that the current state of programming is lacking for residents with memory care issues or who are otherwise not high functioning. They confirmed that the scope of this improvement project does not currently include any changes to how the facility provides one-on-one activities or how residents restricted to their rooms are included in the activities program.

Per interview on 2/27/24 at approximately 11:50 AM, the facility's Activities Director stated that most group offerings are held in the activities room at the front of the building, but occasionally groups will be held on the memory care unit in the Solarium. The Director and one other part-time activities assistant work to meet one-on-one with residents who do not leave their rooms as time allows in their schedules. The Director stated that there are carts on the memory care unit with sensory items that nursing staff can use with residents to engage them, but that they do not see nursing staff utilizing this very much. The Director confirmed that residents who stay in their rooms are not as well-engaged in the activities program, including Resident #52, and that the

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programming for residents with memory care issues in general is insufficient to meet the needs of memory-impaired residents.
2. Per record review, Resident #61 was admitted to the facility on 11/9/2023 following a five month hospitalization related to stroke and heart complications that resulted in profound neurologic impairment. Per a 11/10/23 Nurse Practitioner progress note, Resident #61 is non-verbal and does not speak English. Resident #61's admission record factsheet reveals that his/her primary language is Haitian Creole. Resident #61's Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) dated 2/8/24 reveals that s/he is completely dependent on staff for all activities of daily living (ADLs) and transfers and receives 100% of nutrition via tube feed. Per a physician note dated 12/7/24, Resident #61 does not have noted movement in his/her upper or lower extremities and a neurological exam shows that s/he "Smiles when spoken to. Would not blink eyes on command. Known expressive aphasia (a language disorder that affects a person's ability to communicate), have to consider receptive aphasia as well."

Resident #61 is not observed to be engaged in activities during the recertification survey. Per observation on 2/26/24 at 12:40 PM, Resident #61 was observed in bed, unable to move any parts of his/her body other than his/her head from side to side. Resident #61 was unable to respond verbally or with facial expressions to this surveyor's questions. A TV was on across the room but it did not appear as though it was in Resident #61's line of sight. Resident #61 was not observed to be out of bed at all on 2/26/24 or 2/27/24 and did not observe any recreational or social visits with Resident #61 on these days.

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Resident #61 was observed sitting by the nursing station in his/her wheelchair on 2/28/24 for a couple hours but did not see any activities being held in the common area or any staff or other residents interact with Resident #61 in any social or recreational way.

Per interview on 2/27/2024 at approximately 12:00 PM, a Licensed Nursing Assistant confirmed that Resident #61 did not get out of bed the day before and explained that s/he would not get out of bed today because it was late in the day and s/he would be getting hooked up to their tube feeding soon.
Per record review, Resident #61 does not have documentation that s/he regularly participates in either group or individual activities. The activity log for January 2024 and February 2024 reveals that the only activities that Resident #61 participated in was a weekly call with his/her family, and attendance at one music event on 1/23/24.

Per record review, Resident #61 does not have a care plan that address any type of engagement with others until 1/16/24, over two months since s/he was admitted. The care plan that is created on 1/16/24 does not take into account that Resident #61 does not understand English and cannot communicate with others. See F 656 for more information about failure to develop a person-centered care plan related to communication. As of 2/28/24, Resident #61 does not have a person-centered care plan for activities that incorporates his/her interests, hobbies, cultural preferences, or goals. In addition, there is no evidence that a comprehensive activities assessment was created with the help of Resident #61's

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Representative; instead, this assessment was not answered by anyone.

3. Per record review, Resident #22, was admitted to the facility on 11/16/2023 with diagnoses that include dementia, anxiety, depression, and type 2 diabetes.

Per interview on 2/26/24 at 11:12 AM, Resident #22 expressed frustration and anger that the facility will not let him/her go outside and said it feels like they keep him/her in his/her room all the time. S/He stated, "people here don't give a [explicative] about me. All I do is go to the bathroom, eat, and watch TV."

Per observation on 2/26/24 at 2:22 PM, Resident #22 was brought to BINGO. An LNA brought him/her into the activities room and sat him/her at a table with two BINGO cards and a dabber on the table. There were no staff in the room to assist the residents with setup or instruction. There was only one staff person (the receptionist) in the activities room who was standing at the call machine. Resident #22 was observed for 20 minutes and did not pick up the dabber or look at the cards in front of him/her once.

