VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

May 19, 2023

Ms. Suzanne Anair, Administrator
Center For Living & Rehabilitation
160 Hospital Drive
Bennington, VT 05201-2279

Dear Ms. Anair:

Enclosed is a copy of your acceptable plans of correction for the investigation survey conducted on **March 2, 2023.** 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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475029	A. BUILDING _____ B. WING	C 03/02/2023

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 The Division of Licensing and Protection conducted an onsite, unannounced investigation of the facility's Emergency Preparedness Program on 03/02/2023. There were no regulatory findings related to this investigation.	E 000		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an onsite, unannounced recertification survey and staff vaccination review from 02/27/2023 through 03/02/2023. The following regulatory deficiencies were identified:	F 000	F 583: Confidentiality 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #96 was informed of the breach.	
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F 583	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. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? a. The policies: "Confidentiality of Compliance Department Records and Information" and "Confidentiality of Information• were reviewed and updated as Indicated b. Education regarding confidentiality and HIPPA was provided to ail staff utilizing computers for patient care documentation. c. Documentation equipment was evaluated. Privacy screens were added as indicated.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
		04/03/2023

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 583	Continued From page 1 §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to respect patient rights regarding confidentiality of medical records of residents. Findings include: On 02/28/23 at approximately 08:00 AM on the Allen Unit, a nurse was observed administering morning medications to resident #96. Upon stepping away from the medication cart to proceed to the resident's room, an electronic computer lap-top screen and a paper nurse report sheet containing multiple residents' information was left visible to the public. The open computer screen was observed for approximately 5 minutes, from the resident's doorway down the hall. Upon arrival back to the medication cart, the computer screen had not timed out or locked to prevent unauthorized user access and the potential for an unintended data breach. This observation of non-protection of confidential records was confirmed by the nurse who revealed that the s/he did not close the screen prior to leaving the cart and was not aware if the facility sets time out/locks.	F 583	4. How will the corrective actions be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place? A random audit of patient/resident information location and privacy 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. Date: 04/16/2023 (X5) COMPLETION DATE FORM CMS-2567(02-$) Previous Versions Obsolete Event ID: 9HD611 Facility ID: 475029 If continuation sheet Page 2 of 24 Tag F 583 POC accepted on 5/17/23 by S. Freeman/P. Cota	

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F 657 SS=E	Continued From page 2 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 team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to revise care plans for 2 residents in a sample of 26 Residents (Residents #93, and #18), and failed to conduct a care plan meeting for one resident (Resident #95), or give the resident and or representative notice for participation. Findings include:	F 657 F 657	F 657: Care plan Timing and Revision 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The care plans for residents #18, 93, and 95 were reviewed and updated as indicated. A Care plan meeting was conducted for Resident #95. 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? An audit of all patient/resident care plans was conducted. All care plans were reviewed and updated as indicated. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? A. The policies: "Plan of Care" and "Change In Residents Condition or Status" were reviewed and/or updated as indicated. B. Education was provided to nursing staff, therapy staff, RD, Social workers and Activities director regarding care plan update process and communication of indicated changes. C. Education was provided to interdisciplinary care team members and LNA's regarding the care plan meeting process, including location and use of meeting sign in and documentation. D. An LNA care plan worksheet was created. Education was provided to the LNA's on use and purpose of fonn. E. Agenda forms were developed and implemented for care plan meeting discussion and care plan updates. F. Pertinent care plan updates (post incident and/or those .that directly impact treatment goals) and the schedule of care plan meetings will be reviewed at the morning operations meeting.	

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F 657	Continued From page 3	F 657	4. How will the corrective actions be monitored to ensure the deficient practice I will not recur, ie, what quality assurance program will be put into place? A random audit of updated care plans will I be conducted weekly x 4 weeks then monthly x 3 months then randomly thereafter. Results of the audits will be reported to the facllity Safety-Quality Committee. 5. The dates corrective action will be completed. Date: 4/16/2023 Facility ID: 475029 If continuation sheet Page 4 of 24 Tag F 657 POC accepted on 5/17/23 by S. Freeman/P. Cota	

