Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

October 27, 2022

Ms. Melissa Haupt, Administrator
Burlington Health & Rehab
300 Pearl Street
Burlington, VT 05401-8531

Dear Ms. Haupt:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 21 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 09/21/2022

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
E 000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 9/21/2022. There were no regulatory violations identified.	E 000	Burlington Health and Rehabilitation Center 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 solely because it is required by federal and state law.	
F 000	INITIAL COMMENTS An unannounced, on-site re-certification survey and staff vaccination requirement review was conducted by the Division of Licensing and Protection on 9/19/22 through 9/21/22. The following regulatory violations were identified:	F 000	**F555** Resident chose to remain anonymous. Residents who are admitted to the center have the potential to be affected by the alleged deficient practice.	
F 555 SS=D	Right to Choose/Be Informed Attendg Physician CFR(s): 483.10(d)(1)-(5) §483.10(d) Choice of Attending Physician. The resident has the right to choose his or her attending physician. §483.10(d)(1) The physician must be licensed to practice, and §483.10(d)(2) If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation as specified in paragraphs (d)(4) and (5) of this section to assure provision of appropriate and adequate care and treatment. §483.10(d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.	F 555	A house wide audit of residents admissions paperwork was completed to ensure the resident was explained the attending physician process and the right to have their own PCP or the in-house Medical Director. The Admission Coordinator was re-educated on the admission paperwork and the discussion with the resident/responsible party upon admission in regards to this process and the residents right to have their own PCP. The Administrator or designee will conduct random weekly audits X 4 on all admissions to ensure this process was completed as required and monthly X 2. The results of these audits will be brought to the QAPI committee meeting for review and to determine if any further action is required. Date of compliance: 10/21/22	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature] Administrator	10/14/22	

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F 555	Continued From page 1 §483.10(d)(4) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to assure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options. §483.10(d)(5) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, the facility failed to allow 1 of 31 sampled residents to choose his/her attending physician. Findings include: During a confidential interview on 9/19/22 at 10:55 AM, a resident stated that s/he was told by the facility that s/he cannot have his/her own doctor while s/he is in the facility. The resident, while crying, said "things are hard enough being here. I want my regular doctor, but I was told I can only have the nursing home's doctor." During an interview on 9/20/22 at 12:45 PM, the Admission Licensed Nurse Assistant stated that s/he didn't know residents could have their own provider and confirmed that the facility does not give residents the choice to choose their own provider.	F 555	**Tag F555 POC Accepted on 10/27/2022 by S.Stem/ P.Cota**	
F 645 SS=B	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3)	F 645		

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F 645	Continued From page 2 §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission	F 645	**F645** Resident #5 and #58 continue to reside at the center and had their PASARR forms corrected for accuracy. Residents who are admitted to the center and require a mental disorder or intellectual disability screening prior to admission through completion of a PASARR are at risk for this alleged deficient practice. A house wide audit was completed to ensure all PASARRs were completed accurately. The Director of Social Services and the social services staff have been reeducated on the proper completion of the PASARR forms to include answering all questions to ensure the form is complete. The Administrator or designee will conduct random weekly audits X 4 on all admissions to ensure this process was completed as required and monthly X 2. The results of these audits will be brought to the QAPI committee meeting for review and to determine if any further action is required. Date of compliance: 10/21/22	

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F 645	Continued From page 3 to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to ensure two residents (#5 and #58) of the survey sample of 31 individuals were screened for a mental disorder or intellectual disability prior to admission through completion of a PASARR (a PASARR is Preadmission Screening for Individuals with a Mental Disorder (MD) and Individuals with Intellectual Disability	F 645		

