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 21, 2024

Ms. Alecia Dimario, Administrator
Birchwood Terrace Rehab & Healthcare
43 Starr Farm Rd
Burlington, VT 05408-1321

Dear Ms. Dimario:

Enclosed is a copy of your acceptable revised plans of correction for the recertification survey conducted on **September 3, 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
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
	475003	A. BUILDING _____ B. WING _____	09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCHWOOD TERRACE REHAB & HEALTHCARE	43 STARR FARM RD BURLINGTON, VT 05408

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E 000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 08/28/24. There were no regulatory violations identified.	E 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite annual rectification survey on 08/25/2024 - 08/29/2024 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. On 08/25/24, the survey team identified and notified the facility of deficiencies at the Immediate Jeopardy (IJ) level at F880, related to violations around infection prevention and control. On 08/28/24 at 4:45 PM, prior to the conclusion of the survey, the facility had completed sufficient corrective actions to remove the immediate jeopardy, but the non-compliance with requirements at F880 remains. The survey team identified substandard quality of care related to unsafe water temperatures, a violation at 483.70(e) F 689. An onsite, extended survey was conducted on 9/3/2024 due to the determination of substandard quality of care. The facility is licensed for 144 beds and had a census of 130 at the time of the survey. 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	F 550	F 550 The facility provides meals to those residents at a table at approximately the same time and residents #72, #69, #90, #100, #72, #81, #12 and #47 are being provided, the assistance required to complete their ADLs. A Facility Wide Audit (FWA) was completed including observing residents to ensure if clothing was soiled then the clothing was changed timely, if a resident requested toileting or presented in such a condition that required toileting then the resident was toileted and routine incontinent was provided, meals were provided to all residents sitting at a table at approximately the same time decreasing the risk of one resident eating of another residents tray, there is a staff member present on the special care unit in between activities and meals ensuring that hands and faces are cleaned and the resident is ready for the next meal, the residents have utensils to eat their meals. The SDC or Designee provided education on the policy for Resident Rights focusing on dining service, oversight of special care unit and supervision before and during the meals, routine toileting and routine incontinence	10/2/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alexia O'Mara		09/23/2024

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

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F 550	Continued From page 1 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 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, resident interview, staff interview, and record review, the facility failed to provide a respectful and dignified dining	F 550	care needing to be provided timely. The DON is responsible for overseeing this process. 3 Observations a week of our residents during meals ensuring meals are served timely, residents are not eating off of other residents trays, residents have utensils to eat their meals, oversight of the resident between activities and meals is occurring along with hands and faces being clean supporting that the resident is ready for their meal and that residents who require toileting or incontinent care receive the care timely. The results of these audits will be reviewed and brought to QAPI meeting for further review and recommendations ensuring substantial compliance is achieved. **Tag F 550 POC accepted on 10/21/24 by C. Howard/P. Cota**	

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F 550	Continued From page 2 experience that enhances residents' quality of life as evidenced by failure to serve meals to residents at a table at approximately the same time, and the facility failed to ensure care was provided to residents to maintain their respect and dignity as evidenced by the failure to assist with care related to Activities of daily living (ADLs) for 8 of 47 sampled residents (#72, #69, #90, #100, #72, #81, #12, and #47). Findings include: During observations made on "A" Unit (Special Care Unit (SCU), throughout the survey there were several times that residents were noted to be soiled and unattended. 1. On 8/28/2024 at 9:10 AM Resident #72 was observed propelling her/himself down the hallway. S/he stopped in front of this Surveyor pointed at the door at the end of the hall and stated "I have to go out there. Can you help me out there?" Her/his pants were visibly soiled from the crotch area to halfway down to the knees. The Resident continued to self propel down the hall to the door. At 9:15 AM the Unit Manager approached Resident #72 and brought her/him up the hall to the nurses station area and left her/him there. At 9:20 AM a Licensed Nursing Assistant brought Resident #72 out to the dining room and parked her/him at a table not addressing the wet pants. At 9:40 AM Resident #72 began calling out "help me, I am going to throw up and wet my pants." At this time the Resident's pants were still wet. A Registered Nurse (RN) responded "give me a minute [name omitted]" repeating it 3 times. The RN then moved the Resident back to the nurse's station and gave her/him a cup of water. At 9:46 AM a Licensed Nursing Assistant (LNA) approached her/him and took her/him to the bathroom to change. At approximately 10:15 AM	F 550		

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F 550	Continued From page 3	F 550		

the LNA confirmed that the Resident's pants had been soaked through with urine.

2. On 8/26/24 at 9:10 AM Resident #69 was observed in the dining room with his/her head on the table. There was coffee spilled on floor and her/his socked feet were wet with coffee. At 9:50 AM Resident #69 was observed in the same position with the coffee still on the floor.

3. On 8/26/24 9:50 AM Resident #90 was observed sitting in a wheelchair in the dining room. S/he was periodically standing up from the chair and putting her/his right hand in the back of her/his incontinence brief. Upon approach it was noted that Resident #90's right hand was soiled with a brown substance that appeared to be bowel movement. At approximately 10:00 AM Resident #90 stood up again, a LNA entered the dining room and escorted her/him to the bathroom. At this time this Surveyor approached the LNA and informed her/him that the Resident had been putting her/his hands in her/his pants. The LNA confirmed that the Resident had bowel movement on her/his hands.

4. During observation of the lunch meal service on 8/26/24 at 12:05 PM Resident #69 was sitting at a table eating her/his meal. There were two other Residents sitting at the table, observing Resident #69 eat, who were not served until 12:15 PM.

5. Per observation on 8/26/24 at 4:43 PM of the dining room on the A Unit (Special Care Unit (SCU), there were 15 residents in the dining room and 11 residents out by the nurses station. There were no activities for the residents and no staff present. At 8/26/24 at 4:59 PM, 9 residents were

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F 550	Continued From page 4 observed sitting in recliners with tray tables in front of them for the evening meal, with no activities and no staff present for supervision or meaningful engagement with residents. Resident #47 had food on her/his face and shirt. At 4:59 PM a Licensed Nursing Assistant confirmed that the food on her/his face was from the lunch meal. 6. At 5:05 PM Resident #12 was seen sitting at a table with 2 other Residents, and did not have their food yet. Resident #12 reached over to another Resident's meal tray and took a cup of milk that had been drank from, and began drinking it. At 5:15 PM a Licensed Nursing Assistant (LNA) approached the table with Resident #12's meal tray. The LNA took the cup of milk from Resident #12 and gave her/him their own milk. 7. Per observation on 8/26/24 at 5:43 PM Resident #81 was sleeping in wheelchair at the dinner table. S/He had dropped her/his fork and fruit cocktail on the floor under her/his chair and no assistance was being offered to this resident. 8. On 8/27/24 at 3:03 PM Resident #100 was observed sitting in a straight back chair in the dining room. S/he was noted to have white film at her/his gum line and food was caked in her/his teeth. At 3:15 PM Resident #100 stood up from the chair, it was noted that the back of her/his pants were soaked through with urine. The Activity Aide that was in the room at the time, confirmed that Resident #100 had been soiled with urine. Per interview with the Unit Manager on 8/29/24 4:45 PM s/he stated that it is the expectation that staff provide assistance to clean Residents after	F 550		

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F 550	Continued From page 5 they assist them with meals or if they are soiled. Staff are educated during orientation regarding these expectations.	F 550	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (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	F 656	F 656 Residents #65, #67, #50, #282, #41, #87, #34, #93, #109, and #76 are receiving specific care and services so that the resident can attain or maintain his/her highest practicable physical, mental and psycho-social well-being. A FWA of the care plans for our residents include the required assistance for ADL's including mode of locomotion and transfer status, hygiene task support and aspiration precautions. The SDC or Designee has provided education on Development and Comprehensive Care Plan Policy focusing on developing care plans on: 1. required assistance for ADL needs, 2. hygiene tasks support, and 3. aspiration precautions. Weekly review of resident's care plans will include validation of the following care plans being developed and comprehensive in the residents record focusing on 1. required assistance for ADL needs, 2. hygiene tasks support, and 3. aspiration precautions. The DON is responsible for overseeing this	10/2/24

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F 656	Continued From page 6 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure that resident care plans described the resident specific care and services that will be furnished so that the resident can attain or maintain his/her highest practicable physical, mental and psychosocial well-being for 10 of 40 sampled residents (Residents #65, #67, #50, #282, #41, #87, #34, #93, and #109, and #76) related to activities of daily living (ADL). Findings include: Per record review, Residents #65, #67, #50, #282, #41, #87, #34, #93, #109, and #76 care plans reveal that they have ADL self-care performance deficits. An intervention related to ADL care for all the above residents read "Nursing staff to provide as much assistance that is needed to complete care tasks (...)." There are no resident specific care interventions to describe what type of assistance these residents require to carry out activities such as feeding assistance, transferring, ambulation, and hygiene care. 1. Per record review, Resident #65's dining profile states that s/he needs constant supervision and	F 656	process. The results of these reviews will be brought to the QAPI meeting for further review and recommendation ensuring substantial compliance is achieved. **Tag F 656 POC accepted on 10/21/24 by C. Howard/P. Cota**	

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F 656	Continued From page 7	F 656		

verbal cues/prompting while eating. This information is not included in his/her care plan. Resident #65's therapy profile, last updated on 8/14/24, states that s/he is dependent on staff for all ADLs including transferring and hygiene and uses a wheelchair. This information is not included in his/her care plan.