Per observation on 2/26/24 through 2/28/24, Resident #22 was seen sitting in his/her wheelchair at the nurses station multiple times for extended periods of time with multiple other residents. While music was playing, and multiple staff were in and out of the area during these observations, this surveyor did not observe any staff during these three days encourage any interaction with Resident #22 or any other resident.

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Per record review, the activity log for January 2024 and February 2024 reveals that Resident #22 participated in only 8 group activities and no individual activities. Resident #22 did not have an activities care plan until 1/18/24, two months after admission.

4. Per record review, Resident #28, was admitted to the facility on 7/28/23 with diagnoses that include chronic pain, epilepsy, depression, and anxiety.

Per interview on 2/26/24 at 10:39 AM, Resident #28 explained that there is nothing to do here that meets her needs. S/He said that the activities program does not offer much because the activities staff also transports residents to appointments and that s/he is lucky if there are things that s/he wants to do 3 times a week.

Per record review, the activity log for January 2024 and February 2024 reveals that Resident #28 participated in only 11 group activities and no individual activities and Resident #28 did not have an activities care plan until 9/1/23, over a month after admission.

5. Observations were made of Resident #20 over three days, February 26, 27, and 28, 2024 at different times during the day. On 02/26/24 at approximately 12:20 PM, 2:30 PM, and 4:00 PM, Resident # 20 was observed lying in bed with a sheet over them. The television in the room was off, and the room was dim. Resident # 20 was not taken outside the room or provided any other forms of stimulation. On 2/27/2023 at approximately 9:50 AM, s/he was observed in a

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reclining chair in a common area with several other residents. A television (TV) was on in the room. At approximately 1:40 PM, s/he was observed in the same spot in front of the TV; a staff member spoke to him/her, asking if the TV was loud enough. Resident #20 did not respond but continued with their eyes closed. There was no other sensory stimulation provided. On 2/28/2023 at approximately 11:15 AM, s/he was observed with eyes closed and opening their mouth as directed by staff to eat lunch. S/he was observed again at 2:10 PM with their eyes closed in the same spot. Several staff members walked by but did not attempt to provide any other sensory stimulation. When this surveyor approached and asked their name, Resident #20 opened their eyes, stated their name, and reached for the surveyor's hand.

Per record review, resident # 20 was admitted to the facility on 3/22/22 with a diagnosis of Severe Dementia (A group of symptoms that affect memory, thinking, and social abilities), with limited verbalization. Resident #20 has a care plan for "Dependent on staff for activities, cognitive stimulation, social interaction related to Cognitive deficits and a diagnosis of Dementia" with interventions that include "when [resident's name] chooses not to participate in organized activities, turn on TV, music in room to provide sensory stimulation" and [resident's name] needs 1to 1 bedside in-room visits and activities if unable to attend out of room events." Per a review of the facility's activities participation log, Resident #20 has not been documented as having participated in a group activity, received a 1-to-1 visit, or been provided with sensory stimulation in the last two months.

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F 679	Continued From page 37 In an interview on 2/28 at approximately 1:40 PM, the activity assistant stated, "We bring [Resident #20] when there is music, but most of the time, [Resident #20] watches TV, s/he is not very responsive."	F 679		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and record review, the facility failed to ensure the environment was free of accident hazards for 1 resident [Res.#11] of 34 sampled residents. Findings include: Per record review, Res.#11 was admitted to the facility on 10/9/19 with diagnoses that include 'Hemiplegia and Hemiparesis following Cerebral Infarction affecting Right dominant side' [complete paralysis and partial weakness after a stroke affecting the right side of the body]. Per review of Progress Notes for Res.#11, on 11/5/23, Res.#11 was "evaluated for a blister after burn from coffee spillage on left inner thigh area. Blister is now broken, 2 by 2 centimeters and patient is in burning pain." Res.#11's Care Plan identified the resident as "requires assistance/is dependent for Activities of Daily Living care related to: generalized weakness, impaired mobility". After the blistering	F 689	F689 Specific Corrective Action 1. Resident #11 has a secured lid on hot drinks per the care plan. 2. To identify others at risk, the safety care plans were reviewed to ensure the interventions to prevent them are implemented. 3. The facility assures that residents reside in an environment as free of accident hazards as possible with comprehensive, person-centered care plans that reflect safety needs. The NPE or designee will educate the nurses, the LNAs, and the interdisciplinary team on implementing care plans to prevent accident hazards. 4. The DON or designee will audit care plans and rounds to ensure an environment as free of accident hazards as possible with comprehensive, person-centered care plans that reflect safety needs being implemented. This audit will validate interventions that are in place to prevent these interventions and that these interventions are implemented. These audits will be conducted weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. COMPLIANCE DATE: 04/18/2024.	

