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

January 31, 2022

Mr. Shawn Hallisey, Administrator
Burlington Health & Rehab
300 Pearl Street
Burlington, VT 05401-8531

Dear Mr. Hallisey:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **January 11, 2022.** 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

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 01/11/2022

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 investigations of 8 complaints and 3 facility self-reports 1/10/22 - 1/11/22. The following regulatory violations were cited as a result:	F 000	Burlington Health and Rehab provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed soley because it is required by Federal and State applicable law.	
F 658 SS=E	Services Provided Meet Professional Standards 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 upon observation, interview, and record review, the facility failed to ensure services provided met professional standards of quality regarding resident medications administered as ordered and treatments administered as ordered for 1 resident [Res. #10] of 11 sampled residents. Findings include: Review of the American Nurses Association's Standards of Professional Nursing Practice (Nursing: Scope and Standards of Practice (wordpress.com)) reveals "The Standards of Professional Nursing Practice are authoritative statements of the duties that all registered nurses, regardless of role, population, or specialty, are expected to perform competently". Under 'Standard 5. Implementation: -The registered nurse implements the identified plan. - Implements the plan in a timely manner in accordance with patient safety goals. -Documents implementation and any	F 658	Resident #10 continues to reside at the facility and have his/her needs met. All residents that receive medications and treatments in the facility are at risk for this alleged deficient practice. A house wide audit was conducted of all residents who receive medications and treatments to ensure administration as ordered. All nurses were educated on policy NSG305 Medication Administration-General and policy NSG241 Treatment Administration to include the timely administration and documentation of medications and treatments. The DNS or designee will conduct random weekly X 4 and monthly X 2 audits of residents MARs and TARs to assure compliance with policies. These audits will be brought to the QAPI team for review and interventions if required.	2/3/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shawn T. Hallisey | TITLE: Administrator | (X6) DATE: 1/31/22

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 658	Continued From page 1 modifications, including changes or omissions, of the identified plan'. Per review of Res. #10's medical record, the resident has multiple diagnoses requiring treatment including: asthma, obstructive sleep apnea, congestive heart failure, Diabetes, morbid obesity, acute kidney failure, neuromuscular dysfunction of the bladder, long term use of anticoagulants, generalized anxiety disorder, and major depressive disorder. Per review of Res. #10's Care Plan, the resident is identified as having altered respiratory status, difficulty breathing related to Congestive Heart Failure, asthma, and obstructive sleep apnea, allergies, and chronic cough. Interventions include: 'BIPAP at bedtime as ordered. Encourage use of acapella as ordered. Encourage use of incentive spirometer as ordered.' Review of Res. #10's Treatment Administration Record [TAR] for December 2021 reveals orders for 'BiPAP apply at bedtime, setting 25/8 PS 8 with 2 Liters of Oxygen at bedtime for Obstructive Sleep Apnea.' Review of the TAR reveals blank spaces where the treatment was to be marked if completed on 12/3, 12/5, 12/14, 12/22, 12/24, 12/30/21. Review of Res. #10's Treatment Administration Record [TAR] for December 2021 reveals orders for 'Acapella treatment four times a day for Secretions.' Review of the TAR reveals blank spaces where the treatment was to be marked if completed on 12/3, 12/5, 12/14, 12/16, 12/19, 12/20, 12/21, 12/24, 12/30/21. Review of Res. #10's Treatment Administration Record [TAR] for December 2021 reveals orders for 'Incentive spirometry. Encourage use four times a day to prevent atelectasis. Needs assistance.' Review	F 658	**TAG F 658 POC Accepted on 1/31/22 by R. Tremblay/P. Cota**	