2. Per record review, Resident #109's dining profile states that s/he is on aspiration precautions and requires constant supervision and verbal cues/prompting while eating. This information is not included in his/her care plan. Also, the care plan does not include resident specific interventions related to hygiene task support.

3. Per record review, Resident #87's dining profile states that s/he needs constant supervision and verbal cues/prompting while eating and "if left in bed, will need assistance with feeding." This information is not included in his/her care plan.

4. Per record review, Resident #50's dining profile states that s/he is on aspiration precautions and requires constant supervision while s/he is eating. This information is not included in his/her care plan.

5. Per record review, Resident #41's therapy profile, last updated on 8/20/24, states that s/he requires maximum assistance or is dependent on staff for all ADLs including bed mobility, hygiene, and transferring and uses a tilt in space wheelchair. This information is not included in his/her care plan.

6. Per record review, Resident #34's therapy profile, last updated on 8/21/24, reveals that s/he

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F 656	Continued From page 8 requires minimum 1 assist for bed mobility and requires staff assistance for transferring. This information is not included in his/her care plan. 7. Per record review, Resident #76's therapy profile, last updated on 5/29/24, reveals that Resident #76 can ambulate with a walker and distant staff supervision. This information is not included in his/her care plan. Also, the care plan does not include resident specific interventions related to hygiene task support. 8. Per record review, Resident #93's dining profile, last updated on 2/23/24 states that s/he is to have his/her head of bed elevated while eating. This information is not included in his/her care plan. 9. Per record review, Resident #282's care plan does not include resident specific interventions related to hygiene task support. 10. Per record review, Resident #67's care plan does not include resident specific interventions related to hygiene task support. Per observation during the recertification survey between 8/25/24 and 8/29/24, the above residents were observed not being provided the assistance required to complete ADL tasks. See F 677 for more information. Per interview on 8/29/24 at 4:15 PM, the Nurse Consultant explained that care plans should be as person centered as possible, including what type of assistance residents require to receive proper ADL care.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards	F 658		

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F 658	Continued From page 9 CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that a resident was assessed for injuries and complications in accordance with professional standards and per facility policy after sustaining a fall for 1 of 40 residents in the sample (Resident #22). Findings include: Per observation on 8/28/2024 at 8:40 AM Resident #22 was sitting in his/her wheelchair in unit dining/activity area. S/He was slumped forward and observed to have no upper body control. S/He tried several times to lift his/her head, however, was unable to. Resident #22's eyes were closed, and s/he could not speak. During observation s/he began vomiting. At the time of observation there were no staff monitoring in the dining/activity area. Due to safety concerns the LNA and RN were notified of the surveyor observations immediately. The LNA staff took Resident #22 back to his/her room. Resident #22 was emergently transferred to hospital with altered mental status and low blood pressure. Per Emergency Physician note dated 8/28/2024 in Resident #22 record "Per RN at [facility] patient had unwitnessed fall overnight while trying to use the bathroom. Initially refused EMS transport however around 6:30 this morning, staff noticed she had slurred speech, AMS [altered mental	F 658	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 658 Resident #22 was readmitted to the facility for continued medical management and continues to remain at the facility today. A FWA was completed including reviewing the resident progress notes for the last 30 days have been read by the DNS or designee to validate that there is no other similar situation that has occurred without notification to the physician and to a resident representative with follow though of the decision of the invoked POA. The SDC or Designee has provided education on the policy of notification of change and the Vermont Statues and Advanced Directive including expectation to transfer a resident to the hospital if the resident's mental status is altered and the situation would result in serious and irreversible bodily injury or death if the health care is not provided within 24 hours. The DON is responsible for overseeing this process. There will be a daily (M-F) Point Click Care (EMR) clinical review (includes reviewing admissions, transfers and discharges (ADT), reading progress notes	10/2/24

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F 658	Continued From page 10 status) from baseline with unequal pupils. Upon my interview, [Resident #22] expresses that she is having severe pain when [s/he] urinates. S/He stated s/he has tried to ask for help to go to the restroom, but no one came ..." Resident #22 was admitted to the hospital for pyelonephritis requiring intravenous antibiotics, low blood pressure, and dehydration. Per interview on 8/28/2024 at 8:45 AM, the Licensed Nurse Assistant #1 (LNA) familiar with the resident and his/her care stated that Resident #22 had fallen on night shift at approx. 2:30 AM on 8/28/2024. LNA stated that Resident #22 is normally alert and cooperative and likes to be in his/her room. LNA stated Resident #22 was moved to the dining room that morning because s/he appeared more confused and had been attempting to get out of bed. Per record review, a nursing note dated 8/28/2024 at 2:30 AM " Resident [#22] found on the floor in room @ [at] bedside ... Resident states [s/he] was trying to get up for toileting. Call light within reach & not used. Apparent injury noted to head. Brusing to the top of the forehead @ a skin tear above the left eye ... Resident refuses head to toe assessment ... Resident refuses all care to injuries, VS check, & pupil assessments @ this time. Assisted back to bed by staff ...Alert with mental status @ baseline ...Aggressive with staff during care. Cursing & hitting @ staff. Refusing any assistance & requesting to be left alone ..." Nursing note dated 8/28/2024 at 3:35 AM "Staff attempted to assess resident, VS obtained & recorded ... Complained of burning with urination, low grade fever noted ... agitation noted with continued staff encounter."	F 658	for the last 24 hours which will show any changes in condition and what steps were followed. The DON or Designee will validate that if changes in condition were identified the physician and resident or resident representative were notified, and that the resident was transferred according to the decision of the resident or if their mental status is altered then the POA and physician. The results of these audits will be reviewed and brought to QAPI meeting for further review and recommendations ensuring substantial compliance is achieved. **Tag F 658 POC accepted on 10/21/24 by C. Howard/P. Cota**	

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F 658	Continued From page 11 Per interview on 8/28/2024 at approx. 2:00 PM Registered Nurse (RN) on duty at time Resident #22's hospital transfer stated that s/he was on shift the previous night and cared for Resident #22. S/He stated during the interview that s/he last checked on him/her just before midnight and the resident was resting, alert and oriented. RN reports that s/he arrived back to work on 8/28/2024 at 6:45 AM. S/he stated that s/he and the LPN completed walking rounds at approx. 7:15 AM and during that time the LPN told him/her that the Power of Attorney (POA) was contacted after the fall and s/he requested that Resident #22 be sent to the emergency room. Per RN, the LPN on duty did not send Resident #22 to the emergency room because Resident refused. RN further stated that Resident #22 does not have a history of refusal of care or behaviors. Per interview of the LNA on 8/29/24 at 6:00 PM, the LNA stated s/he was working on 8/28/2024 when Resident #22 fell. S/He stated Resident #22 was alert and cooperative when s/he checked on him/her at approx.10:00 PM. LNA stated that s/he is not aware of any behaviors or refusal of care for Resident #22. LNA stated that Resident s/he was cooperative with care during his/her shift and prior to the fall. LNA stated s/he last checked on Resident #22 around 2:45 AM on 8/28/2024 after the fall and s/he complained of being cold, LNA stated s/he covered Resident #22 with blankets and left the room. Per Nursing interview on 8/29/24 at 6:30 PM with the License Practice Nurse (LPN) on duty when Resident #22 fell at 2:30 AM on 8/28/2024. S/He stated that s/he did speak with the POA multiple times and that s/he did request the resident be	F 658		

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F 658	Continued From page 12 sent to the emergency room. The LPN stated s/he did not send Resident #22 to the hospital even though the POA said to because the resident refused. The LPN stated s/he did not call EMS or contact the Director of Nursing to assess Resident #22. LPN stated s/he did not notify the on-call provider of change in mental status. The LPN stated s/he believed Resident #22 to be at his/her baseline after the fall and that she was not concerned about the change in Resident #22 behavior. According to Resident #22 record review s/he was admitted to the facility on 8/19/2024 for short term rehabilitation. Per" Patient Clinical Evaluation" dated on 8/19/2024 and completed by the Registered Nurse (RN) of Resident #22, section D. titled "Cognitive/Mood" 1. Resident is not cognitively impaired, 2. Resident has no history of behaviors ... Section 7. Titled "Speech" a. "resident is oriented speech/clear." According to Social Work "psychosocial assessment" documented on 8/20/2024, Resident #22 lives alone in senior housing and makes his/her own medical decisions. Nursing note dated on 8/20/2024 at 10:38 PM "Resident was pleasant with some reports of pain in [his/her] left leg. [S/he] is here for weakness and colitis, rectal bleeding, hypotension, hypothyroidism. [S/He] is occasionally incontinent of bowl and bladder ... [S/He] is A&OX3 [alert and oriented to time, person, and place] ..." According to Resident #22 diagnosis list there is no evidence of behavior or cognitive deficit diagnosis. Nursing note dated on 8/27/2024 at 11:56 PM , "Resident is alert, tolerated medication and ADL care well. PRN Ativan was administered ..." (Ativan is a medication used to treat anxiety).	F 658		

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Per record review Resident #22 has the following Care Plan started on 8/19/2024 "[Resident #22] has a DNR/DNI COLST [Resident #22] Advanced Directives are in effect and their wishes and directions will be carried out in accordance with their advanced directives on an ongoing basis through the next review date." Per Advance Directive on file resident POA is also on file. According to Resident #22 Advance Directive POA should be activated when Resident #22 is unable to make their own decisions, and POA should be contacted in the event of life-threatening illness.

Per facility policy "Notification of Changes" last revised 4/2023 "Residents incapable of making decisions:
a. The representative would make any decisions that have to be made ..."