1. Per record review Resident #93 was admitted to the facility on 5/22/2022 with diagnoses that include traumatic subdural hemorrhage, hemiplegia (paralysis of one side of the body) affecting left nondominant side, and type 2 diabetes. A care plan focus initiated on 5/17/2022 reflects that S/he is high risk for skin breakdown related to disease process, immobility, impaired nutrition, altered cardiac status. S/he requires a hoyer lift out of bed, peg tube (tube inserted through the skin into the stomach to provide nutrients) for feeding, and a pacemaker. Another care plan focus written on 5/17/2022 reflects that the "[Resident] has actual impairment to skin integrity of the left lateral leg r/t [related to] fragile skin. Interventions included avoid scratching, excessive moisture, and keep fingernails short, encourage good nutrition and hydration, follow protocols and orders for treatment of injury, keep skin clean and dry, monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration to Physician. Pad bed rails, wheelchair arms and other source of potential injury.

A Wound Care Follow-Up Progress Note dated 5/30/22 reflects that the Resident had an unstageable pressure ulcer in her/his right thigh that was debrided (removal of damaged tissue) on 5/30/2022, a surgical wound of the left and right posterior shin, and a skin tear of the left thigh. On 6/14/2022 the care plan focus was updated to reflect "[Resident] has actual impairment to skin integrity of to the left lateral leg [related to] fragile skin [Resident]has actual impairment to skin integrity of the left thumb, knuckle." However, the care plan was not

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updated to reflect the presence of the right thigh, or the left and right posterior shin surgical wounds. Nor did the care plan provide specific interventions needed to care for or prevent further decline of the actual wounds.

A Wound Care Follow-Up Progress Note dated 7/6/2022 reflects a stage 3 pressure ulcer of the right thigh, left and right posterior shin surgical wounds, and a newly identified stage 2 pressure ulcer of the left and right buttock. On 7/8/22 the care plan focus was updated to reflect "[Resident] has actual impairment to skin integrity of to the left lateral leg r/t fragile skin [Resident] has actual impairment to skin integrity of the left thumb, knuckle, posterior bilateral LE (lower extremities)." The care plan does not address the Resident's right thigh stage 3 pressure area or the stage 2 pressure areas of the right and left buttock.

A Wound Care Follow-Up Progress Note dated 7/11/2022 reflects that there was a newly identified stage 3 pressure ulcer of the Resident's left thumb. The care plan was not updated to reflect the stage 2 pressure areas of the left and right buttock or this newly identified area. On 9/13/2022 an intervention of "Offload heels with boot and ring and make sure that the aid or nurse can run their hand under both heels without touching [name omitted] feet." The actual impairment care plan focus was updated on 9/15/2022 to reflect "actual impairment to skin integrity of to the left lateral leg r/t fragile skin [Resident] has actual impairment to skin integrity of the left thumb, knuckle, posterior bilateral LE and left heel." However, the focus did not address the Resident's stage 2 pressure areas on her/his right and left buttock. On 9/15/2022 the

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Resident's care plan for actual impairment to skin integrity was revised to include the following interventions: "Off load heels while in bed" and "turn and reposition [every] 2-3 hours and PRN [as needed]." On 10/27/2022 a Wound Care Follow-Up Progress Note was written indicating that the left buttock pressure ulcer had progressed to stage 3, and the right buttock wound was moisture associated skin damage (MASD).

A Wound Care Follow-Up Progress Note dated 12/8/2022 reflects that the Resident developed an unstageable pressure area to her/his right 2nd toe. The care plan was not updated to reflect this wound or interventions to prevent further decline of the wound.

On 12/22/2022 a Wound Care Follow-Up Progress Note was written indicating that the Resident's Buttock wound was a MASD that was deteriorating. On 12/29/2022 the Wound Care Follow-Up Progress Note indicated that the wound was now a stage 4 pressure ulcer with 60% slough (a yellowish /white material in a wound bed consisting of dead cells that accumulate in the wound exudate) and 30% eschar (dry dead tissue within a wound). The care plan was not updated to reflect the MASD or the stage 4 pressure ulcer. Review of the Care Plan History Report, the Unit Manager updated the Resident's care plan on 3/1/2023 to reflect "[Resident has actual impairment to skin integrity of to the left lateral leg r/t fragile skin [name omitted] has actual impairment to skin integrity of the left thumb, knuckle, posterior bilateral LE and left heel. Coccyx"

