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

February 24, 2021

Mr. Ross Farnsworth
Burlington Health & Rehab
300 Pearl Street
Burlington, VT 05401-8531

Dear Mr. Farnsworth:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 3, 2021**. Please post this document in a prominent place in your facility.

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

Sincerely,

Pamela M. Cota, RN
Licensing Chief

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475014	A. BUILDING _____ B. WING _____	C 02/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURLINGTON HEALTH & REHAB	300 PEARL STREET BURLINGTON, VT 05401

(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 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced onsite investigation of 10 complaints on 2/1/21 - 2/3/21. On 2/3/21, the survey team identified and notified the facility of deficiencies at the Immediate Jeopardy (IJ) level, resulting in Substandard Quality of Care. The IJ was not able to be removed prior to the conclusion of the survey on 2/3/21; however, the facility submitted an acceptable IJ abatement plan to the team on 2/3/21. The IJ was found to be abated on 2/9/21, during the onsite extended survey. The following regulatory violations were cited as a result of the complaint investigation concluded on 2/3/21:	F 000	The filing of this plan of correction does not constitute an admission of the allegations set forth in the statements of deficiencies. Burlington Health and Rehabilitation has prepared and executed a plan of correction as evidence of the facilities' continued compliance with applicable federal and state laws.	2/26/21
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580	Resident #14 remains in Center. Medical Provider has been notified of residents change in condition and per policy providers recommendations have been followed. Residents that make suicidal gestures have the potential to be affected by this alleged deficient practice. These residents will have the proper notifications made per policy. House wide audit completed 2/3/21 for current residents with suicidal gestures to ensure notifications were completed per policy.	2/26/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ross Farnsworth	Center Executive Director	2/18/2021

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 580	Continued From page 1 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to consult with the resident's physician and notify the resident representative when there is a significant change in health, mental, or psychosocial status for 1 of 15 residents (Resident #14). This citation is at the immediate jeopardy level due to significant risk of serious harm or death as a result of the noncompliance. Findings include:	F 580	Nursing staff have been re-educated on the notification and suicide threats policies ensuring proper notifications are completed in regards to changes resident condition. CNE or designee will conduct audits of these types of events to ensure proper notifications have been made. Audits will be completed weekly x 4, monthly x3, or until such time that substantial compliance has been achieved. The results of these audits will be reviewed by the QAPI committee for further recommendations. F580 POC acccepted 2/24/21 R.Tremblay, RN/P.Cota, RN	

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F 580	Continued From page 2	F 580		

Resident #14 was found making suicidal gestures on two documented occasions. The facility failed to notify the physician and the resident representative of a significant change in the resident's mental status, resulting in ongoing risk of serious harm and/or death, due to lack of assessment of the resident's mental status and lack of assessment of the safety of the resident's environment.

Resident #14 has a history of Lewy body dementia, major depressive disorder, muscle weakness (generalized), and unsteadiness on feet. Resident #14 was admitted in January 2020 and had two significant falls on 06/17/20 and 7/25/20 that required hospital evaluation. The Minimum Data Set (MDS) on 12/21/20 displays that Resident #14 requires a 2 person assist for bed mobility, is non-ambulatory, and has a Brief Interview for Mental Status (BIMS) of 2, indicating severe cognitive impairment.

Per review of nursing progress notes dated 12/25/20, Resident #14 was found by a Licensed Nursing Assistant (LNA) in bed, with a call light cord wrapped around his/her neck. The Licensed Practical Nurse (LPN) documented they would continue "rounding q 2 hours" and that there was "no further attempt by resident to harm self noted for remainder of shift." Another progress note dated 12/30/20 stated that Resident #14 was found by an LNA in bed with a call light cord wrapped around his/her neck. The call light cord was removed at this time and replaced with hand bell "for safety purposes." There is no indication in the clinical record that the LPN notified the management team. On all three survey days, Resident #14 was observed in bed with a long phone cord within arm's reach.