According to Vermont Statues and Advance Directive:

Adults Who Lack Decision-Making Capacity
Adult patients who lack decision-making capacity still retain the right to refuse medical treatment in all but exceptional circumstances. The two circumstances where it is permissible to treat over the objection of an incapacitated patient are:
" If the patient has waived their right to refuse in an advance directive (Ulysses Clause), or
" If the situation would result in serious and irreversible bodily injury or death if the health care is not provided within 24 hours.

Per interview with the Administrator on 8/29/2024 at approx. 5:00 PM stated that s/he was unaware that Resident #22 POA requested resident be sent to the emergency room for evaluation after

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F 658	Continued From page 14 she fell on 8/28/2024.	F 658	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that a resident who is unable to carry out activities of daily living (ADLs) without assistance receives the proper level of assistance for 11 of 40 sampled residents (Residents #65, #67, #50, #282, #41, #87, #34, #93, #109, #76, and #9) Findings include: 1. Per record review, Resident #65's care plan reads "[Resident #65] has swallowing difficulty r/t [related to] Hx [history]: coughing/pocketing on advanced textures with Dx [diagnoses]: Dysphagia [difficulty swallowing] s/p [status post] SLP [speech-language pathologist] evaluation," revised 2/4/22, with the following intervention "[Resident #65] will eat per therapy directed dining profile, which will be located in chart, and therapy profile binder," initiated 11/16/21. Resident #65's dining profile, last updated on 11/17/21, states that s/he needs constant supervision and verbal cues/prompting while eating. Other descriptions of his/her current status include offering the main dining room and placing bites of food on a utensil and saying, "take a bite." Cough to clear and alternate liquids and solid are listed as swallowing strategies. Resident #65's care plan reads "[Resident #65] has an ADL Self Care Performance Deficit r/t	F 677	F 677 Residents #65, #67, #50, #282, #41, #87, #34, #93, #109, #76, and #9 are receiving the proper level of assistance to meet their ADL care needs. A FWA was completed including observation of residents to ensure those that are unable to carry out activities of daily living rare receiving the necessary services to maintain good nutrition, grooming, and personal hygiene. The SDC or Designee provided education to the nursing staff about providing the care that each residents requires for ADL Care including providing the level of supervision they should have during meals which may include bring the resident to the dining room, maintaining aspiration precautions and ensuring if one eats in bed their HOB is elevated, cleaning and clipping finger nails to ensure not long and they are clean under the nail, educating LNAs how to identify the level of supervision or assistance a resident needs with meals and ensuring a resident is not behind a closed door where they can't be supervised, transferring residents in and OOB as	10/2/24

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F 677	Continued From page 15 cognitive impairment and limited mobility," revised on 5/4/21, with an intervention for "Nursing staff to provide as much assistance that is needed to complete care tasks," initiated on 12/15/21. Resident #65's therapy profile, last updated on 8/14/24, states that s/he is dependent on staff for all ADLs including transferring and hygiene and uses a wheelchair. Per observation on 8/25/24 at 5:46 PM, Resident #65 was in the dining room with his/her food in front of him/her. S/He appears to be asleep in his/her wheelchair. It wasn't until 6:02 PM, that a Licensed Nursing Assistant (LNA) went over to Resident #65, put a piece of dinner on the fork and handed it to him/her. Per observation on 8/28/24 at 12:00 PM, Resident #65 was sitting in the dining area with lunch in front of him/her. Resident #65 did not receive any assistance or cueing for at least 25 minutes until an LNA approached him/her at 12:25 PM saying take a bite. Per observation and interview on 8/28/24 at 2:40 PM, Resident #65 had very long nails which appear to have a brown tint and dirt on the underside of each nail. S/He said s/he wanted his/her nails cut and had asked staff to cut them. Per observation and interview on 8/28/24 at 5:34 PM, Resident #65 was in his/her bed with the curtain drawn and a tray of food in front of him/her. S/He stated that s/he does not want to be in bed for dinner and wanted to get up. There was no way to see Resident #65 from the hall and there were no staff in the hallway. Per interview on 8/28/24 at 3:46 PM, the Therapy	F 677	requested by the resident, toileting resident as requested by the resident, ensuring call bells are within reach, and that staff are to be engaging staff in a level of conversation that the resident can relate to when they are able. The DON is responsible for overseeing this process. 3 Observations a week ensuring that residents about receiving the care that each residents requires including providing the level of supervision they should have during meals which may include bringing the resident to the dining room, maintaining aspiration precautions and ensuring if one eats in bed their HOB is elevated, residents fingernails are clipped and clean underneath the nail, ensuring LNAs know how to identify the level of supervision or assistance a resident needs with meals and to ensure a resident is not behind a closed door where they can't be supervised, ensuring residents are being transferred in and OOB as requested by the resident, residents are being toileted as requested by the resident, ensuring call bells are within reach, and that staff are engaging with the residents with a level of conversation that the resident can relate to when they are able. The results of these audits will be reviewed and brought to QAPI meeting for further review and recommendations ensuring substantial compliance is achieved. **Tag F 677 POC accepted on 10/21/24 by C. Howard/P. Cota**	

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F 677	Continued From page 16 Director explained that if a dining profile says constant supervision, the resident should not be eating alone in their room. 2. Per record review, Resident #109's care plan reads "[Resident #109] has swallowing difficulty r/t PMHx [past medical history] of Dysphagia with recurrent aspiration pneumonia. On thickened liquids," revised on 6/20/24 with an intervention to "Provide textures of foods/fluids per physician diet order and any SLP recommendations," initiated 6/17/24. Resident #109's dining profile, last updated on 6/28/24, states that s/he is on aspiration precautions and requires constant supervision and verbal cues/prompting while eating. Chin tuck with swallow, double swallow, alternated liquids and solids, and small single sips, and eat slowly are swallowing strategies listed. Per observation on 8/26/24 at 5:11 PM, Resident #109 is eating in his/her room, alone. There are no staff to be seen in the hallway. Per observation on 8/29/24 at 5:17 PM, Resident #109 is alone in his/her room with dinner and there are no staff in the vicinity. S/He is intermittently coughing while s/he is eating. Per observation and interview on 8/28/24 at 2:50 PM, Resident #109 revealed medium length nails with a dirt-like substance under each nail. S/He said s/he would like his/her nails cut. Resident #209's Spouse said that s/he would like his/her nails cut. 3. Per record review, Resident #87's care plan reads "[Resident # 87] has swallowing difficulty r/t dx: dysphagia following cerebral infarction	F 677		

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[stroke]" revised on 7/17/21 with interventions that include "provide feeding/ dining assistance as needed," initiated on 3/15/24 and "during meals and after each meal observe for signs/symptoms of aspiration," initiated on 3/15/24. Resident #87's dining profile, last updated 11/8/23 states that s/he needs constant supervision and verbal cues/prompting while eating and "if left in bed, will need assistance with feeding." Multiple swallowing strategies include cough to clear, alternate liquids and solids, and small single bites- chew bites very well, slow rate of intake, and small single sips.

Per observation on 8/28/24 at 5:49 PM, Resident #87 was in his/her bed with his/her dinner in front of him/her on the bedside table. There are no staff around. S/He was saying "please help me" with food and drinks.

Per observation on 8/29/24 at 5:10 PM, Resident #87 was in bed with a food tray in front of him/her and no staff present. The LNA who dropped off the food tray to Resident #87 was approached and asked if it was appropriate for Resident #87 to be left alone to eat; s/he said s/he can't answer that question because s/he doesn't know the residents on this unit.

4. Per record review, Resident #50's care plan reads "[Resident #50] has swallowing difficulty r/t Dx: Dysphagia, oropharyngeal phase s/p SLP evaluation," revised on 3/12/23 with an intervention to "follow feeding profile/care plan," initiated on 3/15/24. Resident #50's dining profile, last updated on 5/22/24 states that s/he is on aspiration precautions and requires constant supervision while s/he is eating. Other descriptions of his/her current status include full

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set up of meals, cut up food, alternate liquids and solids, and "full supervision and support will need feeding assistance on occasion if Parkinson's [movement disorder] meds [medications] are not timed correctly."

Per interview on 8/25/24 at 6:25 PM, Resident #50's Representative explained that Resident #50 is not getting help with eating a lot of the time and s/he has a hard time feeding his/herself, especially if his/her Parkinson's meds have worn off. S/He has observed staff leave food in front of Resident #50 and walk away, sometimes they will even leave him/her in bed to eat by his/herself.

Per observation on 8/26/24 at 5:11 PM, Resident #50 is in his/her room with food on the bedside table. There are no staff helping him/her eat and not staff are around in the hall. Resident #50 is trying to eat but appears to be having a very difficult time getting food to his/her mouth.

Per observation on 8/28/24 at 12:00 PM, Resident #50 was sitting in the dining area with lunch in front of him/her. Resident #50 is not assisted with eating for at least 26 minutes until 12:26 PM when an LNA went over to his/her table to help him/her.