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F 689	Continued From page 38 burn from the coffee spill, the intervention "Ensure resident is provided with coffee cup with secured lid" was added to the Care Plan to prevent future burns. Per observation on 2/26/24, Res.#11 was observed eating dinner in their room. On their dinner tray was a cup of coffee with no lid. There was no lid visible on the tray or table. Next to the cup of coffee was the resident's dinner menu, which included the note in capital letters "ALL DRINKS MUST HAVE A LID". Per observation on 2/27/24 and on 2/28/24, Res.#11 was again served hot coffee without a secured lid. An interview was conducted with 3 Licensed Nurses' Aides [LNAs] on 2/28/24. The first LNA was serving hot drinks to residents in their rooms, including Res.#11, and the other 2 LNAs were serving hot drinks to residents in the main dining area. All 3 LNAs stated that the facility's coffee mugs did not have lids and there were no such lids available. An interview was conducted with the facility's Corporate Clinical Specialist on 2/28/24 at 9:02 AM. The Corporate Clinical Specialist confirmed the resident had a history of burns from spilled coffee and due to their stroke was at risk for future burns during meals. The Corporate Clinical Specialist confirmed Res. #11's Care Plan included the intervention to provide a secured lid to the resident's coffee to prevent burns, and that the intervention was not being followed. At 9:24 AM on 2/28/24, the Corporate Clinical Specialist reported that lids had been available for the resident's coffee but had not been used.	F 689	**Tag F 689 POC accepted on 3/27/24 by K. Ruffe/P. Cota**	
F 699 SS=E	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care	F 699	F699 SPECIFIC CORRECTIVE ACTION	

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F 699	Continued From page 39 The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to Identify a resident's past history of trauma, and/or triggers which may cause re-traumatization for 3 applicable residents (Residents #22, #31, and #28). Findings include: 1. Per record review, Resident #22, age 93, was admitted to the facility on 11/16/2023 with diagnoses that include dementia, anxiety, and depression. Per interview on 2/26/24 at 11:12 AM, Resident #22 said that s/he is very sad. S/He explained that his/her past was hard and at one point was held against his/her will and pressured into religion and became teary. Later in the interview Resident #22 expressed frustration and anger that the facility will not let him/her go outside and said it feels like they keep him/her in his/her room all the time. S/He stated, "people here don't give a [explicative] about me. All I do is go to the bathroom, eat, and watch TV." Per review of Resident #22's transfer of care note, his/her active problem list, which was signed by a physician on 9/30/23, includes a diagnosis of post-traumatic stress disorder (PTSD) since 6/25/1999. The first mention of Resident #22 having PTSD in his/her medical record is in a 12/22/23 physician note. Resident	F 699	F699 Continued... 1. The care plans for Residents #22, #28, and #31(315) have been updated to reflect the past history of trauma, accounting for each resident's experience to mitigate or eliminate triggers that may cause re-traumatization. 2. To identify others at risk, interviewable residents and family members of non-interviewable residents were interviewed about a history of trauma along with triggers and needs. Any new information regarding the history of trauma was added to the documentation and comprehensive care plan. 3. The facility assures that trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences to eliminate or mitigate triggers that may cause retraumatization. The NPE or designee will educate the nurses and social services on the evaluation of trauma and ensure a comprehensive, person-centered care plan is in place to eliminate or mitigate triggers for anyone with a history of trauma. 4. The DON or designee will review documentation and care plans to ensure trauma survivors have a comprehensive, person-centered care plan that addresses preferences to eliminate or mitigate triggers. This audit will validate that trauma-informed care is addressed in the care plan for trauma survivors. These audits will be conducted weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. COMPLIANCE DATE: 4/18/24	

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#22 does not have a care plan for PTSD and does not have any triggers identified in his/her care plan or medical record.

Per interview on 2/27/24 at 12:54 PM, the Social Service Specialist (SSS) explained that s/he was unaware of Resident #22's diagnosis for PTSD.

2. Record review reveals that Resident #31 has diagnoses that include dementia with agitation, PTSD, dysphagia (difficulty swallowing), ataxia (poor muscle control that can affect speech) and bipolar. Resident #31's care plan states, "[Resident #31] reports past experience of trauma as evidenced by: [diagnosis] of PTSD," revised 5/21/23, but does not have any triggers identified within the care plan.

