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

October 4, 2024

Mr. John Rainbolt, Administrator
Berlin Health & Rehab Ctr
98 Hospitality Drive
Barre, VT 05641-5360

Dear Mr. Rainbolt:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **August 19, 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, BS
Assistant Division Director
State Survey Agency Director

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 08/19/2024

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 8/7/2024 during a recertification survey. There were no regulatory violations as a result of this survey.	E 000	This plan of correction was written to follow state and federal guidelines. It is not an admission of noncompliance. However, it is the facility's commitment to demonstrate and maintain compliance.	
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and 4 complaint investigations (ACTs #23164, #22989, #22983, and #22967) from 8/5/24 through 8/7/24 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. During the recertification survey, the survey team identified substandard quality of care as a result of a violation at 483.10(i)- F 584. An unannounced, onsite extended survey was conducted on 8/19/24 due to the determination of substandard quality of care. The following deficiencies were identified:	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and	F 550	F550 Specific Corrective Action 1. Resident #5 is currently being transferred by staff with 2 assist to utilize the toilet/ commode for toileting needs. Resident #103 was discharged on 08/27/2024 Resident #6 and #2 are being provided showers with dignity and respect.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: NHA/Market Advisor | (X6) DATE: 9/11/24

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

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F 550	Continued From page 1 promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide dignity and respect for 4 of 23 sampled residents (Residents #2, #6, #5, and #103) and residents on 1 of 2 units (Unit B). Findings include: 1. Per observation on 8/5/24 at 3:12 PM, Res. #103 was observed being transferred by a Licensed Nurse's Aide [LNA] by pulling their wheelchair backwards from the dining room down the hallway to the resident's room. The resident's	F 550	2. All residents have the potential to be affected by the deficient practice 3. The facility ensures that each Patients/ Residents has the fundamental right to considerate care that safeguards their personal dignity along with respecting cultural,social, and spiritual values. This includes staff to resident interaction, dignity during receiving ADL care, and a timely response to resident needs. Education is being done with direct care staff regarding these concerns. 4. NHA/Designee will make rounds to ensure that residents are being treated with dignity and respect. These observations will include staff interaction, dignity with bathing, and timely response to resident needs. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 9/27/2024 **Tag F 550 POC accepted on 10/3/24 by S. Freeman/P. Cota**	

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F 550	Continued From page 2	F 550		

feet were dragging and 'bumping' along the floor, and the resident's urine drainage bag and tubing from the suprapubic catheter were also dragging on the floor during the transport.

Per interview with the LNA on 8/5/24 at 3:15 PM, The LNA confirmed s/he had pulled the resident backwards in the wheelchair and that the resident's feet and catheter bag were dragging on the floor. The LNA stated "[Res.#103] don't pick up [h/her] feet."

2. During an interview with Resident #5 on 8/5/24 at approximately 3:15 PM, s/he stated that s/he is not taken to the bathroom by staff but is told "use your pull up" to "pee or poop". When the Resident was asked how they feel about using her/his pullup s/he stated, "I hate it - I don't like having to wet myself." When asked if s/he is offered a bed pan when s/he is in bed or rings to go to the bathroom, s/he stated, "No they don't."

Per record review a care plan focus revealed that Resident #5 ".....requires assistance with ADL's [activities of daily living] related to limited mobility, incontinence and CHARCOT'S ARTHROPATHY [Definition: A progressive condition of the musculoskeletal system that is characterized by joint dislocations, pathogenic fractures, and debilitating deformities..... Interventions were listed as "Begin weight bearing BLE [bilateral lower extremity], CAM [Controlled Ankle Movement - a type of orthopedic footwear used to immobilize the foot and ankle after an injury or surgery] for initial weight bearing when transferring"; "W/C [wheelchair] with footrest, used for mobility assistance as needed", and "X1 [1 person] assist for toileting". This care plan was

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F 550	Continued From page 3 last revised on 7/2/24. Review of Orthopedic note dated 7/25/24 revealed the following plan: "OK to begin weight bearing" bilateral "lower- ext. Consider using CAM boot for initial weight bearing maneuvers until more comfortable. Should have footwear on when transferring. Consider PT for general conditioning, strengthening". Per interview conducted during the survey, the resident's POA [Power of Attorney] stated that s/he has been telling the facility that s/he does not want the resident to just sit there and wet or mess her/himself, s/he wants the resident toileted. S/he stated that s/he has been telling the facility that s/he does not want the resident to just sit there and wet or mess herself, s/he wants the resident toileted. The residents POA stated that s/he has the orthopedic note that states the resident should be weight bearing with the boot but the facility won't bring the resident to the bathroom. During an interview on 8/7/24 at approximately 4:45 PM, the Nurse Practitioner (NP) stated that the staff have not been bringing the resident to the bathroom because s/he wanted to have the resident bone density testing done first to make sure it was safe to let s/he start ambulating. The NP confirmed that s/he had seen the orthopedic notes regarding the residents ability to weight bear with the CAM boot. 3. Per observation on 8/5/24 at 10:52 AM until approximately 11:15 AM on Unit B, staff pushed three residents in their wheelchairs into the common area by the nurses' station and left them	F 550		

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F 550	Continued From page 4	F 550		

without saying anything to them. Staff did not interact with any of the 7 residents in the common area and talked over the residents to each other about work duties.

Per observation on 8/5/24 at 2:05 PM, 9 residents are sitting in the common area on Unit B. No staff are seen interacting with the residents. The music on the television is very loud and staff are yelling over the loud music to talk about cleaning supplies, passing drinks, and other work duties. At 2:12 PM a staff member, who was around the corner from this surveyor, said something about kicking a coworker in the shin. It wasn't until 2:37 PM, that a staff member came into the common area and started to engage with the 9 residents sitting there by passing a balloon back and forth.

Per observation on 8/6/24 at 7:50 AM, 6 residents were sitting in the common area on Unit B. From 7:50 AM until 8:12 AM, staff pushed two additional residents into the common area without talking to them. During this time, staff did not speak to the residents in the common area but staff did talk loudly to each other across the room, over the residents' heads.

Per observation on 8/6/24 at 2:45 PM, Resident #103 was sitting in his/her wheelchair in the hall holding onto their catheter bag. His/her clothes were significantly wet. S/He was intermittently saying "help." Even though s/he was quiet, s/he could be heard about 10 feet away. Multiple staff, including two aides and a nurse, walked within a foot of him/her and did not address his/her request for help or the fact that s/he was wet and holding his/her catheter bag on his/her lap. At 2:53 PM, the Activity Staff asked Resident #103 if s/he wanted a root beer float. The Activity Staff

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began to hand the root beer float to Resident # 103 without addressing the fact that s/he had a catheter bag in his/her hands and was visibly wet.
4. Per observation on 8/7/2024 at 11:30 AM, Resident #2 was being transferred via shower chair down the hall and into his/her room by a License Nursing Assistant (LNA). The resident had no clothes on and only a bath blanket partially covering her/his upper body. Exposed areas included his/her right leg, thigh, side of buttocks and abdomen.

5. Per observation on 8/7/2024 at 9:25 AM, Resident #6 had been left outside the shower room in a shower chair with wet hair and a bath blanket over the front of him/her without clothes on. At 9:30 AM the Licensed Nursing Assistant (LNA) caring for Resident #6, approached and pushed him/her down the hall to their room. At 9:40 AM Resident #6 was heard hollering in his/her room "Help, Help" and the LNA entered the room. At 9:41 AM this writer entered the room and observed Resident #6 still sitting in the shower chair without clothes on. Resident #6 had been placed in the walkway of the room facing the entry door. S/he had a bath blanket covering part of his/her lap with his/her entire upper body exposed, the LNA was making the Resident's bed. At 9:45 AM the resident asked the LNA to return him/her to bed. Resident #6 stated s/he had pain in his/her legs, thighs and buttocks. Resident #6 stated "I have been sitting here too long." At 9:48 AM the LNA finished making the Resident's bed, asked this Surveyor for assistance with transfer, then left the room to go get someone to help them transfer Resident #6. While the LNA was gone Resident #6 remained in the shower chair with only the lower half of his/her body covered. At 9:50 AM the two LNAs returned