5. Per record review, Resident #41's care plan reads "[Resident #41] has an ADL self-care performance deficit/limited mobility r/t decreased mobility, deconditioning, repeated falls, overactive bladder, cognition," revised on 3/25/24 with an intervention that "[Resident #41 will receive the needed amount of assistance to complete ADL tasks. The level of assistance may vary from day to day and task to task," revised 3/25/24. Resident #41's therapy profile, last updated on

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F 677	Continued From page 19 8/20/24, states that s/he requires maximum assistance or is dependent on staff for all ADLs including bed mobility and transferring and uses a tilt in space wheelchair. Per observation on 8/25/24 at 3:38 PM, Resident #41 was sitting in the common area in his/her wheelchair, which was tilted back approximately 30 degrees. S/He was yelling out for staff to help and there were no staff in sight. S/he explained that s/he has been sitting out here for hours and wants to go back to bed but no one is helping him/her. Resident #41 called out for staff every few minutes saying things like "are you kidding? anyone?... can't wait another day to go to the bathroom. I need to go this minute ...I am pleading with you [and] I can't wait any longer." S/He is not approached by staff until 4:21 PM, 43 minutes after s/he was first observed requesting help. Per observation and interview on 8/28/24 at 2:40 PM, Resident # 41 had long fingernails with a dark brown substance underneath almost all of them. S/He said s/he would like them cut and cleaned. 6. Per record review, Resident #34's care plan reads "[Resident #34] has an ADL self-care performance deficit/limited mobility r/t deconditioning r/t hospitalization for PNA [pneumonia], spinal stenosis, OA [osteoarthritis], hx of falls, cardiac issues," revised on 7/17/24 with interventions that include "encourage [Resident #34] to use bell to call for assistance," revised on 3/17/24, and that "[Resident #34] will receive the needed amount of assistance to complete ADL tasks. The level of assistance may vary from day to day and task to task" revised	F 677		

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F 677	Continued From page 20 3/7/24. Resident #34's therapy profile, last updated on 8/21/24, reveals that s/he requires minimum 1 assist for bed mobility and requires staff assistance for transferring. Per observation and interview on 8/28/24 at 8:57 AM, Resident #34 was wearing a johnny (hospital gown) in bed. S/He explains that s/he needs to go to the bathroom but doesn't know how to get help because s/he does not have call bell in reach. The call bell is not visible. Resident #34 called out for help every few minutes saying that s/he needs help going to the bathroom. By 9:25 AM, Resident #34 is in tears and no staff have approached him/her to help. At 9:37 AM, 40 minutes since first observed yelling for help, the Unit Manager assisted Resident #34 to the bathroom. Per observation on 8/28/24 at 5:44 PM, Resident #34 was sitting on the edge of his/her bed, still in a johnny, crying out for staff for help. S/He said she needs help with the bathroom and doesn't know where his/her call bell is. The call bell is not in his/her reach; it is on the floor on the other side of his/her bed. 7. Per record review, Resident #76's care plan reads "[Resident #76] has an ADL self-care performance deficit/limited mobility r/t Macular Degeneration [eye disease that causes vision loss], and anxiety," revised on 2/13/24 with an intervention that "[Resident #76] will receive the needed amount of assistance to complete ADL tasks. The level of assistance may vary from day to day and task to task" revised 2/13/24, and "place the call light within reach of [Resident #76] and encourage to use it for assistance as needed," revised on 2/13/24. Resident #76's therapy profile, last updated on 5/29/24, reveals	F 677		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 21 that Resident #76 can ambulate with a walker and distant staff supervision. Per observation and interview on 8/29/24 at 11:39 AM, Resident #76 was sitting in his/her recliner in his/her room and explained that s/he needed help but couldn't find his/her call bell. The call bell was not in his/her reach; it was on the opposite side of his/her bed. S/He stated that s/he wants to be in the common area for lunch but no one has come to ask him/her if s/he wants to go and s/he needs help to get to there. Resident #76 was not seen in the dining room during any part of lunch service. At 2:00 PM, Resident #76 explained that no one came to help him/her get to the lunch room before lunch was served. S/He stated that s/he still would like help getting to the common area. Resident #76 is seen in his/her doorway with his/her walker. S/He is asking loudly for a ride to the common area. At 2:09 PM, 2.5 hours after s/he first stated s/he wanted to go to the common area, a therapy staff member helped him/her get to the common area in a wheelchair. 8. Per record review, Resident #93's care plan reads "[Resident #93] has an ADL self-care performance deficit/limited mobility r/t weakness, deconditioning, limited physical mobility, cognitive deficits," revised on 5/25/22 and his/her dining profile, last updated on 2/23/24 states that s/he is to have his/her head of bed elevated while eating. Per observation on 8/28/29 at 5:38 PM, Resident #93 was observed trying to eat his/her dinner while laying in bed with the head of the bed completely flat. The curtains were separating the room in half and Resident #93 was unable to be seen by any staff in the hall.	F 677		

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	475003	A. BUILDING _____ B. WING _____	09/03/2024

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F 677	Continued From page 22	F 677		

9. Per record review, Resident #282's care plan reads "[Resident #282] has an ADL self-care performance deficit/limited mobility r/t Parkinson's disease, Progressive functional and cognitive decline," revised on 5/9/24 with an intervention that "[Resident #282] will receive the needed amount of assistance to complete ADL tasks. The level of assistance may vary from day to day and task to task" revised 5/9/24.

Per observation and interview on 8/28/24 at 3:01 PM, Resident #282 had overgrown nails that had a dark brown substance under each nail. Resident #282 stated that s/he would really like them cut.

10. Per record review, Resident #67's care plan reads "[Resident #67] has an ADL self-care performance deficit r/t dementia, fluid volume excess, use of adaptive equipment, weakness," revised on 5/26/20, with an intervention for "nursing staff will provide any level of assistance that is required to complete care tasks r/t day to day r/t disease process and level of participation."

Per observation and interview on 8/28/24 at 5:04 PM Resident #67 had long, overgrown nails. S/He said s/he would like his/her nails cut.

11. Per record review, Resident #9 was admitted to the facility on 3/13/2023 with diagnoses of Alzheimer's with late onset and dementia with agitation.

Per observation on 8/25/2024 at approximately 3:00 PM, Resident #9 was observed lying in bed with the door closed, the room was dark. The resident was crying and occasionally calling out. During the next few hours, the staff did not enter the resident's room until approximately 5:10 PM,

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F 677	Continued From page 23 when dinner arrived. On 8/26/2024, at approximately 9:15 AM, Resident # 9 was observed in the main dining room sitting by self at a table with breakfast food on her/his face. The resident continued to sit alone for the next two hours without staff interaction. At approximately 11:15 AM, Resident #9 was observed making repetitive noises, and another resident was patting his/her arm; no intervention from staff was observed, though staff were in the room. Per record review, a care plan entry dated 5/23/2023, "[Resident] has an ADL(Activities of daily living) self-care performance deficit/limited mobility r/t (related to) weakness, confusion sx (symptoms) dementia," with an intervention "encourage [resident] to participate to the fullest extent possible with each interaction". There are no resident-specific interventions. Per interview with the Unit Manager on 8/28/2023 at approximately 2:20 PM, s/he confirmed that the care plan was not person-centered regarding ADLs.	F 677	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 679 The facility provides engaging activities for resident #78 in and OOB. The facility provides an opportunity for residents who reside in unit B to go outside, and activities are provided on the weekend for our residents. A FWA was conducted to ensure the activity calendar is set up activities daily. Observations are conducted 3 times a week to validate that the scheduled activities are being held. A FWA has been completed to ensure those residents who chose to not join group activities have independent activities to engage in when in their room.	10/2/24
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence	F 679	The Administrator has provided education to the AD on Activities needing to meet the interest of the resident and the needs for each resident. The Administrator is responsible for over-seeing this process. The Administrator and AD will meet weekly to review activity calendar for the week to adjust staffing or an activity ensuring activities are held and that those who prefer not to join a group activity have options for more independent activities if they chose to remain in their room.	

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F 679	Continued From page 24 and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide engaging activities both in and out of resident rooms for 1 of 40 sampled residents (Resident #78); failed to provide an ongoing activities program to support residents in their choice of group, individual, and independent activities to meet the interests of and support the well-being of each resident as evidenced by a lack of opportunities for residents to go outside of 1 of 3 units (Unit B); and failed to provide weekend activities for all interested residents. Findings include: 1. Per observation and interview on 8/29/24 at 3:05 PM, Resident #78 was in his/her bed staring ahead with no stimulation. S/He stated that s/he is interested in having more independent activities to do and more 1 on 1 activities. When asked about what type of activities s/he is interested in, s/he stated that s/he enjoys music and s/he has discussed his/her interest of audio books with staff but does not have them and is still interested. S/He explained that s/he does refuse activities sometimes but does like to go to things like music, and s/he doesn't always get asked to attend because s/he says no to going sometimes. Per observation, Resident #78 was not observed to be participating in any independent activities during 8/25/24 through 8/29/24. Per record review, Resident #78's care plan read, "[Resident #78] is at risk/experiencing psychosocial distress related to current placement and change in functional status; hx	F 679	The results of these audits will be reviewed and brought to QAPI meeting for further review and recommendations ensuring substantial compliance is achieved. **Tag F 679 POC accepted on 10/21/24 by C. Howard/P. Cota**	

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[history] of suicidal attempt in 2022 and verbalized "thoughts [s/he] would be better off dead," revised 8/3/23 with an intervention to "Break cycle of inactivity. Establish a list of activity events that [Resident #78] enjoys to help re-establish self-worth. Encourage participation." There are no interventions in Resident #50's care plan that are specific to his/her enjoying music. Resident #78's care plan also reads, "[Resident #78] prefers bed rest with little activity interest," initiated on 7/1/24, with a goal that s/he "will express satisfaction with independent activity such as reading or audio books," and an intervention that "[Resident #78] has been offered large print books and audio books. This is something [s/he] expressed interest in. [S/He] has refused or has not made use of these requests regularly. [S/He] often prefers naps," initiated on 7/1/24. There are no interventions in Resident #78's care plan about to continuing to offer audio or large print books, or anything else that s/he might have interest in.

