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

April 25, 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 recertification survey conducted on **March 23, 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

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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 03/23/2022

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BURLINGTON HEALTH & REHAB	300 PEARL STREET BURLINGTON, VT 05401

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E 000	Initial Comments An unannounced onsite annual emergency preparedness review was conducted, in conjunction with the annual recertification survey, by the Division of Licensing & Protection on 3/21/2022 through 3/23/2022. There were no regulatory deficiencies identified as a result of the review.	E 000	The filing of this Plan of Correction does not constitute an admission of the allegations set forth in the statement of deficiencies. Burlington & Rehabilitation Center has prepared and executed a plan of correction as evidence of the facilities' continued compliance with applicable federal and state laws.	
F 000	INITIAL COMMENTS An unannounced onsite recertification survey, investigation of 2 complaints, and staff vaccination requirement review were completed by the Division of Licensing and Protection on 3/21/2022 - 3/23/2022. The following regulatory deficiencies were identified during the survey:	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and 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	F 550	Resident #32 and 36 continue to reside at the facility and have their needs met. All residents who require incontinence products are at risk for this alleged deficient practice. A house wide audit was conducted on all residents who require incontinence products to ensure they feel their dignity is maintained. All licensed nurses and LNA's were reeducated on treating residents with dignity/privacy/HIPAA in the presence of other residents and not using the term diaper when referring to incontinence briefs. Individual education was provided to the unit managers on appropriately addressing staff when issues are noted. The DNS or designee will conduct random weekly audits X 4 and monthly X 2 of residents who require incontinence products to ensure their dignity is maintained. The results of these audits will be reviewed at QAPI for further interventions if needed.	4/22/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shawn T. Hallisey   TITLE: Administrator   (X6) DATE: 4/18/22

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 550	Continued From page 1 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 interviews with residents and staff, the facility failed to ensure that staff treated each resident with dignity for 2 of 30 sampled residents (#32 and #36) by using degrading terms and discussing resident care in front of other residents. Findings include: 1. Per record review, Resident #32 has diagnoses that include quadriplegia, neuromuscular dysfunction, and multiple sclerosis. An activities of daily living (ADL) care plan initiated on 2/9/2021 reflects that the resident is incontinent of urine and bowel and uses disposable briefs, which are to be changed during her/his requested allotted times or as	F 550	**TAG F 550 POC Accepted on 4/25/22 by J. Kendall/P. Cota**	

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F 550	Continued From page 2 needed. During an interview with resident #32 on 03/22/22 11:02 AM, the resident stated that some staff, usually agency staff, call her/his Depends "diapers" and that it is very humiliating. The resident was visibly upset while s/he spoke of this in an angry tone. During an interview on 3/23/22 at 11:05 AM, the UM stated that s/he did recall an incident when staff used the word diaper when caring for resident #32. S/he said that it is a regional term that some of the agency staff use. The UM confirmed that using the term diaper can be undignified, and it should not be used when referring to residents' incontinence products. 2. During an interview with resident #36 on 3/22/22 at 9:06 AM, s/he stated that staff do not treat residents with dignity. S/he said that how staff talk to other residents and their tone of voice is not good. S/he stated that staff talk to each other about not wanting to take care of certain residents in front of other residents and it doesn't make her feel like she is treated well. During an interview on 3/23/2022 at 11:05 AM, the Unit Manager (UM) reported that s/he was not familiar with that specific incident but has heard reports of staff talking about caring for residents in front of other residents. The UM confirmed that staff discussing residents' care in the presence of other residents was not acceptable practice and should not occur. During an interview with the Director of Nursing (DON) on 3/23/22 at 2:00 PM, s/he indicated that staff talking about residents in front of other	F 550		

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F 550	Continued From page 3 residents was unacceptable and confirmed that the UM should have addressed these issues.	F 550		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that abuse and neglect screening policies of potential employees were implemented for 1 of 6 sampled staff. Findings include: Per review of six employee files, the required background checks were not completed for one contracted Licensed Practical Nurse (LPN). As of 3/23/22 at 3:45 PM, the file for this LPN did not include background checks for the Vermont Adult Abuse Registry as required. Per observation and review of schedule, this LPN is currently working at the facility. Per interview with the Human Resource (HR) Manager on 3/23/22 at 3:45 PM, s/he confirmed that the background checks for this LPN had not	F 607	The LPN (RD, doh 1/13/22) noted by the surveyor to not have a background check completed, did in fact have it completed on 1/5/22 (8 days prior to arrival) and was provided to the surveyor on 3/30/22 via email. A house wide audit was conducted of all new employees including agency to ensure continued compliance. The facility is IDR'ing this tag in light of the documentation found and submitted to the surveyor after leaving the facility. The DNS or designee will conduct random weekly X4 and monthly X 2 audits of all new hires to ensure continued compliance with staff back ground checks. The results of these audits will be brought to QAPI for review and interventions if needed. **TAG F 607 POC Accepted on 4/25/22 by J. Kendall/P. Cota**	4/22/22

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F 607	Continued From page 4 been fully completed at the time of hire, and that it should have been done before s/he started working. The HR manager reported that the contracted agency typically sends background checks for their staff. The facility would then conduct their own background checks to include the Adult Abuse Registry, which had not been conducted for this LPN.	F 607		
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	F 656	Residents #49, 68, and 81 continue to reside at the facility and have their needs met. All residents who receive nutrition through a tube feed, have a diagnosis of malnutrition or have impaired swallowing are at risk for this alleged deficient practice. A house wide audit was conducted of all residents who receive nutrition via tube feeding, have a diagnosis of malnutrition or have impaired swallowing to ensure weights are being obtained as ordered. All licensed nurses and LNAs were reeducated on obtaining weights as ordered, including reweights. The DNS or designee will conduct random weekly audits X 4 and monthly X 2 of all tube fed residents, malnourished and residents with impaired swallowing to ensure weights are obtained as ordered. These audits will be brought to QAPI for review and further interventions if needed.	4/22/22