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On 02/02/21 at 1:01 PM, the Center Nursing Executive stated that the policy for suicidal ideations and self-harm includes an assessment for significant change in condition. S/he stated that the resident needs to be assessed and cleared by a physician, and staff should then follow provider recommendations.

On 02/02/21 at 01:41 PM, the Social Services Director confirmed that staff did not notify social services of Resident 14#'s incidents per facility policy. S/he stated that s/he was unaware that the incidents were "suicidal gestures until today," and s/he confirmed that Resident #14 was not assessed by a physician after either event on 12/25/20 and 12/30/20.

On 02/02/21 at 2:10 PM, Resident #14's roommate stated during interview that in December 2020, Resident #14 wrapped a call light cord around his/her neck 4 times and wrapped a phone cord around his/her neck 1 time. S/he stated that the cord was wrapped several times around Resident #14's neck, and that on all the 5 occasions, s/he went to get help from staff. Resident #14's roommate was alert and oriented, with a BIMS score of 15, indicating little to no cognitive impairment.

On 2/02/21, Genesis Health Care Skilled Nursing Centers policy on NSG115 Physician/Advanced Practice Provider (APP) Notification was reviewed. The policy stated that "upon identification of a patient who has a change in condition or abnormal lab values, a licensed nurse will perform appropriate clinical observations, collect pertinent patient information...and data collection and report to

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F 580	Continued From page 4	F 580		

physician/ advanced practice provider (APP). If unable to contact attending physician/APP, the Medical Director will be contacted." Review of policy identifies suicidal gestures as an "immediate notification" to provider.

Per record review on 02/02/21, Resident #14 had no Significant Change of Condition assessment after incident on 12/25/20 and after incident on 12/30/20. There is no documentation that a physician was notified of either event or that the medical director was contacted.

On 02/03/21, facility policy on "Suicide Threats" was reviewed. The policy stated that any "resident threats of suicide" must be reported immediately to nurse supervisor/charge nurse, the resident's attending physician, the resident's responsible party, the Director of Nursing Services and/or Administration, and social services staff.

Per record review on 02/03/21, resident's physician, Center Nursing Executive, social services staff, and Resident #14's family was not notified after either incident on 12/25/20 and on 12/30/20.

On 02/03/21 at 10:54 AM, Resident #14's family was contacted to discuss the events of 12/25/20 and 12/30/20. Resident #14's family confirmed that the facility never contacted family after either event. The family member stated that s/he was told by Resident # 14's roommate that Resident #14 had wrapped a cord around his/her neck.

On 2/3/21 at 12:09 PM, the Center Executive Director (CED) confirmed that management, the physician, and the family should have been

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F 580	Continued From page 5 notified after each incident. The CED also confirmed that this had not been done per facility policy.	F 580		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	Resident #14 remains in Center. Residents with toe cushion orders have the potential to be affected by this alleged deficient practice. These residents will have their care plans followed for implementation of these interventions. House wide audit completed by CNE to identify all residents with toe cushion orders/plan of care and ensure those intervention were in place. Nursing staff will be re-educated on ensuring implementation of the comprehensive care plan for each resident. CNE or designee will conduct audits of residents with care plans for toe cushions to ensure implemented. These audits will be completed weekly x 4, and monthly x3, or until substantial compliance is achieved. The results of these audits will be reviewed by the QAPI committee for further recommendations. F656 POC accepted 2/24/21 R.Tremblay, RN/P.Cota, RN	2/26/21

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F 656	Continued From page 6	F 656		

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.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for 1 of 15 residents (Resident #14). Findings include:

Resident #14 did not receive application of hammer toe cushion daily as ordered by the physician. Per chart review, the resident is at "risk for skin breakdown related fragile skin, incontinence, limited mobility, hyperhidrosis, hx of hammer toe." Resident #14's care plan includes placing a hammer toe cushion as ordered and was initiated on 08/25/2020.