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F 550	Continued From page 6 to the room and transferred Resident #6 to bed with a mechanical lift. At this time 25 minutes had passed since the first observation of Resident #6 in the shower chair in the hall.	F 550	F554 Specific Corrective Action 1. Resident #18 was evaluated for clinical appropriateness to self-administer medications on 08/06/2024 . MD orders are currently in place to self administer medications and may keep at bedside.	
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 and record review the facility failed to assess a Resident for the ability to self-administer medications for 1 of 23 residents in the sample (Resident #18). Findings include: During an interview on 8/5/2024 at 4:00 PM Resident #18 pulled open his/her nightstand drawer revealing two topical medications, Nystatin powder (treatment for skin infections) and Bio Freeze (Pain relief cream that goes on the skin). When s/he was asked what the medications were, s/he explained that s/he had requested his/her family to bring in the Bio Freeze due to pain in his/her shoulder. Resident #18 stated that s/he has chronic pain in both shoulders, and s/he applies his/her own Bio Freeze. S/He also stated that s/he applies her/him own medicated powders to her/him skin and does not want his/her supplies stored outside his/her room. Resident #18 confirmed that s/he does not have a lockbox for his/her medications. During an interview on 8/6/2024 at 12:20 PM a Registered Nurse (RN) familiar with Resident	F 554	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. 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 QAPI Committee for further review and recommendations. Date of Compliance 9/27/2024	

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F 554	Continued From page 7 #18's care confirmed that Resident #18 applies his/her own Nystatin and Bio freeze daily and keeps them both in his/her own room. Per facility policy titled "NSG309 Medications Self- Administration, last revised on 3/1/22, "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. * Patient must be instructed in self-administration * Evaluation of capability must be performed initially, quarterly, and with any significant change in condition." During an interview on 8/6/2024 at approximately 2:00 PM, the Clinical Market Lead confirmed there was no documented assessment for self -administration, there was no evidence of orders to self-administer, and self- administration of medication was not reflected on the Resident's care plan.	F 554	**Tag F 554 POC accepted on 10/3/24 by S. Freeman/P. Cota**	
F 584 SS=F	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including	F 584		

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F 584	Continued From page 8 but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the	F 584	F584 Specific Corrective Action 1. 1.The baseboard radiators were fixed in rooms A4, A7, A9, A17, A19, A22, B4, B7, B9, B14, B15, B16, A24 and B24 and the Unit A living room. The walls have been repaired in rooms A1, A5, A16, B4, B7, B9, B13, B15, B16, B18, B23, and the Unit B hallway near the nurses' station. Chair rails were fixed in rooms A24, B3, B4, and B24. The furniture, including dressers and side table, have been painted/fixed and/or missing handles replaced in rooms A10, A19, B8, B14, B15, and B25. The closet doors with loose or missing handles and/or unable to close properly have been fixed in rooms A7, A9, A10, A12, B3, B4, B8, B9, B10, B12, B13, and B16. The ceiling tiles with stains and/or missing have been repaired/replaced in rooms: A1, A9, A19, A22, B2, B3, B5, B10, B15, B22, B23, and the Unit B living room. The bugs that were noted on the floor and/or inside light fixtures in rooms A7, A24, B3, B23, and B24 have been removed. The blood and/or stool looking substances on toilets and sinks in rooms A5, B5, B7, and B23 have been cleaned. The excessive urine odor in rooms A12, B8, and B9 has been addressed. Food and/or liquid splatter on walls in rooms A5, A11, A12, A13, A22, B5, B9, B11, B18, and the Unit B hallway near the nurses' station has been cleaned.	

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F 584	Continued From page 9 facility failed to provide necessary housekeeping and maintenance services to ensure residents have a safe, clean, comfortable, and homelike environment for 2 of 2 open resident units. Findings include: 1. Per observation on 8/6/24 from approximately 11:00 AM to 2:00 PM, both nursing units (Units A and B) needed multiple functional and cosmetic repairs, and both unit's floors were generally messy in several resident rooms and common areas. a. Baseboard radiators were damaged in rooms A4, A7, A9, A17, A19, A22, B4, B7, B9, B14, B 15, B16, and the Unit A living room. Baseboard radiators were detaching from the wall in rooms A24 and B24. b. Wall had unrepaired holes or unpainted spackle in rooms A1, A5, A16, B4, B7, B9, B13, B15, B16, B18, B23, and the Unit B hallway near the nurses' station. c. Chair rails were damaged in rooms A24, B3, B4, and B24. d. Furniture, including dressers and side table, had peeled laminate exteriors and/or missing handles in rooms A10, A19, B8, B14, B15, and B25. e. Closets doors loose or missing handles and/or were unable to close properly in rooms A7, A9, A10, A12, B3, B4, B8, B9, B10, B12, B13, and B16. f. Ceiling tiles were stained and/or missing in rooms: A1, A9, A19, A22, B2, B3, B5, B10, B15, B22, B23, and the Unit B living room. g. Bugs were on the floor and/or inside light fixtures in rooms A7, A24, B3, B23, and B24. h. Blood and/or stool looking substances on toilets and sinks in rooms A5, B5, B7, and B23. i. Excessive urine odor in rooms A12, B8, and B9.	F 584	F584 continued... The excessive dust on ceiling fixtures (vents or sprinklers) in rooms A1, A16, B1, all hallways, and the main dining room has been cleaned. The dirty tray table legs in rooms B3, B13, B18, and B25 have been cleaned. The floors with debris have been mopped and/or swept in rooms, especially under beds and around furniture in rooms A1, A2, A5, A11, A12, A16, A17, A22, A23, A24, B1, B2, B3, B5, B7, B9, B10, B11, B13, B15, B18, and B22. The following environmental issues have all been fixed: the sharp door handle on closet in room B8, the sharp radiator in room A9, the broken window valance in room B23, a broken lampshade in room B13, exposed nails or screws in the walls below 5 feet in rooms A4, A13, and B2, the missing dome on the bath light has been added in room B23, and unfinished renovation of a bariatric door in room A17. The gym and the equipment was deep cleaned to remove any signs of mold. The center purchased 2 additional dehumidifiers for the building. A vendor was contacted to come and perform and air quaility test, the center will wait for recommendations if any. 2.An audit of all resident rooms and resident common areas was completed to determine that they are in good repair, safe and clean. A maintenance team came to the center August 20, 21 and 22 to address the noted concerns. After completing the center wide audit again, we will have the same maintenance team return if needed.	

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F 584	Continued From page 10 j. Food and/or liquid splatter on walls in rooms A5, A11, A12, A13, A22, B5, B9, B11, B18, and the Unit B hallway near the nurses' station. k. Excessive dust on ceiling fixtures (vents or sprinklers) in rooms A1, A16, B1, all hallways, and the main dining room. l. Excessively dirty tray table legs in rooms B3, B13, B18, and B25. m. Generally dirty floors with debris that do not appear to be mopped and/or swept in rooms, especially under beds and around furniture, in addition to all uncarpeted floors having slight moisture, in rooms A1, A2, A5, A11, A12, A16, A17, A22, A23, A24, B1, B2, B3, B5, B7, B9, B10, B11, B13, B15, B18, and B22. n. Unsafe environment issues, including a sharp door handle on closet in room B8, a sharp radiator in room A9, a broken window valance in room B23, a broken lampshade in room B13, exposed nails or screws in the walls below 5 feet in rooms A4, A13, and B2, no dome on the bath light, making the light extremely bright, in room B23, and unfinished renovation of a bariatric door in room A17. Per interview on 8/6/24 at 11:40 AM, Resident #12 explained that no one has cleaned his/her room in a while. Per interview on 8/6/24 at 1:30 PM, Resident #46 stated that no one cleans the tray table in his/her room and the floor keeps getting ants due to the mess that is left on the floor. Per interview on 8/6/24 at 1:45 PM, Resident #25 said that his/her floor has had a noticeable spill for a couple weeks and no one has cleaned it. Per interview on 8/6/24 at 2:03 PM, the	F 584	F584 continued.. 3. Education with staff completed to enter maintenance issues into TELs (the center's work order system in PCC), the center will use a paper work order form for those staff that don't have access to TELs. The center has created a housekeeping work order form as well that will be given to the Housekeeping director and NHA/designee daily; education will be done on this process as well. 4. The Maintenance Director, Housekeeping Manager and/or Administrator/designee will complete environment rounds weekly x4, monthly x3 to ensure rooms and furniture are in good repair/clean. The Maintenance Director, Housekeeping Manager and/or Administrator/designee will review the work order report weekly x4, monthly x3 to ensure identified issues are being completed/cleaned on time or that parts are ordered. Any concerns/trends identified will be addressed in real time and discussed in QA. Date of Compliance 9/27/2024 **Tag F 584 POC accepted on 10/3/24 by S. Freeman/P. Cota**	

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Housekeeping Director explained that they do not have enough staff to do a detailed clean in each room every day. Since s/he has taken over as the Housekeeping Director at the beginning of the year, there has not been a deep clean to any area of the facility. The facility was supposed to hire an outside service for this job but it never happened. S/He also explained that s/he gets pulled from doing housekeeping duties to help with resident care, like helping with meals. S/He recently took a feeding assistant training to be able to help direct care staff feed residents.