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F 656	Continued From page 5 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to implement Care Plan interventions for 3 residents [Res. #49, #68, & #81] of 44 sampled residents. The Care Plan interventions were regarding weights for residents diagnosed with malnutrition [Res. #49], impaired swallowing [Res. #68], and being fed through a tube [Res.#81]. Findings include: 1.) Review of Res. #49's medical record reveals the resident was admitted to the facility on 10/6/21 with diagnoses that included Dysphagia [difficulty swallowing] and Malnutrition. Shortly after admission, on 10/11/21 Res. #49 was identified in their Care Plan as "may be nutritionally at risk related to dysphagia, weight loss, compromised skin integrity" increased calorie/protein needs to support wound healing, weight loss." Care Plan interventions to be implemented included "Record and Monitor Weights". Review of Physician Orders dated the day after	F 656	**TAG F 656 POC Accepted on 4/25/22 by J. Kendall/P. Cota**	

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admission, 10/7/21, read "Weigh Patient every day shift for Health Monitoring" -start 10/7/21 end 1/13/22. Per record review, out of 99 days the resident was ordered to be weighed, weights are recorded for only 11 days. From admission to the order end date, the resident is recorded as losing 16.7 lbs. [pounds] - a 12.37% weight loss in 3 months. [The Centers for Medicare and Medicaid Services (CMS) defines significant unintended weight loss as a weight loss of : 5% body weight in 30 days, or; 7.5% body weight in 90 days, or; 10% body weight in 180 days]

A Nutritional Assessment was conducted for Res. #49 on 1/17/22. The Assessment reports "Resident status post hospital stay due to pneumonia, empyema [A collection of pus in the pleural cavity, a space between lungs and inner surface of the chest wall]. Noted with worsened skin integrity, infection, which increases calorie/protein needs. Weight loss continues as well." The Assessment identified the resident as:
-At risk for unintended weight loss: multiple medical complications, increased calorie/protein needs;
-At risk for dehydration: infection, compromised skin integrity;
-At risk for pressure ulcer due to nutrition: already compromised skin integrity and increased calorie/protein needs.

Review of Physician Orders for Res. #49 dated 2/10/22 read "Weigh weekly-in the morning every Monday for monitoring" The start date for the order is 2/14/22. The Physician Order includes "Add diagnosis of Malnutrition". Per the physician's order, weights should have been obtained on 2/14, 2/21, 2/28, 3/7, 3/14, & 3/21. Per review of Res. #49's medical record, there

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F 656	Continued From page 7 are no weekly recorded weights, beginning from the order start date of 2/14/22 thru the date of the survey 3/23/22. Review of Nurses Notes for the dates the weights were to be recorded contain no documentation of refusal or why the weights were not obtained. Review of Nursing documentation on 3/2/22 lists the resident's weight from 1/18/22 as the most recent weight. 2.) Review of Res. #68's medical record reveals the resident was admitted to the facility on 10/6/21 with diagnoses that included Paralysis of Vocal Cords and Larynx, Dysphagia [difficulty swallowing], and a history of diseases of the digestive system. Per review of Res. #68's Care Plan, the resident was identified as having "impaired swallowing related to Paralysis of Larynx and dysphagia" with interventions that include "Monitor Weight". The resident's Care Plan also notes the resident "may be nutritionally at risk related to increased calorie/protein needs related to compromised skin integrity, therapeutic diet", with interventions that include "Record and monitor weights". Review of Physician Orders for Res. #68 dated 12/18/21 include "Weight Daily one time a day for Health Monitoring". Review of Res. #68's medical record reveals the resident was never weighed daily per Physician Order on 12/18/21, including up to the day of the survey [3/23/22]. Per record review, the most recent recorded weight on the day of the survey [3/23/22] was 8 days earlier on 3/15/22. Review of recorded weights for the resident document wide fluctuations, with gains of 15 lbs. [pounds] in one week [12/21/21 to 12/28/21], loss of 30 lbs. in 15 days [12/28/21 to 1/12/22] then gain of 23 lbs. in 2 days [1/12/22 to 1/14/22. Further review	F 656		

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F 656	Continued From page 8	F 656		

reveals Res. #68 with an overall weight gain of 20.3 lbs. from the beginning of the Daily Weight order to h/her last recorded weight on 3/15/22.

Nutritional Notes dated 2/2/22 reveal "Wide weight fluctuation noted, likely due to fluid shifts." Review of Res. #68's Care Plan includes Res. #68 identified as "at risk for fluid overload or potential fluid volume overload related to Congestive Heart Failure", with interventions of "Fluid restriction" and "Observe for/document/report to Physician as needed signs and symptoms of fluid overload: ...sudden weight gain". There is no documentation that Res. #68's Physician was notified of the resident's wide fluctuations of weight or that the resident was not being weighed per h/her Care Plan and physician order.

3.) Review of Res. #81's medical record reveals the resident was admitted to the facility on 10/20/21 with diagnoses that included a Gastrostomy [a procedure in which a tube is placed into the stomach for nutritional support], Stroke, and Dysphagia [difficulty in swallowing].

Physician Orders on Res. #81's admission to the facility included "Weight every day shift every 1 month(s) starting on the 1st for 2 day(s) for Health Monitoring" and "Weight -every day shift every Thursday for Health Monitoring until 11/18/2021".