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F 645	Continued From page 4 (ID) which is to be completed prior to admission so that an individual identified with MD or ID receive care and services in the most integrated setting appropriate to their needs). Findings include: 1. Facility failed to complete a PASARR for Resident #5. Resident #5 was admitted to the facility on 2/15/18 with diagnoses including schizophrenia, major depressive disorder, and cerebral infarct (a type of stroke blocking blood vessels to the brain). Review of a record filed as "updated PASARR" signed 8/16/21 in resident #5's medical record revealed PASARR Part C Intellectual Disability or Related Condition was incomplete. This section contains 5 questions that must be answered. If response to any question in part C is a yes, a level II Developmental Disabilities PASARR is required. The following questions in part C were left without a response: Question 1- Does this individual have a diagnosis of intellectual/developmental disability? Question 2-Does this individual have a related condition (e.g. cerebral palsy, epilepsy, brain injury) resulting in significant impairment in intellectual functioning and adaptive behavior. The Director of Social Services was interviewed on 9/20/22 at approximately 2:00 PM and confirmed these questions should have been answered and that the form is incomplete. 2. Per record review, Resident #58 was admitted to the facility on 7/21/22 with diagnoses including anxiety disorder, major depressive disorder, unspecified psychosis not due to a substance or known physiological condition, and cognitive communication deficit. Review of Resident #58's	F 645	***Tag F645 POC Accepted on 10/27/2022 by S.Stem/P.Cota***	

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F 645	Continued From page 5 PASARR signed 7/20/22 revealed two areas in which further action was to be taken by the nursing facility. Part A of Resident #58's PASARR is checked yes indicating that they are likely to require less than 30 days in the facility and would therefore qualify for an exception for the remainder of the screening, unless the individual's stay exceeds 30 days, in which the admitting nursing home is to complete and submit the form in full. Part C of resident #58's PASARR indicates that there is presenting evidence that this individual may have an intellectual/developmental disability or related condition, signaling a Level II Developmental Disabilities PASARR is required. There was no evidence in Resident #58's medical record that a PASARR Level I or PASARR Level II was completed after the 7/20/22 PASARR was submitted to the facility. Per interview on 9/20/22 at 12:01 PM, the Director of Social Services stated that Resident #58's 7/20/22 PASSAR was incorrect. S/he could not produce PASARR Level I or PASARR Level II follow ups to Resident #58's 7/20/22 PASARR or documentation in his record stating why it was not needed.	F 645	F656 Resident #5, #16, #54 and #59 continue to reside at the center and are having their needs met. 1. Any resident who requires weight and intake monitoring due to dialysis have the potential to be affected by the alleged deficient practice. A house wide audit was conducted of residents receiving dialysis treatment to ensure weights and intake are being monitored and documented consistently as care planned. Licensed nurses were educated on the completion, documentation and monitoring of weights and intake for dialysis residents as care planned per NSG253 Dialysis: Hemodialysis (HD) - Communication and Documentation Policy.	
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	F 656	The Director of Nursing or designee will conduct random weekly audits X4 and monthly X2 on all dialysis residents to ensure the weights and intake monitoring for dialysis residents are being completed as care planned.	

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F 656	Continued From page 6 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, the facility failed to develop and/or implement a comprehensive care plan for 4 of 31 sampled residents (Residents #5,	F 656	2. Any residents who have dysphagia diets have the potential to be affected by the alleged deficient practice. A house wide audit was conducted of residents who have dysphagia diets to ensure their care plans reflect this. Licensed nurses and the registered dietician were educated on the developing of care plans with the proper diets. The Director of Nursing or designee will conduct random weekly audits X4 and monthly X2 on residents with dysphagia diets to ensure the care plans accurately reflect the dietary orders. 3. Any resident who has an actual wound is at risk for this alleged deficient practice. A house wide audit was conducted of residents who have actual wounds to ensure the care plan accurately reflects "actual wound" in addition to "at risk for". Licensed nurses were educated on the updating of care plans to indicate "actual wounds", goals, and interventions in place. The Director of Nursing or designee will conduct random weekly audits X4 and monthly X2 on residents with new skin issues to ensure the care plans accurately reflect the actual wound.	