Per interview on 8/29/24 at 2:25 PM, the Activities Director explained that Resident #78 often declines participation in activities but sometimes does show interest. When asked about the care plan intervention "Break cycle of inactivity. Establish a list of activity events that [Resident #78] enjoys to help re-establish self-worth. Encourage participation," s/he explained that s/he was unaware of the care plan intervention. S/He explained that the activities department does not track when residents refuse participation in activities or if residents are participating in independent activities. S/He explained that there is no list of activities that Resident #78 likes to participate that s/he is aware or a way to track if staff are encouraging the resident to participate in

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F 679	Continued From page 26 activities that interest him/her or a way to measure the effectiveness of this intervention, including offering both large print and audio books to the resident. 2. Multiple residents on Unit B expressed interest in spending time outdoors. Observations, interviews, and record review revealed that this interest was not supported by the facility. a. Per record review, Resident #50's Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) Preferences for Routine and Activities assessment dated 5/14/24 reveals that it is "somewhat important" for him/her to go outside and get fresh air when the weather is good. There are no interventions in Resident #50's care plan that are specific to this preference. Per interview on 8/25/24 at 6:25 PM, Resident #50's Representative explained that Resident #50 loves to go outside and, s/he is not going outside enough and s/he is concerned about this. S/He explained that s/he had made staff aware that it is important for Resident #50 to go outside and has been told that there just isn't a place to bring residents unless they want to sit in the parking lot because s/he is not allowed to use the courtyard. The Representative stated that Resident #50 really enjoyed going outside in the past and is concerned that Resident #50 will lose interest in spending time outside because s/he is not offered and can only go out to the parking lot area with his/her visitors. b. Per record review, Resident #23's MDS Preferences for Routine and Activities assessment dated 2/2/24 reveals that it is "very	F 679		

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F 679	Continued From page 27 important" for him/her to go outside and get fresh air when the weather is good. There are no interventions in Resident #23's care plan that are specific to this preference. Per interview on 8/29/24 at 9:27 AM, Resident #23 stated that s/he goes outside with visitors if s/he can but staff usually don't have the time to go outside with him/her and s/he would really like to spend time outside. Per observation, Resident #623 was not observed to be outside at any point during 8/25/24 through 8/29/24. c. Per record review, Resident #106's MDS Preferences for Routine and Activities assessment dated 10/24/23 reveals that it is "somewhat important" for him/her to go outside and get fresh air when the weather is good. There are no interventions in Resident #106's care plan that are specific to this preference. Per interview on 8/29/24 at 12:21 PM, Resident #106 said, s/he does not get to go outside and would like to do so. Per observation, Resident #106 was not observed to be outside at any point during 8/25/24 through 8/29/24. d. Per record review, Resident #65's MDS Preferences for Routine and Activities assessment dated 7/3/24 reveals that it is It is important for him/her to spend time outdoors. There are no interventions in Resident #50's care plan that are specific to this preference. Per observation, Resident #65 was not observed	F 679		

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to be outside at any point during 8/25/24 through 8/29/24.

e. Per record review, Resident #67's MDS Preferences for Routine and Activities assessment dated 8/2/23 reveals that it is "not very important" for him/her to spend time outdoors. There are no additional MDS activities preference assessments since his/her last activities assessment over a year earlier.

Per interview on 8/29/24 at 9:25 AM, Resident #67 said s/he wants to go outside and hasn't been outside at all. S/He explained that staff sometimes say it is too cold to go out when it is scheduled and can't go outside whenever s/he wants to.

Per observation, Resident #67 was not observed to be outside at any point during 8/25/24 through 8/29/24.

f. A review of the Unit B activity program calendars for July 2024 and August 2024 reveal that there were only 3 activities that took place outside during the two months, on 7/2/24, 8/2/24, and 8/16/24.

g. Per interview on 8/29/24 at 2:25 PM, the Activities Director revealed that there is an issue in having residents on unit B to be able to have outside time. S/He explained that Unit B residents do not have an area that they can use and going outside is not user friendly when activity staff are not here and even then, there are not enough staff to take residents out when they want all the time. The Activities Director explained that s/he is not aware that many people want to go outside. When asked how preferences to go outside are

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F 679	Continued From page 29 determined, sh/e explained that it is asked for the annual MDS assessment and does not review it at any other time. 3. Per observation on 8/25/24 (Sunday), no activities took place on Unit B. A review of the Unit B activity program calendars for July 2024 and August 2024 reveal that there were no scheduled activities on Saturdays or Sundays. 4. Per observation on 8/25/2024 at 7:10 PM there were 4 residents sitting in the dining room with no staff present. One resident stated that s/he had been waiting for staff to put a movie on since the end of dinner. On 8/26/24 at 4:43 PM the dining room on the A Unit (Special Care Unit (SCU) there were 15 residents in the dining room and 11 out by the nurses station. There were no activities and no staff present. At 8/26/24 at 4:59 PM 9 residents were observed sitting in recliners with tray tables in front of them for the evening meal. There were no staff present and no activities or other stimulation. Per review of the SCU activity calendar for 7/29/24 through 8/30/24 there were no scheduled activities on Saturdays or Sundays. Per review of the August SCU activities participation logs there was no participation documented on 8/4, 8/11, 8/18, and 8/25. Per interview on 8/29/24 at approximately 3:00	F 679		

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F 679	Continued From page 30 PM the Activities Director (AD) stated that the activity department has been short staffed since March. When fully staffed the facility offers activities 9:30 AM - 6:00 PM seven days per week. There are currently three activities staff members which makes it difficult to keep the structure of the activities program. The AD confirmed that there were limited activities throughout the facility and there were no activities scheduled on Sundays. Per interview on 8/29/24 at 4:45 PM the SCU Unit Manager (UM) stated that the unit is activities based and s/he does not think there were activities on 8/25/2024. When there are no activities nursing staff try to give the residents activities to do. There is not someone stationed in the dinning room with them all the time, but staff try to do frequent checks.	F 679	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F689 The facility water temps are less than 120 degrees in the bathroom sinks on the units.	10/2/24
F 689 SS=F	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that resident environments were free of accident hazards related to providing safe water temperatures of less than 120 degrees Fahrenheit (F). Findings include:	F 689	A FWA was completed ensuring the bathrooms sinks in the resident rooms did not have temps greater than 120 degrees. The Administrator provided education to the Maintenance Director on the policy Safe Water Temperatures. The Maintenance Director or Designee will continue to check temps weekly and these results will be reviewed with the Administrator weekly. If a temp is greater than 120 degrees, the Administrator will be made aware at that time. The results of these audits will be reviewed and brought to QAPI meeting for further review and recommendations ensuring substantial compliance is achieved.	

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F 689	Continued From page 31 1. Per observation on the Special Care Unit ((SCU) a unit that Residents with diagnoses of dementia or other cognitive impairments reside) on 8/25/24 at 4:30 PM, the hot water was assessed from a faucet in the bathroom of room #124. The water was too hot to hold a hand under. Using a thermometer calibrated at 32.2 degrees F, the temperature of the water was 125.8 degrees F. The bathroom sink in room #102 was then checked and the temperature was 127.3. Five minutes later at 4:45 PM, the sink in the bathroom of room #102 was found to be 124 degrees F. The sample was then expanded to include other resident bathroom sinks throughout all three units. The following water temperatures were discovered: B Unit Resident bathroom sinks #215 - 124 degrees F # 221- 124.3 degrees F #207 - 127.02 degrees F C Unit Resident bathroom sinks #319 - 121.2 degrees F #324 - 122.4 degrees F #308 - 123 degrees F #305 - 122 degrees F During an interview on 8/25/24 at approximately 5:45 PM the facility Administrator was asked to feel the water coming from the faucet in the bathroom of room #207. S/he placed her/his hand under the water, removed it, and agreed that the water did feel hot. The temperature at this time read 127.2. Facility policy titled "Safe Water Temperatures," last revised on 2/2024 reads "Water temperatures	F 689	**Tag F 689 POC accepted on 10/21/24 by C. Howard/P. Cota**	