Review of Res. #81's Nutritional Risk Assessment for h/her admission records "Resident is dependent on enteral nutrition for nutritional needs ...Per hospital notes weight has fluctuated ; 180-160 pounds over last few months. Initiating nutrition Care Plan. Continue to monitor tube

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F 656	Continued From page 9 feeding tolerance/weight." Upon admission, Res. #81 was identified in their Care Plan as "may be nutritionally at risk related to enteral nutrition [nutrition thru tube feeding into the intestine] related to dysphagia, increased calorie/protein needs to support wound healing, weight loss." Care Plan interventions to be implemented because the resident was being fed through a tube and had increased nutritional needs included "Record and Monitor Weights". Review of Res.#81's medical record reveals that the day after admission, 10/21/21, the resident's weight is recorded as 152.6 lbs. [pounds]. The next day, 10/22/21, the resident's weight is listed as 144.7 lbs. [a loss of 7.9 lbs. in one day]. Per physician order, the resident was due to be weighed again on 10/28/21 ["weight -every day shift every Thursday for Health Monitoring until 11/18/2021" (10/28, 11/4, 11/11, 11/18)]. Per review of Res.#81's medical record, the next recorded weight is on 11/2/21, 11 days since the previous weight. Per Nursing Notes dated 11/2/21 "Resident presents significant weight gain of about 20 lbs. from last weigh. Writer along with CNA reweighed resident two times ...resident's body weight is 167 lbs." Per physician order, the resident was to be next weighed on 11/4/22. Per record review, there is no documentation of Res. #81 being weighed on that date. Dietary Notes dated 11/8/21 record "Re-weigh done [on 11/2/22]: 167 lbs. Weights noted with wide fluctuation ... Will request weekly weights to establish a new baseline." Multidisciplinary Care Conference Notes dated	F 656		

F 656 Continued From page 10 F 656

11/9/21 reveal Res. #81 "is noted with wide weight fluctuation since admission- question accuracy of some weights. Suggest weighing weekly to establish a baseline... Recommend weekly weights. Goal is weight maintenance, good tolerance of enteral feeding."

Review of Res.#81's medical record reveals the next recorded weight 10 days later on 11/18/21 [per physician order regarding weights every Thursday, the next weight was due on 11/11/21]. The resident's weight is listed as 170.7 Lbs. Review of Res.#81's medical record reveals the next recorded weight on 12/2/21 [14 days after the last recorded weight. There is no record of weekly weights being conducted as requested by Dietary and noted in Multidisciplinary Care Conference Notes.] The resident's weight is recorded as 134.0 Lbs.

Review of Dietary Notes dated 12/8/21 read "December weight shows 36 lb. weight loss in ~3 wks. Requested re-weigh to verify accuracy- pending." Physician Orders dated 12/16/21 list an order to "Obtain weight and document in vital sign section for 12/16 and 12/17. Review of Res.#81's vital sign section in h/her medical chart reveal no weights recorded for 12/16 or 12/17. Dietary Notes dated 12/20/21 read "Resident's re-weigh not done yet despite several requests ...Continue to request re-weigh to verify current weight accuracy."

On 1/3/22, 27 days after Dietary requested Res. #81 be reweighed because of a 36 lbs. weight loss, Res. #81 was reweighed. Per review of Dietary Notes for 1/3/22, "Re-weigh obtained: 156.7#. Previous weight of 134 lbs. struck out due to likely inaccurate. Weight noted with

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F 656	Continued From page 11 continued wide fluctuation." Review of Social Service Notes for 1/10/22 reveal "Social Service Director [SSD] talked to [Res. #81's responsible party] via phone on this day. SSD gave an update on [Res. #81's] progress. SSD informed [Res. #81's responsible party] of increase of [Res. #81's] tube feed due to weight loss." Further review of Res. #81's medical record reveal weights not recorded per physician order ["weight every day shift every 1 month(s) starting on the 1st for 2 day(s) for Health Monitoring"] for the current month of March 2022. An interview was conducted with the facility's Director of Nursing [DON] on 3/23/22 at 12:38 PM. The DON confirmed that Residents #49, #68, & #81 were not weighed per physician orders and per the residents' Care Plans. An interview was conducted with the facility's Dietician on 3/23/22 at 1:31 PM. The Dietician confirmed that Residents #49, #68, & #81 were not weighed per physician orders and per the residents' Care Plans. The Dietician stated that getting consistent and accurate weights for multiple residents at the facility "has been a struggle", and that h/she has "communicated frequently" with staff about missing weights. The Dietician further stated that "I don't know why" residents' weights are not being completed as ordered.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		

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F 657	Continued From page 12 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, Interview, and record review, it was determined that the facility failed to update a care plan for 1 of 33 residents (Resident #34). Findings include: During record review it was revealed that Resident #34 had the following comprehensive care plan: "[proper name omitted] is an elopement risk r/t [related to] cognition deficits and high mobility status". This care plan was initiated on 12/15/2020 and was last revised on 06/28/2021. One of the interventions was listed as: "WANDER ALERT: Expires 01/2022" and the	F 657	Resident #34 continues to reside at the facility and have their needs met. All residents with wandergaurds are potentially at risk for this alleged deficient practice. A house wide audit was conducted of all residents with wandergaurds in place to ensure all care plans are updated with the correct information. All licensed nurses were reeducated to the updating of care plans for residents with wandergaurds. The DNS or designee will conduct random weekly audits X 4 and monthly X 2 on all residents with wandergaurds to ensure their care plans reflect the correct information. These audits will be reviewed at QAPI for further interventions if needed. **TAG F 657 POC Accepted on 4/25/22 by J. Kendall/P. Cota**	4/22/22

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date initiated was 04/23/2021 with a revision date of 04/23/2021. A second comprehensive care plan was noted as follows: "Potential for elopement and associated injury related to exit seeking behavior." This care plan was initiated on 12/15/2020 and was last revised on 02/24/2021. The goal for this care plan was listed as follows: "Resident will not wander out of facility through next review" and the date this care plan was initiated is listed as 12/15/2020, with a revision date of 02/24/2021 and a target date of 06/08/2022. One of the interventions for this goal was listed as: "wanderguard device - check placement and function each shift" and the date this intervention was initiated is listed as 02/09/2021.

