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 23, 2024

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

Dear Ms. Mosso:

Enclosed is a copy of your acceptable revised plans of correction for the recertification survey conducted on **March 27, 2024.** 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

Enclosure

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 03/27/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 3/20/2024. There were no regulatory violations identified.	E 000		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey from 3/18/24 through 3/20/24, with off-site investigation from 3/21/24- 3/27/24 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following deficiencies were identified:	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and record review, the facility failed to ensure that all residents were treated with respect and dignity by all staff for one of 29 sampled residents (resident #87). Findings include: Per interview on 3/19/24 at approximately 2:00 PM, Resident #87 stated that about a month ago a staff member swore at them during an	F 557	F557 Respect, Dignity/Right to have Psnl Property 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #87 has been discharged. 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? Interviews will be conducted with all interviewable residents to evaluate dignified care and communication. 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 following policies will be reviewed and updated as indicated: "Abuse, Neglect, and Exploitation". Education will be provided to all staff regarding resident rights, dignity and respectful communication.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Meaghan T Morris | TITLE: Administrator 5/22/24 | (X6) DATE: 04/26/2024

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 557

Continued From page 1

interaction. They stated that the interaction upset them at the time, but that they worked it out and there is no ongoing concern with the Licensed Nursing Assistant (LNA).

Per record review, Resident #87 has a care plan for "[Resident #87] can be verbally aggressive, yelling at staff, swearing at staff, and gestures aggressive towards staff r/t Poor impulse control" initiated on 5/6/23. Per an MDS assessment on 1/10/24, Resident #87 has a Brief Mental Status Score of 15 (high congnitive function).

Per review of the incident documentation from the facility, the LNA confirmed that they swore at the resident during an interaction in which Resident #87 was swearing at the LNA for the way that the LNA was emptying Resident #87's urinal. The LNA swore at Resident #87 under their breath as they left the room. Per Administrator interview with Resident #87 on 3/20/24, they did not want to stop working with the LNA, as they normally have a very positive relationship, and that they just wanted to have a facilitated conversation with the LNA to "bury the hatchet." This was arranged by the facility to the satisfaction of Resident #87.

Per interview on 3/19/24 at approximately 3:00 PM, the Administrator confirmed that the allegation of undignified treatment by the LNA towards Resident #87 was substantiated.

F 580 SS=D

Notify of Changes (Injury/Decline/Room, etc.)
CFR(s): 483.10(g)(14)(i)-(iv)(15)

§483.10(g)(14) Notification of Changes.
(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident

F 557

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?

For the next four weeks, the DNS and/or designee will conduct minimum 15 weekly random resident interviews to evaluate care and communication. After four weeks, random audits/observations will be conducted monthly for three months and then randomly thereafter. Results of the interviews will be reported to the facility Safety-Quality Committee.

5. The dates corrective action will be completed.

Corrective Action will be completed by 05/09/2024.

Tag F 557 POC accepted on 5/23/24 by S. Freeman/P. Cota

F580 Notification of Changes

1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

Resident #100's weights were reviewed by the medical director and a medical evaluation was completed.

F 580

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 weights of all residents was conducted. All significant weight changes were reviewed with the MD.

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F 580	Continued From page 2 representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement	F 580	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 following policies will be reviewed and updated as indicated: "Weight Assessment Monitoring", "Weight Assessment Monitoring-Unintentional Weight Loss", " Weighing the Resident-CLR" and " Physician Notification". Education will be provided to all nursing staff regarding weight loss, weight monitoring, and physician notification. 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? For the next four weeks, the DNS and/or designee will conduct weekly reviews of weight monitoring and documentation of physician communication. After four weeks, random audits will be conducted monthly for three months and then randomly thereafter. Audit results will be reported to the facility Safety-Quality Committee. 5. The dates corrective action will be completed. Corrective Action will be completed by 05/09/2024. **Tag F 580 POC accepted on 5/23/24 by S. Freeman/P. Cota**	