Per interview on 8/6/24 at 3:45 PM, the Market Operations Advisor explained that deep cleaning has not been done at the facility for a while. The facility has attempted to arrange for deep cleaning services but has yet to have a vendor provide the service. Following this interview, a walk through of the facility was conducted with the Market Operations Advisor and s/he confirmed the environmental observations listed above.

2. During an interview with Resident # 4 on 8/7/2024 at 9:54 AM s/he was sitting in his/her wheelchair. There was a bath towel on the floor under the wheelchair soaked with urine. Resident #4 expressed several concerns related to the cleanliness of the facility stating that the housekeeping department is short staffed and s/he had been told by a housekeeper that they are now being asked to help out the nursing staff. Resident #4 also stated that s/he had been told last week by therapy that they could not take her/him down to the gym for therapy because there was mold.

On 8/7/2024 at 10:15 AM observation of the gym revealed a large dehumidifier running. At this time

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F 584	Continued From page 12 therapy staff confirmed that the dehumidifier had been brought in after mold was discovered on gym equipment and wheelchairs that were located in the gym. Therapy staff reported that housekeeping staff had cleaned the areas of mold and removed the wheelchairs, but to their knowledge there had not been a complete over all cleaning of the gym. During a walk through and interview on 8/07/24 at 11:59 AM the Regional Environmental Services Director confirmed that the Rehab gym was damp due to humidity causing the mold to form. Observations of the social services office revealed that there was mold on a bin that is used to hold papers for shredding. The tub room off of A-Wing was also noted to have mold forming on the upper wall behind the tub. This was confirmed on 8/07/24 at 12:07 PM by the Regional Environmental Service Director and the Market Operations Advisor. 3. Per observation on 8/6/24 at approximately 9:15 AM of Resident #59's room revealed the bathroom door casing to be down to the raw wood and drywall/mudding holding the door frame in/affixed to the wall. It appears as though the door frame was widened to allow better access to the bathroom with the residents electric wheelchair. Interview on 8/7/24 at approximately 10:15 AM with the Clinical Market Advisor and the Market	F 584		

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F 584	Continued From page 13 Operations Advisor specific to the status of this doorway and the bare wood, the Clinical Market Advisor stated s/he would go to the residents room and take a look. The Clinical Market Advisor and the Market Operations Advisor confirmed that work had been started on this residents bathroom doorway to accommodate their electric wheelchair and they had run into issue with the contractor finishing the work. Interview on 8/7/24 at approximately 11:30 AM with Resident #59, they explained their bathroom door modifications/widening had been initiated but never finished. and the process that has taken place regarding the widening of the door. S/he explained that her/him electric wheelchair needs quite a bit of room as it is larger to meet their needs. S/he stated the contractor has been working on the door frame and that s/he knows the facility was having a hard time getting the contractor to come back and finish the doorway. During the interview with this resident, the Clinical Market Advisor came to this resident's room to look at the door frame and acknowledged that the door frame was down to the bare wood to the left of the door frame and the left of the header/top of the door frame. The Clinical Market Advisor agreed that this was an infection control issue since the bare wood could not effectively be cleaned. Upon the completion of the interview with the resident and exiting the room, a maintenance staff member came to the room with a gallon of paint and paint brush and stated s/he was going to finish painting the door frame.	F 584		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625		

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F 625	Continued From page 14 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that residents or resident representatives received written notification of the facility bed hold policy on residents' discharge to the hospital for 1 of 23 residents sampled. (Resident #5), Findings include: During an interview on 08/06/24 at approximately 8:26 AM Resident #5 stated they s/he had recently been to the hospital however s/he was	F 625	F625 Specific Corrective Actions 1. The incident happened in the past and can not be corrected 2. All resident have the potential to be affected 3. When a resident/patient ("resident") is transferred out of the service location to a hospital or on therapeutic leave, the designee will provide the resident and his/her representative, if applicable, with the written Bed Hold Policy Notice & Authorization form regardless of payer. If the resident representative is not present to receive the written notice upon transfer, the notice is delivered via email, fax, or hard copy via mail. Licensed and administrative staff will be re-educated to this process. 4. NHA/Designee will complete audits of residents who discharge or transfer to the hospital to validate that the appropriate notice of bed-hold policy was provided to the resident and resident representative, if applicable. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 9/27/2024 **Tag F 625 POC accepted on 10/3/24 by S. Freeman/P. Cota**	

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not able to state the reason s/he was sent to the hospital or how long they s/he were there.

Record review revealed that the resident had been sent to the ED [Emergency Department] on 8/1/24 for a potential UTI [urinary tract infection]. There was no evidence of a bed hold notice being sent to the POA [Power of Attorney] in the medical record.

Per interview with the Clinical Market Advisor, on 8/7/24 at approximately 4:30 PM s/he could not find a bed hold notification for the resident's transfer to the ED on 8/1/24 but stated s/he would keep looking.

On 8/7/24 at 4:45 PM the Clinical Market Advisor stated that s/he was unable to locate a bed hold notification to the POA and the resident.

On 8/7/24 at 4:50 PM the Market Operations Advisor provided the facility Bed Hold Notice titled, "Bed Hold Notice - Deliver Upon Transfer Eff Jan 2019 - Rev Aug 2022" stated under "Process" paragraph two "Prior to a resident's transfer out of the center to a hospital or for therapeutic leave, the staff member conducting the transfer out will provide both the resident and representative, if applicable, with the Bed Hold Policy Notice & Authorization form (Smartworks form # GHC-4731) Notice must be given regardless of payer. Resident copy is given directly to the resident prior to transfer and noted in the medical record. Representative copy can be delivered electronically via email/secure fax or hard copy via mail if the representative is not present at the time of transfer. (Must be done within 24 hours.)

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F 625	Continued From page 16 The Market Operations Advisor provided at this time the "Genesis Healthcare P&P "AR102 Bed-Holds", effective date is listed as 03/15/00 and was last revised on 01/16/23 was provided. Under "PURPOSE" it stated, "To provide written notice of the bed hold policy to the resident/resident representative at the time of transfer out of the service location - this applies to all payers." Under "PROCESS" it stated, "1. Providing Written Notice to All Residents at the Time of Transfer: 1:1 When it is known that a resident will be temporarily transferred out of the service location, staff involved with the resident's transfer out (e.g., Nursing, Admissions, Social Services, etc.) will: 1.1.1 Provide the Bed Hold Notice of Policy & Authorization form to the resident and representative, if applicable. 1.1.1.1 If the resident representative is not present to receive the written notice upon transfer, the notice will be delivered via e-mail, fax, or hard copy by mail within 24 hours. 1.1.2 Maintain a copy in the medical record. 1.1.3 Provide a copy to the Business Office Manager (BOM)/designee at the next interdisciplinary team meeting. 1.1.3.1 The BOM/designee will maintain a copy in the resident's financial file.	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656	F656 Specific Corrective Action 1. Resident #103 was discharged on 08/27/2024 Resident # 5 is free from UTI and has a CP that has been updated.	

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F 656	Continued From page 17 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care 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 upon observation, interview, and record	F 656	F656 continued... 2. An audit of residents with foley catheters was completed to validate the plan of care has been implemented and followed to include the intervention to care for foley catheters An audit of residents with active urinary tract infection was completed to validate that CP have been developed and implemented for the care of the urinary tract infection and the use of antibiotic therapy. 3. The facility develops and implements a person-centered care plan that includes the instructions needed to provide effective and person-centered care that meet professional standards of quality care. Licensed staff will be re-educated to this process. 4. DON/Designee will complete weekly audits of residents with urinary cath and UTIs to validate CP have been developed and interventions implemented. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 9/27/24 **Tag F 656 POC accepted on 10/3/24 by S. Freeman/P. Cota**	

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review, the facility failed to implement care plan interventions related to catheter care and monitoring for 1 [Res.#103] and failed to identify and implement interventions for an actual urinary tract infection and the use of antibiotic therapy for (Resident #5) for 2 of 2 sampled residents. Findings include:

Per record review, Res.#103 medical conditions include a suprapubic catheter. [A suprapubic catheter is a medical device that helps drain urine from your bladder. It enters your body through a small incision in your abdomen.] (https://my.clevelandclinic.org/health/treatments/25028-suprapubic-catheter).