Per interview on 2/28/24 at approximately 3:30 the Market Clinical Lead confirmed that Resident #31 does not have adequate, person centered care plan interventions related to trauma.

3. Per record review, Resident #28 was admitted to the facility on 7/28/23 with diagnoses that include chronic pain, epilepsy, depression, and anxiety.

Per interview on 3/1/24 at 11:50 AM, Resident #28 indicated that s/he had some bad things happen in her past and then quickly changed the subject. Being cautious, this surveyor did not ask follow up questions, to prevent the conversations from becoming triggering.

A social service assessment used to screen for PTSD was completed on 8/1/23, 8/31/23, and 10/27/23. All three assessments coded Resident #28 as negative for trauma. The screening tool

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F 699	Continued From page 41 used is a two question assessment that asks the resident if they have experienced any consequences from trauma in the past month. It does not ask the resident if they have experienced trauma at any point in their past. Per interview on 2/27/24 at 12:54 PM, the SSS confirmed that the only screening that s/he did for trauma was ask the two questions above. S/He explained that there are no other screening tools that s/he uses to assess for trauma and s/he does not ask resident's family's directly about trauma. S/He explained that s/he usually will know if a resident has trauma because it is in their medical record or nursing staff will inform him/her. S/He explained that this is the system because s/he is not a licensed social worker; the facility did not have a social worker after August 2023.	F 699		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents'	F 726	F726 SPECIFIC CORRECTIVE ACTION 1. Licensed nurses and licensed nursing assistants have had competency skill set documentation reviewed, and anyone lacking has completed competencies. 2. To identify others at risk, The facility staff education files were reviewed to validate the skill sets and competencies are in place to meet the needs of the facility resident population per the facility assessment. 3. The facility assures licensed nurses and licensed nursing assistants are assessed for their competency and skill sets to provide care and respond to each resident's individualized needs based on the facility assessment. The NPE or designee will educate the management and leadership team members on the requirements for competency and skill sets to be completed before working with residents.	

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F 726	Continued From page 42 needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and the facility assessment, the facility failed to ensure that the licensed nurses and licensed nursing assistants were assessed for their competency and skill sets to provide care and respond to each resident's individualized needs. Findings include: The Facility Assessment (an assessment that determines what resources are necessary to care for the residents competently during both day-to-day operations and emergencies), last reviewed in February 2023, states, "Staff training/education and competencies are done that are necessary to provide the level of support and care needed for our residents/patients." Per an interview on 2/26/24 at approximately 12:42 PM with an LPN who states s/he is agency staff who has been working in the facility for less than two weeks. They verified taking reliance training (online training provided by the facility) in abuse, dementia, medication administration, and infection control. They state they did not have	F 726	F726 continued... 4. The DON or designee will conduct audits of newly hired staff members to ensure all competencies are completed before working with residents. This audit will validate that the competencies are completed before the new licensed nurse and licensed nursing assistants work with residents. These audits will be conducted weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. COMPLIANCE DATE: 4/18/2024 **Tag F 726 POC accepted on 3/27/24 by K. Ruffe/P. Cota**	

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F 726	Continued From page 43 competencies performed to assess if they were competent in such things as catheter care or pain evaluations before taking an assignment. Another interview with LPN #2 on 02/27/2024 at approximately 4:00 PM reveals that s/he had been employed at this facility since October. S/he had not been evaluated or signed off for competencies in trauma-informed care, catheter care, change in condition, or any competencies required to care for the residents. Per review of 12 sampled employee education records, 5 of the sampled LNAs and 4 of the sampled licensed nurses revealed no evidence of documentation of the competency evaluation required to demonstrate that they had the necessary skills to provide the care needed. Additionally, one of the sampled LNA files contained competencies that were not completed and signed off as observed. Per an interview with the Clinical Market Consultant on 2/28/2024 at approximately 4:30 PM, s/he confirmed that the facility could not provide evidence of documentation in the employee files that their skill competencies had been assessed or that the necessary skill competencies had been completed. S/he confirmed that newly hired LNAs receive an orientation checklist and must demonstrate competency in several aspects of the LNA role. S/he also confirmed that two of the new employees who were recently hired were given assignments without the usual orientation, before they were assessed for competency skills due to staffing needs.	F 726		
F 745 SS=D	Provision of Medically Related Social Service	F 745	F745 SPECIFIC CORRECTIVE ACTION	