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F 656	Continued From page 7 #16, #54, and #59). Findings include: 1. Review of the medical record for Resident #54 reveals the resident was re-admitted to the facility on 5/6/22 with diagnoses that include end stage renal disease (ESRD) and dysphagia (difficulty swallowing). Resident #54's care plan focus "The resident needs dialysis (hemo) [related to] renal failure, [history] of renal calculus [kidney stone], absence of kidney, [history] of hydronephrosis [a condition of excess urine accumulation in kidney(s) that causes swelling of kidneys]," updated 3/14/22, reveals the following interventions: "monitor intake and output," and "Obtain ... weight per protocol." Resident #54's care plan focus "Resident may be nutritionally at risk related to dysphagia, ESRD on HD [hemodialysis]," updated 7/22/22, reveals the following interventions: "record and monitor intakes," and "record and monitor weights." The last weight documented in the Resident #54's record was on 6/1/2022 and there was no evidence that intake and output was being monitored and recorded consistently. Per interview with a Licensed Practical Nurse (LPN) and Licensed Nurse Aide (LNA) on 09/21/22 at 9:33 AM, the LPN stated that weights are done at the dialysis facility but could not find consistent documentation of weights from the dialysis facility. The LNA stated that they do not monitor Resident #54's intakes or outputs because it does not come up on the LNA assignment. Per interview on 9/20/22 at 4:01 PM, the Assistant Director of Nursing could not find weights, intakes, or outputs for Resident #54 and	F 656	4. Any resident with the care plan intervention for offloading of heels is at risk for this alleged deficient practice. A house wide audit was conducted of residents who require offloading of heels to ensure the care planned interventions are in place following the care plan. Licensed staff were educated on offloading of heels and ensuring the care planned interventions are being followed. The Director of Nursing or designee will conduct random weekly audits X4 and monthly X2 on residents who require heel offloading to ensure the care planned interventions are being followed. The results of these four audits will be brought to QAPI and reviewed for further interventions if required. Date of compliance: 10/21/22 **Tag F656 POC Accepted on 10/27/2022 by S.Stem/P.Cota**	

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F 656	Continued From page 8 confirmed that the care plan was not being followed. 2. The facility failed to develop a care plan for impaired swallow for Resident #5. Resident #5 was admitted to the facility on 2/15/18 with diagnoses including schizophrenia, major depressive disorder, and cerebral infarct (a type of stroke blocking blood vessels to the brain). Record review reveals MDS assessment Section K completed 7/6/22 indicates resident has swallowing disorder. Resident #5 has a physicians order written 7/7/22 for regular/liberalized diet, dysphagia puree texture, thin consistency, staff assist and supervision with all meals, single bites and sips. Resident #5's care plan was reviewed and noted not to contain an entry for impaired swallowing to include the ordered specific textures and viscosity of fluids or direction for assistance and supervision with all meals. A nurses note from 8/6/22 states "resident ate an unknown amount of popcorn which was on the kitchen counter." On 8/31/22 a nurses note states "Resident #5 ate a handful of staff members trail mix left at the nurses' station." On 9/20/22 at approximately 11:00 AM,	F 656		

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F 656	Continued From page 9 the Speech Language Pathologist stated the resident has a significant history of aspiration (entry of materials such as food or drink into portions of the respiratory system), is at high risk for choking, and this problem should be on the care plan. 3. Facility failed to develop a care plan for an actual wound for Resident #16. Resident #16 was admitted to the facility on 2/8/22 with diagnoses including major depressive disorder, osteoarthritis, polyneuropathy, spinal stenosis lumbar region and general muscle weakness. There is no care plan in place to address resident #16's current wound. Record review revealed a Physicians order written 8/12/22 to apply Triad paste every shift and as needed to the left buttock wound. A skin assessment on 9/8/22 identified a pressure ulcer stage I, facility acquired, 4.1 cm x 3.0 cm (centimeter). The care plan was reviewed and noted to contain a problem for risk for skin impairment but no mention of a current wound. The Assistant Director of Nursing was interviewed on 9/20/22 and he/she confirmed this actual problem should be on the care plan. 4. Facility failed to implement the care plan regarding positioning for Resident #59. Resident #59 was admitted to the facility on 12/21/16 with diagnoses including unspecified dementia, cognitive communication deficit, muscle weakness, and osteoarthritis. On 9/19/22 at 10:55 AM the resident was observed lying in his/her bed on his/her back without any supportive devices. Above the residents bed were two signs. One was representative of a clock face with every two hours colored	F 656		