Observation on 3/22/22 at approximately 3:50 PM of Resident #34, in her/his room with travel LPN (Licensed Practical Nurse) revealed that Resident #34 was not wearing a wanderguard device. The nurse asked the resident where her/his bracelet was and s/he did not know. The nurse did a search of the residents room and could not locate the device and did not know what happened to the device or when s/he last saw the device on the resident.

Interview on 3/22/22 at approximately 4 PM with the Unit Manager, stated that the resident did have a wanderguard device in place as the resident was an elopement risk. Review with the Unit Manager of Resident #34's care plan revealed the care plan for elopement listed the following intervention: "WANDER ALERT: Expires 01/2022". The Unit Manager explained that this would be the expiration date of the wanderguard device itself and confirmed that the physician's order for the use of the wanderguard

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F 657	Continued From page 14 device was still in effect. The Unit Manager confirmed that the care plan had not been updated to reveal an updated wanderguard device expiration date as it was listed on the care plan as expiring on 1/2022.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was revealed that the facility failed to ensure the resident receives adequate supervision and assistance devices to prevent accidents for 1 resident in a standard survey sample of 33. (Resident #34) Findings include: Resident #34 During record review it was revealed that Resident #34 had a care plan for elopement risk r/t [related to] cognition deficits and high mobility status. This care plan was initiated on 12/15/2020 and was last revised on 06/28/2021. One of the interventions was listed as: "WANDER ALERT: Expires 01/2022" and the date initiated was 04/23/2021 with a revision date of 04/23/2021. A second comprehensive care plan was noted for potential for elopement and	F 689	Resident #34 continues to reside at the facility and have their needs met. All residents with wandergaurds are potentially at risk for this alleged deficient practice. A house wide audit was conducted of all residents with wandergaurds to ensure they were in place. All licensed nurses were reeducated on the proper procedure for checking and signing off that the wandergaurds are in place as care planned/ordered. The DNS or designee will conduct random weekly audits X 4 and monthly X 2 on all residents with wandergaurds to ensure nurses are properly checking and signing off on wandergaurds as care planned/ordered. These audits will be reviewed at QAPI for further interventions if needed. **TAG F 689 POC Accepted on 4/25/22 by J. Kendall/P. Cota**	4/22/22

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F 689	Continued From page 15	F 689		

associated injury related to exit seeking behavior. This care plan was initiated on 12/15/2020 and was last revised on 02/24/2021. The goal for this care plan was listed as follows: "Resident will not wander out of facility through next review" and the date this care plan was initiated is listed as 12/15/2020, with a revision date of 02/24/2021 and a target date of 06/08/2022. One of the interventions for this goal was listed as: "wanderguard device - check placement and function each shift" and the date this intervention was initiated is listed as 02/09/2021. A physicians order reveals that there is an active order for the Wanderguard device. The order reads: "Wanderguard (Expires 1/2022) Check placement q [every] shift every check for proper placement [sic]? The order was started on 4/23/21 and has not been discontinued.

Observation on 3/22/22 at approximately 3:50 PM of Resident #34, in her/his room with travel LPN (Licensed Practical Nurse) revealed that Resident #34 was not wearing a wanderguard device. The nurse asked the resident where her/his bracelet was and s/he did not know. The nurse did a search of the residents room and could not locate the device and did not know what happened to the device or when s/he last saw the device on the resident.

Interview on 3/22/22 at approximately 4 PM with the Unit Manager, stated yes, indeed the resident needs to have the Wanderguard in place is the resident was an elopement risk. The nurse informed the Unit Manager that the resident was not wearing a wanderguard device and s/he was not sure what happened to the device the resident had been wearing and s/he was not sure when s/he recalls last seeing it on the resident.

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F 689	Continued From page 16 The Unit Manager stated s/he was not aware of the device being removed.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to ensure that a resident maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range by failing to obtain weight(s) and to verify weight(s) as needed for 1 resident [Res. #81] of 1 resident identified as requiring tube feeding. Findings include: Review of Res. #81's medical record reveals the	F 692	Resident #81 continues to reside at the facility and have their needs met. All residents who receive nutrition through a tube feed, have a diagnosis of malnutrition or have impaired swallowing are at risk for this alleged deficient practice. A house wide audit was conducted of all residents who receive nutrition via tube feeding, to ensure weights are being obtained as ordered. All licensed nurses and LNAs were reeducated on obtaining weights as ordered, including reweights. The DNS or designee will conduct random weekly audits X 4 and monthly X 2 of all tube fed residents, to ensure weights are obtained as ordered. These audits will be brought to QAPI for review and further interventions if needed. **TAG F 692 POC Accepted on 4/25/22 by J. Kendall/P. Cota**	4/22/22

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resident was admitted to the facility on 10/20/21 with diagnoses that included a Gastrostomy [a procedure in which a tube is placed into the stomach for nutritional support], Stroke, and Dysphagia [difficulty in swallowing].

Physician Orders on Res. #81's admission to the facility included "Weight every day shift every 1 month(s) starting on the 1st for 2 day(s) for Health Monitoring" and "Weight -every day shift every Thursday for Health Monitoring until 11/18/2021".

