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

March 30, 2022

Mr. J. Michael Rivers
Center For Living & Rehabilitation
160 Hospital Drive
Bennington, VT 05201-2279

Dear Mr. Rivers:

Enclosed is a copy of your acceptable plans of correction for the recertification survey and investigation conducted on **February 16, 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

Pamela M. Cota, RN
Licensing Chief

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/03/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	475029		C 02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER FOR LIVING & REHABILITATION	160 HOSPITAL DRIVE BENNINGTON, VT 05201

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E 000	Initial Comments An unannounced onsite emergency preparedness survey was conducted during the annual recertification survey by the Division of Licensing and Protection on 02/14/22 through 02/16/22. There were no regulatory violations identified related to emergency preparedness.	E 000		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced recertification survey and the investigation of one facility reported incident from 02/14/2022 through 02/16/2022. The following regulatory violations were identified:	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review the facility failed to ensure that one (1) of fifty (50) residents in the sample (Resident #84) was free from abuse. Findings include:	F 600	**F 600** *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* A biopsychosocial assessment was completed for Resident #84. The resident's care plan was reviewed and updated as indicated. *2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* All residents have the potential to be affected.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Mike Rivers — Administrator — 3/10/22

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 600	Continued From page 1 Per record review Resident #84 was admitted on 12/7/2021 with diagnoses that include morbid obesity, pulmonary hypertension, asthma, depression, and anxiety. A care plan for Activities of Daily Living dated 12/7/2021 and revised on 1/10/2022 reflects that the resident requires two assist of staff for toileting /bedpan use. Offer/encourage use of bedpan/toileting every 2-3 hours. LNA documentation on 2/2/2022 reflects that the resident was assisted with the bed pan twice during the evening shift. Per facility investigation report submitted to Licensing and Protection on 2/3/2022, Resident #84 had reported that on 2/2/2022 s/he was struck multiple times by a Licensed Nursing Assistant (LNA) who was assisting her/him with the bed pan. The resident stated "I called for the bedpan about 9:00 PM all went well. Then at about 10:00 PM I had to use the bedpan again. When the LNA came into the room I could tell [s/he] was mad, annoyed, and angry. I helped myself roll over and that's when [s/he] hit me 5-6 times on my right side." The internal report states that the resident pointed at her rib cage area. During interview on 2/14/2022 at 3:25 PM Resident #84 was asked if she had any concerns with the way staff treat her/him. S/he stated that an LNA "was rough with [her/him]." The resident described the alleged incident with no deviation from the 2/3/2022 statement given to the facility. When asked if s/he felt safe, s/he stated "Yes, they took care of it right away, s/he is not here anymore." Per interview with a Registered Nurse (RN) who is acting as Interim Director of Nursing (DON) on	F 600	100% of interviewable residents/patients were interviewed to confirm that all residents feel safe and identify any residents who may have had any concerns. *3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?* 100% Audit of background checks for staff with completion was completed. The policy, "Abuse, Neglect, and Exploitation" was reviewed. The policy, "Resident Rights" was reviewed. Education/re-education was provided to 100% of the staff regarding abuse, neglect, and exploitation including reporting requirements and resident rights. Education was provided to all nursing staff regarding use and revision of resident/patient care plan development and use. *4. How will the corrective actions will be monitored to ensure the deficient practice will not recur (ie: what quality assurance program will be put into place)?*	

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F 600	Continued From page 2 2/16/2022 at 11:30 AM, it was revealed that the LNA who was named in the allegation stated "Oh, you are talking about [the resident], I did not hit [her/him]." The LNA also stated "In fact [s/he] didn't use the bed pan all shift." The RN stated "[the LNA] wasn't even told who it was, or told that [the resident] said that [s/he] hit [her/him]". Per the interim DNS the LNA was let go because "It just didn't feel right, like something was off."	F 600	For the next four weeks, Social Services Coordinator and/or, designee will conduct weekly random interviews to identify resident/patient concerns. After four weeks, random interviews will be conducted monthly for three months and then randomly thereafter. Results of the audit will be reported to the facility Safety-Quality Committee.	
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would	F 623	*5. The dates corrective action will be completed.* March 18, 2022 **TAG F 600 POC Accepted on 3/30/22 by G. Mercure/P. Cota**	

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F 623	Continued From page 3 be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance	F 623	**F 623** **F 623** *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* Resident #39 did not return to the facility and is deceased. Resident #55 has returned to the facility to the same room/living situation. *2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* All residents who leave the building for appointments or for medical treatment/interventions have the potential to be affected. An audit of all transfers from the facility for the past 30 days was conducted. No concerns were noted. *3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?* The policy, "Bed Hold Notification" was reviewed and updated as indicated. Transfer forms will be attached to the appointment cards and given to the resident/patient at the time of scheduling.	

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F 623	Continued From page 4 and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to notify 2 of 50 applicable residents or representatives in the sample (Residents # 39 and #55) of a transfer or discharge. Findings include: 1. Resident # 39 was transfered to a hospital on 10/17/21 and again on 11/24/21. There is no evidence in the clinical record that the facility	F 623	The RN on call will be notified of all unplanned transfers and will be responsible for managing the transfer notification within 24 hours of transfer. Education was provided to all nurses regarding the transfer process and form location in PCC. Transfers will be reviewed during the clinical portion of Administrative Morning Meeting. *4. How will the corrective actions will be monitored to ensure the deficient practice will not recur (ie: what quality assurance program will be put into place)?* An audit of all transfers out of the facility will be conducted weekly x 4 weeks then monthly x 3 months then randomly thereafter. Results of the audits will be reported to the facility Safety-Quality Committee. *5. The dates corrective action will be completed.* March 18, 2022 **TAG F 623 POC Accepted on 3/30/22 by G. Mercure/P. Cota**	

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F 623	Continued From page 5 provided appropriate transfer notices as required by regulation. On 02/16/22 at 2:15 PM, the facility Social Worker confirmed that there is no evidence of transfer notices for the 10/17/21 and 11/24/21 hospitalizations. 2. Resident # 55 was hospitalized from 01/16/22 through 01/25/22. There is no documentation in the medical record to show that the facility provided a written notice of transfer to the resident or representative. The Social Worker and Administrator confirmed that a written notice was not provided per interview on 02/16/22 at 11:23 AM.	F 623		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.	F 625	**F 625** **F 625** *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* Resident #39 did not return to the facility and is deceased. Resident #55 has returned to the facility to the same room/living situation. *2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* All residents who leave the building for appointments or for medical treatment/interventions have the potential to be affected. An audit of all transfers from the facility for the past 30 days was conducted. No concerns were noted. *3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?*	

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F 625	Continued From page 6 §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to notify 2 of 50 applicable residents or representatives in the sample (Residents # 39 and #55) of bed hold policies prior to transfer or discharge. Findings include: 1. Resident # 39 was transfered to a hospital on 10/17/21 and again on 11/24/21. There is no evidence in the clinical record that the facility provided appropriate bed hold policy notifications as required by regulation. On 02/16/22 at 2:15 PM, the facility Social Worker confirmed that there is no evidence of bed hold notifications for the 10/17/21 and 11/24/21 hospitalizations. 2. Resident # 55 was hospitalized from 01/16/22 through 01/25/22. There is no documentation in the medical record to show that the facility provided a written facility policy for bed hold notice, including reserve bed payment to the resident or representative. The Social Worker and Administrator confirmed that a bed hold notice was not given to the resident per interview on 02/16/22 at 11:23 AM.	F 625	The policy, "Bed Hold Notification" was reviewed and updated as indicated. Transfer forms will be attached to the appointment cards and given to the resident/patient at the time of scheduling. The RN on call will be notified of all unplanned transfers and will be responsible for managing the transfer notification within 24 hours of transfer. Education will be provided to all nurses regarding the transfer process and form location in PCC. Transfers will be reviewed during the clinical portion of Administrative Morning Meeting. *4. How will the corrective actions will be monitored to ensure the deficient practice will not recur (ie: what quality assurance program will be put into place)?* An audit of all transfers out of the facility will be conducted weekly x 4 weeks then monthly x 3 months then randomly thereafter. Results of the audits will be reported to the facility Safety-Quality Committee. *5. The dates corrective action will be completed.* March 18, 2022	
F 656 SS=E	Develop/Implement Comprehensive Care Plan	F 656		

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F 656	Continued From page 7 CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (I) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document 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.	F 656	**F 656** *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* Resident #71, #72, and #74 care plans were reviewed. All are currently deceased. Resident #1's care plan was reviewed. He was discharged from the facility. *2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* All resident/patients have the potential to be affected. An audit of 100% of the resident care plans was conducted to identify any missing specialty treatments including catheters, oxygen use, fall interventions, IV access, and specialty feeding requirements. Care plans were updated as indicated. *3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?* The facility protocol for weight monitoring was added to the automated admission orders in PCC.	