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F 580	Continued From page 3 its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to notify the resident's physician of significant weight loss for 1 of 29 sampled residents (Resident #100). Findings include: Record reveals that Resident #100 has diagnoses that include Alzheimer's disease, hypothyroidism, and dementia. Resident #100's nutrition care plan states that s/he "remain at risk for malnutrition in view of need for nutrition supplementation," created on 7/29/23 and has the following goal, "My weight will be stable within 125-135 lbs," revised on 12/8/23. Interventions include, "Monitor my weights and labs as available," created on 7/29/23, and "Notify my MD of any significant weight changes PRN [as needed]," created on 7/29/2023. Resident #100's care plan includes interventions for monitoring, documenting, and reporting weight changes in relation to hydration status and thyroid medications. Record review shows that Resident #100 weighed 126.4 pounds on 2/5/2024. The next weight documented for Resident #100 was 105.8 pounds on 3/8/2024. This weight loss of 20.6 pounds, over approximately one month, indicates that s/he lost 16.3% of their body weight, making it a significant weight loss. There is no evidence that Resident #100's physician was notified about this significant weight loss.	F 580		

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F 580	Continued From page 4 Per Facility policy titled "Weight Assessment Monitoring," last modified on 3/11/2022, licensed nursing staff should report weight loss to the physician. Per interview on 3/20/24 at 2:47 PM, Resident #100's Physician confirmed that s/he has not been made aware of Resident #100's significant weight loss. Per interview on 3/20/24 at 3:54, the Unit Manager confirmed that nursing should have contacted the Physician about Resident #100's weight loss.	F 580		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include	F 607	F607 Develop/Implement Abuse/Neglect Policies 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were affected. 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? (Not applicable) 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 following policies will be reviewed and updated as indicated: "Abuse, Neglect, and Exploitation". Annual background checks were completed on all staff members due for an annual review.	

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F 607 Continued From page 5
but are not limited to the following elements.

§483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.

§483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and policy review, the facility failed to implement policies for screening employees by not completing the required criminal background checks for 4 out of 5 sampled staff. Findings include:

Facility policy titled "Background Checks, Arrests, and Conviction Notification," last revised on 3/4/2024, indicates that the facility will conduct criminal background checks for all current employees at least annually.

Per review of employee human resource files, 4 of 5 sampled direct care staff who have worked at the facility for over a year do not have annual federal background checks completed.

Per interview on 3/20/24 at 11:45 AM, the Human Resource Staff explained that there is no system in place for obtaining annual national background checks for staff that have been here over a year but has worked with the Administrator to implement completing annual background checks in starting in June.

F 609 SS=D Reporting of Alleged Violations
CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)

F 607

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?

For the next four weeks, the Administrator and/or Designee will conduct weekly audits of employee annual background checks. After four weeks, monthly audits will be conducted for three months, and then randomly thereafter. Audit Results will be reported to the facility Safety-Quality Committees.

5. The dates corrective action will be completed.

Corrective Action will be completed by 05/09/2024.

Tag F 607 POC accepted on 5/23/24 by S. Freeman/P. Cota

F 609

F609 Reporting of Alleged Violations

1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

Resident #101 has been discharged.

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F 609	Continued From page 6 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, are reported not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) for 1 resident [Res.#101] of 2	F 609	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? Interviews will be conducted with all interviewable residents to evaluate dignified care and communication. 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 following policies will be reviewed and updated as indicated: "Abuse, Neglect, and Exploitation". Education will be provided to all staff regarding resident rights, dignity and respectful communication. Education will be provided to all staff regarding reporting requirements. Education will be provided to supervisors/managers regarding reporting requirements and investigative protocols. 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? For the next four weeks, the DNS and/or designee will conduct minimum 15 weekly random resident interviews and observations to evaluate care and communication. After four weeks, random audits/observations will be conducted monthly for three months and then randomly thereafter. Results of the interviews will be reported to the facility Safety-Quality Committee.	

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F 609	Continued From page 7 sampled residents regarding abuse allegations. Findings include: Per review of the facility's Investigation Summary of an incident involving Res.#101 on 2/17/24, the Witness Statement by a Licensed Practical Nurse (LPN) present reveals on 2/17/24, a staff member was witnessed "accusing" Res.#101 of tampering with their ostomy appliance, causing the resident's eyes "to tear up". The resident stated they didn't touch it but the staff member continued "as if it were [Res.#101's] fault". The witness statement continues "As [Res.#101] lay naked on the bed with poop all over [her/him], [Staff member] berated [her/him]: again, tears welled up in [Res.#101's] eyes". After the staff member left the room, Res.#101 told the LPN "That [wo/man] has been accusing me all week" and stated it "makes me feel like crap". The LPN's witness statement is dated 2/17/24 at 11:25 PM. A review of the LPN's Supervisor's statement, dated 2/20/24 [3 days after the incident], records the LPN spoke with the supervisor shortly after the supervisor arrived for the 11:00 PM shift on 2/17/24. The Supervisor reported the LPN stated 'there could have been some verbal abuse that happened', and Supervisor asked the LPN to "write down a statement of what happened". [LPN statement dated 2/17/24 at 11:25 PM]. The Supervisor then went to the Unit Manager [UM] to follow up, and the UM informed the Supervisor "that [s/he] had investigated the situation and reported zero findings." Review of the Unit Manager's statement, also dated 2/20/24, 3 days after the incident, records that on 2/17/24 the UM was summoned to	F 609	5. The dates corrective action will be completed. Corrective Action will be completed by 05/09/2024. **Tag F 609 POC accepted on 5/23/24 by S. Freeman/P. Cota**	