Review of Res. #81's Nutritional Risk Assessment for h/her admission records "Resident is dependent on enteral nutrition for nutritional needs ...Per hospital notes weight has fluctuated ; 180-160 pounds over last few months. Initiating nutrition Care Plan. Continue to monitor tube feeding tolerance/weight."

Upon admission, Res. #81 was identified in their Care Plan as "may be nutritionally at risk related to enteral nutrition [nutrition thru tube feeding into the intestine] related to dysphagia, increased calorie/protein needs to support wound healing, weight loss." Care Plan interventions to be implemented because the resident was being fed through a tube and had increased nutritional needs included "Record and Monitor Weights".

Review of Res.#81's medical record reveals that the day after admission, 10/21/21, the resident's weight is recorded as 152.6 lbs. [pounds]. The next day, 10/22/21, the resident's weight is listed as 144.7 lbs. [a loss of 7.9 lbs. in one day].
Per physician order, the resident was due to be weighed again on 10/28/21 ["weight -every day shift every Thursday for Health Monitoring until

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F 692	Continued From page 18 11/18/2021" (10/28, 11/4, 11/11, 11/18)]. Per review of Res.#81's medical record, the next recorded weight is on 11/2/21, 11 days since the previous weight. Per Nursing Notes dated 11/2/21 "Resident presents significant weight gain of about 20 lbs. from last weigh. Writer along with CNA reweighed resident two times ...resident's body weight is 167 lbs." Per physician order, the resident was to be next weighed on 11/4/22. Per record review, there is no documentation of Res. #81 being weighed on that date. Dietary Notes dated 11/8/21 record "Re-weigh done [on 11/2/22]: 167 lbs. Weights noted with wide fluctuation ... Will request weekly weights to establish a new baseline." Multidisciplinary Care Conference Notes dated 11/9/21 reveal Res. #81 "is noted with wide weight fluctuation since admission- question accuracy of some weights. Suggest weighing weekly to establish a baseline... Recommend weekly weights. Goal is weight maintenance, good tolerance of enteral feeding." Review of Res.#81's medical record reveals the next recorded weight 10 days later on 11/18/21 [per physician order regarding weights every Thursday, the next weight was due on 11/11/21]. The resident's weight is listed as 170.7 Lbs. Review of Res.#81's medical record reveals the next recorded weight on 12/2/21 [14 days after the last recorded weight. There is no record of weekly weights being conducted as requested by Dietary and noted in Multidisciplinary Care Conference Notes.] The resident's weight is recorded as 134.0 Lbs. Review of Dietary Notes dated 12/8/21 read "December weight shows 36 lb. weight loss in ~3 wks. Requested re-weigh to verify accuracy- pending."	F 692		

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Physician Orders dated 12/16/21 list an order to "Obtain weight and document in vital sign section for 12/16 and 12/17. Review of Res.#81's vital sign section in h/her medical chart reveal no weights recorded for 12/16 or 12/17.
Dietary Notes dated 12/20/21 read "Resident's re-weigh not done yet despite several requests...Continue to request re-weigh to verify current weight accuracy."
On 1/3/22, 27 days after Dietary requested Res. #81 be reweighed because of a 36 lbs. weight loss, Res. #81 was reweighed.
Per review of Dietary Notes for 1/3/22, "Re-weigh obtained: 156.7 lbs. Previous weight of 134 lbs. struck out due to likely inaccurate. Weight noted with continued wide fluctuation."
Review of Social Service Notes for 1/10/22 reveal "Social Service Director [SSD] talked to [Res. #81's responsible party] via phone on this day. SSD gave an update on [Res. #81's] progress. SSD informed [Res. #81's responsible party] of increase of [Res. #81's] tube feed due to weight loss."
Further review of Res. #81's medical record reveal weights not recorded per physician order ["weight every day shift every 1 month(s) starting on the 1st for 2 day(s) for Health Monitoring"] for the current month of March 2022.

An interview was conducted with the facility's Director of Nursing [DON] on 3/23/22 at 12:38 PM. The DON confirmed that Res. #81 was not weighed per physician orders and that recorded weights were questionable, with recorded weights showing wide fluctuations. The DON confirmed Dietician' requests for reweighs were not addressed for weeks. The DON reported that the facility's Dietician would 'know more' about resident weights

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F 692	Continued From page 20 An interview was conducted with the facility's Dietician on 3/23/22 at 1:31 PM. The Dietician confirmed that Res. #81 was not weighed per physician orders. The Dietician confirmed recorded weights were questionable, with recorded weights showing wide fluctuations, with gains of 7.9 lbs. in one day, another gain of 20 lbs. between weights, and a weight loss of 36 lbs. in 3 weeks. The Dietician also confirmed requests for reweighing were not done for 27 days after multiple requests, and that Res. #81's tube feedings were increased due to weight loss. The Dietician stated that getting consistent and accurate weights for multiple residents at the facility "has been a struggle", and that h/she has "communicated frequently" with staff about missing weights. The Dietician further stated that "I don't know why" residents' weights are not being completed as ordered. The Dietician reported h/she issues a 'Nutrition Weight Report' for all resident units, which includes residents with missing weights. Per review of the Dietician's Nutrition Weight Report dated 3/16/22, Res. #81 is listed as 'missing weights'.	F 692		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and	F 726	This alleged deficiency for all nursing staff in 2021 was identified in December internally and is part of an existing QAPI. A house wide audit of all current employees was conducted at that time to ensure compliance with required competencies. Education has been completed with the DNS, Nurse Educator, HR and the Unit Managers of the new hire process for competencies. This was actively underway during the survey process. In addition competency clinics were held on 4/5/22 and 4/11/22. The DNS or designee will conduct random weekly audits X4 and monthly X2 to ensure that all new nursing staff have appropriate competencies completed per policy. These audits will be brought to QAPI for review and further interventions if needed.	4/22/22

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diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to ensure that the nursing staff had the specific competencies and skill sets necessary to care for residents' needs for 5 of the 6 sampled employee records.