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F 656	Continued From page 8 (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, interview, and record review, it was determined that the facility failed to develop and/or implement care plans for 6 residents in a standard survey sample of 50 residents. (Resident identifiers are: #1, #64 #67, #71, #72 and #74) Findings include: 1. Record review reveals that Resident # 64 has diagnoses that include fluid over load, obesity, lymphedema, venous insufficiency, difficulty walking, and chronic respiratory failure. A care plan focus for chronic lymphedema is in place with an intervention of "should wear bilateral feet and calf ready wraps during the day with black sock underneath. Foot piece should go on over the calf piece. Remove at night and wash and lotion legs." The care plan also states "risk for fluid overload or potential fluid volume overload r/t disease process (CHF) [congestive heart failure], noncompliance with fluid restriction, and past experiences with fluid volume overload. Encourage to elevate [her/his] legs when in recliner and during NOC to assist with fluid retention management. [S/he] also uses bilateral lower leg wraps for edema." Per interview with Resident #64 on 2/15/2022 at 9:30 AM even though her/his legs hurt s/he is able to ambulate independently to her/his bathroom. "I am supposed to have special wraps	F 656	The policies, "Plan of Care", "Weight Assessment Monitoring", "Oxygen Administration", "Implantable Venous Access Device", "Fall Prevention and Protocol", and "Indwelling Foley Catheter" were reviewed and updated as indicated. All nursing staff was educated regarding the care plan process, care plan development, and the facility weight monitoring policy. New orders and care plan updates will be reviewed during the clinical portion of the Administrative Morning Meeting and during the weekly At Risk Meeting. *4. How will the corrective actions will be monitored to ensure the deficient practice will not recur (ie: what quality assurance program will be put into place)?* An audit of weight monitoring will be conducted by the RD and/or designee weekly x 4 weeks then monthly x 3 months then randomly as indicated. An audit of specialty treatments/interventions will be conducted by the DNS and/or designee weekly x 4 weeks then x 3 months then randomly as indicated. Audit results will be reported to the facility Safety-Quality Committee.	

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F 656	Continued From page 9 on my legs for my lymphedema, but they don't put them on." Per interview with the LPN, Team Leader (TL)on 2/16/2022 at 9:34 AM, the TL confirmed that Resident #64 is care planned for leg wraps for lymphedema, and that she does not have them. The TL stated "They come from the hospital and its a size thing. S/he gained more weight and they don't make them large enough. The TL also stated that s/he should remove them from the care plan. 2. Observation on 2/15/22 at 12:30 PM revealed Resident #71 wearing an oxygen face mask with attached tubing that was connected to an operating 02 (oxygen) concentrator next to her/his bed. Interview on 2/16/22 at 1:45 PM with the Unit Team Leader, confirmed that the resident has been receiving oxygen therapy for a couple of weeks due to her/his inability to maintain 02 concentration levels above 90%. The Unit Team Leader explained that the resident has standing orders that allow for use of 02 up to 2 liters per minute (LPM). The Unit Team Leader confirmed that a care plan was not in place for oxygen use. Interview on 2/16/22 at 2:10 PM with the Unit Manager, confirmed that the resident did not have a care plan in place for oxygen use. 3. Observation on 2/15/22 at 11:20 AM revealed Resident #74 in bed with a catheter bag suspended from the side of her/his bed. Interview on 2/15/22 at 11:25 AM with Resident	F 656	*5. The dates corrective action will be completed.* March 18, 2022 **TAG F 625 POC Accepted on 3/30/22 by G. Mercure/P. Cota** **TAG F 656 POC Accepted on 3/30/22 by G. Mercure/P. Cota**	

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F 656	Continued From page 10 #74 confirmed she/he currently had a catheter in place. Record review of Resident #74's medical record revealed Resident #74 had an appropriate diagnosis for the catheter. Review of the Minimum Data Set (MDS) dated 1/5/22, under section H revealed the resident was coded for an indwelling catheter. Resident #74 did not have a care plan in place for the indwelling catheter. Interview on 2/16/22 at 1:50 PM with the Unit Team Leader, confirmed that a care plan was not in place for the residents catheter. Interview on 2/16/22 at 2:15 PM with the Unit Manager, confirmed that Resident #74 did not have a care plan for her/his catheter. Surveyor: Terrence Dougherty 4. Review of Res. #67's Care Plan reveals the resident was identified as 'at risk for sub-optimal intakes and weight loss due to sore on his gums and need for mechanically altered diet. He has had weight loss that was felt to be due to a combination of fluid loss and sub-optimal intakes.' Care Plan interventions to be implemented to achieve the goals include: 'Weigh per policy'. Review of the facility's Weight Assessment Monitoring procedure- [modified 7/15/2020] reads: - 'Nursing staff weighs resident/patient per nursing protocol weekly, or as ordered for the first 4 weeks after admission. If resident/patient is identified to be at risk for weight loss/gains, weights may be continued weekly. - 'If a resident/patient is noted to have a weight loss/gain of 5 or more pounds since their last weight, a re-weight is to be obtained by nursing	F 656		

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F 656	Continued From page 11 within 24 hours.' - 'RN or LPN reports any confirmed wight loss to the RD or diet tech/CDM, nurse manager, physician, and family.' Additionally, per review of Res. #67's medical chart, included under Licensed Nursing Aide Tasks is "Weight weekly / Monday". Review of Res. #67's medical chart on 2/14/22 revealed the two most recent weights dated 11/8/2021 and 1/19/2022- greater than 7 weeks apart. Res. #67's weight on 11/8/2021 is recorded as 115.6 pounds. The weight on 1/19/2022 is 103 pounds: a 10.9% loss of weight in under 3 months. An interview was conducted with Res. #67 on 12/14/22 at 3:38 PM. The resident stated that he/she had not been weighed since January. During an interview between the facility's Dietician and the resident the next day, 2/15/22, the resident reported he had not been weighed since January and requested his/her weight be checked. Per record review, Res. #67's weight on 2/15/22 was 99.6 pounds, an additional weight loss of 3.4 pounds since the previous weight, less than a month earlier. Res. #67's total weight loss from 11/8/2021 to the day he/she requested to be weighed, 2/15/2022 was 13.84% in under 4 months. An interview and record review were conducted with the facility's Director of Nursing [DON] on 2/16/22 at 9:59 AM. The DON confirmed the resident suffered a significant weight loss of 13.84% in under 4 months, during the time the resident's weights were not monitored per the facility's policy or the resident's Care Plan.	F 656		