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F 609	Continued From page 8	F 609		

Res.#101's room where the LPN was saying something "was inappropriate", with the UM writing "I am unsure of what "this" was, as I was not in the room". The UM continues that after shift change the LPN reported Res.#101 requested to speak to the UM. The UM recorded that Res.#101 was "emotional when I went to see [her/him]", and prefaced "I did not hear what was said" regarding the abuse allegation. The UM's statement does not report any further investigation into the abuse accusation, including speaking with the accused staff member, speaking with the LPN or another staff member present in the room, or reading the LPN's witness statement. The UM's statement does include acknowledgment that the accused staff member was allowed to continue working with Res. #101 "all night".

Review of the facility's Investigation Summary reveals "On Monday 02/19/2024 at 4 p.m. it was brought to the attention of the Administrator and the Director of Nursing that [the LPN] felt that [the staff member] was verbally inappropriate when providing care to [Res.#101's] Ileostomy on Saturday 02/17/2024."

An interview was conducted with the Director of Nursing on 3/19/24 at 2:19 PM. The DON confirmed that the allegation of Verbal Abuse of Res.#101 which occurred on 2/17/24 was not reported to the mandated agencies within 24 hours, as required by state and federal regulations. The DON also confirmed that per regulation and per the facility's policy, after the LPN reported the abuse allegations to the Supervisor, the Supervisor and the Unit Manger failed to 'report to the Administrator and/or Director of Nursing Services or designee, who

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F 609	Continued From page 9 reports to the Division of Licensing and Protection.'	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to assure that further potential abuse, neglect, exploitation, or mistreatment did not occur after an allegation of abuse for 1 resident [Res.#101] of 2 sampled residents regarding abuse allegations. Findings include: Per review of the facility's Investigation Summary of an incident involving Res.#101 on 2/17/24, the Witness Statement by an LPN present reveals on 2/17/24, a staff member was witnessed "accusing" Res.#101 of tampering with their	F 610	F610 Investigation/Prevention/Correct Alleged Violation 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #101 has been discharged. 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? Interviews will be conducted with all interviewable residents to evaluate dignified care and communication. 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 following policies will be reviewed and updated as indicated: "Abuse, Neglect, and Exploitation". Education will be provided to all staff regarding resident rights, dignity and respectful communication. Education will be provided to all staff regarding reporting requirements. Education will be provided to supervisors/managers regarding reporting requirements and investigative protocols.	

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F 610	Continued From page 10 ostomy appliance, causing the resident's eyes "to tear up". The resident stated they didn't touch it but the staff member continued "as if it were [Res.#101's] fault". The witness statement continues "As [Res.#101] lay naked on the bed with poop all over [her/him], [Staff member] berated [her/him]: again, tears welled up in [Res.#101's] eyes". After the staff member left the room, Res.#101 told the LPN "That [wo/man] has been accusing me all week" and stated it "makes me feel like crap". The LPN's witness statement is dated 2/17/24 at 11:25 PM. A review of the LPN's Supervisor's statement, dated 2/20/24 [3 days after the incident], records the LPN spoke with the supervisor shortly after the supervisor arrived for the 11:00 PM shift on 2/17/24. The Supervisor reported the LPN stated, 'there could have been some verbal abuse that happened', and Supervisor asked the LPN to "write down a statement of what happened". [LPN statement dated 2/17/24 at 11:25 PM]. The Supervisor then went to the Unit Manager [UM] to follow up, and the UM informed the Supervisor "that [s/he] had investigated the situation and reported zero findings." Review of the Unit Manager's statement, also dated 2/20/24, 3 days after the incident, records that on 2/17/24 the UM was summoned to Res.#101's room where the LPN was saying something "was inappropriate", with the UM writing "I am unsure of what "this" was, as I was not in the room". The UM continues that after shift change the LPN reported Res.#101 requested to speak to the UM. The UM recorded that Res.#101 was "emotional when I went to see [her/him]", and prefaced "I did not hear what was said" regarding the abuse allegation. The UM's	F 610	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? For the next four weeks, the DNS and/or designee will conduct minimum 15 weekly random resident interviews and observations to evaluate care and communication. After four weeks, random audits/observations will be conducted monthly for three months and then randomly thereafter. Results of the interviews and observations will be reported to the facility Safety-Quality Committee. 5. The dates corrective action will be completed. Corrective Action will be completed by 05/09/2024. **Tag F 610 POC accepted on 5/23/24 by S. Freeman/P. Cota**	