On all three days of the survey, Resident #14 was observed lying in bed without the hammer toe cushion. Per record review on 02/01/21, application of the hammer toe cushion in Resident #14's Treatment Administration Record (TAR) was not completed on 18 days in November 2020, 15 days in December 2020, and 7 days in January 2020.

On 02/02/21 at 1:48 PM, unit Licensed Practical Nurse (LPN), confirmed s/he was aware of Resident 14's care plan and orders for hammer

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F 656	Continued From page 7 toe cushion, and confirmed that Resident #14 was not wearing device at this time.	F 656		
F 689 SS=J	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 observations, interviews, and record review, the facility failed to prevent accidents by providing an environment that is free from hazards over which the facility has control for 1 of 15 residents (Resident #14). This citation is at the immediate jeopardy level due to significant risk of serious harm or death as a result of the noncompliance. Findings include: Resident # 14 was found making suicidal gestures on two documented occasions. The facility failed to take adequate measures to ensure resident safety, resulting in ongoing risk of serious harm and/or death, due to lack of assessment of the resident's mental status and lack of assessment of the safety of the resident's environment.. Resident #14 has a history of Lewy body dementia, major depressive disorder, muscle weakness (generalized), and unsteadiness on feet. Resident #14 was admitted in January 2020 and had two significant falls on 06/17/20 and	F 689	Resident # 14 remains in the center. An assessment has been completed of resident # 14's environment for further safety hazards. Hazards have been removed from resident's environment. Residents that make suicidal gestures have the potential to be affected by this alleged deficient practice. These residents will have their safety maintained with appropriate care plan interventions. House wide audit completed 2/3/21 for current residents with suicidal gestures to ensure their care plan has interventions implemented to maintain their safety. Nursing staff will be re-educated on the Suicidal Threats Policy to ensure resident safety.	2/26/21

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F 689	Continued From page 8 7/25/20 that required hospital evaluation. The Minimum Data Set (MDS) on 12/21/20 indicates that Resident #14 requires a 2 person assist for bed mobility, is non-ambulatory, and has a Brief Interview for Mental Status (BIMS) of 2, indicating severe cognitive impairment. Per review of nursing progress notes dated 12/25/20, Resident #14 was found by a Licensed Nursing Assistant (LNA) in bed, with a call light cord wrapped around his/her neck. The Licensed Practical Nurse (LPN) documented that would continue "rounding q 2 hours" and that there was "no further attempt by resident to harm self-noted for remainder of shift." A progress note dated 12/30/20 stated that Resident #14 was found by an LNA in bed with a call light cord wrapped around his/her neck. The call light cord was removed at this time and replaced with hand bell "for safety purposes." LPN reported that resident was last checked on "approximately 1.5H ago." There is no indication in the clinical record that management was notified or that additional precautions were put into place. On 02/02/21 at 1:01 PM, the Center Nursing Executive stated that the policy for suicidal ideations and self-harm includes an assessment for significant change in condition. S/he stated that the resident needs to be assessed and cleared by a physician, and staff should then follow provider recommendations. On 02/02/21 at 01:41 PM, the Social Services Director stated that facility policy for self-harming behaviors includes removing harmful objects from resident and placing the resident on a one-to-one observation until seen by a physician. S/he confirmed that Resident #14 was not placed	F 689	CNE or Designee will conduct audits of residents with suicidal gestures to ensure appropriate care plan interventions have been implemented to maintain their safety. These audits will be completed weekly x 4 and monthly x 3 or until such time that substantial compliance has been achieved. The results of these audits will be reviewed by the QAPI committee for further recommendations. F689 POC accepted 2/24/21 R. Tremblay, RN/P.Cota, RN	

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F 689	Continued From page 9	F 689		

on one-to-one observation, per facility policy, after either incident on 12/25/20 and 12/30/20.