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F 656	Continued From page 12 5. Per review of Res. #67's Care Plan, the resident is identified as having a "Portacath", an implantable venous access catheter, with Care Plan interventions that include "Access and manage per protocol." Review of Physician Orders dated 12/10/2021 list "Heparin Lock Flush Solution - Use 10 ml [milliliters] intravenously every shift every 30 day(s) for protocol. RN [Registered Nurse] to access port, ensure blood return, flush with Normal Saline, then heparin. Then de-access." Per review of Res. #67's Medication Administration Record [MAR] for January 2022 and February 2022, there is no documentation that the Portacath was accessed, flushed, and de-accessed per Physician Order and per the resident's Care Plan. Review of the January 2022 MAR reveals the Portacath care was scheduled for 1/9/22. Next to the order for the Portacath care, the MAR is marked with the code '9', which the MAR indicates as "9 = Other / See Progress Notes". Review of Progress Notes on 1/9/22 regarding the Portacath care reveals "Per [staff member] being done Monday" [1/10/22, the next day]. An additional note on 1/9/22 reads "RN supervisor notified." Progress notes dated the next day, 1/10/22, read "not in place", and review of the MAR reveals no documentation that the Portacath care was done on 1/10/22 or any other date in January. Review of the February 2022 MAR reveals the Portacath care was scheduled for 2/8/22. Next to the order for the Portacath care, the MAR is again marked with the code '9' for 'See Progress Notes' and a code '5', which the MAR indicates as 'Hold/See Progress Notes'. Review of Progress Notes regarding the Portacath care for 2/8/22 reveals the notations "to	F 656		

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be given at night by RN once every 30 days" and "Unable to locate port-a-cath needle. Will order some."
Further review of the MAR reveals no documentation that the Portacath care was done on any of the days that followed in February, up through the survey date of 2/15/22.

An interview and record review were conducted with the facility's Director of Nursing [DON] on 2/16/22 at 9:59 AM. The DON confirmed Res. #67's Portacath was not accessed, flushed, and de-accessed every 30 days per Physician's Order and per the resident's Care Plan.

6. Per record review, Res. # 72 was admitted to the facility on 12/31/21 with diagnoses that include Encephalopathy [a disease that affects brain structure or function], morbid obesity, stroke, and aphasia [a communication disorder resulting from damage or injury to a specific area in the brain].
Per review, the facility's 'Post Fall Follow Up' procedure includes "Care Plan updated with Intervention identified during Post Fall Huddle" and "Fall Risk Evaluation completed".

Review of Progress Notes for Res. #72 records on 2/1/22 "Fall Note: I found the pt. on the floor after the aide left [him/her] in [his/her] room after lunch sitting in [his/her] wheelchair. I heard a yell and went to check on [him/her] and [h/she] was sitting on [his/her] butt on the floor next to [his/her] bed. [H/She] seemed to have tried to transfer [his/herself] into bed but fell."
Further review of Progress Notes reveals on 2/10/22 Res. #72 "calling out for help, found sitting on buttocks on floor directly in front of [his/her] wheelchair which was facing

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F 656	Continued From page 14 approximately 2 feet away from [his/her] bed. Patient was not fully able to participate in assessments or verbalize what happened ..." Review of Res. #72's Care Plan reveals the resident was identified on admission on 12/31/21 as a "Moderate risk for falls related to Gait/balance problems, History of CVA [stroke], basically wheelchair bound at home." Further review on 2/14/22 reveals no new interventions added to the Care Plan to prevent future falls after recorded falls on 2/1/22 and 2/10/22. Additionally, after a Fall Risk Assessment was completed after the fall on 2/10/22, the resident was identified as a "High Risk for potential falls", though the resident's Care Plan continued to list the resident as a "Moderate Risk". An interview was conducted the Unit Manager [UM] and the Team Leader [TL] on Res. #72's Unit on 2/16/22 at 11:42 AM. The UM and TL both stated that a new Fall Risk Evaluation should be completed after every fall of a resident, and Care Plans should be revised with new interventions to prevent future falls after each resident fall. The UM and TL confirmed that Res. #72's Care Plan was not revised to include new interventions after falls on 2/1/22 and 2/10/22, and the Care Plan was not revised to indicate the resident was now assessed as a "High Risk" for falls. 7. Per record review, Res. #1 was readmitted to the facility on 1/29/22 with diagnoses that include Muscle Weakness, Difficulty in Walking, Hemiplegia and Hemiparesis [Hemiplegia is defined as paralysis of partial or total body function on one side of the body, hemiparesis is characterized by one-sided weakness but without complete paralysis], Morbid Obesity, and Memory	F 656		

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Deficit.
Review of Res. #1's Care Plan reveals the resident is identified as "at risk for falls related to Deconditioning, Gait/balance problems".
Care Plan interventions include 'Follow facility fall protocol'.
Per review, the facility's 'Post Fall Follow Up' procedure includes "Care Plan updated with intervention identified during Post Fall Huddle" and "Fall Risk Evaluation completed".

Review of Progress Notes for Res. #1 records on 2/6/22 "Fall Note: [Res. #1] was found lying on the floor next to [his/her] bed this AM. Small skin tear on left elbow, area cleansed steri- strips placed over area. Patient was evaluated and assisted back to bed via Hoyer lift."
Further review of Progress Notes reveals on 2/12/22 "Fall Note: [Res. #1] was found sitting wedged between a locked bed and a locked wheelchair. [H/she] was facing the head of [his/her] bed and the overbed table was next to [him/her] ...Said [H/she] tried self-transferring and slid gently to the floor."
Review of Progress Notes dated 2/14/22 record "Fall Note: ...resident had an unwitnessed fall in [his/her] room. Upon entering room resident was noted to be laying on the floor next to [his/her] bed on [his/her] back, window side of the room. As per resident [h/she] had fallen out of bed."
Review of Res. #1's Care Plan reveals no new interventions added to the resident's Care Plan to prevent future falls after recorded falls on 2/6/22, 2/12/22 and 2/14/22. Additionally, review of Res. #1's medical record revealed no Fall Risk Evaluations completed after any of the 3 falls.

An interview was conducted with the Unit Manager [UM] and the Team Leader [TL] on Res.

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F 656	Continued From page 16 #1's Unit on 2/16/22 at 11:42 AM. The UM and TL both stated that a new Fall Risk Evaluation should be completed after every fall of a resident, and Care Plans should be revised with new interventions to prevent future falls after each resident fall. The UM and TL confirmed that Res. #1's Care Plan was not revised to include new interventions after falls on 2/6/22, 2/12/22, and 2/14/22, and Fall Risk Evaluations were not completed per the Care Plan after each of the 3 falls.	F 656		
F 657 SS=E	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. (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	F 657	**F 657** *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* The care plans of residents #1 and #102 were reviewed and updated as indicated. Both have been discharged to home. Resident #72 is deceased. The care plan for resident #11 has been reviewed and updated as indicated. *2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* All residents with wounds and/or falls have the potential to be affected. The care plans for all residents/patients with wounds and/or falls have been reviewed and updated as indicated.	

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F 657	Continued From page 17 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to revise the plan of care for 4 of 50 applicable residents in the sample (Residents #1, #11, #72, #102). Findings include: 1. Staff failed to revise the plan of care for Resident # 102 to reflect an actual stage 2 pressure ulcer. Resident # 102 developed a stage 2 pressure ulcer on 1/25/22, 1 day after admission to the facility. A 1/25/2022 Skin/Wound Note described the ulcer as a "new stage 2 left gluteal fold 1 cm x 1 cm x 0.1 cm". A nursing note dated 2/15/22 stated " left back of thigh near buttock Pressure Ulcer / Injury Stage: Stage II - Partial thickness skin loss. Additionally, a wound note by a Nurse Practitioner dated 2//4/22 described the ulcer as follows; "#5 left posterior Thigh Pressure ulcer Stage 2". On 02/16/22 at 12:29 PM, the Unit Manager confirmed that the care plan for skin integrity had not been revised to reflect goals and treatment interventions for a stage 2 pressure ulcer. 2. Per record review, Res. # 72 was admitted to the facility on 12/31/21 with diagnoses that include Encephalopathy [a disease that affects brain structure or function], morbid obesity, stroke, and aphasia [a communication disorder resulting from damage or injury to a specific area in the brain].	F 657	*3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?* The policies, "Plan of Care", "Falls Prevention and Protocol", "Skin Care", "Maintains Optimal Skin Integrity", and "Skin Inspection and Monitoring" were reviewed and updated as indicated. Education was provided to all nursing staff regarding the care plan process, care plan development, and falls/post fall management. All falls and wounds including the associated interventions will be reviewed by the IDT team during the weekly At Risk meetings. Wounds will be assessed during weekly wound rounds. *4. How will the corrective actions will be monitored to ensure the deficient practice will not recur (ie: what quality assurance program will be put into place)?* An audit of all falls management and wound management will be conducted by the DNS and/or designee weekly x 4 weeks then monthly x 3 months then randomly as indicated. Audit results will be reported to the facility Safety-Quality Committee. *5. The dates corrective action will be completed.* March 18, 2022	