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F 610	Continued From page 11 statement does not report any further investigation into the abuse accusation, including speaking with the accused staff member, speaking with the LPN or another staff member present in the room, or reading the LPN's witness statement. The UM's statement does include acknowledgment that the accused staff member was allowed to continue working with Res.#101 "all night". An interview was conducted with the Director of Nursing on 3/19/24 at 2:19 PM. The DON confirmed that despite abuse allegation regulations and per the facility's Abuse, Neglect and Exploitation policy [modified on 3/4/24] , the facility failed to prevent further potential abuse, neglect, exploitation, or mistreatment when the Supervisor and UM failed to "remove the alleged perpetrator, providing safety to the resident" after the allegation of Verbal Abuse of Res.#101 which occurred on 2/17/24. The DON confirmed that Resident Task records document that the accused staff member continued to work with the resident after the incident on 2/17/24 into the morning of 2/18/24, which was also confirmed in the UM's statement on 2/20/24. Further review of the facility's Investigation Summary reveals "On Monday 02/19/2024 at 4 p.m. it was brought to the attention of the Administrator and the Director of Nursing that [the LPN] felt that [the staff member] was verbally inappropriate when providing care to [Res.#101's] Ileostomy on Saturday 02/17/2024." The DON confirmed that a full investigation into the abuse allegation on 2/17/24 was not initiated until 2/19/24.	F 610	F 656 Develop/Implement Comprehensive Care Plan 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #266 has been discharged. 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?	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656	An audit of all resident fall care plans will be conducted. Fall Care Plans will be reviewed and updated as indicated.	

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F 656	Continued From page 12 §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. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656	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 following policies: "Fall Prevention and Protocol", "Plan of Care", " Multidisciplinary Care Plan- Changes or Additions-CLR", and "Interdisciplinary (IDT) Plan of Care (POC) Document" will be reviewed and updated as indicated. Education will be provided to all nurses regarding the process for review and updating of care plans. Education will be provided to all nursing staff regarding use of the Kardex for communication of fall prevention interventions. 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? For the next four weeks, the DNS and/or designee will conduct weekly audits of all falls and the corresponding resident care plans. After four weeks, random audits will be conducted monthly for three months and then randomly thereafter. Audit results will be reported to the facility Safety-Quality Committee. 5. The dates corrective action will be completed. Corrective Action will be completed by 05/09/2024. **Tag F 656 POC accepted on 5/23/24 by S. Freeman/P. Cota**	

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requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to ensure that staff implemented a resident's individualized comprehensive care plan related to fall prevention for 1 of 29 residents in the sample (Resident #266). Findings include:

Per observation on 3/18/24 at approximately 3:00 PM, Resident #266 had multiple bruises on their face in varying degrees of healing.

Per record review, Resident #266 was admitted to the facility on 3/11/24 after sustaining a significant fall at their Senior Living facility. Resident #266 sustained a fall on 3/12/24 in their bedroom and a second fall on 3/17/24 in the nurse's station after breakfast. Per Resident #266's care plan, it included a focus for "[Resident #266] has had an actual fall with minor injury, to [their] face with bruising prior to admission". An intervention was placed on the care plan on 3/19/24 after the second fall in the facility, which states "lay resident down after meals".