Findings include:

Per New Employee Competency Completion Log, facility determined onboarding competencies include: medication administration, dressing changes, safe handling skills, and hand hygiene. Per the Facility Assessment, specific care and practices offered by the facility for resident care include: transferring residents, performing pressure injury prevention and care, wound care,

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administration of medications, and infection prevention and control practices. Per review of 6 sampled employee files revealed;

1. One contracted Licensed Practical Nurse (LPN), hired in March 2022, and one Registered Nurse (RN), hired in June 2021, did not have onboarding competencies to demonstrate that they had the skills necessary to perform resident care.

2. One contracted LPN, hired in December 2021, did not have all facility determined onboarding competencies to demonstrate that they had the skills necessary to perform resident care. Specifically, medication administration was not documented as reviewed, but instead had a red dot next to it.

Per interview with the Regional Nurse Consultant on 3/23/2022 at 2:00 PM, s/he had gone over the competencies with this LPN by having a conversation with him/her after s/he observed the LPN demonstrate the skills. S/he explained that s/he checked off the competencies that s/he observed the LPN demonstrate and put a dot next to the ones that s/he was unable to demonstrate because there was not an opportunity to do so. Per observation and review of schedule, this LPN is currently working at the facility administering medications.

3. Two License Nurse Aids (LNAs), hired before 2021, did not have evidence that annual competencies had been completed during 2021.

Per interview with the Nurse Educator on 3/23/22 at 11:27 AM, s/he is new to the position, and was not sure when annual competencies were done

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	475014	A. BUILDING ______ B. WING ______	C 03/23/2022

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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 726	Continued From page 23 last. S/he confirmed that there are no cultural competencies included in the training's. On 3/23/22 at approximately 2:30 PM, the Nurse Educator produced staff files with competencies completed in 2021. Upon examination it was determined that they were onboarding competency checks for new hires, and not annual competencies for permanent staff. The facility was unable to provide evidence that the 6 employees reviewed were assessed for competency in 2021.	F 726		
F 741 SS=E	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents 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 §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be	F 741	All residents with behavioral health needs/dementia are at potential risk for this alleged deficient practice. A house wide audit of all current employees was conducted to ensure compliance with behavioral health/dementia training. Education has been completed with the DNS, Nurse Educator, and HR on the required new hire behavioral health/dementia training required. New orientation checklists have been implemented. The DNS or designee will conduct random weekly audits X4 and monthly X2 to ensure that all new nursing staff have appropriate competencies completed per policy. These audits will be brought to QAPI for review and further interventions if needed.	4/22/22

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F 741	Continued From page 24 implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure that 3 of 6 sampled staff members were provided with dementia specific training. Findings include: Per review of the facility Resident Matrix (a Centers for Medicare and Medicaid [CMS] form completed by the facility, used to identify pertinent care areas) dated 3/21/2022, revealed 36 of 107 residents residing in the facility have diagnoses of Alzheimer's/Dementia. Per review of 6 sampled employee files, one contracted Licensed Practical Nurse (LPN), hired in December 2021, did not have evidence of dementia specific training in their education file. Two License Nurse Aids (LNAs), both hired before 2021, did not have evidence of dementia specific training in their education files for 2021. Per interview with the Director of Nursing on 3/23/2022 at 1:49 PM s/he reported that the previous educator may have done these training's, but they are unable to find them. There was no evidence provided that the LPN or Two LNAs received any dementia specific training since 2020.	F 741	**TAG F 741 POC Accepted on 4/25/22 by J. Kendall/P. Cota**	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review.	F 756	Resident #38 continues to reside at the facility and have their needs met.	4/22/22

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F 756	Continued From page 25 §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, and interview, it was	F 756	An AIMs test was conducted as recommended. The proper diagnosis was added to the residents medication order. All residents who receive pharmacy recommendations and are on antipsychotic medications are at risk for this alleged deficient practice. A house wide audit was conducted on all residents who are prescribed antipsychotic medications to ensure the proper AIMs tests and diagnosis are listed. All licensed nurses were reeducated on obtaining proper diagnosis for antipsychotic medications along with performing AIMs tests as indicated. A process was put in place to ensure pharmacy recommendations are addressed timely. The DNS or designee will conduct random weekly audits X 2 and monthly X 4 to ensure continued compliance with pharmacy recommendations for residents who are prescribed antipsychotic medication. The results of these audits will be brought to QAPI for review and further interventions if needed.	

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F 756	Continued From page 26	F 756		

determined that the facility failed to act on a recommendation from the pharmacist for 1 resident in a standard survey sample of 33 residents (Resident #38).

TAG F 756 POC Accepted on 4/25/22 by J. Kendall/P. Cota

Findings include:

Per record review, Resident #38 had a Physician order for Risperidone. The facility's consulting Pharmacist completed a pharmacy review on 12/7/21, 1/7/22, and again on 2/3/22 and made a recommendation for ".......movement test, such as AIMS, be performed initially (within 30 days), and then at least every six months while this resident continues on antipsychotic therapy". The facility did not follow the facility's consulting Pharmacist's recommendations until 2/6/22 almost 2 months after the initial recommendation was made. The facility's consulting Pharmacist completed a pharmacy review on 1/7/22, making the following recommendation, "Please either add this dx/ICD-10 to the Med Diag code or change diagnosis on eMAR [electronic Medication Administration Record] to something resident has in MEd Diag tab, like dementia with behavioral disturbances, thanks!". On 2/3/22, a similar recommendation was made that stated, "Please add Bipolar to the Med Diag/ICD-10 list", the risperdone was ordered "[sic] for bipolar [sic], or change indication to "[sic] dementia with behavioral disturbances/psychotic disorder w/delusions"[sic], which is in ICD-10, thanks!"