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F 657	Continued From page 18 Per review, the facility's 'Post Fall Follow Up' procedure includes "Care Plan updated with intervention identified during Post Fall Huddle". Review of Progress Notes for Res. #72 records on 2/1/22 "Fall Note: I found the pt. on the floor after the aide left [him/her] in [his/her] room after lunch sitting in [his/her] wheelchair. I heard a yell and went to check on [him/her] and [h/she] was sitting on [his/her] butt on the floor next to [his/her] bed. [H/She] seemed to have tried to transfer [his/herself] into bed but fell." Further review of Progress Notes reveals on 2/10/22 Res. #72 "calling out for help, found sitting on buttocks on floor directly in front of [his/her] wheelchair which was facing approximately 2 feet away from [his/her] bed. Patient was not fully able to participate in assessments or verbalize what happened ..." Review of Res. #72's Care Plan reveals the resident was identified on admission on 12/31/21 as a "Moderate risk for falls related to Gait/balance problems, History of CVA [stroke], basically wheelchair bound at home." Further review on 2/14/22 reveals no new interventions added to the Care Plan to prevent future falls after recorded falls on 2/1/22 and 2/10/22. Additionally, after a Fall Risk Assessment was completed after the fall on 2/10/22, the resident was identified as a "High Risk for potential falls", though the resident's Care Plan continued to list the resident as a "Moderate Risk". An interview was conducted the Unit Manager [UM] and the Team Leader [TL] on Res. #72's Unit on 2/16/22 at 11:42 AM. The UM and TL both stated that Care Plans should be revised with new interventions to prevent future falls after	F 657	**TAG F 657 POC Accepted on 3/30/22 by G. Mercure/P. Cota**	

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F 657	Continued From page 19 each resident fall. The UM and TL confirmed that Res. #72's Care Plan was not revised to include new interventions after falls on 2/1/22 and 2/10/22, and the Care Plan was not revised to indicate the resident was now assessed as a "High Risk" for falls. 3. Per record review, Res. #1 was readmitted to the facility on 1/29/22 with diagnoses that include Muscle Weakness, Difficulty in Walking, Hemiplegia and Hemiparesis [Hemiplegia is defined as paralysis of partial or total body function on one side of the body, whereas hemiparesis is characterized by one-sided weakness but without complete paralysis], Morbid Obesity, and Memory Deficit. Review of Res. #1's Care Plan reveals the resident is identified as "at risk for falls related to Deconditioning, Gait/balance problems". Care Plan interventions include 'Follow facility fall protocol'. Per review, the facility's 'Post Fall Follow Up' procedure includes "Care Plan updated with intervention identified during Post Fall Huddle" and "Fall Risk Evaluation completed". Review of Progress Notes for Res. #1 records on 2/6/22 "Fall Note: [Res. #1] was found laying in the floor next to [his/her] bed this AM. Small skin tear on left elbow, area cleansed steri- strips placed over area. Patient was evaluated and assisted back to bed via Hoyer lift." Further review of Progress Notes reveals on 2/12/22 "Fall Note: [Res. #1] was found sitting wedged between a locked bed and a locked wheelchair. [H/she] was facing the head of [his/her] bed and the overbed table was next to [him/her] ...Said [H/she] tried self-transferring and slid gently to the floor."	F 657		

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Review of Progress Notes dated 2/14/22 record "Fall Note: ...resident had an unwitnessed fall in [his/her] room. Upon entering room resident was noted to be laying on the floor next to [his/her] bed on [his/her] back, window side of the room. As per resident [h/she] had fallen out of bed." Review of Res. #1's Care Plan reveals no new interventions added to the resident's Care Plan to prevent future falls after recorded falls on 2/6/22, 2/12/22 and 2/14/22. Additionally, review of Res. #1's medical record revealed no Fall Risk Evaluations completed after any of the 3 falls.

An interview was conducted the Unit Manager [UM] and the Team Leader [TL] on Res. #1's Unit on 2/16/22 at 11:42 AM. The UM and TL both stated that a new Fall Risk Evaluation should be completed after every fall of a resident, and Care Plans should be revised with new interventions to prevent future falls after each resident fall. The UM and TL confirmed that Res. #1's Care Plan was not revised to include new interventions after falls on 2/6/22, 2/12/22, and 2/14/22, and Fall Risk Evaluations were not completed per the Care Plan after each of the 3 falls.

4. Review of Resident #11's medical record revealed a nurses note dated 2/11/22 that included the following statement: ".....midback pressure ulcer 1x0.5x0.1 80% slough 20% granulation and moderate serosang [sic] drainage." The resident's care plans were reviewed and revealed several care plans for pressure ulcers, however, the care plans were not updated to include this residents midback pressure ulcer.

Interview on 2/16/22 at 1:40 PM with the units Team Leader who confirmed that Resident #11

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F 657	Continued From page 21 does have a pressure ulcer on her/his midback. The Team Leader was able to locate a care plan for this resident specific to a pressure ulcer on her/his coccyx 9/2021 but no update was noted for this midback pressure ulcer. Interview on 2/16/22 at 2 PM with the Unit Manager, confirmed that Resident #11 did not have an updated care plan for the midback pressure ulcer.	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 observations, resident and staff interviews, and record review the facility failed to provide supervision to ensure the safety per plan of care of one resident in the applicable sample (Resident #62). Findings include: Per record review, Resident #62 was admitted on 7/30/2021 with diagnoses of major depressive disorder, dementia, and a fractured left hip. S/he has a history of resident to resident altercations, attempted elopement, and falls while wandering unsupervised. Per review of the care plan the resident has "mood problem r/t major depressive	F 689	**F 689** *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* Resident #62's plan of care was reviewed and updated as indicated. A daily activities routine was developed and implemented. *2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* All residents with undesired behaviors are at risk. An audit resident behavior documentation was conducted was identified to have undesired behaviors including history of altercations, agitation, wandering, and/or exit seeking. The care plans of those identified were reviewed for person-specific interventions and were updated as indicated.	

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F 689	Continued From page 22 disorder. [S/he] likes to be "in charge". [S/he] can be intrusive and inquisitive. [Her/his] tone of voice can be perceived as 'bossy' as [s/he] likes to direct others. Assist [her/him] in developing and provide with a program of activities that is meaningful and of interest.", "Can be intrusive and enjoys self ambulating with walker throughout the unit. [S/he] is confused and believes that [s/he] is the unit manager. [S/he] is an elopement risk/wanderer r/t [her/his] disorientation to place, History of attempts to leave facility unattended, Impaired safety awareness, and [her/his] history of significantly intruding on the privacy or activities of others. Please redirect patient from sitting in the nurses station unsupervised." and "High risk for falls r/t Gait/balance problems poor safety awareness r/t hip fracture and dementia. Risk for elopement. Wanderguard right ankle, monitor whereabouts [whereabouts] when out of bed." Review of progress notes reveal that s/he had an verbal disagreement with her/his room mate on 9/5/2021 causing her/his room to be changed. On 1/20/2022 at 2:49 PM she was sitting in her/his wheel chair in front of the reception when she was hit in the face two times by another resident. On 1/23/2022 the resident "was behind the nurses station and attempt to self transfer into one of the office chairs that was on wheels, it moved when [s/he] grab a hold of it. falling to the floor. I heard [him/her] yell as she was falling, in time to see her hit the floor. [s/he] hit [her/his] head on the floor." A plan of care note written on 1/26/2022 at 11:57 AM states "Reviewed by IDT team for increased wandering. Appears stressed and more frantic with her wandering. Not easily distracted--appears 'manic' and disheveled at times." A plan of care note written on 2/2/2022	F 689	*3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?* The policies, "Safety Checks", "Activities Programming", and "Biopsychosocial Assessment/Reassessment" were reviewed and updated as indicated. Education was provided to all staff on Dementia. Education was provided to all nursing staff regarding safety checks and care planning. Education was provided to activities staff regarding meaningful activities and program development. *4. How will the corrective actions will be monitored to ensure the deficient practice will not recur (ie: what quality assurance program will be put into place)?* The Activities Director and/or designee will conduct a random audit of program participation and observation of those residents identified to have behaviors. The random audit will be conducted weekly x 4 weeks then monthly x 3 months then randomly thereafter.	