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F 656	Continued From page 10 indicating how the resident should be positioned. The turn clock indicated the resident should he positioned on his/her left side between 10:00 AM and 12:00 PM. The second sign said keep heels floated using pillows, heels off of pillow every time (every time underlined) signed "therapy". At 11:00 AM the Unit Manager confirmed the resident should have been turned and should have both heels elevated. On 09/20/22 at 9:00 AM Resident #59 was found with both heels on bed, no extra pillow or heels up device in bed. The LPN confirmed the resident has his/her heels on the bed without the support device and was not familiar with the resident having or needing foam boots. A record review revealed an order from the Physician written 1/27/22: Ensure patient's heels are floated OFF of the bed at all times and is wearing her foam protector boots (when not in wheelchair) every day and evening shift AND as needed. The care plan was reviewed and noted to contain the problem: Potential for pressure ulcer development with interventions to include; off load heels for pressure reduction while in bed using heels up pillow, assist with turning and repositioning approximately every two hours and as needed. On 09/20/22 at approximately 10:00 AM the Unit Manager confirmed the care plan was not being followed as written.	F 656		
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	F 692		

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F 692	Continued From page 11	F 692	F692	

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 on observations, interviews, and record review, the facility failed to ensure that one applicable resident was offered sufficient fluid intake to maintain proper hydration and health. Findings include:

Facility failed to maintain proper hydration for Resident #10. Review of Resident #10's medical record reveals the resident was admitted to the facility on 4/30/21 with diagnoses that included chronic systolic (congestive) heart failure. A fluid restriction was ordered (a fluid restriction is used to avoid overloading the heart in persons with heart failure). The physicians order dated 5/3/21 stated: Fluid restriction 1500 cc: Dietary 960cc, 7-3 shift 220cc, 3-11 shift 220cc, 11-7 shift 100cc. Resident #10's care plan contained the same breakdown of allotted amounts of fluids per shift. On 09/19/22 a LNA (Licensed Nursing Assistant) was observed providing Resident #10 a cup of ice, when asked about the fluid

Resident #10 continues to reside at the facility and has had the fluid restriction order discontinued. Residents who require fluid restrictions are at risk for this alleged deficient practice.

A house wide audit was conducted on residents who require fluid restrictions to ensure they are not given fluids exceeding the restrictions.

Licensed staff were educated on following the care plan of residents on fluid restrictions.

The Director of Nursing or designee will conduct random weekly audits X4 and monthly X2 on residents who require fluid restrictions to ensure the care plans are being followed.

The results of these audits will be brought to QAPI and reviewed for further interventions if required.

Date of compliance: 10/21/22

Tag F 692 POC Accepted on 10/27/2022 by S.Stem/P.Cota

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	475014	A. BUILDING _____ B. WING _____	C 09/21/2022

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F 692	Continued From page 12 restriction, the LNA denied awareness of a restriction. Review of the record of fluids provided by shift for the past between 09/01/22-09/20/22 reveals the allotted amount of fluids was exceeded nine times during the day shift, ten times during the evening shift, and eighteen times during the night shift. During an interview with the Unit Manager conducted 9/20/22 at approximately 1:00 PM, he/she confirmed the resident should not be given fluids in excess of the ordered amounts and that the care plan was not being followed.	F 692	F697 Resident #368 no longer resides at the facility. Any resident admitted and receiving pain medication is at risk for this alleged deficient practice. A house wide pain assessment was conducted on current residents to ensure pain is being managed and medication was administered as ordered.	
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure pain medication was administered per physician order for 1 of 31 sampled residents (Resident #368). Findings include: Per record review, Resident #368 was admitted to the facility on 9/12/22 for pain management and therapy following back surgery. Resident #368 had an order for "HYDROmorphone HCl Tablet 2 MG Give 1 tablet by mouth every 3 hours as needed for Pain -Start Date-	F 697	Nurses were educated on the pharmacy protocol for ordering and obtaining medications for newly admitted residents, including the STAT ordering process. In addition, nurses were educated on pain management in the residents. The Director of Nursing or designee will conduct random weekly audits X4 and monthly X2 on residents who are admitted to ensure they received their pain medication as ordered. The results of these audits will be brought to QAPI and reviewed for further interventions if required. Date of compliance: 10/21/22 **Tag F697 POC Approved on 10/27/2022 by S.Stem/P.Cota**	