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F 658	Continued From page 2 of the TAR reveals blank spaces where the treatment was to be marked if completed on 12/3, 12/5, 12/14, 12/16, 12/20, 12/22, 12/24, 12/30/21. Per review of Res. #10's Care Plan, the resident is identified as having Congestive Heart Failure. Interventions include: 'Monitor output related to edema.' Review of Res. #10's Treatment Administration Record [TAR] for December 2021 reveals orders for 'Suprapubic catheter output every shift. every shift for monitoring'. Review of the TAR reveals blank spaces where the treatment was to be marked if completed on 12/1, 12/3, 12/4, 12/5, 12/14, 12/16, 12/20, 12/21, 12/22/21. Per review of Res. #10's Care Plan, the resident is identified as having Diabetes Mellitus with interventions that include: 'Check all of body for breaks in skin and treat promptly as ordered by doctor. Diabetic foot care every evening. Inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness.' Review of Res. #10's Treatment Administration Record [TAR] for December 2021 reveals orders for 'Diabetic foot care. every evening shift'. Review of the TAR reveals blank spaces where the treatment was to be marked if completed on 12/3, 12/5, 12/14, 12/22/21. Per review of Res. #10's Care Plan, the resident is identified as having potential/actual impairment to skin integrity related to Suprapubic tube site, history of pressure, scratches to back of thigh. Interventions include: 'Treatment as ordered by MD'. Review of Res. #10's Treatment Administration Record [TAR] for December 2021 reveals orders for 'Remove adhesive foam dressings from Right posterior thigh and Left	F 658		

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F 658	Continued From page 3 buttocks in AM. one time a day for wound treatment'. Review of the TAR reveals blank spaces where the treatment was to be marked if completed on 12/16, 12/20, 12/22, 12/24/21. Per review of Res. #10's Care Plan, the resident is identified as having an Activities of Daily Living Self Care Performance Deficit related to Activity Intolerance, Limited Mobility, with Interventions that include 'Pt requires compression socks to be put on every morning and removed every evening before bed' and identified as having fluid overload or potential fluid volume overload related to Disease process of Congestive Heart Failure, edema, with interventions of 'Knee high compression stockings as ordered'. Review of Res. #10's Treatment Administration Record [TAR] for December 2021 reveals orders for 'Compression stockings - one time a day on in the AM off at bedtime and remove per schedule'. Review of the TAR reveals blank spaces where the treatment was to be marked if completed on 12/3, 12/5, 12/14, 12/16, 12/20, 12/22, 12/24, 12/30/21. Per review of Res. #10's Care Plan, the resident is identified as having a Suprapubic Catheter related to urinary retention and neuromuscular dysfunction of bladder, with Interventions that include 'Check tubing for kinks each shift/per policy.' Review of Res. #10's Treatment Administration Record [TAR] for December 2021 reveals orders for '16 Fr suprapubic catheter with 10ml balloon for urinary retention Related to neuromuscular dysfunction of bladder. Every shift Check placement and patency.' Review of the TAR reveals blank spaces where the treatment was to be marked if completed on 12/3, 12/5, 12/14, 12/16, 12/20, 12/22/21.	F 658		

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F 658	Continued From page 4 Per review of Res. #10's Care Plan, the resident is identified as at risk for complications secondary to anticoagulation, therapy, Red blood cell antibody positive, with Interventions that include 'Observe for signs and symptoms of bleed/bruising and report.' Review of Res. #10's Treatment Administration Record [TAR] for December 2021 reveals orders for 'Check for bleeding & bruising every Shift'. Review of the TAR reveals blank spaces where the treatment was to be marked if completed on 12/3, 12/5, 12/14, 12/16, 12/22/21. Per review of Res. #10's Care Plan, the resident is identified as using anti-anxiety medications related to Adjustment issues, Anxiety disorder, with interventions that include 'Give anti-anxiety medications as ordered by physician. Observe for/document side effects and effectiveness'. Review of Res. #10's Treatment Administration Record [TAR] for December 2021 reveals orders for 'Monitor for Side Effects of Antianxiety Medications'. Review of the TAR reveals blank spaces where the treatment was to be marked if completed on 12/3, 12/5, 12/14, 12/16, 12/20, 12/22/21. Per review of Res. #10's Care Plan, the resident is identified as using anti-depressant medications related to depression, with interventions that include 'Give anti-depressant medications as ordered by physician. Monitor/document side effects and effectiveness'. Review of Res. #10's Treatment Administration Record [TAR] for December 2021 reveals orders for 'Monitor for Side Effects of Antidepressant Medications'. Review of the TAR reveals blank spaces where the treatment was to be marked if	F 658		