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F 689	Continued From page 23 at 11:42 reveals that the resident continues to wander and is intrusive at times. During observations throughout the survey the resident was observed self propelling throughout the facility. On 2/14/2022 at 2:14 PM Resident # 62 was observed entering room # 112. The resident in that room told her/him to "get out" of the room. The other resident then stated "you know you are not supposed to be in here, now turn around and go back out there." Resident #62 said "oh, okay" and backed out of the room. There were no staff in the hall during this interaction. On 2/14/2022 at 12:15 PM s/he was observed in front of the nurses station tangled up with three other residents also in wheelchairs. One of the other residents was visually irritated and stated "[s/he] does this all the time and you don't do anything about it! It's not fair" The irritated resident managed to get her/himself untangled and quickly wheeled her/himself down Moses Hall to her/his room. On 02/15/22 at 10:14 AM Resident # 62 was observed self propelling in her/his wheel chair. S/he was observed traveling down the hall, through the activity/dining room, down Stark Hall, through the reception area, and back down Moses Unit. Staff and other residents would speak to her/him along the way however, during this time s/he was without any type of planned supervision. Per interview with a Licensed Nursing Assistant (LNA) on 2/15/2022 at 2:34 PM Resident #62 is a "busy body and just doesn't stop. [S/he] is all over the place." When asked if there was any expectation for staff to supervise her/him the LNA stated "[S/he] is on 15 minute checks." The LNA reported that other residents do become bothered	F 689	The DNS and/or designee will conduct random audits of safety check completion and compliance x 4 weeks then monthly x 3 months then randomly thereafter. Audit results will be reported to the facility Safety-Quality Committee. *5. The dates corrective action will be completed.* March 18, 2022 **TAG F 689 POC Accepted on 3/30/22 by G. Mercure/P. Cota**	

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F 689	Continued From page 24 by the resident's intrusive behaviors and staff need to intervene often. During interview with the Team Leader LPN on 02/16/22 at 09:57 AM s/he confirmed that the resident does wander about the facility, and there is not a specific plan in place to ensure adequate supervision. The LPN stated " There is always someone on the hall." When this surveyor shared that there had been multiple times throughout survey that there were no staff in the hall or monitoring the resident's whereabouts, the TL confirmed that there is not always someone on the floor to monitor."	F 689		
F 692 SS=G	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.	F 692	**F 692** *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* The plan of care and physician orders for resident #67 were reviewed and updated as indicated. *2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* All residents with suboptimal intake are at risk to be affected. No other residents are currently receiving tube feedings.	

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F 692	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to ensure a resident receiving enteral feedings maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range for 1 resident [Res. #67] of 1 residents receiving tube feedings. Findings include: Review of the medical record for Res. #67 reveals the resident was admitted to the facility on 7/1/21 with diagnoses that include severe protein-calorie malnutrition, adult failure to thrive, personal history of diseases of the digestive system, esophageal cancer, and iron deficiency anemia. Review of Res. #67's Care Plan reveals the resident was identified as having 'a PEG tube due to esophageal cancer' [Percutaneous Endoscopic Gastrostomy (PEG) is a procedure to place a feeding tube, called PEG tubes]. Review of Res. #67's Minimum Data Sheet [MDS] Quarterly Review, dated 1/5/22, under Sec. K: Swallowing and Nutritional Status lists Res. #67's Nutritional Approach as 'Feeding Tube', with 'Portion of total calories the resident received through tube feeding' marked as "51% or more". Review of the facility's Tube Feeding Infusion Monitoring policy- [modified 2/18/21] reveals: - 'Every shift the nurse will enter the volume infused, in a cumulative manner in the patient's/resident's electronic chart, IV hydration folder. The Nurse will verify solution, infusion rate against MD orders.' - 'Rate will be reflected by entering it when	F 692	The weights of 100% of the residents were reviewed. Residents identified to have or be at risk for weight loss were reviewed by the RD and IDT team. Their care plans and orders were reviewed and updated as indicated. *3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?* The policies, "Weight Assessment Monitoring", "Physician Orders", "Transcription of Physician's Orders", "Nutrition Assessment", "Plan of Care", and "Tube Feeding Infusion Monitoring" were reviewed and updated as indicated. Education was provided to all nurses regarding documentation, supplemental documentation for orders, and MD notification. Education was provided to all nursing staff regarding weight monitoring. The facility protocol for weight monitoring was added to the automated admission orders in PCC. All residents with tube feedings and/or actual or risk for weight loss will be reviewed at the weekly At Risk Meetings.	

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F 692	Continued From page 26 documenting assessments and evaluations.' - 'At the end of the shift, the 8 hour volume infused will be entered in the patient's/resident's electronic chart, IV hydration folder, and volume infused cleared on the pump.' Per record review of Physician Orders, beginning 10/14/21, Res. #67 was to receive tube feeding at 60 ml [milliliters] an hour for 12 hours, and increase by 5 ml (if tolerated) every 4 days, to a goal of 90 ml an hour for 12 hours. [The goal rate of 90 ml an hour would be achieved in one month, on 11/14/21]. The tube feeding was ordered to be administered from 7:00 PM to 7:00 AM. Per review of Res. #67's Medication Administration Record [MAR], there is no record of the rate the tube feeding was infused, or the amount infused on any given date between the initial order date of 10/14/21 and 1/27/22 [105 consecutive days]. Additionally, per review of Nurses Notes for Res. #67, there are multiple times between the start date of Oct. 14, 2021, and the Survey date of 2/14/22 when the tube feeding is documented as being stopped up to one hour prior to the ordered time of 7:00 AM. Review of the October 2021 Medication Administration Record [MAR] reveals no record of the rate or the amount of the tube feeding infused on any date, and notations recording 9 times [out of 17 days] as the feedings not administered as ordered [stopped early/refused]. Review of the November 2021 MAR reveals no record of the rate or the amount of the tube feeding infused on any date, and notations recording 14 times as the feedings not administered as ordered [out of 30 days].	F 692	*4. How will the corrective actions will be monitored to ensure the deficient practice will not recur (ie: what quality assurance program will be put into place)?* The RD and/or designee will conduct an audit of all weight changes weekly x 4 weeks then monthly x 3 months then randomly thereafter. The DNS and/or designee will audit all tube feeding orders for accuracy, compliance and MD communication (as indicated) weekly x 4 weeks then monthly x 3 months then randomly thereafter. Audit results will be reported to the facility Safety-Quality Committee. *5. The dates corrective action will be completed.* March 18, 2022 **TAG F 692 POC Accepted on 3/30/22 by G. Mercure/P. Cota**	