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F 745	Continued From page 44 CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide medically necessary social services related to communication and discharge for 1 of 34 sampled residents (Residents #61) who did not have person-centered care plan interventions to reflect his/her inability to understand English or a discharge plan that reflected his/her representative's goals. Based on Resident #61's severe neurological impairment and inability to communicate, and using the reasonable person concept, the resident has the potential for more than minimal psychosocial harm including anxiety, isolation, distress, and depressed mood due to not being able to see family and communicate with others. Findings include: Per record review, Resident #61 was admitted to the facility on 11/9/2023 following a five month hospitalization related to stroke and heart complications that resulted in profound neurologic impairment. Per a 11/10/23 Nurse Practitioner progress note, Resident #61 is non-verbal and does not speak English. Resident #61's Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) dated 2/8/24 reveals that s/he is completely dependent on staff for all activities of daily living (ADLs) and transfers and receives 100% of nutrition via tube feed. His/her preferred language is marked as English. Per a physician note dated 12/7/23, Resident #61	F 745	F745 Continued... 1. Resident #61 was discharged to another center closer to the family on 3/7/2024. 2. To identify others at risk, the discharge goals and communication status of all residents have been reviewed to determine if anyone wishes to be discharged or if anyone has impairments with communication. 3. The facility assures that residents receive medically necessary social services related to communication and discharge. The NPE or designee will educate the social services department regarding providing medically necessary social services to meet the needs of the residents. 4. The Administrator or designee will conduct audits of residents to identify those with new communication impairments or discharge preferences and ensure medically necessary social services assistance is occurring. This audit will validate that social services are assisting these types of residents. These audits will be conducted weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. COMPLIANCE DATE: 04/18/2024. **Tag F 745 POC accepted on 3/27/24 by K. Ruffe/P. Cota**	

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does not have noted movement in his/her upper or lower extremities and a neurological exam shows that s/he "Smiles when spoken to. Would not blink eyes on command. Known expressive aphasia (a language disorder that affects a person's ability to communicate), have to consider receptive aphasia as well."

Per observations made during the recertification survey between 2/26/24 and 2/28/24 Resident #61 did not seem to have established a method to communicate with this surveyor or any staff member. On 2/26/24 at 12:40 PM, Resident #61 was in bed and did not show any audible response to this surveyor's presence. While this surveyor was unable to get either verbal or physical responses to questions, Resident #61 did make eye contact with this surveyor and tears fell from his/her eyes. At 12:51 PM, a Licensed Nursing Assistant (LNA), who entered Resident #61's room, explained that Resident #61 doesn't understand English but can understand French. The LNA explained that s/he speaks to the resident in English and does not use interpretive services. The LNA indicated that Resident #61 does not understand him/her but s/he can identify if Resident #61 has physical pain or discomfort. Resident #61's head and eyes tracked the LNA as s/he spoke and moved around the resident's bed. When this LNA spoke directly to Resident #61, s/he smiled. Resident #61 was not observed to be out of bed at all on 2/26/24 or 2/27/24 and did not observe any recreational or social visits with Resident #61 on these days. Resident #61 was observed sitting by the nursing station in his/her wheelchair on 2/28/24 for a couple hours but did not see any activities being held in the common area or any staff or other residents interact with Resident #61 in any social or

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recreational way.

Per phone interview on 2/28/24 at 1:46 PM, Resident #61's Representative explained that Resident #61 had only been in America for a short time before being hospitalized, speaks Creole, and does not understand French or English. S/He has told this to the facility many times and is unsure what they are doing to help him/her communicate. S/He was told that the facility tried to use an interpreter in therapy once over video and it was not successful. S/He explained that s/he would expect that because Resident #61 is not familiar with that type of technology. S/He expressed concern that Resident #61 does not understand what happened to him/her, where s/he is, and why s/he does not have any visitors. S/He has been trying to get Resident #61 transferred to a nursing facility in the town where his/her family lives since December. The Representative believes that if Resident #61 can have visitors that speak to him/her in Creole, the visitors can see how much Resident #61 understands of his/her situation, find out what Resident #61 needs, and see if the visitors can help staff learn how to communicate with Resident #61 better. S/He expressed concern that Resident #61 is not happy and is possibly depressed due to language barriers and lack of visitors, of whom can speak Creole.