Per observation on 8/5/24 at 3:12 PM, Res.#103 was observed being pulled backward in h/her wheelchair from the dining room to his/her room by a Licensed Nursing Aide [LNA]. The resident's urine drainage bag and tubing from the suprapubic catheter were dragging on the floor during the transport. Per interview, the LNA confirmed Res.#103's catheter bag and tubing were both touching the floor while the resident was being moved.

Per review of Res.#103's Care Plan, the resident is identified as "requires suprapubic catheter-resident is high risk for Urinary Tract Infection". Care Plan interventions include "Keep catheter off floor" and "record output."

Per observation on 8/5/24 at 5:20 PM, Res.#103 was sitting in h/her wheelchair in the facility's dining room. Res.#103's catheter bag and tubing again were observed touching the floor beneath the wheelchair while the resident ate. Per interview on 8/5/24 at 5:22 PM, two LNA's both

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confirmed the resident's catheter bag was hanging too low and the bag and tubing were touching the floor.

An interview was conducted with a staff LNA on 8/6/24 at 2:20 PM. The LNA stated staff does not keep track of the resident's supra pubic tube [SPT] output because "there is no order for it. "The LNA confirmed that Res.#103's Care Plan includes "record output", and confirmed during interview and per record review, there was no documentation in Res.#103's medical record of the resident's SPT output.

An interview was conducted with the facility's Market Clinical Advisor [MCA] on 8/7/24 at 1:26 PM. The MCA confirmed that Res.#103's urine drainage tubing on the floor and being dragged during transport represented infection control risks for a resident susceptible to Urinary Tract Infections, and that Care Plan interventions included "keep catheter off floor", and that infection control intervention was not being implemented. The MCA also confirmed that Res.#103's Care Plan regarding their SP tube included "record output" and this also was not being done.

2. Per reivew of Resident #5's record on 7/17/24 an order was received to obtain a urinalysis (UA) to determine if the resident had a Urinary Tract Infection (UTI). On 7/19/24 the UA came back as abnormal, indicating the resident was positive for a UTI. The culture and sensitivity (a test used to determine which antibiotics would work best to treat the infection based on the organism that caused the infection) was received back from the

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F 656	Continued From page 20 hospital on 7/24/24 and at that time the resident was placed on an antibiotic to treat the infection. Review of the resident Medication Administration Record for July 2024 revealed that resident had refused several doses of the antibiotic. On 8/1/24 the resident was transported to the ED (Emergency Department) for a suspected UTI (Urinary Tract Infection). The resident was seen by the ED providers and was diagnosed with a UTI. S/he was prescribed a one time antibiotic (one dose). Review of the resident's care plan did not include a care plan specific to the resident's diagnosis of an UTI or the use of an antibiotic. During an interview with the Clinical Market Advisor on 8/7/24 at approximately 3:20 PM, s/he could not provide a care plan specific to the resident's diagnosis of a UTI and/or the use of an antibiotic.	F 656	F657 Specific Corrective Action 1. Resident #16 is free from medications errors and eye pain. 2. An audit of residents with significant medication errors was completed to validate the plan of care was revised to include monitoring of the effects of medication error inclusive of pain as it applies to the medication error.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657	3. The facility staff revises the resident's current care plan to reflect changes or necessary monitoring of resident conditions. Licensed staff will be re-educated to this process. 4. CNE/Designee will complete audits of residents with medication errors to validate CP have been revised as appropriate to include the monitoring of conditions related to the specific medication error. These audits will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 9/27/2024	

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F 657	Continued From page 21 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to revise the care plan for 1 of 23 residents sampled (Resident #16), related to significant medication error and symptomatic eye pain. Findings include: Per record review Resident #16 was admitted to the facility in November of 2023 with diagnoses that include, Pseudophakia OU (artificial lens in both eyes) mild retinopathy (bleeding in the small vessels in the eye), and dry eyes. During an interview with Resident #16 on 8/6/2024 at 2:00 PM s/he stated that s/he received drops for his/her ears to both of his/her eyes. Resident #16 stated "It hurt like hell and burned." An Emergency room Physician note written on 07/23/2024 states that Resident #16 "was seen in the emergency department today for a recent chemical exposure to [his/her] eye ... We flushed [his/her] eyes and have started [him/her] on some antibiotic eyedrops to prevent infection ... If	F 657	**Tag F 657 POC accepted on 10/3/24 by S. Freeman/P. Cota**	

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F 657	Continued From page 22 [she/he] experiences worsening symptoms, especially worsening pain, please return to the emergency room." Per the facility policy titled "Person Centered Care Plan" revised on 10/24/2022 states: "7. Care plans will be: 7.2 Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments, and as needed to reflect the response to care and changing needs and goals; and 7.3 Documented on the Care Plan Evaluation Note." Review of Resident #16's care plan reveals there is no documented evidence that the facility revised the care plan to monitor Resident #16 for adverse effects related to a significant medication error which involved incorrectly administering ear drops into the resident's eyes. Per interview with the Clinical Market Lead (Registered Nurse) on 8/7/2024 at 8:30 AM s/he was unable to provide evidence or documentation that Resident #16 was monitored for pain, redness or burning in his/her eyes after returning from the hospital on 7/23/2024. Per interview on 8/7/2924 at 3:00 PM the Director of Nursing (DON) stated that the expectation would be to update the care plan and obtain a Physician's order to monitor both eyes and document findings in the facilities Medication/Treatment Record. The DON confirmed that there were no revisions made to the care plan after the significant medication error	F 657		

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F 657	Continued From page 23 for Resident #16.	F 657		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 690	F690 Specific Corrective Action 1. Resident # 103 was discharged on 08/27/2024 2. An audit of residents with foley catheters was completed to validate that the residents tubing and drainage bag was affixed off the floor. 3. The facility ensures that staff secure catheter tubing to keep the drainage bag below the level of the patient's bladder and off the floor. Facility nursing staff will be re-educated to this process. 4. DON/Designee will complete observations of residents with catheters to ensure the drainage bag is off the floor. These observations will be weekly x 4 weeks, bi-weekly x 4 weeks, and then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of compliance 9/27/24 **Tag F 690 POC accepted on 10/3/24 by S. Freeman/P. Cota**	

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F 690	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and record review, the facility failed to implement infection control measures related to catheter care for 1 resident [Res.#103] of 2 sampled residents. Findings include: Per record review, Res.#103 medical conditions include a suprapubic catheter. [A suprapubic catheter is a medical device that helps drain urine from your bladder. It enters your body through a small incision in your abdomen.] (https://my.clevelandclinic.org/health/treatments/25028-suprapubic-catheter). Per observation on 8/5/24 at 3:12 PM, Res.#103 was observed being pulled backward in h/her wheelchair from the dining room to the resident's room by a Licensed Nursing Aide [LNA]. The resident's urine drainage bag and tubing from the suprapubic catheter were dragging on the floor during the transport. Per interview, the LNA confirmed Res.#103's catheter bag and tubing were both touching the floor while the resident was being moved. Per review of Res.#103's Care Plan, the resident is identified as "requires suprapubic catheter-resident is high risk for Urinary Tract Infection." Per observation on 8/5/24 at 5:20 PM, Res.#103 was sitting in h/her wheelchair in the facility's dining room. Res.#103's catheter bag and tubing again were observed touching the floor beneath the wheelchair while the resident ate. Per interview, two LNA's both confirmed the resident's catheter bag was hanging too low and the bag and tubing were touching the floor.	F 690		

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F 690	Continued From page 25 An interview was conducted with the facility's Market Clinical Advisor [MCA] on 8/7/24 at 1:26 PM. The MCA confirmed that Res.#103's urine drainage tubing on the floor and being dragged during transport represented infection control risks for a resident susceptible to Urinary Tract Infections.	F 690	F711 Specific Corrective Action 1. Resident # 103 was discharged on 08/27/2024 Resient #35 MD orders have been reviewed	
F 711 SS=E	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Per interview and record review, the facility failed to ensure that physicians sign and date all physician orders for 4 of 6 sampled residents (Residents # 403, #11, #103, and #35). Findings include: Record review reveals that Resident #403 was admitted to the facility on 7/19/24 and had a regulatory physician admission visit on 7/22/24.	F 711	and signed by the provider Resident #403 MD orders have been reviewed and signed by the provider Resident #11 MD orders have been reviewed and signed by the provider 2. An audit of resident records was completed to validate the physician reviewed the resident's total program of care, including medications and treatments, at each visit. This includes writing, dating, and signing progress notes, signing and dating all orders with the exception of influenza/pneumococcal vaccines as this can be administered per physician approved facility policy. 3. The resident physician/Designee completes required visits that include review of the resident's total program of care, including medications and treatments, at each visit. This includes writing, dating, and signing progress notes and signing and dating all orders with the exception of influenza/ pneumococcal vaccines as this can be administered per physician approved facility policy. Physicians, APP, NHA, and Nursing Leadership will be re-educated to this process.	