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F 697	Continued From page 13 09/12/2022" [Dilaudid, used to treat severe pain]. Per interview on 09/19/22 at 01:09 PM, Resident #368 stated that s/he didn't have his/her pain medication for almost 15 hours after admission. S/he said s/he was admitted to the facility around 5 PM in the evening and his/her pain was okay at first but became increasingly worse after arrival. S/he informed the nurse repeatedly of his/her pain. S/he was finally offered Tylenol and Robaxin [methocarbamol; a muscle relaxant] around 2:00 AM which didn't help manage the pain completely. S/he stated the nurse told her/him that the Dilaudid wasn't available because the pharmacy was closed, and the day shift would have to work on getting it. S/he reemphasized that it was the worst pain s/he had felt since surgery, s/he constantly asked for pain medication, and didn't get any relief until the following morning around 8:00 AM when s/he received her first dose of Dilaudid since being admitted to the facility. Per review of Resident #368's Medication Administration Record, Hydromorphone was not administered until 7:50 AM on 09/13/2022. Per interview on 9/20/22 at 11:05 AM, the Director of Nursing stated that Resident #368's Dilaudid was not available because the pharmacy did not have the faxed physician's orders. A faxed order is required to gain access to the CubeX [medication dispenser holding emergency medications], which is where the nurse would get the Dilaudid from at that time. Per interview on 9/20/22 at 2:16 PM, the Admission's Licensed Nurse Aide (ALNA)	F 697		

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F 697	Continued From page 14 confirmed that Resident #368's order for Dilaudid was not faxed to the pharmacy until the following morning and it was the responsibility of the nurse that admitted Resident #368 to fax the order to the pharmacy on admission. S/he later revealed the order was faxed to the pharmacy at 7:30 AM on 9/13/22.	F 697	F698 Resident #54 continues to reside at the center and have their needs met. Any resident who receives dialysis has the potential to be affected by the alleged deficient practice.	
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents who require dialysis receive services, consistent with professional standards of practice, and the comprehensive, person-centered care plan for one of 31 residents (Resident #54). Findings include: Review of the medical record for Resident #54 reveals the resident was re-admitted to the facility on 5/6/22 with diagnoses that include end stage renal disease, anemia in chronic kidney disease, unspecified hydronephrosis, acquired absence of kidney, and dependence on renal dialysis. Per review of Resident #54's care plan, the resident is scheduled for dialysis treatments on Tuesdays, Thursdays, and Saturdays. Facility policy titled "NSG261 Dialysis: Hemodialysis (HD) Provided by a Certified	F 698	A house wide audit was conducted of residents receiving dialysis treatment to ensure the standards for professional communication is being adhered to utilizing the dialysis communication process. Licensed nurses were educated on the review of documentation and monitoring of dialysis residents as care planned per NSG261 Dialysis: Hemodialysis (HD) Provided by a Certified Dialysis Facility" to ensure ongoing communication and collaboration with the certified dialysis facility. The Director of Nursing or designee will conduct random weekly audits X4 and monthly X2 on all dialysis residents to ensure the communication books are being utilized and completed by both the center and the dialysis facility per policy. The results of these audits will be brought to QAPI and reviewed for further interventions if required. Date of compliance: 10/21/22	