Per interview on 2/27/24 at 12:54 PM, the Social Service Specialist (SSS) explained that s/he is not a social worker and the social service department had been short staffed since the social worker left in August. S/He stated that it was the responsibility of nursing staff to ensure that communication needs were addressed in care plans and interventions. On 2/28/24 at 3:44

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F 745	Continued From page 47 PM, the SSS explained that in December, Resident #61's Representative had brought the request to transfer Resident #61 to a different nursing facility so Resident #61 could have more visitations with his/her family. The SSS explained that s/he was not aware of the status of this request because s/he had not followed up on it and was unable to produce evidence that a referral to this other facility was started. S/He explained that both the Administrator-in-Training and the Administrator were supposed to follow through with the family about the request. The SSS confirmed that the care plan was not revised to reflect the discharge goals and there was no other discharge plan in place that evaluated the resident's discharge needs and discharge plan. Per interview on 2/28/24 at approximately 3:30 PM, the Market Clinical Lead stated that the Social Service department was responsible for updating the care plans to address communication needs and confirmed that Resident #61's care plan did not contain sufficient, person-centered interventions to meet his/her communication needs. On 2/28/24 at approximately 5:00 PM, the Market Clinical Lead confirmed Resident #61's Representative's discharge goals had not been addressed by the facility.	F 745		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review	F 756	F756 SPECIFIC CORRECTIVE ACTION 1. The pharmacy recommendations for the following residents and months have been followed up on and scanned into the medical record: • Resident #16 – July, 2023 and December, 2023 • Resident #31(315) – September, 2023 and December, 2023 • Resident #32 – July, 2023, August, 2023, and December, 2023	

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F 756	Continued From page 48 of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that monthly pharmacist drug regimen reviews, recommendations, and attending physician responses are completed and documented in the resident record for 3 of 5 sampled residents (Resident #16, #32, and #31).	F 756	F756 continued.... 2. To identify others at risk, the pharmacy recommendations over the last 30 days were reviewed to ensure all had adequate follow-up and were located in the medical record. 3. The facility assures that residents receive monthly drug regimen reviews, recommendations, and attending physician responses to these drug regimen reviews. The NPE or designee will educate the nurses on ensuring all pharmacy drug regimen reviews are received and provided to the NP or physician or review and follow up with corresponding documentation. 4. The DON or designee will conduct audits of drug regimen reviews to ensure timely followup and documentation in the medical record by the physician. This audit will validate that there is a follow-up to drug regimen reviews with documentation provided. These audits will be conducted weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. COMPLIANCE DATE: 04/18/2024. **Tag F 756 POC accepted on 3/27/24 by K. Ruffe/P. Cota**	

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Findings include:

1. Record review reveals that Resident #16 has diagnoses that include bipolar disorder, schizophrenia, and major depressive disorder. There is no evidence that a monthly pharmacist review was completed in July 2023 or December 2023. While the facility was able to produce a pharmacist review recommendation for November 2023, it was not documented in Resident #16's medical record.

2. Record review reveals that Resident #32 has diagnoses that include major depressive disorder and anxiety. There is no evidence that the monthly pharmacist review and recommendations for 7/18/23 and 12/21/23 were responded to by Resident #32's attending physician. While the facility was able to produce the pharmacist review recommendations for 7/18/23 and 12/21/23, they were not documented in Resident #32's medical record. Resident #32's medical record was also missing the monthly pharmacy review recommendation for 8/21/23.

3. Record review reveals that Resident #31 has diagnoses that include dementia with agitation, post-traumatic stress disorder, and bipolar. A pharmacist medication review recommendation made on 9/19/23 was for the facility to complete an Abnormal Involuntary Movement Scale assessment (AIMS; a rating scale to measure involuntary movements that sometimes develops as a side effect of medications). This was not followed up with by the facility until 12/22/23. While the facility was able to produce a pharmacist review recommendation for 9/19/23, it was not documented in Resident #31's medical record. Resident #31's medical record was also

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F 756	Continued From page 50 missing the monthly pharmacy review recommendation for 12/22/23. Per observation on 02/28/24 at 8:45 AM, the Director of Nursing was heard talking to other staff about reaching out to the pharmacy for the pharmacist reviews because they do not have them all in the facility. Per interview on 2/28/24 at approximately 5:00 PM, the Administrator was unable to produce evidence of Resident #16's missing pharmacy recommendations or evidence that an attending physician reviewed pharmacy recommendations for Resident #32 in July 2023 and December 2023. S/He confirmed the above recommendations were missing from the residents' medical records.	F 756		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761	F761 SPECIFIC CORRECTIVE ACTION 1. Resident #49's medications are properly stored. 2. To identify others at risk, rounds were made to ensure medications were stored securely for all residents. 3. The facility assures that medications are stored properly. The NPE or designee will educate the nurses and medication aides on storing medications. 4. The DON or designee will conduct rounds to ensure medications are stored as per policy. This audit will ensure that medications are locked up and secure. These audits will be conducted weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. COMPLIANCE DATE: 04/18/2024.	