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F 658	Continued From page 5 completed on 12/3, 12/5, 12/14, 12/16, 12/20, 12/22/21. Per review of Res. #10's medical record, documentation is absent or does not address whether or not the resident received the ordered treatments or refused treatments and/or assessments. Per interview with Res. #10's assigned Staff Nurse on 1/11/22 at 10:37 AM, the Staff Nurse confirmed the blank spaces in Res. #10's treatment record and the absence of documentation regarding completion of treatment and implementation of physician orders. The Staff Nurse confirmed there should be no blanks spaces on any resident's TAR. The Staff Nurse confirmed the TAR should be initialed if the treatment or assessment was completed, or there should be documentation as to whether the treatment and assessments were not completed as ordered and per Res. #10's Care Plan, but there was none. Per review of Physician Orders for Res. #10, the resident's blood sugar levels are to be checked daily before meals and at bedtime. Per the order, if the blood sugar level is "greater than 500, notify MD". [Per Health Guide Info: Diabetes Complications, "blood sugar levels over 500 can be life-threatening." (https://www.healthguideinfo.com/diabetes-complications)] Review of Res. #10's MAR on 12/3/21 reveal the resident's blood sugar level recorded as '503'. There is no documentation that the physician was notified of the critical lab value, per physician order. Further record review reveals the resident's blood sugar was checked again later and registered '529'. Per review of Physician Orders, Res. #10 was	F 658		

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F 658	Continued From page 6 ordered to receive 'Trazodone- give 50 milligrams by mouth at bedtime for insomnia'. Per review of Res. #10's Medication Administration Record [MAR] on 12/17/21, next to the Trazodone order there is a blank space where the Nurse would initial if the medication was administered. Additionally, there are numeric codes listed to be entered if the medication was not administered for reasons including 'drug refused, hospitalized, sleeping, nauseated/vomiting, spit out meds, partial administration, leave of absence, hold/see nurses notes', and 'vitals/labs outside of parameters'; none of which were entered on the MAR. Per review of Nurses Notes for Res. #10, there is no documentation regarding why the medication was not administered as ordered. Additional reference: Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott, Williams & Wilkins, pg. 17.	F 658	F677 Resident #5 no longer resides at the facility. 2/3/22 All residents that require assistance with personal hygiene are at risk for this alleged deficient practice. A house wide audit was conducted of all residents who require services to maintain good proper hygiene to ensure care is provided and documentation occurred. All nurses and LNA/CNA's were educated on provided care as care planned and documenting appropriately. The DNS or designee will conduct random weekly X 4 and monthly X 2 audits of residents POC charting to assure compliance with policies. These audits will be brought to the QAPI team for review and interventions if required.	
F 677 SS=D	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 record review and interview, the facility failed to ensure 1 of 11 sampled residents received necessary services to maintain good personal hygiene (Resident #5). Findings include: Per record review, Resident #5 was admitted to the facility on 8/6/2020 with multiple diagnoses including Alzheimer's Disease, Malignant	F 677		

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F 677	Continued From page 7 Neoplasm of Bone. Per review of the facilities grievance/concern log for the month of September, on 9/22/2021 a grievance was submitted on behalf of Resident #5's regarding cleanliness of her/his room and shower times. According to the grievance/ concern log the facility initiated a "Plan of Care Checklist" and it was resolved on 10/6/2021. Per Resident #5's care plan s/he required assistance from 1 staff member for bathing. Review of the September, October, and November 2021 LNA Intervention and Task sheets revealed that Resident #5 was scheduled to receive a shower or bed bath on Tuesdays, Thursdays, and Saturdays. Documentation reflects that s/he received a shower on 9/14, 10/19, 11/9 and a bed bath on 10/21, 10/23, 11/6, and 11/16 2021. Resident #5 did not receive her/his scheduled shower or bed bath on 9/2, 9/4, 9/7, /9/9, 9/11, 9/16, 9/18, 9/21, 9/23, 9/25, 9/28, 9/30, 10/2 10/5, 10/7,10/9, 10/12, 10/14, 10/16, 10/26, 10/28, 11/2, 11/4, 11/11, 11/13, or 11/18/2021. There is no documented evidence that the resident was unavailable or refused the scheduled showers or bed baths. During interview on 1/11/22 between 12:05 and 12:30 PM the Director of Nurses (DON), confirmed that staff had not documented the above showers or bed baths on Resident #5's LNA Intervention and Task sheets. S/he also confirmed that any blank areas in the LNA Interventions and Task sheet are considered not done.	F 677	**TAG F 677 POC Accepted on 1/31/22 by R. Tremblay/P. Cota**	