On 02/02/21 at 2:10 PM, Resident #14's roommate stated during interview that in December 2020, Resident #14 wrapped a call light cord around his/her neck 4 times and wrapped a phone cord around his/her neck 1 time. S/he stated that the cord was wrapped several times around Resident #14's neck, and that on all the 5 occasions, s/he went to get help from staff. Resident #14's roommate was alert and oriented, with a BIMS score of 15, indicating little to no cognitive impairment.

On 02/03/21, facility policy on "Suicide Threats" was reviewed. The policy stated that in the event that there is a resident threat of suicide, "the resident will be placed on 1:1 observation until the acute episode has been resolved if the resident is physically capable of self-injury."

On all three survey days, Resident #14 was observed in bed with a long phone cord within arm's reach.

On 02/03/21 at 10:54 AM, Resident #14's family was contacted to discuss the events of 12/25/20 and 12/30/20. Resident #14's family confirmed that the facility never contacted family after either event. The family member stated that he/she was told by Resident # 14's roommate that Resident #14 had wrapped a cord around his/her neck.

On 2/3/21 at 12:09 PM, the Center Executive Director (CED) confirmed that the resident should have been placed on 1:1 supervision immediately after each incident and that management, the

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F 689	Continued From page 10 physician and the family should have been notified. The CED also confirmed that this had not been done per facility policy. Refer also to F580.	F 689		
F 725 SS=G	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (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, interviews and record	F 725	Residents #1, 2, 7, 8, 10, 11, 12, and 13 continue to resident in center and are having their needs met. Resident #15, has been discharged. Residents requesting or requiring staff assistance have the potential to be affected by this alleged deficient practice. These residents will have this assistance provided in a timely manner. A resident interview tool has been implemented to monitor resident satisfaction related to staffing and its impact on having their needs met. An audit of the facility's current linen inventory has been completed to ensure an adequate supply is available. The meal delivery system is being changed on the long term care units from tray line service to point of service/steam table meal delivery as the infection control guidance allows.	2/26/21

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F 725	Continued From page 11 review, the facility failed to have sufficient nursing staff with the appropriate competencies and skill 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. Findings include: 1. Per interview and confirmed via staff interview, Resident # 7 received her medications 2.5 hours late on 2/1/21. During interview on 2/3/21, Resident # 7 that all his/her medications were late on 2/1/21, including pain medications. The resident stated that s/he was in "terrible pain" due to the late medications. Review of the Medication Administration Record (MAR) indicates the Resident # 7 is supposed to be administered 20 medications at 8:00 AM, including 5 pain medications. The resident also stated that s/he is a 1 assist for toileting, but staff don't come so s/he goes by him/herself. States s/he is supposed to get a weekly shower but hasn't had one for over 2 weeks due to lack of staff. States food is always cold and that s/he doesn't even bother with asking staff to heat it because they are too busy with other things. States s/he often runs out of clean washcloths and towels. States bed linens have not been changed for 3 weeks. On 2/1/21 at 11:35 AM, the Unit Nurse stated that it is impossible to administer resident medications on time with one nurse on the unit. S/he also stated that resident care is really suffering and "it's not ok". States this is the second time s/he's worked alone on the unit. The nurse confirmed that the 8:00 AM medications were given at least 2 hours late on 2/1/21. Facility reports indicate that administration of the 8:00 AM med's was documented at 11:14 AM.	F 725	Licensed staff have been re-educated on ensuring medications are administered timely as per physician orders. Nursing, dietary and management staff have been reeducated on the change in the meal delivery system. Laundry staff have been reeducated on ensuring adequate linens are available to the residents. All staff have been reeducated on the Grievance policy and to report concerns brought to their attention through the appropriate channels. CNE/designee will conduct audits of residents requiring/requesting assistance with med administration, toileting, showers, hair washing, and bed linen changes to ensure they are responded to/completed timely. These audits will be completed weekly x 4 and monthly x 3 or until substantial compliance has been achieved.	