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F 692	Continued From page 27 Review of the December 2021 MAR reveals no record of the rate or the amount of the tube feeding infused on any date. Nursing notes for December 2021 include "Taken off at 1:38 AM" [12/19/21], "Taken off at 3:00 AM" [12/27/21], and "Requested to start a couple hours late, said he felt full at 7:00 PM" [12/27/21] with no start time and no total amount infused. Review of Res. #67's January 2022 MAR reveals the tube feeding stopped 10 times between 1 ½ and 2 ½ hours early, with no record of the rate or the amount of the tube feeding administered. Review of February 2022's MAR reveals intake volume recorded beginning on the first of the month. There is no documentation of the infusion rate. Per review, the volume infused is less than the minimum rate ordered [60 ml over 12 hours = 720 ml] on 6 of 10 days, with no amounts recorded on the 4 other days. [From 2/1/22 thru the Survey date of 2/14/22]. Nurses notes in February 2022 regarding the tube feeding include "Was off when I got here" [2/6/22] and "Resident reports he did not receive tube feeds last night" [2/14/22]. Review of Res. #67's Care Plan reveals the resident was identified as 'at risk for sub-optimal intakes and weight loss due to sore on [his/her] gums and need for mechanically altered diet. [He/she] has had weight loss that was felt to be due to a combination of fluid loss and sub-optimal intakes.' Care Plan goals include '[Res. #67] will maintain adequate nutritional and hydration status as evidenced by weight stability and/or hydration' and 'maintain [his/her] weight within 5% of 122'. Care Plan interventions to be implemented to achieve the goals include: 'Weigh per policy'.	F 692		

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F 692	Continued From page 28 Review of the facility's Weight Assessment Monitoring procedure- [modified 7/15/2020] reads: - 'Nursing staff weighs resident/patient per nursing protocol weekly, or as ordered for the first 4 weeks after admission. If resident/patient is identified to be at risk for weight loss/gains, weights may be continued weekly. - 'If a resident/patient is noted to have a weight loss/gain of 5 or more pounds since their last weight, a re-weight is to be obtained by nursing within 24 hours.' - 'Registered Nurse or Licensed Practical Nurse reports any confirmed weight loss to the Registered Dietician or diet tech/Certified Dietary Manager, nurse manager, physician, and family.' Additionally, per review of Res. #67's medical chart, included under Licensed Nursing Aide Tasks is "Weight weekly / Monday". Review of Res. #67's medical chart on 2/14/22 revealed the two most recent weights dated 11/8/2021 and 1/19/2022- greater than 7 weeks apart. Res. #67's weight on 11/8/2021 is recorded as 115.6 pounds. The weight on 1/19/2022 is 103 pounds: a 10.9% loss of weight in under 3 months. According to 'Involuntary Weight Loss and Protein-Energy Malnutrition: Diagnosis and Treatment' [https://www.medscape.org/viewarticle/416589_2] "The definition of significant weight loss is a loss of 10% of body weight over a 6-month period." Further review reveals "To improve quality of care for the elderly and the incapacitated, the federal government defined specific healthcare criteria in the Omnibus Reconciliation Act (OBRA) of 1987. The OBRA Act defines significant unintentional	F 692		

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F 692	Continued From page 29 weight loss as a 5% loss in 30 days and a 10% loss in 6 months and considers this process a deviation from proper care. ... the OBRA Act ... requires that long-term care facilities develop strategies to prevent involuntary weight loss in their residents. Nutritional plans and body weight monitoring are mandatory for all patients." An interview was conducted with Res. #67 on 12/14/22 at 3:38 PM. The resident stated that [he/she] had not been weighed since January. During an interview between the facility's Dietician and the resident the next day, 2/15/22, the resident repeated [he/she] had not been weighed since January and requested [his/her] weight be checked. Per record review, Res. #67's weight on 2/15/22 was 99.6 pounds, an additional weight loss of 3.4 pounds since the previous weight, less than a month earlier. Res. #67's total weight loss from 11/8/2021 to the day [he/she] requested to be weighed, 2/15/2022 was 13.84% in under 4 months. An interview and record review were conducted with the facility's Director of Nursing [DON] on 2/16/22 at 9:59 AM. The DON confirmed the following: - There was no documentation that Res. #67's tube feeding was administered as ordered regarding the infusion rate increased as tolerated. - There was no documentation regarding the amount of tube feeding infused for 105 consecutive days. - There were multiple Nursing Notes from the date of the tube feeding order on 10/14/21 through the survey date of 2/14/22 that indicated the tube feeding was stopped before the ordered time. Additionally, when the amount of tube	F 692		

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F 692	Continued From page 30 feeding was recorded, it was lower than the minimal amount ordered on multiple dates. - There was no documentation that weights were monitored per policy and per the resident's Care Plan. - There was no documentation that the Physician was ever notified when the resident was not receiving the minimal amount of tube feeding as ordered, or that the tube feeding was not increased by increments as ordered. - The DON also confirmed the resident suffered a significant weight loss of 13.84% in under 4 months, during the time the resident's tube feedings and weights were not monitored per the facility's policy or the resident's Care Plan.	F 692		
F 693 SS=G	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia,	F 693	**F 693** *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* The plan of care and physician orders for resident #67 were reviewed and updated as indicated. *2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* All residents requiring tube feedings are at risk to be affected. No other residents are currently receiving tube feedings.	

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F 693	Continued From page 31 diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to ensure a resident receiving enteral feeding received appropriate care and services for 1 resident [Res. #67] of 1 residents receiving tube feedings. Findings include: Review of the medical record for Res. #67 reveals the resident was admitted to the facility on 7/1/21 with diagnoses that include severe protein-calorie malnutrition, adult failure to thrive, personal history of diseases of the digestive system, esophageal cancer, and iron deficiency anemia. Review of Res. #67's Care Plan reveals the resident was identified as having 'a PEG tube due to esophageal cancer' [Percutaneous Endoscopic Gastrostomy (PEG) is a procedure to place a feeding tube, called PEG tubes]. Review of Res. #67's Minimum Data Sheet [MDS] Quarterly Review, dated 1/5/22, under Sec. K: Swallowing and Nutritional Status lists Res. #67's Nutritional Approach as 'Feeding Tube', with 'Portion of total calories the resident received through tube feeding' marked as "51% or more". Review of the facility's Tube Feeding Infusion Monitoring policy- [modified 2/18/21] reveals: - 'Every shift the nurse will enter the volume infused, in a cumulative manner in the patient's/resident's electronic chart, IV hydration folder. The Nurse will verify solution, infusion rate against MD orders.' - 'Rate will be reflected by entering it when	F 693	*3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?* The policies, "Weight Assessment Monitoring", "Physician Orders", "Plan of Care", "Nutrition Assessment", "Transcription-Physician Orders", and "Tube Feeding Infusion Monitoring" were reviewed and updated as indicated. Education was provided to all nurses regarding documentation, supplemental documentation for orders, and MD notification. Education was provided to all nursing staff regarding weight monitoring and documentation. All residents with tube feedings and/or actual of risk for weight loss will be reviewed at the weekly At Risk Meetings. *4. How will the corrective actions will be monitored to ensure the deficient practice will not recur (ie: what quality assurance program will be put into place)?* The RD and/or designee will conduct a nutritional review of all residents receiving tube feedings and those with actual or at risk for weight loss weekly x 4 weeks then monthly x 3 months then randomly thereafter.	