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F 711	Continued From page 26 As of 8/19/24, 29 days after admission, Resident #403's admission orders, including medications, were not signed by a physician. Record review reveals that Resident #11 was admitted to the facility on 6/19/24 and had a regulatory physician admission visit on 7/8/24. As of 8/19/24, 62 days after admission, Resident #11's admission orders, including medications, were not signed by a physician. Record review reveals that Resident #103 was admitted to the facility on 7/17/24 and had a regulatory physician admission visit on 7/20/24. As of 8/19/24, 31 days after admission, Resident #103's admission orders, including medications, were not signed by a physician. Record review reveals that Resident #35 was admitted to the facility on 7/9/24 and had a regulatory physician admission visit on 7/22/24. As of 8/19/24, 39 days after admission, Resident #35's admission orders, including medications, were not signed by a physician. Per interview on 8/19/25 at 12:44 PM, the Market Clinical Lead confirmed that the Attending Physician did not sign admission orders for Residents # 403, #11, #103, and #35 and should have.	F 711	F711 Continued... 4. NHA/Designee will complete audits of new admissions and residents due for required MD visits to ensure this process is followed. These audits will be weekly x 4 weeks, bi-weekly times 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 9/27/2024 **Tag F 711 POC accepted on 10/3/24 by S. Freeman/P. Cota**	
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest	F 725		

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F 725	Continued From page 27 practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and record review, the facility failed to ensure there are a sufficient number of skilled licensed nurses, nurse aides, and other nursing personnel to provide care and respond to each resident's basic needs and individual needs as required by the resident's diagnoses, medical condition, or plan of care, potentially impacting all residents of the facility. Findings include: Per interview on 8/5/2024 at 4:00 PM, Resident #18 stated s/he feels there is not enough staff and sometimes his/her call light is on for 45 minutes before it is answered. Resident #18 stated that a few months ago s/he was left in	F 725	F725 Specific Corrective Action 1. The facility currently has staffing patterns in place, based on census and acuity, that are sufficient to assure patient safety and attain or maintain the highest practicable physical,mental, and psychosocial well-being of each patient. This includes a PPD of 2.0 for LNA and an overall nursing PPD of 3.0 at a minimum. 2. All residents have the potential to be affected 3. The facility ensures they have sufficient nursing staff, including nurse aides in accordance with state and federal regulations, with the appropriate competencies and skills sets to provide nursing and related services to assure patient safety and attain or maintain the highest practicable physical,mental, and psychosocial well-being of each patient. Facility NHA and nursing leadership will be re-educated to this process. 4. NHA/Designee will conduct random resident interviews to validate that the facility has sufficient nursing staff to meet the needs of the residents. The facility will also at a minimum staff the facility with a PPD of 2.0 for nurses aides and an overall nursing PPD of 3.0. These interviews will be weekly x 4 weeks, then bi weekly x 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 9/27/2024 **Tag F 725 POC accepted on 10/3/24 by S. Freeman/P. Cota**	

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his/her own urine overnight. S/He stated that the nurse on duty answered his/her call light and stated that s/he would get help to change him/her. The resident stated that no one came to help her, and s/he did not receive incontinent care until 7:30 in the morning.

Per interview on 08/05/2024 at 11:30 AM, Resident #2 stated that it takes a long time for call bells to be answered. S/He stated that often the staff will turn off the call light and not return to assist him/her. S/He stated that recently s/he turned on his/her call light to use the bedpan, and when no one answered the call light s/he urinated in the bed.

Per interview on 8/6/24 at 1:30 PM, Resident #46 explained that there are not enough staff to help him/her get other things to eat when s/he is served something that s/he does not like for meals, which happens frequently.

Per interview on 8/6/2024 at approximately 10:00 AM, the Unit Nurse stated that they were promoted to Unit Manager but are unable to transition to the manager position for the unit due to not having enough staff to work the floor.

Per interview on 8/7/24 at approximately 2:40 PM, an LNA stated that there are not enough staff to give residents a choice in what they would like to eat prior to meals being served. S/He explained that it is too much of a hassle to ask residents what they want to order for because they are short staffed, especially after 3:00 PM. S/He explained that s/he cannot do morning care for all residents on his/her assignment until after lunch when s/he works on Unit A. Unit A has residents are very needy because so many residents need

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F 725	Continued From page 29 a lot of assistance or two staff to help because there are a lot that require lifts. S/He stated that sometimes residents have to sit on bed pans or toilets for a long time because there are not enough staff to get to them right away. Per interview on 8/7/2924 at 3:00 PM, the Director of Nursing (DON) stated that s/he often is working the medication cart due to not enough staff at the facility. The DON further stated that s/he is often unable to update care plans or complete other manager related tasks due to working the medication cart. S/He also stated that s/he has been doing wound care because they currently do not have a wound nurse on staff. Per joint interview with two Licensed Nursing Assistants on 8/7/24 at 3:54 PM LNA #1 explained that 5 residents (on Unit A) use a lift and the residents on the unit have high acuity and need a lot of help. LNA #2 explained that it takes a long time to do things with the residents not enough and there is not enough staff to provide quality care because the care is rushed. LNA #1 continued to explain that sometimes there is only one aide on the unit, which is hard because they need to do medications, so it can be hard to get to people, especially if they need two people to assist. LNA #2 said it is hard to get to someone that needs something during mealtimes because they have to pass the trays. They both explained that they are working around 80 hours a week sometimes and that they need more staff. Per review of direct care schedules from June 2024 through August 7th, 2024, there is only one week in June that has unit managers scheduled. Review of the Facility Assessment dated active from 8/1/24 through 8/22/24 reveals on page 23	F 725		

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F 725	Continued From page 30 that the staff needed to provide care to the resident population include 2 full time unit managers and one full time skin health nurse and reads "We have daily discussions on unit by unit staffing. The unit manager gives updates on patient needs hen with nursing leadership involved the scheduler will make staffing adjustments." Per interview on 8/07/24 at 5:19 PM, the Scheduler explained that sometimes s/he has to work the floor as a LNA because there are not enough staff. S/He described that when s/he creates the direct care schedule, it is based in census, not on the acuity of the residents in the facility. The Scheduler confirmed that the facility has not had anyone to work as the Unit Manager for over a month now on either unit.	F 725		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and employee files, the facility failed to ensure that Licensed Nursing Assistants (LNAs) received annual performance evaluations for 3 of 3 LNAs reviewed. Findings include: Per review of employee files for LNAs that have worked at the facility longer than a year, there	F 730	F730 Specific Corrective Action 1. LNAs employed at the facility for greater than one year have had their annual performance reviews completed. 2. An audit of LNA employed at the facility for greater than one year was completed to validate that annual performance reviews have been completed. 3. The facility completes a performance review of every nurse aide at least once every 12 months, and provides regular in-service education based on the outcome of these reviews. The DON and nursing leadership will be re-educated to this process. 4. NHA will complete audits of employee files to validate that yearly performance reviews are completed timely. These audits will be weekly x 4 weeks, then bi weekly x 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of compliance 9/27/2024	

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F 730	Continued From page 31 were no nurse aide performance evaluations completed within the past year for LNA #1, hired on 5/31/18, LNA #2, hired on3/28/22, and LNA #3, hired on 7/4/22. Per interview on 8/7/24 at 2:36 PM, the Market Operations Advisor confirmed that the facility did not have annual nurse aide performance evaluations for the above 3 LNAs.	F 730	**Tag F 730 POC accepted on 10/3/24 by S. Freeman/P. Cota** F760 Specific Corrective Action 1. Resident#16 is receiving his medications as ordered. Resident#16 has no evidence of injury or pain currently as a result of the medication error.	
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 out of 5 sampled residents (Resident #16) was free from significant medication errors related to the administration of medication by the wrong route, causing pain and requiring medical attention to Resident #16's eyes. Findings include: Per record review, Resident #16 was admitted to the facility with diagnoses that include, dry eyes, Pseudophakia OU (artificial lens in both eyes) and mild retinopathy (damage to the small vessels in the eye as defined by the "American Academy of Opthahalmolgy, 2024"). During an interview with Resident #16 on 08/06/2024 at 2:00 PM s/he stated that they received drops for his/her ears to both of his/her eyes. Resident #16 stated "It hurt like hell and burned."	F 760	2. All residents have the potential to be affected by the deficient practice. 3. The Center, in an effort to prevent medication errors and ensure safe medication administration, Educates nurses to verify the right medication, dose, route, time of administration, right patient and right documentation. Licensed complete medication pass competencies upon hire, yearly, and as identified by nursing leadership to validate competent practice and prevent medication errors. Licensed staff and MNAs will be re-educated to this process. 4. NPE/Designee will complete random medication pass observations to validate nurses and MNAs are verifying the right medication, dose, route, time of administration, right patient and right documentation during medication administration. These observations will be weekly x 4 weeks, then bi weekly x 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 9/27/2024	