During interview on 3/2/2023 at 9:55 AM the Unit

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Manager confirmed that the care plan had not been revised to accurately reflect the resident's changing skin conditions. The UM also confirmed that the care plan was updated to reflect the presence of the Resident's stage 4 coccyx wound on 3/1/2023.
2. Review of a medical record indicates that resident #95 was admitted to Centers for Living and Rehabilitation on 08/09/22. The record contains a written comprehensive care plan but does not reflect documented attempts by the interdisciplinary team (IDT) to notify the resident and or family of any scheduled care plan meetings to discuss decisions related to the residents goals and interventions. There was no documented evidence, i.e. attendee signatures, or progress notes indicating that IDT members and resident or family participated in a care plan meeting.

Interview on 03/01/23 02:00PM with the Allen/Stark Unit Manager and Director of Nursing (DON) and two social workers confirmed there is no documentation in the residents record regarding care plan meetings.
3. Resident #18 was admitted to the facility on 03/27/18 with diagnoses that include Abnormalities of Gait and Mobility. Review of Resident #18's Care Plan reflects this resident was assessed as having an, "ADL (activities of daily living) Self-Care Performance Deficit related to: Activity Intolerance, Decreased Mobility and Weakness Secondary to Impaired Gait, Generalized Weakness, Obesity, Schizophrenia, and Drug Induced Dyskinesia (uncontrolled, involuntary muscle movements)". Interventions for eating included: "(Resident #18) requires SBA (stand by assistance) with self-feeding, meal set-up assistance by 1 staff, Please have

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(resident) transfer to an armchair during meals for improved positioning and body mechanics." The Care Plan for eating was initially dated on 03/28/2018, and the last revision is recorded as 12/21/2021.

Observations on 02/27/23 and 02/28/23 during lunchtime meals showed this resident to be seated in a wheelchair which sits very low to the floor. The resident was not seated in an armchair as the Care Plan directed. The resident was leaning significantly to the left, the upper body weight was pressing against the resident's left arm which was leaning into the arm of the wheelchair. Resident #18 was being fed by a licensed nursing assistant during both meals in the Allen Dining Room. After the resident was finished eating his/her meal on 02/27/23 this surveyor asked her/him if s/he was comfortable in this position while eating. Resident #18 stated, "No, I'm not comfortable. I would like to get out of my wheelchair but not be placed in my bed."

Review of the Nurse's Notes dated 01/31/2023 read: "Plan of Care Note: resident reviewed by IDT (interdisciplinary team) ... Resident requiring total feeding assistance with meals due to tremors. Appetite unchanged. RD (Registered Dietician) consulted for nutritional needs."

An interview with the Therapy Department Manager and the Director of Nursing (DNS) was conducted on 03/01/23 at 01:16 PM. The DNS and Therapy Manger confirmed that positioning of this resident in his/her wheelchair during meals did not reflect this resident's Care Plan directives. When asked why this resident was not in the armchair for meals in accordance with the Care Plan, the Therapy Manager stated " ...s/he is too

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F 657	Continued From page 8 difficult to transfer into an armchair at this point and they (therapy staff) have tried many different modalities for positioning." The Therapy Manager further stated the process for evaluating positioning would be "a screen sent to therapy by nursing with identified concerns, but no screen was sent" to address that Resident #18 "has declined to the point that (s/he) is unable to transfer to the armchair and maintain positioning in it for meals." The DNS confirmed that the Care Plan for eating has not been updated and revised as required to reflect that this resident requires total feeding assistance for meals, and that this resident has physically declined to the point where positioning needs to be addressed and updated in the Care Plan.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the facility failed to provide 1 of 24 medications observed being passed according to accepted standards of clinical practice as evidenced by: Resident #211 was admitted with diagnoses including alcohol abuse in remission, repeated falls, opioid dependence, and hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease.	F 658	F 658: Medpass Standards 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The medication order for Resident #211 was addressed with the physician and the order was updated as indicated. In addition, resident #211 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? An audit of all medication orders for form/route discrepancies was conducted.	