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F 725	Continued From page 8	F 725	All residents are at risk for this alleged deficient practice.	2/3/22
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest 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 observations, resident and staff interview, and record review the facility failed to provide sufficient nursing staff to ensure residents received timely administration of medications and nursing and personal care as directed by physicians orders and resident care plans. This has the potential to affect all residents. Findings	F 725	The facility will have the minimum staffing levels met to maintain the highest practical physical, mental and psychosocial well-being of each resident. The Administrator, Assistant Administrator, DNS, ADON, and the Scheduler have all been inserviced on requirements regarding sufficient nursing staff to maintain the highest practicable physical, mental and psychosocial well-being. The Administrative team has radio advertisement, People Powered recruitment firm, Indeed postings, Zip Recruiter, Monster, Facebook, and Appoli. The center has also offered high sign on bonuses and new refer-a-friend bonus's. The center has re-hired the previous experienced HR/Payroll Manager, which will facilitate the timely management of contract staff. The new clinical leadership team is complete with: ADON, Nurse Educator, Infection Preventionalist and three Unit Managers. This clinical leadership team will focus on orienting, coaching and mentoring the staff. They will also provide increased oversite by inspecting and verifying processes and procedures are being completed. The Administrator or designee will conduct random weekly X 4 and monthly X 2 schedule audits to ensure sufficient nursing staffing requirements are in place. The results of these audits will be brought to QAPI for review and interventions as needed.	

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F 725	Continued From page 9 include: Observation on 1/11/22 at 9:30 AM revealed one nurse and one LNA working on the third floor. Interview with the LPN on the third floor who confirmed that at the time of the above observation, the floor/unit was being cared for by one LPN traveling nurse and one LNA. The LPN stated, "the facility is trying to get more staff but we have a lot of call outs, so we just have to make do with what we have." The LPN confirmed that it is often that the facility does not have enough staff to cover the needs of the residents. Observation with the LPN assigned to this floor/unit on 1/11/22 at 9:50 AM of the Medication Administration Record (MAR) (the system that is used to provide medications to the residents), it was determined that out of 20 residents on this unit, 15 residents had not received their scheduled 8 AM medications. Interview with the LPN who was assigned to both medication carts on 1/11/22 at 10:00 AM, confirmed that these 15 residents medications were "late". The LPN explained that medications are to be given within a 2 hour window - no earlier than 1 hour before they are scheduled and not more than 1 hour after they are scheduled, therefore the 8:00 AM medications needed to be administered no later than 9:00 AM for them to be considered "administered on time". The LPN explained that since there were only 2 staff on this floor/unit s/he needed to help the LNA with feeding those that could not feed themselves, answering call lights, and providing care that could not wait. S/he explained that there are a number of residents who require the use of a mechanical lift to get in	F 725	**TAG F 725 POC Accepted on 1/31/22 by R. Tremblay/P. Cota**	