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F 689	Continued From page 32 will be set to a temperature of no more than 120 [degrees] F or the state allowable maximum water temperature." At approximately 6:05 PM the Environmental Services Director (ESD) arrived, and along with the facility Administrator and two Surveyors began checking water temperatures. Using the facility thermometer, the bathroom sinks water temperatures in rooms #308, #207, #102, and #124 were all under 120 degrees F. In room #102 the Surveyor's thermometer read 121 degrees F, and in room #308 it read 120.4 degrees F. Per interview on 8/25/24 at 6:15 PM the ESD stated that s/he checks the water temperatures weekly in random resident bathrooms. If water temperatures are found to be high s/he will adjust the mixing valve. The ESD stated that s/he calibrates her/his thermometer weekly. On 8/29/24 at 7:15 PM the water temperature in the bathroom of Room #104 checked by two Surveyors using a thermometer that had been checked for accuracy per manufacturer instructions read 124.3 degrees F. Per the facility matrix printed on 8/26/25, 75 of the 130 residents in the facility are identified as having dementia or Alzheimer's. Cognitive impairment can put residents at increased risk for burns caused by scalding.	F 689		
F 699 SS=E	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are	F 699		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 699	Continued From page 33 trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to ensure that residents who are trauma survivors receive trauma-informed care that mitigates triggers that may re-traumatize residents for two of 5 residents sampled for trauma (Residents # 91, #18). Findings include 1. Per record review, Resident # 92 was admitted on 11/19/2021 with a diagnosis of PTSD (Post Traumatic Stress Disorder) and Dementia. A Psychosocial Quarterly Evaluation with a date of 7/12/2023 indicates a diagnosis of PTSD, with supporting trauma documentation obtained from the resident's family. Per review of Resident # 92's record, no evidence was found that Resident # 92 was assessed for triggers that may re-traumatize the Resident. No evidence was found in Resident #92's plan of care regarding the Resident's triggers or how staff can provide care that avoids re-traumatizing the resident. Additionally, there is evidence of only three quarterly assessments in the resident's medical record. Per interview with an LNA on 8/28/2024 at approximately 2:15 PM, s/he stated s/he was unaware of Resident #92's diagnosis of PTSD or of any identified triggers. Per interview on 8/29/2024 at approximately 11:10 AM, the Medical Social Worker stated the Psychosocial Assessments should be done quarterly, but the Social Service Department was	F 699	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F699 Residents # 91 and #18 are receiving trauma-informed care support to mitigate triggers that may re-traumatize these residents, and their care plans have been updated to reflect the triggers, goals and interventions to prevent this from happening. A FWA has been completed identifying other residents that are trauma survivors and ensuring clinical assessments and care plans are completed and that they are receiving trauma-informed- care support to mitigate triggers that may re-traumatize these residents. The SDC has provided education to the clinical staff on our Trauma Informed Care Policy ensuring support is provided to our residents to mitigate triggers that may retraumatize these residents through their clinical assessments and a that the care plan is to be reflective of what these triggers if known, goals and interventions might be. The DON is responsible for overseeing this process. Through the completion of the clinical assessments on a quarterly and as needed basis and through psych consults those residents identified to be trauma	10/2/24

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F 699	Continued From page 34 not up to date completing the assessments. Additionally, s/he indicated, "I do not push residents or family members to identify their triggers." S/he stated there should be a specific Trauma care plan included in Resident # 92's plan of care. Per interview with the Unit Manager on 8/29/2024 at approximately 3:00 PM, s/he confirmed that Resident # 91's care plan should contain information to assist staff in providing care that avoids re-traumatizing the resident. S/he was not aware that the Psychosocial assessments were not being done. 2. Per observation on 8/27/2024 at approx. 11:00 AM Resident #18 was sitting alone in the dining/activity area weeping, asking for help several times. During the observation the License Nursing Assistant (LNA) arrived to assist Resident #18. The LNA did not explain to Resident #18 what s/he was doing and pulled the wheelchair backwards. Resident #18 stated "who's there, what are you doing." Resident #18 was observed again later that afternoon sitting alone in the activity area asking for help several times, no staff were with resident at time of observation. On 8/28/2024 approx. 8:39 AM Resident #18 was sitting in the dining/activity area asking for help, with a gait belt around his/her waist. Resident # 18 is shivering stating s/he is cold, asking for his/her daughter. Per record review Resident #18 was admitted to the facility on 8/15/2024 with a history of failure to thrive and post tramatic stress disorder. Resident #18 had a completed psychosocial assessment on 8/16/2024 which revealed a history of	F 699	survivors will receive support to mitigate triggers that may retraumatize these residents and the triggers if known goals and interventions will be reflected in the care plan. The results of these audits will be reviewed and brought to QAPI meeting for further review and recommendations ensuring substantial compliance is achieved. **Tag F 699 POC accepted on 10/21/24 by C. Howard/P. Cota**	

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F 699	Continued From page 35 post-traumatic stress disorder (PTSD) related to abuse history. There is no evidence that a care plan was initiated related to history of post traumatic stress disorder, there are no identifiable triggers to alert staff on the care plan to care for the resident with PTSD. Per interview with the director of social services on 8/28/2024 at 12:30 PM, stated once PTSD is identified a special care plan is developed for the resident and should address trauma and triggers that may be associated to the past events. SW stated the triggers are important on the care plan so that staff know how to care for the resident. SW confirmed during interview that there was no active care plan for Resident #18 who has a confirmed history of PTSD.	F 699	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	F 725	F725 Resident #79 is receiving her pain medication timely and as ordered. Resident #13, #45, #50, #20 are receiving their medications within the timeframe allowed related to the time ordered for. Resident #34, #41, and #76 has their call bell within reach and can reach the staff for assistance with ADL's. Aspiration precautions are being maintained for resident #50 and is receiving assistance as required for her meals. Resident #65 is receiving the supervision required for eating. A FWA has been completed ensuring that residents requests are being addressed timely, call bells are within reach and are answered timely, required amount of supervision is being provided during mealtimes and between activities and mealtimes, medication pass is completed within the allowed time frame related to time ordered. The SDC or Designee has provided education to the staff ensuring they are placing call bells within place and that we respond to the call light timely and provide the service needed, providing the amount of supervision for meals that the residents require, maintaining aspiration precautions as ordered and administering	10/2/24

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F 725	Continued From page 36 (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, interview, 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 services to attain the highest practicable well-being for each resident and in accordance with each resident's plan of care, potentially impacting all residents of the facility. Per review of the Facility Assessment dated 6/10/24, the percentage of residents that require a one or two person assist for activities of daily living (ADL) is 49% for transferring, 11% for eating, and 45% for toileting and residents that are completely dependent on staff assistance for ADLs is 25% for transferring, 15% for eating, and 25% for toileting. The facility determined the staffing needs to meet the care requirements of the resident population is based on meeting or exceeding the minimum PPD requirements. 1. Per interview and observation on 8/28/24 at 5:13 PM, Resident #79 was yelling from his/her room for help. His/Her call light is on. S/He explained that s/he had pushed his/her call light 30 minutes ago and needs pain medications as s/he is in 8 out of 10 pain. At 5:18 PM, a Licensed Nursing Assistant (LNA) went into Resident #79's	F 725	medications within the allowed timeframe related to the time the medication was ordered. The DON is responsible for overseeing this process. Through 3 observations a week validation of timeliness of medication administration, call bells will be within reach (may se handbells if not near a wall mounted call light), enough assistance with provided for meal supervision, and other ADLs that need to be met. The results of these audits will be reviewed and brought to QAPI meeting for further review and recommendations ensuring substantial compliance is achieved. **Tag F 725 POC accepted on 10/21/24 by C. Howard/P. Cota**	

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F 725	Continued From page 37 room, turned off the call light and then left the room saying s/he would let a nurse know. At 5:45, 32 minutes after Resident #79 was first observed yelling out for help, a Licensed Practical Nurse (LPN) went to the room with medications saying that s/he was too busy to come sooner because s/he was giving other residents their medications. 2. Per observation of medication administration on 8/29/24, 4 residents were administered medications over an hour later than prescribed. Per interview on 8/29/24 at 10:30 AM, the Registered Nurse who administered medications late for Residents #13 and #45 revealed that medications were late because the unit is big and there are a lot of medications to administer. Per interview on 8/29/24 at 7:04 PM, the Licensed Practical Nurse who administered medications late for Residents #50 and #20 explained that it is very busy on the unit and medication passes get interrupted because aides need his/her assistance since there are not enough aides staffed for the unit. 3. Per record review, Resident #34's therapy profile, last updated on 8/21/24, reveals that s/he requires minimum 1 assist for bed mobility and requires staff assistance for transferring. Per observation and interview on 8/28/24 at 8:57 AM, Resident #34 was wearing a johnny in bed. S/He explains that s/he needs to go to the bathroom but doesn't know how to get help because s/he does not have call bell in reach. The call bell is not visible. Resident #34 called out for help every few minutes saying that s/he needs help going to the bathroom. By 9:25 AM, Resident #34 was in tears and no staff had approached him/her to help. At 9:37 AM, 40 minutes since	F 725		

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F 725	Continued From page 38	F 725		

first observed yelling for help, the Unit Manager assisted Resident #34 to the bathroom.

4. Per record review, Resident #76's care plan reads "[Resident #76] has an ADL [activities of daily living] self-care performance deficit/limited mobility r/t [related to] Macular Degeneration [eye disease that causes vision loss], and anxiety," revised on 2/13/24 and therapy profile, last updated on 5/29/24, reveals that Resident #76 can ambulate with a walker and distant staff supervision.

Per observation and interview on 8/29/24 at 11:39 AM, Resident #76 was sitting in his/her recliner in his/her room and explained that s/he needed help but couldn't find his/her call bell. The call bell was not in his/her reach; it was on the opposite side of his/her bed. S/He stated that s/he wants to be in the common area for lunch but no one has come to ask him/her if s/he wants to go and s/he needs help to get to there. Resident #76 was not seen in the dining room during any part of lunch service. At 2:00 PM, Resident #76 explained that no one came to help him/her get to the lunch room before lunch was served. S/He stated that s/he still would like help getting to the common area. Resident #76 is seen in his/her doorway with his/her walker. S/He is asking loudly for a ride to the common area. At 2:09 PM, 2.5 hours after s/he first stated s/he wanted to go to the common area, a therapy staff member helped him/her get to the common area in a wheelchair.