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F 761	Continued From page 51 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy, the facility failed to ensure medications were properly stored for 1 of 34 residents (Resident #49) who had improperly stored medications in their room. Findings include: Per facility policy titled "NSG309 Medications Self- Administration," last revised 3/1/22, states "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 is able to self-administer: A physician/advanced practice provider (APP) order is required. Self-administration and medication storage must be care planned. When applicable, patient must be provided with a secure, locked area to maintain medications." Per observation on 2/26/24 at 12:03 PM, Resident # 49 had multiple bottles of pills, in clear sight, on his/her beside table and in his/her nightstand. When asked what the bottles were, s/he explained that they are supplements and showed this surveyor a bottle of elderberry and zinc pills and a bottle of pills that s/he explained	F 761	**Tag F 761 POC accepted on 3/27/24 by K. Ruffe/P. Cota**	

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F 761	Continued From page 52 were for his/her spouse and roommate (Resident #47), to help with his/her eyesight. S/He explained that facility staff have taken them away in the past but that no one had said anything recently and is glad because they are really important to him/her and s/he doesn't want them to be taken away. S/He stated that s/he does not have a lockbox for the medications. A 2/27/24 Nurse Practitioner note confirms that Resident #47 had multiple medications improperly stored at his/her bedside table and had to remove them. Record review reveals that s/he has not been assessed to self-administer medications, does not have a care plan to self-administer medications, and does not have physician orders for the medications and supplements listed above. Per interview on 2/27/24 at approximately 2:00 PM, the Administrator confirmed that Resident #49 should not have medications at his/her bedside.	F 761		
F 840 SS=E	Use of Outside Resources CFR(s): 483.70(g)(1)(2) §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section.	F 840	F840 SPECIFIC CORRECTIVE ACTION 1. The facility is currently contracted with a behavioral healthcare company and will resume providing talk therapy at the center as early as April 1, 2024. 2. To identify others at risk, the center understands that residents receiving mental health services who could benefit from talk therapy have the risk of being affected.	

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F 840	Continued From page 53 §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to have written arrangements with agencies outside the facility that furnish behavioral health services. Findings include: Review of the facility's Facility Assessment dated 2023 reveals that resident population profile indicates that 52% of the residents are diagnosed with depression, 20.4% of the residents are diagnosed with anxiety, 3.6 % of the residents are diagnosed with manic depression, 0.4% of the residents are diagnosed with a psychotic disorder, 5.1% of the residents are diagnosed with schizophrenia, and 1.5% of the residents are diagnosed with post-traumatic stress disorder. A summary of the sufficient staff required to care for the population listed above includes behavioral health services. Per interview on 2/27/24 at 12:54 PM, the Social Service Specialist (SSS) explained that there has not been any therapy services in the facility since October. S/He explained that the Psychiatric Nurse Practitioner did not do therapy. S/He confirmed that there were residents in the facility not receiving behavioral health services that should be.	F 840	F840 continued.... 3. The facility assures residents with mental health needs who could benefit from talk therapy could utilize these outside resources. The NPE or designee will educate the leadership team and social services on having outside resources that address the specific needs of the resident population, as indicated in the facility assessment. 4. The DON or designee will conduct audits of residents who could benefit from outside resources of behavioral health services featuring talk therapy. This audit will validate that talk therapy is occurring using outside resources. These audits will be conducted weekly x 4 weeks, biweekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. COMPLIANCE DATE: 04/18/2024. **Tag F 840 POC accepted on 3/27/24 by K. Ruffe/P. Cota**	

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F 840	Continued From page 54 Per interview on 2/27/24 at approximately 1:10 PM, the Market Clinical Advisor conformed that the Psychiatric Nurse Practitioner was currently only offering psychiatric medication management and there was no one in the facility offering talk therapy at this time.	F 840		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care	F 842	F842 SPECIFIC CORRECTIVE ACTION 1. The dental records for Resident #28 were scanned into the medical record on 03/25/2024. The pharmacy recommendations were uploaded for Resident #16, Resident #31(315), and Resident #32 on 03/26/2024. 2. To identify others at risk, the pharmacy recommendations and dental appointment records over the last 30 days were reviewed to ensure all were in the medical record. 3. The facility assures that medical records are complete, accurately documented, readily accessible, and systematically organized. The NPE or designee will educate the nurses and medical records department on ensuring that medical records are complete, accurately documented, readily accessible, and systematically organized. 4. The DON or designee will conduct audits to ensure pharmacy recommendations and appointment records get scanned into the medical record. This audit will validate that the records are readily available in the medical records. These audits will be conducted weekly x 4 weeks, biweekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. COMPLIANCE DATE: 04/18/2024.	