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F 725	Continued From page 10 and out of bed, on and off the toilet/commode, and in and out of their wheelchair. Safe use of the mechanical lift requires 2 staff. Observation on 1/11/22 at 10:00 AM on the 4th floor revealed, 2 medication carts and a nurse was identified for each medication cart. Observation on 1/11/22 at 10:05 AM, with the nurse (LPN) assigned to the A side cart (low side), of the MAR (on the computer) revealed that s/he had 1 resident that had not received their 8 AM medications. Interview with the LPN assigned to the A side cart on 1/11/22 at 10:10 AM revealed that the medication pass is very heavy and that many of the medications were vitamins and supplements. The LPN confirmed that she had 1 resident who had not received their 8 AM medications. Observation on 1/11/22 at 10:15 AM, with the nurse (LPN) assigned to the B side cart (high side), of the MAR (on the computer) revealed that s/he had 1 resident that had not received their 8 AM medications. Interview with the LPN (traveler) assigned to the B side cart on 1/11/22 at 10:15 AM revealed that staffing is problematic on the 4th floor. S/he explained that both her/him and the other LPN on the A side, work well together but it's hard when they work 12 hour shifts (6 AM - 6 PM) and at the end of their shift, when they are supposed to be going home, only 1 person comes is assigned to work the next shift. This means that only one of the nurses gets to go home and the other has to stay until another nurse comes to relieve them. This floor/unit has mostly dementia residents,	F 725		

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F 725	Continued From page 11 Long Term Care residents, and some patients/residents are there for rehabilitation. The floor/unit has several residents that need to be fed. S/he stated, "On Christmas, we had no LNA's to do care - that was challenging to make sure everyone's needs were met." S/he explained that the biggest issue is "not enough staff". Observation on 1/11/22 at 10:25 AM on the 5th floor revealed, 2 medication carts and a nurse was identified for each medication cart. Interview on 1/11/22 at 10:30 AM with the LPN (traveler) assigned to the B side cart (high side), revealed that today was her/his day off but "they called me in to take the cart". S/he stated that the overnight nurse had to stay until she was relieved so s/he came in so that nurse could go home. Review of the MAR (on the computer) with the LPN revealed that there were 5 residents on the B side that had not received their 8 AM medication. Review of the Medication Administration policy and procedure, titled, "NSG305 Medication Administration: General" with a Revision Date of 11/01/19, revealed the following: Page 1 "Purpose" "To provide a safe, effective medication administration process." Under "PRACTICE STANDARDS", #4 states, "Doses will be administered within one hour of the prescribed time unless otherwise indicated by the prescriber." Interview on 1/11/22 at approximately 11:00 AM with the DON regarding the 3rd floor having 1 nurse and 1 LNA - the DON confirmed s/he was	F 725		

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F 725	Continued From page 12 aware that this was the situation. The DON confirmed that it is the expectation that all medications will be administered within the guidelines of the policy and procedure. S/he confirmed that the time frame for administering medications was 1 hour before the scheduled dose and no later than 1 hour after the scheduled dose and medications administered outside of these parameters would be considered late.	F 725		
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 record review, observation, and interview, it was determined that the facility failed to ensure medication error rates were not 5% or greater. Findings include: Observation on 1/11/22 at 9:30 AM revealed one nurse and one LNA working on the third floor. Interview with the LPN on the third floor who confirmed that at the time of the above observation, the floor/unit was being cared for by one LPN traveling nurse and one LNA. Observation with the LPN assigned to this floor/unit on 1/11/22 at 9:50 AM of the Medication Administration Record (MAR) (the system that is used to provide medications to the residents), it was determined that out of 20 residents on this unit, 15 residents had not received their scheduled 8 AM medications. Interview with the	F 759	F759 All residents that receive medications in the facility are at risk for this alleged deficient practice. A house wide audit was conducted of all residents who receive medications administered to ensure administration as ordered. All nurses were educated on policy NSG305 Medication Administration-General to include the timely administration and documentation of medications and treatments. The DNS or designee will conduct random weekly X 4 and monthly X 2 audits of residents MARs and TARs to assure compliance with policies. These audits will be brought to the QAPI team for review and interventions if required.	2/3/22