5. Per record review, Resident #50's dining profile, last updated on 5/22/24 states that s/he is on aspiration precautions and requires constant supervision while s/he is eating. Other descriptions of his/her current status include full

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F 725	Continued From page 39 set up of meals, cut up food, alternate liquids and solids, and "full supervision and support will need feeding assistance on occasion if Parkinson's [movement disorder] meds [medications] are not timed correctly." Per interview on 8/25/24 at 6:25 PM, Resident #50's Representative explained that Resident #50 is not getting help with eating a lot of the time and s/he has a hard time feeding his/herself, especially if his/her Parkinson's meds have worn off. S/He has observed staff leave food in front of Resident #50 and walk away. Sometimes they will even leave him/her in bed to eat by his/herself. Per observation on 8/28/24 at 12:00 PM, Resident #50 was sitting in the dining area with lunch in front of him/her. Resident #50 is not assisted with eating for at least 26 minutes until 12:26 PM when an LNA went over to his/her table to help him/her. 6. Per record review, Resident #41's therapy profile, last updated on 8/20/24, states that s/he requires maximum assistance or is dependent on staff for all ADLs including bed mobility and transferring and uses a tilt in space wheelchair. Per observation on 8/25/24 at 3:38 PM, Resident #41 was sitting in the common area in his/her wheelchair, which was tilted back approximately 30 degrees. S/He was yelling out for staff to help and there are no staff in sight. S/he explained that s/he has been sitting out here for hours and wants to go back to bed but no one is helping her. Resident #41 calls out for staff every few minutes saying things like "are you kidding? anyone?... can't wait another day to go to the bathroom. I need to go this minute ...I am pleading with you	F 725		

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F 725	Continued From page 40 [and] I can't wait any longer." S/He is not approached by staff until 4:21 PM, 43 minutes after s/he was first observed requesting help. 7. Per record review, Resident #65's dining profile, last updated on 11/17/21, states that s/he needs constant supervision and verbal cues/prompting while eating. Per observation on 8/25/24 at 5:46 PM, Resident #65 was in the dining room with his/her food in front of him/her. S/He appeared to be asleep in his/her wheelchair. It wasn't until 6:02 PM, that an LNA went over to Resident #65, put a piece of dinner on the fork and handed it to him/her. Per observation on 8/28/24 at 12:00 PM, Resident #65 was sitting in the dining area with lunch in front of him/her. Resident #65 did not receive any assistance or cueing for at least 25 minutes until a LNA approached him/her at 12:25 PM saying take a bite.	F 725	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F759 Residents #50, #20, #13, and #45 are receiving their medications timely. Medication error reports were completed for these residents who received medications outside the allowed time to have medications administered based on time ordered. FWA was completed through observations of medications being administered compared to the time ordered to ensure medications are being administered timely.	10/2/24
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure medication error rates were not 5% or greater. The total error rate for all observations was calculated at 72% for 4 of 10 sampled residents (Residents #50, #20, #13, and #45). Findings include:	F 759	The SDC or Designee has provided education to the licensed nursing staff that medications are to be administered as ordered using 1 hour before and 1 hour after as a window of which they need to be aware of. If medications for any reason are not given within the time frame allowed, then the next step is to notify the physician and determine what the next steps are. The DON is responsible for overseeing this process. Through 3 observations a week by the SDC or designee validation of timely administration of medications will be completed.	

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F 759	Continued From page 41 1. Medication administration was observed on 8/29/24 between 10:15 AM and 10:30 AM for Resident #13 and Resident #45. The Registered Nurse (RN) administered Resident #13's medication which included Tylenol 650mg, Asprin81mg, Vit D 2000U 2 tabs, Apixaban 5mg (used to prevent blood clots), Gabapentin 300 mg (used to treat nerve pain), Multi Vitamin with minerals, and Oxycodone 7.5mg (used to treat pain), Per review of Resident #13's physician orders, these medications were ordered to be administered at 8:00 AM. The RN then administered Resident # 45's medications which included Allopurinol 300mg (used to treat or prevent gout), Amlodipine 5mg (used to treat (used to treat high blood pressure), Zoloft 150mg (used to treat depression), Hydrochlorothiazide 12.5 mg (used to treat high blood pressure and fluid retention), and Metformin 500 mg (used to treat diabetes). Per review of Resident #45's physician orders, these medications were ordered to be administrated at 8:00 AM. Per interview with the RN at 10:30 AM, the unit is very big and there are a lot of medications to administer. The RN confirmed that the above medications were administered over an hour late. 2. Medication administration was observed on 8/29/24 at 6:28 PM for Resident #50. The Licensed Practical Nurse (LPN) administered 1.5 tablets of Carbidopa-Levodopa Oral Tablet 25-100 MG (used to treat symptoms of Parkinson's disease) and 0.5 tablets of Entacapone Oral Tablet 200 MG (used to treat symptoms of Parkinson's disease). Per review of	F 759	The results of these audits will be reviewed and brought to QAPI meeting for further review and recommendations ensuring substantial compliance is achieved. **Tag F 759 POC accepted on 10/21/24 by C. Howard/P. Cota**	

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F 759	Continued From page 42 Resident #50's physician orders, these two medications were ordered to be administered at 5:00 PM. At 6:52 PM the LPN administered 4 ounces of Ensure and 2 drops of Artificial Tears Ophthalmic Solution 1 % in both eyes to Residenti #20. Per review of Resident #20's physician orders, these two medications were ordered to be administered at 5:00 PM. Per interview at 7:04 PM, the LPN confirmed that the above medications were administered over an hour late. S/He explained that it is very busy on the unit and medication passes get interrupted because aides need his/her assistance since there are not enough aides staffed for the unit.	F 759	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F761	10/2/24
F 761 SS=B	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761	Expired medications and covid tests have been removed from storage areas and destroyed. A FWA was completed to ensure there were no expired medications or covid tests in medication storage areas. The SDC or Designee has provided education to the licensed nursing staff on the Medication Storage Policy. The DON is responsible for overseeing this process. Through weekly auditing of the medication storage areas there will be validation of no expired medications or covid tests. The results of these audits will be reviewed and brought to QAPI meeting for further review and recommendations ensuring substantial compliance is achieved.	

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F 761	Continued From page 43 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: Per observation and staff interview the facility failed to ensure that medications and biologicals were removed from use when expired. Findings include: On 8/29/2024 at 9:33 AM during review of the A-Wing medication storage room there was a vial of glucose control solution with the expiration date of 8/3/24 that was labeled as opened on 7/9/24. There was also 1 opened BinaxNow COVID test with an expiration date of 1/7/2024, and 2 with the expiration dates of 2/14/2024. At this time the Unit Manager confirmed that the control solution and the COVID tests present in the medication room where expired. On 8/29/2024 at 10:42 AM during review of the facility medication storage room on B-Wing it was noted that there was a Diabetic Hypoglycemic Emergency Kit hanging on a hook for staff to utilize in the event of a diabetic hypoglycemic emergency. Inside the kit was a tube of Glucagon 1mg Emergency Injection Kit, Glucose Gel 40%. with an expiration date of 6/2024. Per interview on 8/29/24 at 10:15 AM the Registered Nurse (RN) on the Unit confirmed that the Glucagon in the Diabetic Hyperglycemic Kit was expired. The RN stated that it is all nurses responsibility to check for expired medications.	F 761	**Tag F 761 POC accepted on 10/21/24 by C. Howard/P. Cota**	

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F 880 F 880 SS=L	Continued From page 44 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880 F 880	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F880 The facility has an Infection Prevention and Control Program implemented that follows the accepted national standards regarding preventing identifying, controlling communicable diseases. The facility has implemented the state health department recommendations for outbreak management related to testing and other containment and personal protective equipment use. Staff are observed to be appropriately donning PPE when near resident including when providing direct care. COVID-19 Policies reflect CDC guidelines for managing COVID-19 outbreak. Staff is providing isolation, distancing, cohorting, and additional source control measures to limit spread of COVID-19 to other residents. Facility Leadership, including the Administrator, Director of Nursing, Infection Preventionist, and Medical Director received training in current nationally accepted standards of infection prevention and control recommendations related to COVID-19.	10/2/24

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F 880	Continued From page 45 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to implement an infection prevention and control program that follows the accepted national standards regarding preventing, identifying and controlling communicable diseases. Specifically, the facility failed to follow the CDC (Centers of Disease Control) and state health department recommendations for outbreak management,	F 880	The SDC/IP or Designee has provided education to all staff on the facilities infection control policies for managing COVID-19. The facility follows the COVID-19 infection control polices related to following CDC and health department guidance for outbreak management related to testing and other mitigation strategies; and utilizes proper PPE, current recommendations for discontinuing PPE and mitigation strategies for a COVID positive resident, to prevent the spread of infection. Route cause analysis conducted and results will be incorporated into the intervention plan. The Administrator is responsible for over-seeing this process. Observations will be done validating that staff are implementing isolation precautions when required, appropriate PPE is being worn during care, that staff is following appropriate discontinuation strategies of precautions, and that mitigating risk is being accomplished by implementing source control measures that are recommended. The results of the observations will be reviewed weekly by the IP, DNS and or the Administrator and then brought to the QAPI Committee for further review and recommendations to ensure substantial compliance is achieved.	