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F 760	Continued From page 32 Per review of Resident #16's medication orders written on 07/19/2024, the Advance Practice Registered Nurse (APRN) ordered "Debrox Otic (ear) Solution 6.5% (Carbamide Peroxide) Instill 5 drop[s] both ears four times a day for ear wax for 5 Days." Per the Manufacturer, Debrox contains peroxide and oils that help break up the wax in the ear canal. (Drugs.com, 2024) The Advance Practice Registered Nurse telehealth provider, contacted by facility to assess Resident #16, wrote the following note on 07/22/2024 "Nurse reports 93-year-old [Resident #16] received carbamide peroxide [Debrox] 1 drop into both eyes. Patient reports irritation ...Diagnosis ocular pain, bilateral ... condition is guarded." The following orders were received: Irrigate eyes and then apply artificial tear drops 2 drop in each eye [follow up] with primary care in the morning." A Follow up note written by the APRN dated 07/23/2024 reads "[Resident #16] seen for an acute visit after [s/he] was given incorrect eye drops last night. Per patient [he/she] was given the drops which [he/she] stated burned. Per on call note, patient was given carbamide peroxide 1 drop in both eyes. [S/He] has been getting to [the] ear drops for wax build up. Patient states [his/her] eyes are irritated and itchy ... Called the Northern New England Poison Center who recommended patient be sent to the ED [Emergency Department] for urgent follow up on context of extensive discomfort and redness and length of time since event occurred... Bilateral conjunctiva is red and excessively watery ... Both eyes red, significant discomfort. Plan to send patient to ED for more urgent follow up."	F 760	**Tag F 760 POC accepted on 10/3/24 by S. Freeman/P. Cota**	

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F 760	Continued From page 33 An Emergency Department note written on 07/23/2024 reads the following "[Resident #16] seen in the emergency room today for recent chemical exposure to the eye. Thankfully his eye PH (acidity or alkalinity of fluid around the eye) is normal. We have flushed [his/her] eyes and started [him/her] on antibiotic eyedrops to prevent infection. I have placed a referral to the ophthalmology department." A Note written on 07/24/2024 by the APRN reads "[Resident #16] seen for follow up eye irritation, [s/he] reports [his/her] eyes are still burning a little." Review of the facility policy "Medication Errors," last revised 07/01/2024, reads "Medication Error means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order; manufacturer 's specifications (not recommendations) regarding the preparation and administration of the medication or biological ... Significant Medication Error means one which causes the patient discomfort or jeopardizes their health and safety ... The Center shall ensure medications will be administered as follows: 1.1 According to prescriber's orders ... 2.1 Medication administered not in accordance with the prescriber's order. Examples include, but are not limited to: 2.1.1 Incorrect dose, route of administration, dosage form, time of administration" safety To prevent medication errors and ensure safe medication administration, nurses should verify the following information: 5.1 Right medication, dose, route, and time of administration; 5.2 Right patient and right documentation."	F 760		

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F 760	Continued From page 34 During an Interview with the Advance Practice Registered Nurse on 08/06/2024 at approximately 2:40 PM the APRN confirmed that Resident #16 did receive Debrox to his/her eyes in error. The APRN stated that during his/her assessment of Resident #16 on 07/23/2024 the Resident's eyes were very red, and s/he complained of pain and burning in both eyes. The APRN also stated that s/he was concerned that Resident #16 needed more flushing of his/her eyes, and s/he felt that Resident #16 needed fluoroscopy (imaging of the eye) to determine if there was damage to the eyes. The APRN contacted Poison control, and they recommended sending Resident #16 to the emergency room. Reference List of Cerumenolytics - Drugs.com Diabetic Retinopathy: Causes, Symptoms, Treatment - American Academy of Ophthalmology (aao.org)	F 760		
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	F 761	F761 Specific Corrective Action 1. Resident #18 medications for self administration are stored in a locked box in the residents room. 2. An audit of residents wishing to keep medications at bedside for self or supervised administration was completed to validate medications are stored in a locked compartment. 3. The facility provided residents wishing to keep medications at bedside for approved self administration or supervised administration a secure, locked area to maintain Medications. Licensed nurses and NHA will be re-educated to this process. 4. DON/Designee will complete audits of residents wishing to keep medications at bedside to ensure that residents are provided a secure, locked area to maintain Medications. These audits will be weekly x 4 weeks, then bi weekly x 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 9/27/2024	

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F 761	Continued From page 35 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy, the facility failed to ensure medications were properly stored for 1 of 23 residents (Resident #18) who had improperly stored medications in their room. Findings include: Per observation on 8/5/2024 at 4:00 PM Resident #18 pulled open his/her nightstand drawer revealing two topical medications. The medications included Nystatin powder (treatment for skin infections) and Bio Freeze (Pain relief cream that goes on the skin). When s/he was asked what the medications were, s/he explained that s/he requested his/her family to bring in the Bio Freeze due to pain in his/her shoulder. S/he has chronic pain in both shoulders, and s/he applies his/her own Bio Freeze. Resident #18 also stated that s/he does not have a lockbox to store his/her medications. 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	F 761	**Tag F 761 POC accepted on 10/3/24 by S. Freeman/P. Cota**	

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F 761	Continued From page 36 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 interview on 8/6/2024 at approximately 2:00 PM, the Clinical Market Lead confirmed that Resident #18 had no evidence of orders to self-administer their own medications, and the facility had not provided a lockbox to the Resident because they did not know s/he was self-administering the medications. However, in a previous interview on 8/6/2024 at 12:20 PM a Registered Nurse (RN) familiar with Resident #18's care confirmed that Resident #18 applies his/her own Nystatin and Bio freeze daily and keeps them both in his/her own room.	F 761		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet	F 791	F791 Specific Corrective Action 1. Resident #25 was seen by the dentist to address her dental needs and was seen by the dental hygienist for a cleaning. 2. An audit of residents records was completed to validate dental services were offered by the consultant dentist at least yearly. Those still in need of dental services were added to the dental visit list and will be seen on the next scheduled visit.	

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F 791	Continued From page 37 the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide or obtain from an outside resource routine and emergency dental services to meet the needs of each resident for 1 of 23 sampled residents (Resident #25). Findings include:	F 791	F791 continued... 3. The facility ensures that residents are provided routine dental care that includes an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiographs as needed, dental cleaning, fillings (new and repairs), minor partial or full denture adjustments, smoothing of broken teeth, and limited prosthodontic procedures, e.g., taking impressions for dentures and fitting dentures. Nursing leadership, providers, and NHA will be re-educated to this process. 4. DON/Designee will complete an audit of resident records to validate dental services have been offered and completed at a minimum of yearly. These audits will be weekly x 4 weeks, then bi weekly x 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of compliance 9/27/2024 **Tag F 791 POC accepted on 10/3/24 by S. Freeman/P. Cota**	

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F 791	Continued From page 38 Per observation and interview on 8/5/24 at 12:22 PM, Resident #25 was grinding his/her teeth. S/He explained that s/he has been grinding his/her teeth for a while and can't help it, and s/he would like for the dentist to check it out. S/He would also like to wear his/her patrial plate again but it is at his/her home. S/He has mentioned to staff that s/he would like to get this partial plate from home and see the dentist. Per record review, a dentist note dated 9/25/23 reveals that Resident #25 had requested a teeth cleaning. There is no evidence in his/her medical record that s/he had received a teeth cleaning or was provided any dental services since then. A 7/21/24 Nurse Practitioner note reveals that Resident #25 has a chronic issue with teeth grinding and "discussed possibly a mouth guard at nighttime to help with nighttime symptoms." Resident #25's care plan reads "[Resident #25 is at risk for oral health or dental care problems as evidenced by broken, carious teeth," revised on 4/3/23. The care plan does not include any interventions about obtaining or having a partial plate, providing dental services such as teeth cleaning, or any mention of his/her teeth grinding. Per interview on 8/7/24 at 1:06 PM, the Nurse Practitioner explained that s/he was aware that Resident #25 has been grinding his/her teeth for a while and knew about his/her partial plate at home but does not know how to get it. S/He was unsure of the process for residents to get their follow up cleanings, including Resident #25. S/He explained that there is a binder used to keep track of dentist referrals. S/He stated that s/he did not put Resident #25 on the list to be seen by the dentist regarding his/her teeth grinding and	F 791		