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F 759	Continued From page 13 LPN who was assigned to both medication carts on 1/11/22 at 10:00 AM, confirmed that these 15 residents medications were "late". The LPN explained that medications are to be given within a 2 hour window - no earlier than 1 hour before they are scheduled and not more than 1 hour after they are scheduled, therefore the 8:00 AM medications needed to be administered no later than 9:00 AM for them to be considered "administered on time". Observation on 1/11/22 at 10:00 AM on the 4th floor revealed, 2 medication carts and a nurse was identified for each medication cart. Observation on 1/11/22 at 10:05 AM, with the nurse (LPN) assigned to the A side cart (low side), of the MAR (on the computer) revealed that s/he had 1 resident that had not received their 8 AM medications. Interview with the LPN assigned to the A side cart on 1/11/22 at 10:10 AM revealed that the medication pass is very heavy and that many of the medications were vitamins and supplements. The LPN confirmed that she had 1 resident who had not received their 8 AM medications. Observation on 1/11/22 at 10:15 AM, with the nurse (LPN) assigned to the B side cart (high side), of the MAR (on the computer) revealed that s/he had 1 resident that had not received their 8 AM medications. Observation on 1/11/22 at 10:25 AM on the 5th floor revealed, 2 medication carts and a nurse was identified for each medication cart. Review of the MAR (on the computer) with the LPN revealed that there were 5 residents on the B side that had not received their 8 AM medication.	F 759	**TAG F 759 POC Accepted on 1/31/22 by R. Tremblay/P. Cota**	

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F 759	Continued From page 14 Review of the Medication Administration policy and procedure, titled, "NSG305 Medication Administration: General" with a Revision Date of 11/01/19, revealed the following: Page 1 "Purpose" "To provide a safe, effective medication administration process." Under "PRACTICE STANDARDS", #4 states, "Doses will be administered within one hour of the prescribed time unless otherwise indicated by the prescriber." Interview on 1/11/22 at approximately 11:00 AM with the DON, the DON confirmed that it is the expectation that all medications will be administered within the guidelines of the policy and procedure. S/he confirmed that the time frame for administering medications was 1 hour before the scheduled dose and no later than 1 hour after the scheduled dose and medications administered outside of these parameters would be considered late. A request was made by the surveyor for a facility report for the last 7 days that revealed any late medications for all residents. On 1/11/22 at approximately 11:05 AM, the DON provided a 91 page report of all medications that were given outside of the parameters of the facility's policy and procedure of 1 hour before the medication was scheduled and no later than 1 hour after the medication was scheduled. The DON confirmed that s/he had just run this report and that it was accurate. This report included a date range of 1/4/22 - 1/11/22. Review of this report revealed that there were 799 medications that were late in the 7 day period and 72 residents were affected by these late	F 759		

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F 759	Continued From page 15 medications. The following is a list of medication classes that were listed in this report as having been administered late: Blood Pressure medications; Anti-Arrhythmics (heart medications); Anti-depressants; Analgesics both Opioid and non-opioid (Pain medications); Respiratory Support (Chronic Obstructive Pulmonary Disease medications and Asthma medications); Anti-seizure medications; Anticoagulants (blood thinning medications); Neuropathic pain medications; Tube Feeds (the latest administration was 7 hours and 57 minutes LATE); Diuretic medication (to treat excess fluid); Anti-spasmodics and medications for tremors; Anti-Anxiety medications; Antibiotics; Antipsychotic medication; Oral Hyperglycemics (for diabetes); Insulin - Sliding scale (more than 7 hours late); Insulin - scheduled (more than 3 hours late); Hormones (for uterine bleeding); Multiple Sclerosis medication; Appetite Stimulants; Fortifed foods; Proton Pump Inhibitors (for Gastroesophogeal Reflux Disease); Allergy medication; Dopamine Agonists (for Restless Leg Syndrome); Nutritional Supplements; Cholesterol medication (for Hyperlipidemia/high cholesterol); Antifungals;	F 759		