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On 2/28/23 at 7:45 AM during observation of medication pass to Resident # 211, the LPN (Licensed Practical Nurse) was observed taking out a packet containing Buprenorphine 2- 0.5 mg, cutting the top off the packet and allowing the Resident to remove the film from the packet. Thin-film drug delivery is an alternative to more traditional forms of medications such as tablets. Similar in thickness to a postage stamp, thin-film strips are designed to dissolve under the tongue (sublingual) or along the inside of the cheek (buccal) allowing the medication as it dissolves to enter the blood stream directly.
Resident #211 was observed removing the film and placing it into his/her mouth without instruction from the LPN after a minute or so the LPN asked Resident # 211 if the strip was dissolved to which he/she responded that it (the strip) was stuck behind his/her front teeth to the LPN responded "it always sticks" when again asked if it had dissolved Resident # 211 responded it was almost gone but his/her mouth had become numb.

3/1/23 9:30 AM interviewed Resident # 211 (who is alert and oriented to person, place, and time) about how he/she receives Buprenorphine while in the facility. Resident # 211 described his/her daily routine of taking the film from the packet and putting it into his/her mouth. "I try to put in under my tongue, but it usually goes behind my teeth". Resident #211 denied receiving any education regarding the administration of this medication, Resident 211 also denied being encouraged to take a drink to wet his/her mouth prior to the administration of the medication.

Order reviewed: Buprenorphine HCL Tab SL

F 658

3. What measures will be put Into place or what systemic changes will be made to ensure that the deficient practice does not recur?

a. Education regarding medication pass procedures was completed by all nurses.
b. The policies: "Suboxone Use",· Medication Administration" and "Medication Administration via Enteral Tubes" were I reviewed and updated as Indicated.
c. Updated Med pass competencies were completed for all nurses.

4. How will the corrective actions be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place?
An audit of narcotic orders will be conducted weekly x 4 weeks then monthly x I 3 months then randomly thereafter. Results of the audits will be reported to the facility Safety-Quality Committee.
Random med pass observations 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.
Date: 04/16/2023

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Tag F 658 POC accepted on 5/17/23 by S. Freeman/P. Cota

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F 658	Continued From page 10 (sublingually=under the tongue) in the morning for chronic pain with a start date of 2/12/23. Medications are given sublingually with the intent of being absorbed directly into circulation by avoiding the digestive system whereby the concentration of a drug, specifically when administered orally, is greatly reduced before it reaches the systemic circulation. Per a Medwatch Alert posted 1/12/22 published online at Medlineplus.gov/druginfo/meds/a605002.html entitled Buprenorphine Sublingual and Buccal: Buprenorphine was approved in 2002 as a tablet to be administered under the tongue to treat opioid use disorder. In 2015 it was approved as a film to be placed inside the cheek or under the tongue to treat pain. The following instructions were provided in the alert: Rinse your mouth with water before you place the film. Place the film with a dry finger under your tongue to the right or left of the center and hold it in place for 5 seconds, it can then be left in that position to dissolve. Do not tear, swallow, touch, or move the film while it dissolves. Resident #211 was not educated by the LPN as to how to self-administer a medication sublingually contributing to decreased efficacy of the prescribed medication as the teeth do not absorb medication, the drug was instead being swallowed as it dissolved.	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F 686	686: Skin integrity I 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The plan of care and wound care regime for Resident #93 were reviewed and updated as indicated. A full skin assessment was completed by the wound care team.	