Interview on 3/23/22 at approximately 2:40 PM, the DON (Director of Nurses) confirmed that the Pharmacist's recommendation made on 12/7/21, and 1/7/22 had not been acknowledged by the physician, and there had been no follow through on these recommendations.

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F 880 SS=E	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; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880	Resident #21 and 47 continue to reside at the facility and have their needs met. All residents have the potential to be affected by this alleged deficient practice. All staff who interact with residents have be reeducated on hand hygiene expectations, with a focus on when it is needed, when performing glove changes and when it is needed upon interacting with residents or leaving residents rooms. All staff who enter residents room have been educated on the proper use of PPE for residents on precautions. All nurses and LNAs have had hand washing competencies completed. A root cause analysis was conducted and is attached. The DNS or designee will conduct random audits weekly X 4 and monthly X2 to ensure proper hand hygiene compliance. The results of these audits will be brought to QAPI for review and further interventions if needed.	4/22/22

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(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 observation and staff interviews the facility failed to adhere to infection prevention and control program standards for 2 applicable sampled residents and hand hygiene during dining services (Resident #21, and#47).

Findings include:

1. Per observation on 03/22/22 at 9:57 AM, staff failed to perform hand hygiene between glove changes during a dressing change. Resident # 47

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has a stage 3 pressure ulcer in coccyx area. There is a physician order to change the dressing on a daily basis.
On 03/22/22 at 1:44 PM, the nurse that did the dressing change confirmed that h/she did not sanitize his/her hands between glove changes and stated that he/she should have.

2.) Per observation and interview with direct care staff on the facility's 3rd floor resident unit, Res. #21 was placed on infection control precautions due to an active medical condition. Staff reported that all people entering the resident's room were required to don disposable gloves, a disposable gown, an N95 respirator mask and a face shield. Additionally, all persons were to sanitize their hands before and after leaving the resident's room. Signage on Res. #21's doorway read "Patient Specific: Contact Plus Airborne Precautions. Wear N95 respirator, gown, face shield and gloves upon entering room." A clear plastic cart to right side of resident's doorway contained Personal Protective Equipment [PPE], including gowns and 4 boxes of various size gloves on top of plastic cart.
Per observation, on 3/21/22 at 11:06 AM the facility's Administrator [ADM] entered Res. #21's room without PPE- gown or gloves. After approximately 10 minutes, the ADM was observed exiting the room, closing door, and walking down hallway. The ADM was not observed performing hand hygiene before or after exiting room.

3.) Observation on 3/21/22 at 12:00 noon during

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F 880	Continued From page 30 meal pass, revealed an LNA (Licensed Nurses Aide) donning and doffing gloves between tasks of making tea, handling food covers/lids, delivering drinks to residents, passing meal plates, moving a table to accommodate the need for more room to assist a resident with eating, s/he moved a cardiac chair from one place to another in the dining area. S/he went to the steam table to get a straw, and then s/he went into room 411 to obtain a chair so s/he could feed a resident. During all these tasks the LNA donned and doffed gloves 5 times without performing hand hygiene in between. Interview at approximately 1:30 PM with the LNA noted above, who stated s/he knows the policy and procedure of the facility is to perform hand hygiene with either soap and water or an alcohol based hand rub between donning and doffing gloves. S/he explained the expected procedure and confirmed that s/he had not done any hand hygiene in between donning and/or doffing gloves during the tasks that she performed during meal time. The LNA stated that the facility has had some issue with their supply of hand sanitizer and often times the dispensers are empty. The LNA attempted to demonstrate that the hand sanitizers in the dining area on the 4th floor. The hand sanitizer in question was full of alcohol based hand rub. Other staff were noted at the 12:00 noon to be using the hand sanitizer dispensers during meal time, including the one in question. The LNA stated, "Well at least I did part of the process."	F 880		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse	F 947		

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F 947	Continued From page 31 aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure that the nursing staff received required abuse training and had the specific competencies and skill sets necessary to care for residents with dementia for 2 of the 3 Licensed Nursing Assistants (LNAs). Findings include: Per review of employee files, 2 License Nurse Aide's (LNAs) do not have evidence of dementia or abuse training being completed since 2020. The facility Resident Matrix (a Centers for Medicare and Medicaid [CMS] form completed by the facility, used to identify pertinent care areas) dated 3/21/2022, revealed 36 of 107 residents residing in the facility have diagnoses of	F 947	This alleged deficiency for all LNAs in 2021 was identified in December internally and is part of an existing QAPI. A house wide audit of all current employees was conducted at that time to ensure compliance with required competencies. Education has been completed with the DNS, Nurse Educator, of the annual dementia and abuse training that is to be done annually. This was actively underway during the survey process. The DNS or designee will conduct random weekly audits X4 and monthly X2 to ensure that all current LNA's have the required annual dementia and abuse training. These audits will be brought to QAPI for review and further interventions if needed. **TAG F 947 POC Accepted on 4/25/22 by J. Kendall/P. Cota**	4/22/22

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F 947	Continued From page 32 Alzheimer's/Dementia. Per interview with the Director of Nursing on 3/23/2022 at 1:49 PM s/he reported that the previous educator may have done training and competencies, but they are unable to find them. There was no evidence provided by the facility that the two LNAs received the required abuse or dementia training since 2020.	F 947		

ROOT CAUSE ANALYSIS REPORT

ORGANIZATION	
FACILITY	BURLINGTON HEALTH AND REHAB – QUEEN CITY NURSING
DATE OF EVENT 3/23/2022	DATE RCA COMPLETED 4/9/2022

EVENT DETAILS	
EVENT DESCRIPTION	LIST RCA TEAM MEMBERS
1) Nurse during a treatment was being observed by surveyor, nurse did not sanitize hands between glove change *2) LNA wore gloves while passing trays, did not sanitize hands between glove changes* *3) Staff member entered isolation room without proper PPE*	

BACKGROUND SUMMARY

Answer these questions with a brief summary. Attach supporting documents, if available.