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F 759	Continued From page 16 Nicotine patches; Anti-Parkinson medications; Glaucoma medications; Insomnia medications; Kidney Stone management/prevetion medication; Overactive bladder medication; Alpha blockers (for Benign Prostatic Hyperplasia); NSAID's (Non-Steroidal Anti-inflammatorys); Immunosuppressive medications; Cholinesterase Inhibitors (for Dementia); Fasting Blood Sugars for known diabetics.	F 759		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-	F842 F 842	Resident # 5, 6, and 7 continue to reside in the facility and have their needs met by both internal staff and hospice staff. Resident # 3 & 8 no longer resides at the facility. All residents who require care, regardless of hospice involvement, are at risk for this alleged deficient practice. All Nurses and LNAs/CNAs were educated on the requirement for LNAs/CNAs to provide complete and accurate documentation of all ADL tasks, regardless of hospice involvement. The DNS or designee will conduct random weekly audits X 4 and monthly X 2 of LNA/CNA charting to ensure complete and accurate documentation. The results of these audits will be brought to QAPI for review and interventions as needed.	2/3/22

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F 842	Continued From page 17 (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic	F 842	**TAG F 842 POC Accepted on 1/31/22 by R. Tremblay/P. Cota**	

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F 842	Continued From page 18 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to maintain medical records on each resident that are complete and accurately documented for 6 residents in a sample of 11 residents. Resident identifiers: #3, #5, #6, #7, #8, #9. Findings include: 1. Per review Resident #9's Licensed Nurse's Aide (LNA) Intervention and Task sheets for the months of December 2021, and January 2022 were missing documentation that acknowledged completion of specific care areas. The following are areas where documentation was missing: ADL - Bathing shower/bed bath ADL - Bed Mobility ADL - Dressing ADL - Locomotion off Unit ADL - Locomotion on Unit ADL - Personal Hygiene ADL - Toilet Use ADL - Transferring ADL - Walk in corridor ADL - Walk in Room Apply house stock hydraguard to all extremities BID [twice a day] Bladder Continence Bowel Continence Bowel Movements Change resident's bed linen on shower days and as needed Hydration pass Oral Care Pressure Reducing Device Bed Skin Observation Apply house stock hydra-guard to all extremities	F 842		

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F 842	Continued From page 19 Staff to wash assistive devices on shower ADL - Eating and amount eaten HS SNACK Personalized hourly rounding for safety and fall prevention Interview on 1/11/22 at 12:05 PM with the Director of Nurses (DON), confirmed that there were numerous LNA tasks that were not documented as completed for the month of December 2021 - January 10, 2022. The DON confirmed that any blank areas in the LNA Interventions and Task sheet are considered not done. 2. Per record review Resident #5 was admitted on 8/6/2020 and began receiving Hospice services on 7/22/2021 and died in the facility on 11/19/2021. Review of the Licensed Nurse's Aide (LNA) Intervention and Task sheets for the months of September, October, and November 2021 revealed incomplete documentation as evidenced by multiple blank spaces in the following documentation areas: Bathing shower/bed bath, Bed Mobility, Dressing, Locomotion off and on Unit, Personal Hygiene, Toilet Use, Transferring, Walk in corridor, Walk in Room, Bladder Continence, Bowel Continence, Bowel Movements, Call Bell Alarm, Catheter, Float Heels at all times when in bed, Staff to wash wheelchair on shower day, Hydration pass, Oral Care, Pressure Reducing Device Bed, Pressure Reducing Device in Chair, Preventative Skin Care, Skin Observation, Turned and Repositioned, Eating and amount eaten, HS SNACK, Out of bed to dinette for all meals, Personalized hourly rounding for safety and to prevent falls, TED Stockings on when out of bed TED Stockings off in bed.	F 842		