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F 880	Continued From page 46 related to testing and other mitigation strategies including containment and personal protective equipment (PPE) use. The deficient practices associated with the lack of infection control measures led to the determination that the residents in the facility were in immediate jeopardy of serious harm and/or death. At the time that the facility was notified of the immediate jeopardy on 8/27/2024 at 11:44 AM, 42 residents had tested positive for COVID-19 since the beginning of the facility outbreak that began on 7/13/2024. One resident (Resident #9) was positive for COVID-19 at the time of survey entrance, who resides on Unit A, which is the designated Special Care Unit for dementia. That resident was symptomatic and tested positive on 8/20/24. Per the facility assessment, there are seven residents who are immunocompromised, which increases the risk of infection and complications of COVID-19. Per the facility's vaccine and line list, there are eighteen (18) residents on the special care unit (SCU) that are not up to date with their COVID-19 immunizations, nineteen (19) on Unit B, and twenty-four 24 on Unit C, due to refusals, eligibility timelines, and/or being overdue. Per observation during the survey, staff on Units B and C were not consistently wearing facemasks. Findings include: 1. The current facility outbreak began on 7/13/24, transmission to other residents within the facility and between units occurred in the following days and weeks, and the outbreak was ongoing at the time of survey, commencing on 8/25/24. During	F 880	**Tag F 880 POC accepted on 10/21/24 by C. Howard/P. Cota**	

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F 880	Continued From page 47 the outbreak, the facility failed to follow CDC and Vermont Department of Health (VDH) recommendations to identify infections and limit spread, when continued targeted testing revealed additional infections and spread between units. Per current CDC recommendations titled "Infection Control Guidance: SARS-CoV-2": "If an expanded testing approach is taken and testing identifies additional infections, testing should be expanded more broadly. If possible, testing should be repeated every 3-7 days until no new cases are identified for at least 14 days." Also, CDC states "Healthcare facilities responding to SARS-CoV-2 transmission within the facility should always notify and follow the recommendations of public health authorities." Nursing home specific recommendations continue, and include: "Perform testing for all residents and HCP [Health Care Personnel] identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days."	F 880		

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F 880	Continued From page 48 Per the facility policy "COVID-19 Prevention, Response and Reporting" last revised 01/2024 it states "The facility will perform viral testing for SARS-Cov-2 [COVID-19] as per the national standard such as CDC recommendations." During an interview on 8/26/2024 at 11:54 AM the Infection Control Nurse (ICN) stated the facility did not test all residents for COVID-19 throughout the outbreak beginning on 7/13/2024. S/he stated residents were being tested based on symptoms and close contact with positive residents. The infection control nurse stated there was no process in place to monitor close contact or resident's symptoms except for staff observation. S/he also stated that there were several residents that were unable to adhere to precautions due to dementia, which made it difficult to contain the outbreak. The ICN stated the outbreak started on unit B, on 7/13/2024 then spread to SCU on 7/23/2024. Despite the uncontrolled spread, a broad based testing approach was not implemented. The ICN stated s/he contacted the Vermont Health Department on 7/15/2024 and received current CDC recommendations. Per interview with the Vermont Department of Health (VDH) Epidemiologist on 8/26/2024 at 1:47 PM, the following recommendations and CDC guidelines were provided to the facility on 7/15/2024 based on a determination that they were in "outbreak status." -Identify any close contacts for the positive residents (Close contact: Being within 6 feet for a cumulative total of 15 minutes). - Recommend testing those individuals on days 1, 3 and 5 following the last contact date.	F 880		

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F 880	Continued From page 49 - Concerned about more widespread contact, you could test the impacted unit every 2-3 days until you reach 14 days with no new positives. - Masking in the facility seeing as you are currently in outbreak status -Improve indoor air ventilation -Cohorting individuals during dining and activities -Having activity outside/distancing individuals as best you can -Universal masing for both staff and residents until you reach 14 days with no positives - If the residents are not able to wear the mask the staff when working with the residents should have a N95. Per further interview with the Epidemiologist on 8/26/2024 at 1:47 PM, s/he stated that the facility ICN did not contact VDH after 7/26/2024 for guidance. The Epidemiologist stated that s/he reached back out to the facility on 8/14/2024 to obtain an update on the outbreak. S/he stated that s/he was unsure if the facility understood the guidance based on the facility's lack of communication to VDH even though the facility continued to have several positives on multiple units, indicating uncontrolled spread. A bulletin board located in the main entrance of the facility had a sign posted stating that all staff must be out of work for five days if they test positive for COVID-19. Staff may return to work after five days if their symptoms have improved and they have been afebrile for 48 hours with no medication. Per interview on 8/26/2024 at 3:53 PM, the facility Administrator confirmed that broad based testing was not performed on staff to identify and isolate all positive staff to prevent further spread to residents.	F 880		

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On 8/27/24, after the facility was notified of the Immediate Jeopardy, broad based testing of residents was completed, which identified 2 more COVID-19 positive residents on Unit B.

2. On 8/26/2024 at 8:20 AM, in the Special Care Unit (SCU) two LNAs (Licensed Nursing Assistants) were observed entering Resident #9's room with a mechanical lift machine to assist the resident out of bed. Both LNAs were wearing only a surgical mask. Per the sign on Resident #9's door s/he was on airborne precautions. Per the sign, all staff that enter require PPE when entering the room. The two LNA's were then observed exiting the room with Resident #9 and brought him/her into the dinning/activity area. At approximately 9:30 AM, Resident #9 was observed at a table seated directly across from another resident, and neither resident was wearing mask. On 8/26/2024 at 11:15 AM Resident #9 was observed seated in his/her wheelchair, in the dining room, actively coughing without a mask. Several residents were in the same dining room during the observation, and many of them coughing. There was no evidence of staff monitoring the residents or attempting to assist with social distancing.

Per the facility policy "COVID-19 Prevention, Response and Reporting" last revised 01/2024 "HCP [Health care personnel] who enter the room of a patient/resident with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection."

Per CDC recommendations titled "Infection Control Guidance: SARS-CoV-2" regarding

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nursing home residents with an active COVID-19 infection: "Patient Placement - Limit transport and movement of the patient outside of the room to medically essential purposes" and "In general, patients should continue to wear source control until symptoms resolve or, for those who never developed symptoms, until they meet the criteria to end isolation".

Per record review, Resident #9 had symptoms that included a non-productive cough and nasal drainage and, per a Nurse's note dated on 8/20/2024, a rapid COVID-19 test was done and the resident was positive for COVID-19 on that date. A Nurse's note dated on 8/20/2024 states "resident resting in the day room [activity/dining room]".

Per observation on 8/27/2024 at 8:30 AM, the isolation equipment had been removed from Resident #9's door. The LNA leaving Resident #9's room at that time was wearing only a surgical mask for PPE. The LNA then transported Resident #9 into his or her wheelchair and brought them to the dining room, without the resident wearing a mask.

During an interview on 8/27/2024 at approximately 9:40 AM the SCU Unit Manager (UM) confirmed that the unit does not offer a mask to the residents on the dementia unit. S/he stated due to a diagnosis of dementia residents may not understand or know what to do with the mask. S/he further stated the facility only tests a COVID-19-positive resident once before discontinuing transmission based precautions (TBP). During interview the UM also stated precautions are managed differently for residents with dementia. The UM stated that the resident

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may not be placed on precautions for COVID-19 if the staff believes the resident's dementia or anxiety prevents the isolation. The Unit Manager confirmed during the interview that s/he was not aware of the health department's mitigation recommendations.

Per the same CDC recommendations noted above, if using a test based strategy to discontinue TBP, two consecutive tests must be utilized.
"Patients who are not symptomatic:
- Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.
Patients who are symptomatic:
- Resolution of fever without the use of fever-reducing medications and
- Symptoms (e.g., cough, shortness of breath) have improved, and
- Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT."

During an interview on 8/26/2024 at 11:54 AM the Infection Control Nurse (ICN) confirmed that the facility was not following the current CDC guidance related to ending transmission based precautions for symptomatic residents.

Per interview with the Medical Director on 8/27/2024 at approximately 2:30 PM, s/he explained that residents who tested positive for COVID-19 are isolated in their room for five days. S/He stated if the resident is on the SCU, the nursing staff adjusts isolation/PPE according to the resident's needs. S/he further stated TBP

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precaution use for the special care unit is at the discretion of the nurse, and there is no policy or written guidance. The Medical Director stated it is the current practice of the facility to complete one follow up COVID-19 test before discontinuing TBP precautions and the facility does not have enough staff to utilize dedicated staffing for the affected unit to prevent cross-contamination of the units. As a result, s/he stated staff are scheduled where they are needed. The Medical Director confirmed that the facility was ending transmission-based precautions after one negative antigen test at day seven, versus the CDC recommendations for test-based removal of TBP after two negative antigen tests within 48 hours.

During an interview, on 8/28/2024 at 2:20 PM, the LNA assigned to Resident #9?s roommate stated that s/he works as needed and on all units at the facility. The LNA stated that another LNA is assigned to the COVID positive Resident #9. Since the roommate was no longer positive for COVID-19, it was their understanding that staff do not need to wear full PPE when caring for the roommate of the positive resident.

Per interview on 8/28/2024 at approximately 2:40 PM, a travel License Practice Nurse (LPN) working on unit B stated that s/he has been in the facility for several months. S/he has been assigned to all the units in the building, including the SCU several times during the COVID-19 outbreak.

Per interview and observation on 8/28/2024 at 4:00 PM of the LPN on duty providing care to residents on unit C, s/he stated that s/he is a travel nurse and floats to all units. The LPN

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F 880	Continued From page 54 stated that s/he worked in the SCU the prior week during active COVID cases. The LPN was observed providing care to residents and administering medications on unit C without a mask. During the interview the LPN stated s/he was tested for COVID-19 by the facility earlier in the day but did not know his/her results prior to starting his/her shift. The policy also states that source control includes appropriate PPE when working with an individual positive for COVID-19 which includes a proper fitting N-95 mask. Per the policy, source control is recommended when an individual has had close contact with a person positive for COVID-19 and should be used for 10 days after exposure. Source: https://www.cdc.gov/covid/hcp/infection-control/?CDC_AAref_Val=https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html	F 880		