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F 791	Continued From page 39 should have. Per interview on 8/7/24 at 1:36 PM, a Licensed Nursing Assistant, who had also coordinated scheduling resident dental appointment until June 2024, explained that s/he is not sure how Resident #25's cleaning was missed. S/He explained that there is a referral binder where nurses can put in referrals for the dentist for concerns such as teeth grinding. Per review of the referral binder for dentist appointments, there are no entries referring Resident #25 to be seen by the dentist for any reason including teeth grinding, a dental cleaning, or for a possible mouth guard.	F 791		
F 800 SS=F	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and record review, the facility failed to ensure each resident was provided with scheduled food items to fulfill dietary requirements determined by the facility that meet each resident's daily nutritional and dietary needs and choices. Findings include: An interview was conducted on 8/6/27 at 10:15 AM with the facility's Dietary Manager. The Dietary Manager reported that facility's meal delivery system had been experiencing some	F 800	F800 Specific Corrective Action 1. Residents are being provided with scheduled food items to fulfill dietary requirements determined by the facility that meet each resident's daily nutritional and dietary needs and choices. 2. All residents have the potential to be affected by the deficient practice. 3. Dietary staff have been educated on reviewing incoming food orders before time of service so that missing or damaged/rotten food items can be replaced and residents are notified of any changes and have the opportunity to adjust their order. 4. The NHA/designee will monitor that menus are correct or that residents are updated of any changes by random interview and observation weekly x4, monthly x3. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 9/27/2024	

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F 800	Continued From page 40 difficulties in the past two weeks, and this has been reported to the facility's Administrator, the Market Clinical Advisor, and the Regional Market President-Operations. The Dietary Manger shared that carts with multiple meal trays are prepared in advance and delivered in each of the two residence hallways, to be available for residents who wish to remain in their rooms and have their meals there. In addition to the already prepared meal trays, the facility sets up a steam table in a central dining room, where residents can gather and sit at tables, and their meals are assembled there at the steam table after they arrive. The Dietary Manager reported that facility staff will bring residents who have already expressed their preference to remain in their rooms down into the dining room to eat. The Dietary Manager explained that those residents already have a meal tray waiting for them on one of the meal carts, and when they are brought down into the dining room, a second meal tray is prepared for them there, thereby creating two meal trays for one resident and leaving one meal to waste. The Dietary Manager explained that this contributes to food shortages at the facility. The Dietary Manager further explained that current produce deliveries contained amounts of unusable items, such as rotted lettuce and ripe bananas that quickly spoiled, which also contributed to the menu items shortages and substitutions. The Dietary Manager stated that the facility's food service is on a rigid budget, and any requests outside of the budgeted items are relayed to the facility's corporate entity by the Dietary Manager via a phone app [a type of software designed specifically for use on a mobile device] where they first must be approved. The Dietary Manager	F 800	**Tag F 800 POC accepted on 10/3/24 by S. Freeman/P. Cota**	

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F 800	Continued From page 41	F 800		

reported that sometimes items are not approved, or previous approved amounts are reduced.

Observations were made of the facility's meal services on 8/5, & 8/6/24. Random residents were interviewed in resident rooms and in the facility's dining room during the meal services.

Per review of the facility's posted Lunch menu for 8/5/24, as well as the individual printed menus handed to residents, Lunch meal items available included lettuce and tomato half slices, creamy Dill potato salad, watermelon, saltines, and egg salad on wheat bread. An observation was made of the facility's Lunch meal on 8/5/24. Random residents were interviewed in resident rooms and in the facility's dining room during Lunch on 8/5/24. Res. #39 reported h/her menu listed lettuce and tomato half slices, Creamy Dill Potato Salad, and Watermelon- none of which s/he received.
Res.#7 reported h/her menu listed lettuce and tomato half slices, and saltines which s/he did not receive, along with an egg salad sandwich on white not wheat bread.

Per review of the facility's posted menu for 8/5/24, as well as the individual printed menus handed to residents, the Dinner meal for 8/5/24 was posted as "Beef Lasagna [1 square] with marinara sauce", along with tossed salad with Parmesan ranch dressing, and garlic bread. Observations were made of residents in their rooms during the Dinner service and in the dining room during the facility's Dinner meal on 8/5/24.
Per observation, the main entrée being served was penne pasta [a type of pasta with tubular pieces, with ends cut at an angle] with meat sauce and/or plain penne, accompanied by a cold

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F 800	Continued From page 42 cooked beet salad. No resident was observed received the scheduled Beef Lasagna with marinara sauce for the Dinner meal. Random residents were interviewed in resident rooms and in the facility's dining room during Dinner on 8/5/24. Res. #46 pointed to the penne entrée on h/her plate and stated, "this is not lasagna". Res.#35 reported in addition to not receiving the scheduled lasagna entrée, h/her menu listed tossed salad with Parmesan ranch dressing, and s/he received no salad. Res.#38 reported in addition to not receiving the scheduled lasagna entrée, h/her menu listed tossed salad with Parmesan ranch dressing, and s/he received no salad. Res.#38 stated "Why didn't I get my salad? This happens all the time." The resident reported s/he requested salad with dinner and s/he received beets instead. Res.#4 reported in addition to not receiving the scheduled lasagna entrée, h/her menu listed garlic bread and s/he did not receive any. During the Dinner meal service on 8/5/24, kitchen staff were interviewed and stated that they ran out of salad and served beets instead. The Kitchen staff stated that the residents receiving the substitutions were not notified in advance. An observation was made of the facility's Breakfast meal on 8/6/24. Per review of the facility's posted menu for 8/6/24, as well as the individual printed menus handed to residents, Breakfast meal items available included 1 banana per resident, yogurt, and oatmeal. Random residents were interviewed in resident rooms and in the facility's dining room during Breakfast on 8/6/24. Res.#33 reported s/he received no banana as	F 800		

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F 800	Continued From page 43 listed on h/her menu. Res.#25 reported s/he received no yogurt or banana as listed on h/her menu. Res.#28 reported s/he received no oatmeal or banana as listed on h/her menu. Per Interview with Resident #34 on 8/5/2024 at 2:30 PM s/he stated that the facility runs out of several food items including ginger ale toward the end of the week. S/He stated the facility is sometimes out of items for several days. S/he stated, "I look forward to the food truck delivery." Per interview with the Dietary Manager [DM] on 8/6/27 at 10:15 AM, the DM reported that current produce deliveries contained amounts of unusable items, such as rotted lettuce and ripe bananas that quickly spoiled, which contributes to the menu items shortages and substitutions. The DM stated that menu changes and substitutions are relayed to Nursing staff in a daily 'morning meeting', with the changes to be passed on to the residents. An interview was conducted with a Staff Registered Nurse [RN] on 8/7/24 at 9:07 AM. The RN stated that no menu changes are communicated to nursing staff during the daily interdisciplinary team "morning meeting". The RN stated, "I don't want to rat anyone out, but that doesn't happen." Per interview with the Dietary Manager [DM] on 8/6/27, the DM reported residents should receive all items on their menu to ensure their dietary requirements are fulfilled. The DM stated that if an item is not available, an item of similar nutritional value should be substituted. The Dietary Manager stated that items missing from residents' meals "shouldn't happen".	F 800		
F 801 SS=D	Qualified Dietary Staff	F 801		

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F 801	Continued From page 44 CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of	F 801	F801 Specific Corrective Action 1. The center has a qualified dietary manager and/or qualified full-time coverage will be put into place until this happens. 2. All residents have the potential to be affected by the deficient practice. 3. The center ensures that a qualified Dietary Manager will be in place or that appropriate coverage will be in place to include a regional qualified dietary Manager or full-time dietician. The NHA will be re-educated on the policy for a qualified Dietary Manager. 4. The NHA/designee will ensure that a qualified Dietary Manager is in place at the center or that a full-time Dietitian is in place for coverage weekly x4, monthly x3. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 9/27/2024 **Tag F 801 POC accepted on 10/3/24 by S. Freeman/P. Cota**	

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F 801	Continued From page 45 this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations	F 801		

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F 801	Continued From page 46	F 801		

from a qualified dietitian or other clinically qualified nutrition professional.
This REQUIREMENT is not met as evidenced by:
Based upon interview and record review, the facility failed to ensure that if a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services, and that director must meet certain required qualifications. Findings include:

Food safety certification is a formal recognition of an individual's knowledge and competency in food safety practices. It serves as proof that an individual has completed a recognized food safety training program and has demonstrated the necessary skills to handle food safely. Food safety certification is often required by regulatory authorities and can be a legal requirement for certain positions, such as food managers. Obtaining food safety certification enhances an individual's credibility and demonstrates the organization's commitment to food safety. Having trained managers in place helps to ensure that food safety practices are consistently followed, reducing the risk of foodborne illnesses and maintaining a safe workplace environment. (https://alwaysfoodsafe.com/en/benefits-food-safety-training)

An interview was conducted with the facility's Dietitian on 8/7/24 at 2:20 PM. The Dietitian stated that s/he works at the facility on a part-time basis, along with several other facilities, and is present at the facility one day a week.