Per observation on 3/20/24 at 12:15 PM, Resident #266 was being fed lunch by staff. At 1:00 PM, Resident #266 was observed sitting outside of the nurse's station in their wheelchair, nodding off to sleep with eyes closed and head hanging downward. Resident #266's assigned

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F 656	Continued From page 14 Nurse and two LNAs (licensed nursing assistants) were observed walking by Resident #266 multiple times and verbally checking in with Resident #266 between 1:00 PM and 1:15 PM. At 1:15 PM, this surveyor asked Resident #266 if they were tired, and they replied "yes." At 1:18 PM, Resident #266 attempted to stand up out of their wheelchair and walk away. An LNA and Resident #266's assigned nurse came over and encouraged Resident #266 to sit back down. At this time, the nurse and the LNA were asked if Resident #266 should be in bed, as they appear tired. The LNA stated that Resident #266 sometimes gets laid down after meals but not all the time. Both the LNA and the Nurse confirmed that they were not aware that Resident #266's care plan includes that they be laid down in bed after meals. Resident #266 continued to stay up out of bed after this interaction and was given coloring materials.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (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).	F 657	F657 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 Resident #62 were reviewed and updated as indicated. Resident #79 had an IDT Care Plan Meeting in March 2024. 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 resident Fall Care Plans will be conducted. Fall Care plans will be reviewed and updated as indicated. An audit of the most recent quarterly Care Plans was conducted, any missing or outstanding meetings were scheduled.	

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F 657	Continued From page 15 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 upon interview and record review, the facility failed to review and revise Care Plans regarding prevention of future falls for 1 of 29 residents sampled (Res.#62). The facility also failed to ensure that the Resident's comprehensive care plan was reviewed and revised by the interdisciplinary team for one of 79 sampled residents (Resident #79). Findings include: 1.) Per review of Res.#62's medical record, the resident was admitted to the facility with diagnoses that include Parkinsonism, dementia, muscle weakness and a history of falling. Review of the facility's 'Fall Prevention and Protocol' policy [last modified 3/11/22] reads "Every resident admitted to [the facility] will have the Fall Risk Evaluation done for the first 24 hours of admission or readmission ... and after each fall." Upon admission, Res. #62 scored a '21', with the facility policy listing "If the score is 10 or greater, the resident/patient is considered to be at HIGH risk for falls and should be evaluated by the interdisciplinary care team for identification	F 657	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 following policies: "Fall Prevention and Protocol", "Fall Risk Evaluation Tool", " Plan of Care", "Interdisciplinary(IDT) Plan of Care (POC) Document", and "Care Plan Meeting" will be reviewed and updated as indicated. Education will be provided to all nurses regarding the process for review and updating of care plans and use of the Kardex for fall prevention measures. Education will be provided to nursing staff regarding Fall Risk Evaluation/Assessment completion. 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? For the next four weeks, the DNS and/or designee will conduct weekly audits of all falls and scheduled IDT meetings. After four weeks, random audits will be conducted monthly for three months and then randomly thereafter. Audit results will be reported to the facility Safety-Quality Committee. 5. The dates corrective action will be completed. Corrective Action will be completed by 05/09/2024. **Tag F 657 POC accepted on 5/23/24 by S. Freeman/P. Cota**	

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and implementation of individualized fall prevention interventions."

Review of Res.#62's medical record reveals the resident fell on:
1/5/24, 1/11/24, 1/14/24, 1/24/24, 2/19/24, 3/4/24, and 3/9/24.
Nursing description of Res.#62's falls include "Resident found face down on floor diagonal to bed with face toward bed and feet toward the door", "found to be on the floor in the doorway ... feet were sticking partially out into the hallway", "sitting next to the bed on the right side and hanging onto the 1/4 side rail". Results of the resident's falls included "complained of pain to right side of face near eye", "bright red drainage from left Nare and from abrasion to right posterior wrist", "Skin tear to right hand and right knee", and knee "was sore; exposed knee to find previous skin tear had abraded [a skin injury caused by rubbing or scraping against a rough surface] with this fall."

Per the interview on 3/20/24, the DON stated that after each resident fall the resident's Care Plan is reviewed and revised to include new interventions to prevent future falls.

Review of the facility's 'Fall Prevention and Protocol' includes 'Care Planning', which notes "ensure that all interventions related to prevention of falls remains appropriate."