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	475014	A. BUILDING _____ B. WING _____	C 02/03/2021

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F 725	Continued From page 12 2. Per interview, Resident # 12 was left sitting in feces for over 1 hour. During interview on 2/1/21 at 2:21 PM, Resident # 12 stated that this had occurred "several times" and that it was very upsetting to him/her. The resident resides on the 4th floor. Minimum Data Set (MDS) dated 1/5/21 indicates that Resident # 12 requires extensive assist of 1 staff for activities of daily living (ADLs). Per interview with the Center Executive Director (CED), the 4th floor has 3 residents that use mechanical lifts and that there are 5 residents that require assist of 2 staff for ADLs. On the morning of 2/1/21, per observation there was only 1 nurse and 3 Licensed Nursing Assistants (LNA's) working on the 4th floor. 3. During interview on 2/1/21 at 11:00 AM, fourth floor residents # 10 and 11 stated that the food is generally cold when delivered because they need more help to deliver meals. 4. During an interview on 2/1/21 at 12:00 PM, Resident # 1 reported concerns for his/her "safety and health." Stated that s/he waited "up to an hour and a half" for the call light to be answered and has been left lying in his/her feces for an extended period. Stated that s/he uses the Hoyer mechanical lift to get out of bed but has only been able to get up for 10-minute intervals. Resident #1 identified working on a bowel management program before being admitted to the facility, but with the lack of staff, his/her bowel regimen is gone. Stated that his/her hair has not been cleaned during his/her whole stay. Stated that staff are "grossly overworked and horrifically understaffed." Stated that "the food always comes cold," so he/she has been ordering chef's salads.	F 725	Dietary Director/designee will conduct random audits of food temperatures daily at point of service to ensure food is being served at desirable temperatures. These audits will be completed weekly x 4 and monthly x 3 or until such time substantial compliance has been achieved. CED/designee will conduct audits of linen to ensure availability to residents.These audits will be completed weekly x 4 and monthly x 3 or until such time that substantial compliance has been achieved. The results of these audits and related grievances will be reviewed by the QAPI committee for further recommendations. CNE or designee will review the Census and Condition tool daily to ensure the residents' needs are met with sufficient staffing. Timely Care audit to be utilized for evaluation of sufficient staffing. Additional Unit Manager added to Nursing Management Staff to provide additional supervision and staff support.	

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F 725	Continued From page 13 5. Per interview, Resident #13 received medications 1.75 hours late on 12/24/20, 1.5 hours late on 1/11/21, 1.75 hours late on 12/27/20, 1.5 hours late on 12/31/20, and 2.5 hours late on 1/16/21. During interview on 02/01/21 at 14:32, Resident #13 stated that his/her medications were late on 12/24/20, 12/27/20, 12/31/20, 1/11/21, and 1/16/21. Review of the Medication Administration Record (MAR) indicates that Resident #13 is supposed to be administered 16 medications at 08:00 AM, including 5 pain medications, is supposed to be administered 11 medications at 08:00 PM, including 5 pain medications, and is supposed to be administered 1 medication at 02:00 AM, which is also a pain medication. The resident also stated that in December, his/her head was not washed for 3 weeks, and that in January, there were multiple occasions where s/he waited 30 to 40 minutes for staff to use the bed pan. Resident #13 stated fear to have a bowel movement because s/he was worried to be left on the bed pan for an extended period in pain. Resident #13 stated the unit did not have enough linen, especially washcloths, and that staffing was so low, that the lady who helps with her finances has also been helping to pass out meal trays. Resident #13 cried and stated, "this place is so bad for me; it's so bad for my mental health." 6. During an interview on 02/01/21 at 11:51 AM, Resident #12 stated that unit residents "are not getting help at a reasonable time." S/he identifies that the facility is understaffed, and that his/her bed linen "hasn't been changed in three weeks." Resident #12 stated that the food was always cold on arrival to the room.	F 725	Regarding staff recruitment, the Center is paying for LNA classes to onboard new staff. The Center has revamped the orientation process to provide an extended orientation process for new staff. The Center has implemented sign-on bonuses as an incentive to recruit new staff. Regarding staff retention, the Center has implemented a Staff Excellence team which develops and implements employee appreciation events each month on all shifts. The Center has implemented referral bonuses for existing staff. Center Executive Leadership holds all staff Town Hall meetings to provide opportunity for feedback related to areas for improvement. The audit will occur daily x4 weeks, weekly x 3 months, or until such time that substantial compliance has been achieved F725 POC accepted 2/24/21 R. Tremblay, RN/P.Cota, RN	