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F 686	Continued From page 11 resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record reviews the facility failed to ensure that 1 of 26 Residents in the sample (Resident #93) received care and services to prevent actual or worsening pressure ulcers. Findings include: Per record review Resident #93 was admitted to the facility on 5/22/2022 with diagnoses that include traumatic subdural hemorrhage, hemiplegia (paralysis of one side of the body) affecting left nondominant side, and type 2 diabetes. Per review of the Follow-up Progress Notes, the Resident had developed 4 pressure areas since admission that include a stage 4 pressure ulcer (a pressure injury that can reach into the muscle, bone and tendons) of the coccyx, and a left heel stage 4 pressure ulcer that progressed to a surgical wound. A physicians wound care order states "Medihoney Wound/Burn Dressing Gel (Wound Dressings) Apply to buttocks coccyx topically every day shift for wound care, pack with calcium alginate, cover with sacral dressing AND Apply to buttock coccyx topically as needed for wound care, "pack" with calcium alginate cover with sacral dressing."	F 686	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? An audit of the treatment regimes for all patient/residents with wounds was conducted. Care plans and treatment regimes were updated as indicated. 3. What measures will be put into plaoe or what systemic changes will be made to ensure that the deficient practice does not recur? a. The policies: "Skin Inspection and Monitoring", "Body Audit, "Dressing Change, Clean Procedure", "Dressing Change, Sterile Procedure", "Pressure Ulcer Management'," Pressure Ulcer Risk Assessmenr, "Skin Care", "Skin Integrity Management", and" Wet to Dry Dressing" were reviewed and updated as indicated. b. Education was provided to all nurses regarding dressing change procedures and wound care prevention. c. Dressing change competencies were completed by all nurses. d. Education regarding wound care prevention positioning was completed by all LNA's including return demonstration of , positioning and safe patient handling , techniques. e. RN unit managers and/or designee will participate in weekly wound rounds.	

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F 686	Continued From page 12	F 686		

During observation of a Licensed Practical Nurse (LPN) performing wound care on 3/1/2023 at approximately 10:30AM the LPN removed the dressing over the Resident's coccyx exposing a stage 4 pressure area. The base of the wound was noted to have a small piece of gauze in the corner of the wound exposing a large open area. Packing a wound is used to soak up drainage from the wound, helping the tissue to heal from the inside out. Without packing, the wound could close at the top. This would trap fluid and possibly bacteria in the deeper areas of the wound, impede healing, and lead to infection. Per the LPN the wound should actually be "packed" with gauze. When asked if the Physicians order reflected how much packing should be used in the wound S/he stated "No, but it should be more than this." The LPN filled the wound with gauze strips and confirmed that the previous dressing was not done per physicians order and that the packing should fill the wound.

A care plan focus initiated on 5/17/2022 reflects that S/he is high risk for skin breakdown related to disease process, immobility, impaired nutrition, altered cardiac status. S/he requires a Hoyer lift out of bed, peg tube (tube inserted through the skin into the stomach to provide nutrients) for feeding, and a pacemaker. Another care plan focus written on 5/17/2022 reflects that the "[Resident] has actual impairment to skin integrity of the left lateral leg r/t [related to] fragile skin." The Activities of Daily Living care plan revised on 6/13/2022 reveals that S/he requires total to moderate assist for repositioning and turning in bed every 2 hours and as necessary, and an actual impairment to skin integrity care plan, revised on 9/15/2022 includes the following

4. How will the corrective actions be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place?

An audit of the treatments and care plans of patients/residents with wounds will be I conducted weekly x 4 weeks then monthly x 3 months then randomly thereafter. Additionally, in addition to routine skin evaluations, random skin assessments will be conducted by the RN unit managers and/or RN designee monthly to evaluate wound prevention techniques. Results of the audits will be reported to the facility Safety-Quality Committee.

5. The dates oorrective action will be completed. Date: 4/16/2023

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Tag F 686 POC accepted on 5/17/23 by S. Freeman/P. Cota

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interventions: "Off load heels while in bed" and "turn and reposition [every] 2-3 hours and PRN [as needed]."

During observation of the LPN performing wound care on 3/1/2023 at approximately 10:30AM it was noted that the Resident's calves were resting on a pillow and her/his heels were resting on the mattress. The LPN repositioned the pillow to "float the heels" and stated " this doesn't really help with the leg wounds." When asked what S/he meant, s/he stated that the Resident has pressure areas on her/his calves too.

On 3/2/2023 at 10:45 AM Resident #93 was observed in bed with her/his heels resting on her/his mattress. While repositioning the Resident, a Licensed Nursing Assistant (LNA) was asked if there was anything in place to keep the Resident's heels off the bed. The LNA picked up a round blue cushion that is meant to wrap around the Resident's lower leg to elevate the heel, and stated "this is what we are supposed to use." The LNA then placed it under the Resident's calf and repositioned her/him. The LNA confirmed that it was the expectation that the heels be elevated off the mattress at all times.