Review of Nursing Progress Notes dated 1/5/24, 2 days after the resident's admission, record "This unit manager was notified by staff that resident had an unwitnessed fall in [h/her] room." Review of Res.#62's Care Plan reveals no new interventions added to the Care Plan after the

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resident's first fall on 1/5/24, with the resident then falling again 6 days later, on 1/11/24. Review of Physician Notes for Res.#62 reveal on 1/11/24, the Physician reported "I saw [Res.#62] at CLR [Center for Living and Rehab] today, one week after [his/her] initial admission for long-term placement due to gait instability with multiple falls in the setting of Parkinson's disease and dementia. In fact, I was called to see [h/her] urgently because they fell. It looks like [s/he] scraped [his/her] hand on the grip strips on the floor next to [his/her] bed

Review of Res.#62's Care Plan reveals no new interventions added after the fall on 1/11/24 to prevent future falls. 3 days later, the resident suffered another fall on 1/14/24. Per review of Physician notes dated 1/11/24, grip strips were already in place "on the floor next to [his/her] bed" prior to the fall on 1/11/24. Nursing Notes from the fall on 1/14 record "there was a couple of grip strips in front of [h/her] recliner chair". After falls on 1/11/24 and 1/14/24, the Care Plan lists as a 'new' intervention "grip strips to the left side and right side of bed", dated 1/15/24. After grip strips failed to prevent falls on 1/11/24 and 1/14/24, 'new' interventions added after falls on 1/24/24 and 3/4/24 included more grip strips, "in front of the closet" and "in front of bedside stand": both of which were followed by other falls.

Further review of Res.#62's fall Care Plan reveals the intervention "PT [Physical Therapy] to evaluate and treat as ordered or PRN [as needed]". The intervention first appears in the Care Plan on 1/3/24 upon admission, then is repeated and marked as 'initiated' and 'created' on 1/4/24. After falls on 1/5, 1/11, & 1/14/24, the identical wording of the intervention is repeated

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F 657	Continued From page 18 and marked as a 'revision' to the Care Plan and dated 1/18/24. Per interview with the Director of Nursing [DON] on 3/20/24 at 10:47 AM, the DON confirmed that the facility failed to evaluate the effectiveness of fall prevention interventions regarding the grip strips and failed to revise the Care Plan after each fall with new interventions in order to prevent future falls, some of which resulted in injury. 2. Per record review Resident #79 was admitted to the facility on 5/23/2022. Review of progress notes and care plan sign in sheets indicate that the interdisciplinary team (IDT) met to review and revise Resident #79's care plan on the following dates: 3/12/2023, 7/13/2023, and 1/4/2024. There is no documented evidence that the IDT met to review and revise Resident #79's care plan in October of 2023 between the 7/13/23 and 1/4/2024 review. Per interview with the Long Term Care Manager on 3/20/2024 at 5:13 PM there were no progress notes or care plan meeting sign in sheets in Resident #79's medical record that indicate that the IDT held a quarterly care plan meeting, or reviewed and revised Resident #79's care plan in October of 2023 as required. The Long Term Care Manager confirmed that there should be evidence that Resident #79's care plan was reviewed and revised as indicated by the IDT in October of 2023.	F 657	F677 ADL Care Provided for Dependent Residents 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Nail care was performed for Resident #100. 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 resident nails will be conducted. Nail care will be provided as indicated.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		

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F 677	Continued From page 19 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident/representative interview, staff interview, and record review, the facility failed to ensure that a resident who is unable to carry out activities of daily living without assistance receives the proper level of assistance for one of 29 sampled residents (Resident #100). Findings include: Per record review, Resident #100's care plan states that s/he "has potential for impairment to skin integrity [related to] dementia, incontinence," with the intervention to "Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short," created on 10/20/23. Per observation on 3/18/24 at 3:44 PM, Resident #100 is in bed, wearing just a brief on his/her lower body. His/her nails are very long nails and appear to have a dark brown substance underneath most of the nails. S/He is tugging at his/her brief and groin area. Per observation and interview on 3/20/24 at 1:40 PM, a Licensed Nursing Assistant (LNA) confirmed that Resident #100's nails were very long and dirty and explained that they should be shorter because s/he scratches himself/herself. S/he stated s/he does not cut his/her nails because s/he thinks that the Nurse Practitioner cuts them. While the surveyor and the LNA were looking at Resident #100's fingernails, Resident #100 stated that s/he doesn't like scratching but s/he does.	F 677	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 following policy: "Nail Care" will be reviewed and updated as indicated. Education will be provided to all nursing staff regarding nail care. Education will be provided to nursing staff regarding use of Kardex for ADL care specifics. 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? For the next four weeks, the DNS and/or designee will conduct weekly audits of the condition of resident nails. After four weeks, random audits will be conducted monthly for three months and then randomly thereafter. Audit results will be reported to the facility Safety-Quality Committee. 5. The dates corrective action will be completed. Corrective action will be completed by 05/09/2024. **Tag F 677 POC accepted on 5/23/24 by S. Freeman/P. Cota**	