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F 693	Continued From page 32 documenting assessments and evaluations.' - 'At the end of the shift, the 8 hour volume infused will be entered in the patient's/resident's electronic chart, IV hydration folder, and volume infused cleared on the pump.' Per record review of Physician Orders, beginning 10/14/21, Res. #67 was to receive tube feeding at 60 ml [milliliters] an hour for 12 hours, and increase by 5 ml (if tolerated) every 4 days, to a goal of 90 ml an hour for 12 hours. [The goal rate of 90 ml an hour would be achieved in one month, on 11/14/21]. The tube feeding was ordered to be administered from 7:00 PM to 7:00 AM. Per review of Res. #67's Medication Administration Record [MAR], there is no record of the rate the tube feeding was infused, or the amount infused on any given date between the initial order date of 10/14/21 and 1/27/22 [105 consecutive days]. Additionally, per review of Nurses Notes for Res. #67, there are multiple times between the start date of Oct. 14, 2021, and the Survey date of 2/14/22 when the tube feeding is documented as being stopped up to one hour prior to the ordered time of 7:00 AM. Review of the October 2021 Medication Administration Record [MAR] reveals no record of the rate or the amount of the tube feeding infused on any date, and notations recording 9 times [out of 17 days] as the feedings not administered as ordered [stopped early/refused]. Review of the November 2021 MAR reveals no record of the rate or the amount of the tube feeding infused on any date, and notations recording 14 times as the feedings not administered as ordered [out of 30 days].	F 693	The DNS and/or designee will audit all tube feeding orders for accuracy, compliance and MD communication (as indicated) weekly x 4 weeks then monthly x 3 months then randomly thereafter. Audit results will be reported to the facility Safety-Quality Committee. *5. The dates corrective action will be completed.* March 18, 2022 **TAG F 693 POC Accepted on 3/30/22 by G. Mercure/P. Cota**	

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F 693	Continued From page 33 Review of the December 2021 MAR reveals no record of the rate or the amount of the tube feeding infused on any date. Nursing notes for December 2021 include "Taken off at 1:38 AM" [12/19/21], "Taken off at 3:00 AM" [12/27/21], and "Requested to start a couple hours late, said he felt full at 7:00 PM" [12/27/21] with no start time and no total amount infused. Review of Res. #67's January 2022 MAR reveals the tube feeding stopped 10 times between 1 ½ and 2 ½ hours early, with no record of the rate or the amount of the tube feeding administered. Review of February 2022's MAR reveals intake volume recorded beginning on the first of the month. There is no documentation of the infusion rate. Per review, the volume infused is less than the minimum rate ordered [60 ml over 12 hours = 720 ml] on 6 of 10 days, with no amounts recorded on the 4 other days. [From 2/1/22 thru the Survey date of 2/14/22]. Nurses notes in February 2022 regarding the tube feeding include "Was off when I got here" [2/6/22] and "Resident reports he did not receive tube feeds last night" [2/14/22]. Review of Care Plan interventions regarding Res. #67's tube feeding include 'Registered Dietician to evaluate quarterly and as needed.' Review of Res. #67's medical chart reveals a Nutritional Evaluation completed the day after his/her admission on 7/1/21. Further record review reveals the next Nutritional Evaluation dated over 7 months later, on 2/14/22. The Nutritional Evaluation dated 2/14/22 lists the resident's 'Most Recent Weight' as unknown, and available weight as 103 pounds dated 1/19/22. The evaluation further lists the resident's usual weight as unknown, and the resident's ideal weight as 154 pounds [51 pounds more than the	F 693		

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F 693	Continued From page 34 resident's listed weight on the evaluation]. The evaluation cites the resident requires a special order for tube feeding due to "inadequate PO [oral] intake". Review of Res. #67's Care Plan reveals the resident was identified as 'at risk for sub-optimal intakes and weight loss due to sore on [his/her] gums and need for mechanically altered diet. [He/she] has had weight loss that was felt to be due to a combination of fluid loss and sub-optimal intakes.' Care Plan goals include '[Res. #67] will maintain adequate nutritional and hydration status as evidenced by weight stability and/or hydration' and 'maintain [his/her] weight within 5% of 122'. Care Plan interventions to be implemented to achieve the goals include: 'Weigh per policy'. Review of the facility's Weight Assessment Monitoring procedure- [modified 7/15/2020] reads: - 'Nursing staff weighs resident/patient per nursing protocol weekly, or as ordered for the first 4 weeks after admission. If resident/patient is identified to be at risk for weight loss/gains, weights may be continued weekly. - 'If a resident/patient is noted to have a weight loss/gain of 5 or more pounds since their last weight, a re-weight is to be obtained by nursing within 24 hours.' - 'Registered Nurse or Licensed Practical Nurse reports any confirmed weight loss to the Registered Dietician or diet tech/Certified Dietary Manager, nurse manager, physician, and family.' Additionally, per review of Res. #67's medical chart, included under Licensed Nursing Aide Tasks is "Weight weekly / Monday".	F 693		

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F 693	Continued From page 35 Review of Res. #67's Minimum Data Sheet [MDS] Quarterly Review, dated 1/5/22, under Sec. K: Swallowing and Nutritional Status includes: 'Weigh: base weight on most recent measure in last 30 days. Measure weight consistently, according to standard facility practice.' The space to record the resident's weight was left blank. Review of Res. #67's medical chart on 2/14/22 revealed the two most recent weights dated 11/8/2021 and 1/19/2022- greater than 7 weeks apart. Res. #67's weight on 11/8/2021 is recorded as 115.6 pounds. The weight on 1/19/2022 is 103 pounds: a 10.9% loss of weight in under 3 months. According to 'Involuntary Weight Loss and Protein-Energy Malnutrition: Diagnosis and Treatment' [https://www.medscape.org/viewarticle/416589_2] "The definition of significant weight loss is a loss of 10% of body weight over a 6-month period." Further review reveals "To improve quality of care for the elderly and the incapacitated, the federal government defined specific healthcare criteria in the Omnibus Reconciliation Act (OBRA) of 1987. The OBRA Act defines significant unintentional weight loss as a 5% loss in 30 days and a 10% loss in 6 months and considers this process a deviation from proper care. ... the OBRA Act ... requires that long-term care facilities develop strategies to prevent involuntary weight loss in their residents. Nutritional plans and body weight monitoring are mandatory for all patients." An interview was conducted with Res. #67 on 12/14/22 at 3:38 PM. The resident stated that he/she had not been weighed since January.	F 693		

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F 693	Continued From page 36 During an interview between the facility's Dietician and the resident the next day, 2/15/22, the resident repeated he/she had not been weighed since January and requested his/her weight be checked. Per record review, Res. #67's weight on 2/15/22 was 99.6 pounds, an additional weight loss of 3.4 pounds since the previous weight, less than a month earlier. Res. #67's total weight loss from 11/8/2021 to the day he/she requested to be weighed, 2/15/2022 was 13.84% in under 4 months. An interview and record review were conducted with the facility's Director of Nursing [DON] on 2/16/22 at 9:59 AM. The DON confirmed the following: - There was no documentation that Res. #67's tube feeding was administered as ordered regarding the infusion rate increased as tolerated. - There was no documentation regarding the amount of tube feeding infused for 105 consecutive days. - There were multiple Nursing Notes from the date of the tube feeding order on 10/14/21 through the survey date of 2/14/22 that indicated the tube feeding was stopped before the ordered time. Additionally, when the amount of tube feeding was recorded, it was lower than the minimal amount ordered on multiple dates. - There was no documentation that weights were monitored per policy and per the resident's Care Plan. - There was no documentation that the Physician was ever notified when the resident was not receiving the minimal amount of tube feeding as ordered, or that the tube feeding was not increased by increments as ordered.	F 693		

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F 693	Continued From page 37 - A Nutritional Evaluation was not conducted quarterly by a Registered Dietician per the facility's policy and per the resident's Care Plan, and when completed 7 months after the previous evaluation, the resident's listed weight was 51 pounds less than the evaluation's "ideal weight". The DON also confirmed the resident suffered a significant weight loss of 13.84% in under 4 months, during the time the resident's tube feedings and weights were not monitored per the facility's policy or the resident's Care Plan.	F 693		
F 697 SS=D	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 resident and staff interview and record review the facility failed to ensure that a prescribed pain medication was available to provide adequate pain control for one resident in the applicable sample (Resident #48). Findings include: On 2/15/2022 at 11:21 AM during an interview with Resident #48 s/he has an order for Oxycodone 70 mg (two 30 mg tablets and one 10 mg tablet) every three hours for pain. The resident reported that the 10 mg tablets ran out on Friday 2/4/2022 and the nurse did not reorder them. Over the weekend of 2/5 - 2/6/2022 s/he	F 697	**F 697** *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* The pain management regime, orders and care plan for Resident #48 were reviewed and updated as indicated. *2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* All residents receiving pain management are at risk to be affected. All residents were evaluated for pain. The plan of care and orders for those identified were reviewed and updated as indicated.	