During interview on 3/2/2023 at 11:45 AM the Unit Manager confirmed that the Resident's heels should be off loaded per physicians order. S/he also confirmed that the Resident's coccyx wound should be packed with gauze per Physician's order.

Refer also to example #1 of F0657 regarding failure to revise the care plan of resident #93 relating to wounds.

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F 693 SS=D	Continued From page 14 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, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that the administration of enteral nutrition (nutrition administered directly into the stomach] was consistent with and followed the practitioner's orders, requiring the Resident to receive additional insulin coverage for an elevated blood sugar for one applicable resident in the sample. Findings include: Per record review Resident #93 was admitted to the facility on 5/22/2022 with diagnoses that	F 693 F 693	F 693 Tube Feeding 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #93 was monitored for potential adverse effeLone were noted. In addition, MD was notified at the time and no new orders. 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 patients/residents receiving tube feeding have the potential to be affected. The orders and documentation for all residents receiving tube feedings were reviewed. No discrepancies were noted. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? a. Education was provided to all nurses regarding tube feeding orders and process. b. Medpass competencies were completed on all nurses. c. The policies: "Medication via Enteral Tubes" "Tube Feeding Infusion Monitoring", and Gastrostomy Tube and Jejunostomy Tube-Care or were reviewed and updated as indicated. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place? An audit of tube feeding Infusions 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.	

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F 693	Continued From page 15 include Type 2 Diabetes Mellites and a gastrostomy tube (G-Tube, a tube that is inserted through the skin and stomach wall, used to provide nutrition directly to the stomach). Review of physicians orders revealed an order for "Enteral Feeding in the evening Enteral Nutrition via Pump Glucerna at 140 ml per hour for 12 hours via pump per G-tube. Start at 6 pm and stop at about 6 am for a total of 1680 total formula volume. Clear pump and document amount at infusion end. AND one time a day Run until total prescribed amount infused. Clear pump and enter infused amount." A Communication to Physician Note written on 3/1/2023 at 7:05 PM states "Made [Physician] aware that feed was run during the day also. [S/he] stated that we should still run the feed overnight also. Will continue to monitor." At 9:12 PM a Health Status Note was written that states "Resident had a blood glucose of 379 at 1600 [4:00 PM] today. This nurse gave [her/him her/his] scheduled dose of Lantus which was 34 units. Rechecked [her/his] blood glucose at 2030 [8:30 PM] and it was 538..." This nurse also documented that when S/he notified the Physician S/he gave her/him an order for "Humilin R (10 units). [Humulin is a short acting insulin used to cover blood sugar increases from meals eaten within 30 minutes] now and to recheck in approximately 20 minutes." A Health Status Note written at 9:41 PM states "It's now 2140 [9:40 PM] and this nurse just checked on [Resident] and [her/his] blood glucose level. [S/He's] now down to 456. Notified the supervisor and [S/he] stated that this is much better than it was." During interview on 03/02/23 at 8:53 AM with the Registered Dietician (RD) and the Unit Manager (UM), the UM confirmed that the Resident did receive an additional feeding on 3/1/2023, and	F 693	. The dates corrective action will be completed. Date: 4/16/2023 Tag F 693 POC accepted on 5/17/23 by S. Freeman/P. Cota	

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F 693	Continued From page 16 that the physician provided an order for an administration of additional insulin. The RD stated that the Resident's prescribed feeding meets about 100% of her/his protein requirements and about 80% of her/his energy needs, and that the extra administration of Glucerna would elevate the Resident's blood sugar. The UM reported that the Resident's blood sugar was 269 the morning of 3/2/23.	F 693		
F 847 SS=F	Entering into Binding Arbitration Agreements CFR(s): 483.70(n)(2)(i)(ii)(3)-(5) §483.70(n) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(n)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement;	F 847	F 847 Arbitration Agreements 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Arbitration agreements were reviewed with Residents #46, #105, and #316. 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 new admissions are at risk to be affected. An audit was conducted with those who have signed agreements to determine if they want to retract the agreement. A written communication was sent to the patients who signed the agreement and have discharged from the facility. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The arbitration agreement process has been discontinued.	