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	475020	A. BUILDING _____ B. WING _____	C 03/01/2024

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

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F 842	Continued From page 55 operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that records	F 842	**Tag F 842 POC accepted on 3/27/24 by K. Ruffe/P. Cota**	

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F 842	Continued From page 56	F 842		

are complete, accurately documented, readily accessible, and systematically organized related to dental records for all residents and medication reviews for 3 of 5 sampled residents (Residents #16, #32, and #31). Findings include:

1. Per interview on 2/26/24 at 10:39 AM, Resident #28, admitted to the facility on 7/28/23, explained that they had been seen at the facility by a dentist in regard to getting him/her bottom dentures. Per review of Resident #28's medical record, there were no dentist notes that documented that s/he had been seen by a dentist or that a plan was made to get him/her bottom dentures.

On 2/28/24 at 3:22 PM, the Administrator showed this surveyor a large binder that contained notes for all the residents seen by the dentist. S/He explained that the Dentist had asked that notes all be kept in the same spot. The Administrator confirmed that all residents' dental records, including Resident #28, were not kept in their medical record and should be.

2. Record review reveals that monthly pharmacist medication reviews with identified irregularities and medication recommendations and documentation that the attending physician has reviewed the recommendation and their action based on the recommendation, were not included in Resident #16, #32, and #31's medical record. The following were missing:

Resident #16's medical record was missing pharmacist recommendations and physician reviews of these recommendations on 7/19/23, 11/15/23, and 12/12/23.
Resident #32's medical record was missing pharmacist recommendations and physician

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F 842	Continued From page 57 reviews of these recommendations on 7/18/23, 8/21/23, and 12/21/23. Resident #31's medical record was missing pharmacist recommendations and physician reviews of these recommendations 9/19/23, 12/21/23, and 2/5/24. Per observation on 02/28/24 at 8:45 AM, the Director of Nursing was heard talking to other staff about reaching out to the pharmacy for the pharmacist reviews because they do not have them all in the facility. Per interview on 2/28/24 at approximately 5:00 PM, the Administrator confirmed that the above reviews were not in the resident's medical record.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880	F880 SPECIFIC CORRECTIVE ACTION 1. The suction machine was removed from the resident's room and cleaned on February 28, 2024. 2. To identify others at risk, rounds were made of all resident rooms to locate equipment to ensure the devices were clean and sanitary. 3. The facility assures that resident equipment is cleaned and properly stored. The NPE or designee will educate the nurses on cleaning and storing the equipment properly. 4. The DON or designee will conduct audits of resident rooms to ensure equipment is cleaned and stored in a sanitary manner. This audit will validate that equipment is stored in a manner that reduces the spread of infection.	

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F 880	Continued From page 58 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880	F880 Continued.. These audits will be conducted weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. The results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. COMPLIANCE DATE: 04/18/2024. **Tag F 880 POC accepted on 3/27/24 by K. Ruffe/P. Cota**	

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F 880	Continued From page 59	F 880		

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 observation and staff interview, the facility failed to maintain proper infection control practices related to cleaning and storing medical equipment for 1 applicable resident with a suction machine (Resident #61). Findings include:

Per observation on 2/27/24 at 11:25 AM, a suction machine was resting on Resident #61's bedside table. On inspection, there were centimeter sized clear, dark colored, fluid in a couple areas of the tubing; the end of the tubing was bunched into the drawer of the bedside table; and the suction tip was also in the drawer attached to the end of the tubing resting in an open wrapper that was in contact with other drawer contents such as gloves, papers, and lotions. There was no date on the tubing and the suction machine had a thin layer of dust all around.

Per record review, Resident #61 did not have orders to clean or store the suction machine or any evidence that it was cleaned at all in 2024.

Per interview on 2/27/24 at 11:57 AM, the Unit Manger observed the above and confirmed that it had not been cleaned or stored properly. S/He explained that it would be the responsibility of the licensed nurse on the unit to properly maintain the machine and would know to do this by following the orders to do so. S/He confirmed that there

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F 880	Continued From page 60 were no orders to clean the machine.	F 880		