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F 697	Continued From page 38 had to wait for the nurse to get an order just to be able to take the 60 mg they had available. The resident stated "I have lymphedema and my dressing changes are painful. They didn't have the right dose to give me before my dressing change either. When someone comes in and tells you that they don't have your pain meds, it more than ruins your day, it scares the crap out of you." Per review of Resident #48 had a physicians order dated 1/1/2022 for Oxycodone HCl Tablet 30 mg give 70 mg by mouth every three hours for chronic pain please wake patient to administer, per [her/his] request. On 2/5/2022 at 1:17 AM a new physicians order was obtained to give 60 mg by mouth every 3 hours for chronic pain. Give Oxycodone 60 mg until script for 70 mg is sign in am. Discontinue order afterwards. Start date 2/5/2022 3:00 AM. Review of the February, 2022 medication administration record reveals that on 2/4/2022 Resident #48 received Oxycodone 70 mg at 10:31 PM and then received Oxycodone 60 mg, 4.5 hours later on 2/5 at 3:00 AM. S/he continued to receive 60 mg of Oxycodone throughout 2/5/2022 at 6:00 AM, 9:00 AM, and 12:00 PM. A nursing progress note written by the Registered Nurse (RN) supervisor on 2/5/2022 at 1:03 AM states "RN supervisor was paged to resident's room to discuss an issue with [her/his] Oxycodone order. This RN supervisor, along with Frost charge nurse, entered [the resident's] room and I introduced myself as the night supervisor. Resident informed me that [s/he] was very upset to find out that [s/he] didn't have anymore Oxycodone left. Resident is supposed to get 70 mg of Oxycodone every three hours scheduled. [Her/His] last dose was at HS (2100) [hour of	F 697	*3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?* The policies, "Pain Management", "Physician Orders", and "Narcotic Administration" were reviewed and updated. Education was provided to all nursing staff on pain interventions. Education was provided to all nursing staff regarding narcotic, physician order management, and pain management. *4. How will the corrective actions will be monitored to ensure the deficient practice will not recur (ie: what quality assurance program will be put into place)?* The DNS and/or designee will conduct a random audit of late medication administration weekly x 4 weeks then monthly x 3 months then randomly thereafter. *5. The dates corrective action will be completed.* March 18, 2022	

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F 697	Continued From page 39 sleep 9:00 PM]. [S/He] stated that [s/he] was frustrated that no one told [her/him] earlier today that [s/he] was going to run out of [her/his] Oxycodone and that this isn't the first time [s/he's] run out of it. I apologized to the resident that this happened and explained that while I can't change what has happened before, I was working to resolve the current issue at hand. I informed the resident that [s/he] still has 30 mg tablets of Oxycodone left. [Her/His] charge nurse has paged the telemedicine doctor and requested an order to give [her/him] 60 mg (two 30 mg tablets) every three hours until we can get more 10 mg tablets in and get [her/him] back to the 70 mg dose. I explained that we need an order to do this, we can't just give him 60 mg. Resident verbalized understanding. [S/He] stated that [s/he] would be fine with 60 mg until we can get more 10 mg tablets, [s/he] just can't go without anything. I again apologized to the resident that this happened and informed [her/him] that we would keep [her/him] informed of what was going on with getting a new order from the telemedicine doctor. Resident verbalized understanding and agreement with this plan. Call bell within reach." A Nurse Practitioner progress note written on 2/5/2022 at 6:21 PM states "The patient has had a difficult day. [S/He] reports numerous problems with [her/his] dosing of pain medication. [S/He] is scheduled to receive Oxycodone 70 mg every 3 hours with an additional dose to be given around the time of [her/his] wound change. Unfortunately there was a shortage of 10 mg tablets so [s/he] was not able to receive the full dose. [S/He] feels that [s/he] has been suffering quite a bit with the extra pain throughout the day and that [s/he] has not been able to get good relief. [S/He] was medicated with 60 mg of Oxycodone prior to the	F 697	**TAG F 697 POC Accepted on 3/30/22 by G. Mercure/P. Cota**	

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F 697	Continued From page 40 dressing change tonight because the 10 mg tablets were not available." During interview with the Unit Manager and the Team leader on 2/16/2022 at 10:00 AM the facility did not have the prescribed dosage of 70 mg of Oxycodone available to administer on 2/5/2022. The nurse contacted the on call physician and obtained an order for 60 mg Oxycodone every 3 hours, and put the 70 mg dose on hold. Confirmation was made that the Oxycodone dose was decreased from 70 mg to 60 mg because the prescribed dose was not available.	F 697		
F 726 SS=F	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 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	F 726	**F 726** *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?* No residents were identified. *2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?* All residents have the potential to be affected. Annual competency education was completed by all staff members.	

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F 726	Continued From page 41 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 staff interviews and record review the facility failed to ensure that licensed nurses and licensed nursing assistants had specific competencies and skill sets, to care for residents' needs based on the facility assessment, resident assessment, and individual resident plans of care. Findings include: The facility assessment lists common resident conditions and care needs of the residents who are cared for that include; psychiatric/mood disorders, cardiac conditions, neurological diseases, respiratory disease, cancers, renal disease, and infectious diseases. Care needs include but are not limited too, intravenous drug therapy, Gastrostomy Tube care (a tube surgically placed into the stomach used to provide nutrients and administer medications), wound dressing, mechanical lifts, and behavior management. The facility assessment also outlines staff training and education as: 1. General orientation 2. Annual competencies 3. Annual Netlearning Review of six employee education files; two	F 726	*3. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not reoccur?* The facility assessment was reviewed and updated as indicated. Competency documentation forms and the process for temporary staff and new hires was updated. Competency audits for all nurses and LNA's were completed. The policies, "Educational Program and Request Policy" and "Mandatory In-Service Requirement" were reviewed and updated. *4. How will the corrective actions will be monitored to ensure the deficient practice will not recur (ie: what quality assurance program will be put into place)?* The Clinical Educator and/or designee will audit completion of all mandatory education weekly x 4 weeks then monthly. Audit reports will be submitted to the facility Safety-Quality Committee. *5. The dates corrective action will be completed.* March 18, 2022	

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F 726	Continued From page 42 Licensed Practical Nurses (LPNs), two Registered Nurses (RNs), and two Licensed Nursing Assistants (LNAs) revealed that there was no evidence that competency evaluations were conducted either at the time of hire or annually if applicable. Per interview with a contract LNA on 2/15/2022 at 2:41 PM s/he did have prior training and competencies provided and assessed by the agency that s/he works for. However, the facility has not assessed her/his competency or provided inservice training since the beginning of her/his contract in October of 2021. During an interview with the interim Director of Nursing and the RN Staff Educator on 2/16/2022 at 11:30 AM confirmation was made that the RNs, LPNs, and LNAs were not being assessed for competency in the skills needed to provide care in accordance with the residents needs such as mechanical lifts, dressing changes, PICC line maintenance, and obtaining blood sugars, either upon hire of new staff or annually there after. Per interview with the per diem LPN on 2/16/2022 at approximately 12:45 PM s/he reported that s/he had received four shifts of training as a new nurse before being on her/his own. S/he confirmed that the facility did not assess her/him for competency in any skills related to her nursing duties or resident care needs. Per interview with a full time RN on 2/16/2022 at 1:10 PM, some of her/his responsibilities are wound care, medication administration including administering medications through a PICC (peripherally inserted central catheter) line, and dressing changes. S/he confirmed that s/he does	F 726	**TAG F 726 POC Accepted on 3/30/22 by G. Mercure/P. Cota**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	475029		C 02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 726	Continued From page 43 have years of experience as an RN, however the facility did not assess her/his competency during or after orientation.	F 726		