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F 847	Continued From page 17 §483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(n) (4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(n) (5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to ensure that the binding arbitration agreement was explained in a form or manner the resident or resident's representative acknowledges that he/she understands. In addition, the agreement does not clearly state the resident or resident's representative has the right to rescind the agreement within 30 calendar days of signing it nor does it explicitly state that the agreement is not required as a condition of admission to or as a requirement to continue to receive care at the facility as evidenced by: On 3/1/23 at 3 PM the business office manager and director of ancillary services who are listed as the points of contact regarding the facility's	F 847	4. How will the corrective actions be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place? Not applicable. 5. The dates corrective action will be completed. Date: 4/16/2023 Tag F 847 POC accepted on 5/17/23 by S. Freeman/P. Cota	

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F 847	Continued From page 18	F 847		

binding arbitration process were interviewed. Per this interview, the facility began to roll out the binding arbitration agreement with admission paperwork for new admissions on 1/1/23. All previous admission agreements were audited and residents who were present in the facility and without the binding arbitration agreement were identified. When asked how binding arbitration was explained the following were examples given to residents or their representatives of situations where binding arbitration may be used: if the bill was not paid or there was an outstanding balance this could be mediated without going to court and an arrangement could be found.

There was no clarity regarding the resident's understanding of potential care concerns or allegations of abuse being managed through binding arbitration. When asked how an evaluation was made to determine if the resident was appropriate to engage in this discussion the following were taken into consideration: if the person knew their first and last name and date of birth and if the person stated they handled their own finances. The team being interviewed added that they might speak with the nurse or social services, and check BIMS (Brief Interview for Mental Status) scores prior to entering into the discussion.

A review of the binding arbitration document reveals it does not contain language stating the resident or representative has the right to rescind the agreement within 30 calendar days of signing it nor does it explicitly state that the agreement is not required as a condition of admission to, or as a requirement to continue to receive care at the facility.

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F 847	Continued From page 19	F 847		

Three residents or their representatives identified as having signed a binding arbitration agreement and that were currently in the sample were chosen for an interview.

On 3/1/23 at 3:40 PM the spouse who is the representative of Resident #105 was interviewed regarding the binding arbitration agreement that had been signed on 2/16/23. Resident #105 was admitted on 1/17/23 with diagnoses including acute respiratory failure, malignant neoplasm of prostate, secondary malignant neoplasm of bone, severe protein-calorie malnutrition, acute kidney failure, and dysphagia (difficulty swallowing). The representative's understanding of the agreement was that it would disallow court proceedings in favor of arbitration in cases of failure to pay the bill or if personal property went missing, he/she stated that a "payment plan" could be worked out in this process versus being taken to court. When asked about rescinding the form within 30 calendar days he/she expressed uncertainty; "Everything is in a fog and has been for the past 30 days", and "I'm trying to get through everything I should have known more or asked more".

On 3/1/23 at 4:45 PM, the representative of Resident #316 was interviewed regarding their understanding of the binding arbitration agreement signed on 2/20/23. Resident #316 is an 87-year-old person admitted on 2/17/23 with diagnoses including dementia. When asked about their understanding of the arbitration process when a dispute arises he/she responded "I have no clue". When asked if they understand that they are giving up their right to litigation in a court proceeding, they responded "no", and he/she continued to respond that he/she had no clue when asked further questions regarding the

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F 847	Continued From page 20 agreement, and when asked if the agreement was explained in a way that he/she understood his/her response was "everything was thrown at me so I'm not sure". On 3/1/23 at 6 pm Resident #46 who is a 71-year-old person admitted on 1/17/23 with diagnoses including a malignant neoplasm of the left lower lung, and a secondary malignant neoplasm of the brain was interviewed regarding their understanding of the binding arbitration agreement. Resident #46 was not sure what the arbitration process would entail if a dispute were to arise, he/she was not able to answer any specific questions about the agreement but stated "I'm sure they must have said something to me".	F 847		
F 848 SS=C	Binding Arbitration Agreements CFR(s): 483.70(n)(2)(iii)(iv)(6) §483.70(n)(2) The facility must ensure that: (iii) The agreement provides for the selection of a neutral arbitrator agreed upon by both parties; and (iv) The agreement provides for the selection of a venue that is convenient to both parties. §483.70(n)((6) When the facility and a resident resolve a dispute through arbitration, a copy of the signed agreement for binding arbitration and the arbitrator's final decision must be retained by the facility for 5 years after the resolution of that dispute on and be available for inspection upon request by CMS or its designee. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure binding arbitration agreements	F 848	F848 Arbitration Agreements 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Arbitration agreements were reviewed with Residents #46, #105, and #316. 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 new admissions are at risk to be affected. An audit was conducted with those who have signed agreements to determine if they want to retract the agreement. A written communication was sent to the patients who signed the agreement and have discharged from the facility.	