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F 725	Continued From page 14	F 725		

7. During an interview on 02/02/21 at 02:02 PM, Resident #15 stated that his/her stay at the facility "has not been a good experience." Stated that s/he fell, broke his/her nose, and laid there. Stated that staff at the facility are "spread too thin," and that "help is desperately needed." Resident #15 stated that the food is always cold and stated, "it sucks to eat cold food, three times a day, 7 days a week."

8. During an interview on 02/01/21 at 11:15 AM, Resident #2 stated that there is just not enough staff, some days and shifts are worse than others. S/he reported that just that morning s/he put on her/his call light after breakfast to request her "pain patch" be placed on her knee, and it still had not be done. While we continued our interview, I asked her/him to again put on the call light and ask for the patch, 6 minutes later a Licensed Nursing Aide (LNA) responded and stated, "I will tell the nurse". After completing the interview at 11:45 AM, I went out and told the nurse that the resident was in pain and wanted the patch placed. S/he responded, "I'll get to it". Upon reviewing the physician's orders for the resident the order is for a Lidocaine 5% patch to be applied to the right knee every morning for chronic pain. In reviewing the (MAR) for 02/01/21 for this resident the documentation indicates that the Lidocaine Patch was documented as being placed at 1:38 PM. The same resident reported that there are times in which her/his finger stick for diabetes is not done before s/he eats, because there is not enough staff to do so and they will come either when s/he is eating or after s/he is finished.

9. During an interview on 02/01/21 at 2:00 PM, Resident #8 reported that they are short staffed,

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that s/he has had to wait over an hour for someone to respond to her call light and that there have been times that medications have arrived late, even hours late. S/he feels that weekends are worse and stated, "it is kind of frightening that I might need help, and no one will come". S/he also reports that there are times s/he has had to ask staff to change her/his bedding, because there does not seem to be a specific time when this occurs.

Per observation of the 5th floor on 2/1/21 at 11:35 AM, 4 staff members were present on the unit. During an interview on 2/1/21 at 11:40 AM with the 5th floor Unit Manager, s/he stated that the unit currently had 35 long term care residents; and that there was 1 Licensed Practical Nurse (LPN) and 3 Licensed Nursing Assistants (LNA's) "working today". S/he stated that "18" of the 35 residents needed to have "total care" with their Activities of Daily Living (ADL's); and that "10" of the 35 residents used mechanical "lifts" which required 2 staff members. Per interview at approximately 12:15 PM with 2 LNAs on the 5th floor, they stated that at times they only "run 2 staff" and that this was "not enough". And that when this happens, they "can't get the work done". They also stated that they "don't ever stop" and that "it's hard" and they "have learned how to manage".

On 02/02/2021 at 08:37 AM, the Dietary Services Manager, stated that he/she was aware of residents' complaints of cold entrees. Stated that s/he keeps food temperature logs and knows that residents' meals are warm when they are delivered to the floors. Stated that resident complaints of cold food trays have become a heightened issue since COVID-19, as residents