1) Nurse did not frequently work on floor or perform treatments often; she was nervous about having a surveyor watch her perform the treatment. Nurse was aware of need to sanitize between glove changes.
2) The LNA knew policy of needing to sanitize hands between glove changes, stated the sanitizer dispensers were not working.
3) The administrator entered a resident's room who was on isolation precautions without donning PPE or sanitizing hands, administrator also exited room without sanitizing hands before heading down the hall.

Was there any deviation from the expected sequence?	☐ YES ☐ NO X	*If YES, explain the deviation.*

If deviation occurred from the expected sequence, was it likely to have contributed to the adverse event?	☐ YES ☐ NO X ☐ UNKNOWN	*If YES, explain the contribution.*

Was the expected sequence described in policy, procedure, written guidelines, or included in staff training?	☐ YES X ☐ NO ☐ UNKNOWN	*Staff have been educated on sequence of sanitizing hands or washing with soap and water*

Was there a human action or inaction that contributed to the adverse event?	☐ YES X ☐ NO ☐ UNKNOWN	*Staff did not perform proper infection control practices*

Was there a defect, malfunction, misuse of, or absence of equipment that contributed to this event?	☐ YES ☐ NO X ☐ UNKNOWN	*If YES, describe the equipment and how it appeared to contribute.*

Did the procedure/activity involved in the event being carried out take place in the usual location?	☐ YES X ☐ NO ☐UNKNOWN	*If NO, explain where and why a different location was utilized.*

Was the procedure/activity carried out by regular staff familiar with the consumer and activity?	☐ YES X ☐ NO ☐UNKNOWN	*The nurse performing the dressing change did not work on the floor often and was nervous*

Did the involved staff have the correct credentials and skills to carry out the tasks expected of them?	☐ YES X ☐ NO ☐UNKNOWN	*If NO, explain the perceived inadequacy.*

Was the staff trained to carry out their expected responsibilities?	☐ YES X ☐ NO ☐UNKNOWN	*If NO, explain the perceived inadequacy.*

Were the staffing levels considered adequate at the time of the incident?	☐ YES X ☐ NO ☐UNKNOWN	*If NO, explain why.*

Were there any additional staffing factors identified as responsible for or contributing to the adverse event?	☐ YES ☐ NO X ☐ UNKNOWN	*If YES, explain those factors.*

Was there any inaccurate or ambiguous information that contributed to or caused the adverse event?	☐ YES ☐ NO X ☐ UNKNOWN	*If YES, explain what information and how it contributed.*

Was there any lack of communication or incomplete communication that contributed to or caused the adverse event?	☐ YES ☐ NO X ☐ UNKNOWN	*If YES, explain who, what, and how it contributed.*

Were there any environmental factors that contributed to or caused the adverse event?	☐ YES ☐ NO X ☐ UNKNOWN	*If YES, explain what factors and how they contributed.*

Were there any organizational or leadership factors contributing to or causing the adverse event?	☐ YES ☐ NO X ☐ UNKNOWN	*If YES, explain what factors and how they contributed.*

Were there any assessment or planning factors that contributed to or caused the adverse event?	☐ YES ☐ NO X ☐ UNKNOWN	*If YES, explain the factors and how they contributed.*

Were there any other factors that are considered relevant to the adverse event?	☐ YES ☐ NO X ☐ UNKNOWN	*Describe:*

Rank in order the factors considered responsible for the adverse event, beginning with the proximate cause, followed by the most important to less important contributory factors. Attach the Contributory Factors Diagram, if available.
1) Staff did not sanitize hands between glove changes
2) Staff were under the impression hand sanitizers in dining area were not working
3) Nurse was nervous and not used to doing the treatments
4) Administrator did not follow proper PPE procedure

Was there a root cause identified?	☐ YES X ☐ NO ☐UNKNOWN	*Staff was in need of further education of handwashing/sanitizing and proper PPE procedures*

RISK-REDUCTION ACTIONS TAKEN

List the actions that have already been taken to reduce the risk of a future occurrence. Note the date of implementation.

DATE	EXPLAIN ACTION TAKEN
4/5/22 & 4/11/22	Competencies and education workshops for handwashing/sanitizing and donning and doffing of PPE
3/24/22	Individual education provided to administrator concerning donning and doffing of PPE and when to don PPE
	Individual education performed with nurse concerning handwashing and sanitizing between glove changes
	Individual education with LNA on hand sanitizing between glove changes

PREVENTION STRATEGIES

List the recommended actions planned to prevent a future occurrence of the adverse event. Begin with a rank of 1 (highest). Provide an estimated cost (if known) and any additional considerations/recommendations for implementing the strategy.

STRATEGY	ESTIMATED COST	SPECIAL CONSIDERATIONS
• Continued competencies of handwashing performance	0	
• Continued competencies for donning and doffing of PPE	0	

•		

INCIDENTAL FINDINGS

List and explain any incidental findings that should be carefully reviewed for corrective action.

APPROVAL

After review of this summary report, all team members should notify the team leader of either their approval or recommendations for revision. Following all revisions, the report should be signed by the team leader prior to submission.

TEAM LEADER SIGNATURE: R. Larrabee, RN DNS

DATE SIGNED: 4/18/22