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F 842	Continued From page 20 3. Per record review Resident #6 was admitted to the facility on 6/2/2020. Review of the LNA Intervention and Task sheets for the months of November, December 2021, and January 2022 reflect multiple blank spaces in the following areas: Bathing shower/bed bath, Bed Mobility, Dressing, Locomotion off Unit, Locomotion on Unit, Personal Hygiene Toilet Use, Transferring, Walk in corridor, Walk in Room, Bowel Continence, Bowel Movements, Call Bell Alarm, Float Heels at all times when in bed, Staff to wash wheelchair on shower day, Hydration pass, Oral Care, Pressure Reducing Device Bed, Pressure Reducing Device in Chair, Preventative Skin Care, Skin Observation, Turned and Repositioned, Eating and amount eaten, HS SNACK, Out of bed to dinette for all meals, Personalized hourly rounding for safety and fall prevention. 4. Per review of Resident #7 was admitted on 5/13/2021. The LNA Intervention and Task sheets for the months of December 2021 and January 2022 reflected incomplete documentation as evidenced by multiple blank spaces in the following areas: Bathing shower/bed bath, Bed Mobility, Dressing, Locomotion off Unit, Locomotion on Unit, Personal Hygiene, Toilet Use, Transferring, Walk in corridor, Walk in Room, Bladder Continence, Bowel Continence, Bowel Movements, Call Bell Alarm, Float Heels at all times when in bed, Hydration pass, Oral Care, Pressure Reducing Device Bed, Pressure Reducing Device in Chair, Preventative Skin Care, Skin Observation, Turned and Repositioned, Eating and amount eaten, HS SNACK, and Hourly rounding. 5. Per record review Resident #8 was admitted	F 842		

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F 842	Continued From page 21 on 1/6/2022 medical record, it was revealed that Licensed Nurse's Aide Intervention and Task sheets for January 6- January 9, 2022 were incomplete with multiple blank spaces, at least once daily in the following areas: Bathing shower/bed bath, Bed Mobility, Dressing, Locomotion off Unit, Locomotion on Unit, Personal Hygiene, Toilet Use, Transferring, Walk in Corridor, Walk in Room, Eating, Amount Eaten, Bladder Continence, Bowel Continence, Bowel Movements, Call Bell Alarm, Float Heels at all times when in bed, HS SNACK, Hydration Pass, Oral Care, Preventative Skin Care, Skin Observation, Bowel and Bladder Diary. During interview on 1/11/22 at 12:25 PM with the Director of Nurses (DON), s/he confirmed that Resident #5, #6, #7, and #8's LNA Intervention and Task sheets reflected incomplete documentation in the above care areas. The DON stated that it was recently identified that some of the traveling staff did not have access to the electronic medical records and others may need additional training in how to properly document. 6. Per revierw of LNA documentation, there is no documentation of ADL care being provided to Resident # 3 on 11/19/21. This is confirmed by the DON on 1/10/22 at 2:15 PM.	F 842		
F9999	FINAL OBSERVATIONS Based on staff interview and record review, the facility failed to maintain adequate staffing levels as required by Vermont State licensing regulations. Findings include:	F9999		

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F9999	Continued From page 22 Per review of facilty staffing levels, Licensed Nursing Assistant (LNA) hours did not meet regulatory requirements for December 2021. Regulation requires 2.0 LNA hours per resident per day (PPD). The following averages were calculated based on documents provided by the facility: 12/1/21 - 12/7/21 = 13.1 LNA PPD = 1.87 12/8/21 - 12/17/21 = 18.3 LNA PPD= 1.83 12/18/21 - 12/31/21 = 24.9 LNA PPD =1.70 Total LNA PPD 12/1/21 - 12/31/21 = 56.3 = 1.80 On 1/11/22 at 12:32 PM, the Director of Nurses confirmed that the facility did not meet the regulatory requirement for LNA staffing.	F9999	F9999 All residents are at risk for this alleged deficient practice. The facility will have the minimum staffing levels met to maintain the highest practical physical, mental and psychosocial well-being of each resident. The Administrator, Assistant Administrator, DNS, ADON, and the Scheduler have all been inserviced on requirements regarding sufficient nursing staff to maintain the highest practicable physical, mental and psychosocial well-being. The Administrator or designee will conduct random weekly X 4 and monthly X 2 schedule audits to ensure sufficient nursing staffing requirements are in place. The results of these audits will be brought to QAPI for review and interventions as needed. **TAG F 9999 POC Accepted on 1/31/22 by R. Tremblay/P. Cota**	2/3/22