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F 725	Continued From page 16 are confined to their room during mealtimes, instead of using the communal dining area. Stated that s/he believes that once arriving to the floor, trays are not getting dispersed to resident rooms in a timely manner.	F 725		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 2 of 15 applicable residents (Resident #6 and #13) are free of any significant medication errors. Findings include: 1. Resident #6 received his/her medications 2.5 hours late on 2/1/21. During interview on 2/3/21, Resident # 6 that all his/her medications were late on 2/1/21, including pain medications. The resident stated that s/he was in "terrible pain" due to the late medications. Review of the Medication Administration Record (MAR) indicates Resident #6 is supposed to be administered 20 medications at 8:00 AM, including 5 pain medications. On 2/1/21 at 11:35 AM, the Unit Nurse stated that it is impossible to administer resident medications on time with one nurse on the unit. S/he also stated that resident care is really suffering and "it's not ok". S/he states this is the second time s/he has worked alone on the unit. The nurse confirmed that the 8:00 AM medications were given at least 2 hours late on 2/1/21. Facility reports indicate that administration of the 8:00 AM	F 760	Residents #2 and #6 continue to resident in center and are receiving their pain meds as ordered. Residents receiving pain medications have the potential to be affected by this alleged deficient practice. These residents will have their meds administered timely. Licensed staff have been re-educated on ensuring meds are administered timely as per physician orders. CNE/designee will conduct audits of residents receiving pain medications to ensure timely administration. These audits will be completed weekly x 4 and monthly x 3 or until such time that substantial compliance has been achieved. The results of these audits will be reviewed by the QAPI committee for further recommendations. F760 POC accepted 2/24/21 R.Tremblay, RN/P.Cota, RN	2/26/21

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F 760	Continued From page 17 medications were documented at 11:14 AM. 2. During an interview on 02/01/21 at 11:15 AM, resident #2 stated that s/he has been waiting all morning for her "pain patch" to be placed on her knee and at this point s/he was experiencing significant pain. Upon reviewing the physician's orders for the resident there is an order for a Lidocaine 5% patch to be applied to the right knee every morning for chronic pain. The (MAR) indicates 8:00 AM as the time it should be placed. In reviewing the (MAR) for 02/01/21 for this resident the documentation indicates that the Lidocaine Patch was documented as being placed at 1:38 PM.	F 760		
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act.	F 825	Resident #3 remains in Center, resident # 5 discharged to home. Residents with MD orders for PT services have the potential to be affected by this alleged deficient practice. These residents will have these services provided timely as ordered. Therapy staff have been educated on ensuring timely PT services are provided to residents per their MD orders. Therapy Director/designee will conduct audits of residents with MD orders for PT services to ensure they are being provided timely. These audits will be completed weekly x 4 and monthly x 3 or until substantial compliance has been achieved.	2/26/21

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F 825	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to provide specialized rehabilitative services in a timely manner for physician-ordered physical therapy services for 2 of 15 applicable residents (Residents #3 and #5). Findings include: 1. Resident #3 did not receive physical therapy (PT) services as ordered by the physician. The resident was admitted on 12/19/20 for short term rehab. There is a physician order dated 12/23/20 to consult physical therapy as needed. PT records indicate that services did not start until 12/29/20. Therapy staff are employed by the facility. In December 2020, staffing was 1 full time equivalent (FTE) PT, 1 FTE physical therapy assistant (PTA) and 1 per diem PT. The Therapy Manager stated that this is not enough staff to handle the workload. During an interview on 2/2/21 at 8:58 AM the Therapy Manager confirmed the above physician order, and that Resident #3 was not evaluated by PT until 10 days after admission due to a lack of PT staff. The Therapy Manager also stated that Resident #3 could have benefited from PT services sooner than s/he got them. 2. Resident #5 was admitted on 1/8/21 for short term rehab. There are physician orders for PT evaluation and treatment dated 1/8/21. Therapy records indicate that Resident #5 was not evaluated by PT until 1/12/21. On 2/2/21 at 9:15 AM the Therapy Manager confirmed the above physician order, and that Resident #5 was not evaluated by PT until 1/12/21.	F 825	The results of these audits will be reviewed by the QAPI committee for further recommendations. F825 POC accepted 2/24/21 R.Tremblay, RN/P.Cota, RN	