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F 677	Continued From page 20 Per observation and interview on 3/20/24 at approximately 3:45 PM, the Unit Manager explained that the nursing staff are able to cut Resident #100's nails and confirmed that Resident #100's nails were very long and should have been cut.	F 677		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assist residents in making audiology appointments for 1 of 29 sampled residents (Resident #71). Findings include: Record reveals that Resident #71 was admitted to the facility on 9/2/2021. Per his/her care plan, initiated on 9/2/2021, Resident #71 has a communication problem related to a hearing deficit. Per interview on 3/18/2024 at 1:32 PM, Resident #71 requested that this surveyor speak loudly because they are hard of hearing and needs	F 685	F685 Treatment/Devices to Maintain Hearing/Vision 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? An audiology appointment was scheduled for Resident #71. 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 residents with audiology appointments will be conducted. 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 following policy: "Vision and Hearing" will be reviewed and updated as indicated. The policy "Appointment Management Procedure" will be developed. Education will be provided to all nurses regarding order processing and the appointment process. Education will be provided to the Scheduler regarding the appointment process.	

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F 685 Continued From page 21

hearing aids. Resident #71 explained that s/he was frustrated because s/he has been trying to get new hearing aids for a while. S/He had an audiology appointment on Friday that was canceled by the provider and s/he hasn't heard any follow up on when it is rescheduled for.

Record review reveals a care plan meeting note dated 1/31/2024 indicating that Resident #71 needs an appointment to get new hearing aids. A 3/15/24 progress note confirms that Resident #71 did have an appointment with audiology early that morning but did miss his/her appointment due to transportation reasons. The note indicates that the facility will reschedule.

Per interview on 3/20/2024 at 4:18 PM, the Scheduler explained that s/he would be responsible for rescheduling the audiology appointment and confirmed that it has not been rescheduled.

Per interview on 3/20/24 at approximately 4:30 PM, the Director of Nursing stated that it would be the expectation that if a resident missed an appointment, it should be rescheduled as soon as possible, and indicated that Resident #71's audiology appointment should have been rescheduled already.

F 685

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?

For the next four weeks, the DNS and/or designee will conduct weekly audits of all audiology appointments. After four weeks, random audits will be conducted monthly for three months and then randomly thereafter. Audit results will be reported to the facility Safety-Quality Committee.

5. The dates corrective action will be completed.

Corrective Action will be completed by 05/09/2024.

Tag F 685 POC accepted on 5/23/24 by S. Freeman/P. Cota

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

F 689

F689 Free of Accident Hazards/Supervision/Devices

1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

The care plan and the fall risk evaluations for Resident #62 were reviewed and updated.

Resident #266 has been discharged.

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F 689	Continued From page 22 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to ensure an environment free of Accident hazards regarding implementing interventions to reduce hazards and risks and monitoring for effectiveness related to falls for Res.#62, and regarding falls with a possible brain bleed for Res.#266, 2 of of 29 sampled residents. Findings include: 1.) Per review of Res.#62's medical record, the resident was admitted to the facility with diagnoses that include Parkinsonism, dementia, muscle weakness and a history of falling. Review of the facility's 'Fall Prevention and Protocol' policy [last modified 3/11/22] reads "Every resident admitted to [the facility] will have the Fall Risk Evaluation done for the first 24 hours of admission or readmission ... and after each fall." Upon admission, Res. #62 scored a '21', with the facility policy listing "If the score is 10 or greater, the resident/patient is considered to be at HIGH risk for falls and should be evaluated by the interdisciplinary care team for identification and implementation of individualized fall prevention interventions." Review of Res.#62's medical record reveals the resident fell on: 1/5/24, 1/11/24, 1/14/24, 1/24/24, 2/19/24, 3/4/24 and 3/9/24. Review of Fall Risk Evaluations for Res.#62 demonstrated that after scoring '21' on admission [>10 = HIGH risk], before their first fall in the facility on 1/5/24, Res.#62 was re-evaluated by the facility as only a moderate risk for falls, scoring a '9' after their 7th fall [on 3/9/24] in 3	F 689	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 fall risks evaluation scores for all residents will be conducted. Fall risk evaluations will be updated as indicated. The corresponding care plans will be 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? The following policies: "Fall Prevention and Protocol", "Fall Risk Evaluation Tool", " Plan of Care" and "Interdisciplinary (IDT) Plan of Care (POC) Document" will be reviewed and updated as indicated. Education will be provided to all nurses regarding the process for completing the Fall Risk Evaluation. Education will be provided to all nursing staff regarding use of the Kardex. 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? For the next four weeks, the DNS and/or designee will conduct weekly audits of all falls and their corresponding fall risk evaluation scores and updated fall prevention interventions. After four weeks, random audits will be conducted monthly for three months and then randomly thereafter. Audit results will be reported to the facility Safety-Quality Committee.	