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F 848	Continued From page 21 provide for the selection of a neutral arbitrator and for the selection of a venue convenient for both parties, should arbitration be required. Findings include: On 3/1/23 at 3 PM the business office manager and director of ancillary services, who are listed as the points of contact regarding the facility's binding arbitration process, were interviewed. Per this interview, the facility began to roll out the binding arbitration agreement with admission paperwork for new admissions on 1/1/23. All previous admission agreements were audited and residents who were present in the facility and without the binding arbitration agreement were identified. The binding arbitration agreement used by the facility was reviewed by the surveyor who noted the absence of the required elements including selection of a neutral arbitrator and the selection of a venue convenient for both parties should arbitration be required.	F 848	3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The arbitration process has been discontinued. 4. How will the corrective actions be monitored to ensure the deficient practice will not recur, ie, what quality assurance program will be put into place? Not applicable. 5. The dates corrective action will be completed. Date: 4/16/2023 Tag F 848 POC accepted on 5/17/23 by S. Freeman/P. Cota	
F 885 SS=C	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must — §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information;	F 885		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475029	A. BUILDING _____ B. WING _____	C 03 /02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 885 Continued From page 22

(ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and
(iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to inform all residents, their representatives, and families following the occurrence of confirmed COVID-19 infections or of mitigating actions taken by the facility to prevent or reduce the risk of transmission. Findings include:

On 2/28/23, during the annual recertification survey, an interview with the Infection Preventionist was conducted. S/he revealed that the facility had 2 confirmed positive cases of COVID-19 on 1/29/23. S/he reported that it was her/his understanding that they were only required to notify all residents, their representatives, and families if there were more than 3 cases in the facility. S/he stated based on this incorrect information, notifications were only made to those who actually tested positive and the roommates of those residents.

Per review of the facilities own Coronavirus (COVID-19) Infection Control Policy, last modified on 11/8/2022 it lists under "Notifying resident and their representatives, informed of conditions inside the facility". It states:

F 885 **F 885: COVID Outbreak notification**
1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?
No patients/residents were Identified.
2. How will you identify other residents clr. having the potential to be affected by the same deficient practice and what corrective action will be taken?
All patients/residents have the potential to be affected.
3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?
a. The policies: "Coronavirus (COVID 19) Pollcy-CLR Infection Control", "Family/POA notification during COVID Emergency/Outbreak" end • Outbreak-Infectious Disease-Decision , Making" were reviewed and updated as l indicated.
l b. The CLR websHe was updated to provide weekly updates on facility COVID status.
c. Education was provided to all staff regarding outbreak procedures.
d. Residents/families will be notified via preferred method of contact
4. How will the corrective actions be monitored to ensure the deficient practice will not recur, le, what qualify assurance program will be put into place?
An audit of all COVID outbreaks and notification 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 885	Continued From page 23 1. Residents and representatives will be informed by 5:00 PM the next calendar day of the occurrence of a single confirmed infection of COVID-19, or three or more residents/staff with new onset of respiratory symptoms that occur within 72 hours. 2. Update residents and their representatives must be provided regularly and/or each subsequent time a confirmed infection of COVID-19 is identified within 72 hours. 3. Mitigating actions implemented to prevent or reduce the risk of transmission, included if normal operations in the nursing home will be altered. 4. Report in accordance with exiting privacy regulations and statue. 5. Management will follow Centers for Living and Rehabilitation (CLR)'s phase 1-2-3-4 outlines when the threat or any cases before admission, in the community and notification from the hospital that they have a case. On 2/28/23 at approximately 10:00 AM the Infection Preventionist, confirmed that these required notifications had not taken place.	F 885	**Tag F 885 POC accepted on 5/17/23 by S. Freeman/P. Cota**	