An interview was conducted with a facility staff member on 8/5/24 at 10:30 AM. The staff

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F 801	Continued From page 47 member identified h/herself as the Dietary Manager and stated that h/she had been the Dietary Manager for the past year and was currently working on h/her certification for the position, which h/she reported they were "halfway through". Per review of the facility's "Department Heads" phone list, the staff member interviewed is listed as the facility's "Dietary Manager" two times on the list. The phone list is marked as "updated 8/1/24" by the Regional Market President-Operations. Per interview with the facility's Dietary Manager, s/he had not yet obtained the required certification and/or qualifications to ensure that food safety practices are consistently followed at the facility.	F 801		
F 803 SS=F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's	F 803	F803 Specific Corrective Action 1. Menus are being updated in real time with any changes and residents are being notified of these changes. 2. All residents have the potential to be affected by the deficient practice. 3. Dietary Staff have been educated on making edits to daily menus if ingredients are changed and then staff are to notify the residents of any changes. 4. The NHA/designee will monitor that menus are correct or that residents are updated of any changes by random interview and observation weekly x4, monthly x3. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 9/27/2024 **Tag F 803 POC accepted on 10/3/24 by S. Freeman/P. Cota**	

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F 803	Continued From page 48 dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and record review, the facility failed to follow the Dinner Menu on 8/5/24 as posted, and the change was not noted or updated on the menu and residents were not notified of the change. Findings include: Per review of the facility's posted Dinner menu for 8/5/24, as well as the individual printed menus handed to residents, the Dinner meal for 8/5/24 was posted as "Beef Lasagna [1 square] with marinara sauce". Observations were made of residents in their rooms during the dinner service and in the dining room during the facility's Dinner meal on 8/5/24. Per observation, the main entrée being served was penne pasta [a type of pasta with tubular pieces, with ends cut at an angle] with meat sauce and/or plain penne. No resident was observed receiving the scheduled Beef Lasagna with marinara sauce for the Dinner meal. Random residents were interviewed in resident rooms and in the facility's dining room during Dinner on 8/5/24. Res. #46 pointed to the penne entrée on h/her plate and stated, "this is not lasagna". The resident stated s/he would have preferred lasagna and had not been notified that the lasagna would not be served. Per interview on 8/5/24, Residents #35, #38, & #4 reported they had anticipated lasagna for dinner,	F 803		

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F 803	Continued From page 49 and had not been notified that the lasagna would not be served. An interview was conducted on 8/6/27 at 10:15 AM with the facility's Dietary Manager. The Dietary Manager confirmed that the posted Dinner menu for 8/5/24 was Beef Lasagna with marinara sauce. The Dietary Manager also confirmed the menu was changed prior to Dinner, and the change was not noted or updated on the menu and residents were not notified of the change.	F 803		
F 806 SS=F	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and record review, the facility failed to effectively provide and communicate alternate food choices and appealing meal options to residents who choose not to eat food that is initially served. Additionally, the facility failed to provide options based on resident's food preferences. Findings include: Observations were made of the facility's meal services on 8/5, 8/6, & 8/7/24. Random residents were interviewed in resident rooms and in the	F 806	F806 Specific Corrective Action 1. Residents are being provided with food choices based on their preferences by way of ordering there meals ahead of time. 2. All residents have the potential to be affected by the deficient practice. 3. Residents are being asked for their meal orders. Staff have been educated on this process. 4. The NHA/designee will ensure residents are offered an alternative via observation and resident interview of 10 random residents per week for 4 weeks and monthly x3.The center will invite residents to a monthly food committee to ensure satisfaction and results of this monitoring will be discussed in monthly QAPI for recommendations and further review. Date of compliance 9/27/2024 **Tag F 806 POC accepted on 10/3/24 by S. Freeman/P. Cota**	

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F 806	Continued From page 50 facility's dining room during the meal services. Per interview with Resident #18 on 8/5/24 at 4:00 PM s/he stated the kitchen runs out of food items and salad sometime is just Lettuce. Resident #18 stated s/he is not offered a choice prior to the meal, and any alternative is only offered after s/he declines the meal served. An interview was conducted with Res. #33 on 8/6/24 at 8:45 AM. Per observation the resident was in bed eating breakfast. His/her roommate was eating scrambled eggs. Res.#33 said s/he wished s/he got eggs for breakfast. The resident stated 'no one ever asks' what s/he likes to eat. Per Interview with Resident #6 on 8/6/24 at 1:00 PM, S/He stated that s/he is only offered a grilled cheese as an alternative. Resident #6 stated "I do not like grilled cheese." Per observation of Resident #6's lunch tray on 8/6/24, the resident did not consume food on his/her plate including the grilled cheese sandwich. Per interview with Res.#20 and Res. #47 on 8/7/24 at 9:50 AM, the roommates reported that they are not given any notice of upcoming meal options. Both residents stated there was "no notice ahead of time" about what was to be served and had no way of knowing what the alternatives were if they didn't like that meal's offering. An interview was conducted on 8/6/27 at 10:15 AM with the facility's Dietary Manager. The Dietary Manager stated that residents can request a meal option any time during the day. The Dietary Manager reported that residents can tell a Licensed Nurse's Aide [LNA] their order	F 806		

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ahead of any meal. Per interview with a staff LNA on 8/7/24 at 2:40 PM, the LNA stated that 'it was too much of a hassle to ask residents what they want because we are short staffed', and there is not enough staff to ask residents what they want for meals.

An interview was conducted with the facility's Dietitian on 8/7/24 at 2:20 PM. The Dietitian stated that the facility does not ask residents what they would like for meals or alternatives, the facility bases the meals choices on the resident's "Preference List". [Per interview with the District Manager and confirmed by record review, the "Preference List" does not ask residents what foods they prefer: it asks what foods they dislike]. The Dietitian stated there is no formal process to ask residents if they want something other than what is posted as that day's meal item. The Dietitian stated that asking residents if they want something different "is not what [the facility's corporate ownership] wants us to do."

Per interview on 8/7/24 at approximately 2:40 PM, an LNA stated that there are not enough staff to give residents a choice in what they would like to eat prior to meals being served. S/He explained that it is too much of a hassle to ask residents what they want to order for because they are short staffed, especially after 3:00 PM.

An interview was conducted with the facility's dietary District Manager on 8/7/24 at 3:03 PM. The District Manger stated that the facility does not print out or share with the residents the alternative menu: residents have to ask what they have as an option. The District Manager further stated that the facility serves residents food based on their dislikes, not their preferences.

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F 925 SS=D	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based upon observation and interview, the facility failed to ensure effective pest control was maintained related to an open window without a screen adjacent to food preparation areas. Findings include: During the initial tour of the kitchen on 8/5/24 at 10:30 AM, an open window was observed without a screen. The screenless window was adjacent to food preparation areas in the kitchen. An interview was conducted with the facility's Dietary Manager on 8/6/24 at 9:08 AM. The Dietary Manager confirmed that the window was without a screen and adjacent to food preparation areas. The Dietary Manager stated that the open window "should have a screen" as a preventative measure to inhibit insects and common pests from entering the kitchen and triggering infection control issues.	F 925	F925 Specific Corrective Action 1.A screen was installed in the kitchen window. The center has a current contract with a pest control vendor. 2. All residents have the potential to be affected by the deficient practice. 3. Dietary staff have been educated on the need to complete a maintenance work order for missing screens or other maintenance needs in the kitchen. The center is contracted with pest control and has no reported issues. 4. The NHA/designee or Maintenance Director will ensure the kitchen windows have screens and that other maintenance needs are addressed via work order and completed timely 4 weeks and monthly x3. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 9/27/2024 **Tag F 925 POC accepted on 10/3/24 by S. Freeman/P. Cota**	