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F 698	Continued From page 15 Dialysis Facility," revised on 6/1/21, states "Patients who require HD services receive care consistent with professional standards of practice... Professional standards of practice include: ... Ongoing communication and collaboration with the certified dialysis facility regarding HD care and services." Per interview on 09/20/22 at 3:30 PM, a Licensed Practical Nurse (LPN) stated that communication between the dialysis facility and the nursing center is kept in a binder. The binder travels to and from the dialysis facility with the resident. The dialysis facility is to return documentation which includes pre and post weights for the resident receiving dialysis and any concerns with the treatment. The LPN could not find documentation between the dialysis facility and the nursing center for Resident #54's past four appointments (9/13, 9/15/22, 9/17/22, and 9/20/22). This LPN discovered sheets filled out by nursing center staff to send to the dialysis facility for the above days, but the dialysis facility portion of the communication sheet was blank. The LPN stated that the nurse is supposed to look at the communication sheet every time the resident comes back from dialysis and if it is not there, the nurse is supposed to call the dialysis facility to get the information. S/he stated that this had not been done for the above dates. Per interview on 9/20/22 at 4:01 PM, the Assistant Director of Nursing stated that nursing center staff are to review the dialysis communication binder when a resident returns from his/her dialysis appointment and acknowledge their review by signing the bottom of the communication sheet. The ADON stated	F 698	**Tag F698 POC Approved on 10/27/2022 by S.Stem/P.Cota**	

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F 698	Continued From page 16 that if the sheet was not completed by the dialysis facility, the nursing staff would notify the dialysis facility of the missing information and enter a nursing note into the record that the dialysis office was notified. S/he confirmed that this process was not followed for Resident #54's past four appointments and did not meet the professional standards of communication as outlined in the facility policy.	F 698	Resident # 28 and # 90 continue to reside at the center and have their needs met. Resident #28 and #90's PRN psychotropics were discontinued. Residents who are prescribed PRN psychotropic medications are at risk for this alleged deficient practice.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758	A house wide audit was conducted of residents prescribed PRN psychotropic medications to ensure a 14-day stop is in place or a documented rationale in the resident's medical record. Nurses were educated on the federal requirement for PRN psychotropic medications to have a 14-day stop OR documented rationale from the provider in the resident's chart. The Director of Nursing or designee will conduct random weekly audits X4 and monthly X2 on all residents who are prescribed PRN psychotropic medications for the required 14 day stop or the providers documented rational. The results of these audits will be brought to QAPI and reviewed for further interventions if required. Date of compliance: 10/21/22	

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F 758	Continued From page 17 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that PRN (as needed) orders for psychotropic drugs are limited to 14 days, or if the prescribing provider believes that it is appropriate for the PRN order to be extended beyond 14 days, that there is a documented rationale in the resident's medical record and an indicated duration for the PRN order for 2 of 6 sampled residents (Resident #28 & #90). Findings include: 1. Per record review, Resident #28 has diagnoses that include but are not limited to Dementia with Behavioral Disturbances and Palliative Care.	F 758		

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F 758	Continued From page 18 Per record review, there is a physician order dated 8/3/2022 for "Lorazepam Concentrate 2mg/ml, give .25ml by mouth every 4 hours as needed for restless, agitation," with the end date listed as indefinite. In the Medication Regiment Review form dated 8/24/2022 the physician listed Hospice as rationale but did not address the lack of a stop date. Confirmation per interview with the Assistant Director of Nursing on 9/20/22 at approximately 4:00 pm, that the attending physician did not provide an end date for the PRN order of Lorazepam as required by Federal Regulation. 2. Per record review, Resident #90 has diagnoses that include but are not limited to Vascular Dementia with Behavioral Disturbances and Anxiety. Per record review, there is a physician order dated 9/7/2022 for "Lorazepam Tablet 0.5mg, give 1 tablet by mouth every 24 hours as needed for Anxiety, only to be administered when trimming toenails and is anxious," with the end date listed as indefinite. Confirmation per interview with the Assistant Director of Nursing on 9/21/22 at approximately 10:30am, that the attending physician did not provide an end date for the PRN order of Lorazepam as required by Federal Regulation.	F 758	**Tag F758 POC Approved on 10/27/2022 by S.Stem/P.Cota**	