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F 689	Continued From page 23	F 689		

months.

Per interview with the Director of Nursing [DON] on 3/20/24 at 10:47 AM, the DON confirmed that the Fall Risk Evaluations for Res.#62, part of the facility's Fall Prevention and Protocol, were inaccurate and reported facility staff "did not have consistent documentation" when it came to assessing risks. The DON also confirmed that implementing Fall Risk Evaluations after each fall was part of the facility's program to prevent future falls, and the facility failed to conduct Fall Risk Evaluations after falls on 1/14/24 and 2/19/24. During the interview on 3/20/24, the DON reported that falls were identified as incidents, and an incident reporting and tracking system was used to develop fall prevention measures for individuals and the facility overall. Per record review and confirmed by the DON, 2 of Res.#62's 7 falls [1/5/24 & 3/4/24] were not listed as incidents, with no incident report filed.

Nursing description of Res.#62's falls include "Resident found face down on floor diagonal to bed with face toward bed and feet toward the door", "found to be on the floor in the doorway ... feet were sticking partially out into the hallway", "sitting next to the bed on the right side and hanging onto the 1/4 side rail". Results of the resident's falls included "complained of pain to right side of face near eye", "bright red drainage from left Nare and from abrasion to right posterior wrist", "Skin tear to right hand and right knee", and knee "was sore; exposed knee to find previous skin tear had abraded [a skin injury caused by rubbing or scraping against a rough surface] with this fall."

Per the interview on 3/20/24, the DON stated that

Provider's Plan of Correction (F 689):

5. The dates corrective action will be completed.

Corrective action will be complete by 05/09/204.

Tag F 689 POC accepted on 5/23/24 by S. Freeman/P. Cota

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F 689	Continued From page 24 after each resident fall the resident's Care Plan is reviewed and revised to include new interventions to prevent future falls. Review of the facility's 'Fall Prevention and Protocol' includes 'Care Planning', which notes "ensure that all interventions related to prevention of falls remains appropriate." Review of Nursing Progress Notes dated 1/5/24, 2 days after the resident's admission, record "This unit manager was notified by staff that resident had an unwitnessed fall in [h/her] room." Review of Res.#62's Care Plan reveals no new interventions added to the Care Plan after the resident's first fall on 1/5/24, with the resident then falling again 6 days later, on 1/11/24. Review of Physician Notes for Res.#62 reveal on 1/11/24, the Physician reported "I saw [Res.#62] at CLR today, one week after [his/her] initial admission for long-term placement due to gait instability with multiple falls in the setting of Parkinson's disease and dementia. In fact, I was called to see [h/her] urgently because they fell. It looks like he scraped [his/her] hand on the grip strips on the floor next to [his/her] bed." Review of Res.#62's Care Plan reveals no new interventions added after the fall on 1/11/24 to prevent falls. 3 days later, the resident suffered another fall on 1/14/24. Per review of Physician notes dated 1/11/24, grip strips were already in place "on the floor next to [his/her] bed" prior to the fall on 1/11/24. Nursing Notes from the fall on 1/14 record "there was a couple of grip strips in front of [h/her] recliner chair". After falls on 1/11/24 and 1/14/24, the Care Plan lists as a 'new' intervention "grip strips to the left side and	F 689		

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F 689	Continued From page 25 right side of bed", dated 1/15/24. After grip strips failed to prevent falls on 1/11/24 and 1/14/24, 'new' interventions added after falls on 1/24/24 and 3/4/24 included more grip strips, "in front of the closet" and "in front of bedside stand": both of which were followed by other falls. Further review of Res.#62's fall Care Plan reveals the intervention "PT [Physical Therapy] to evaluate and treat as ordered or PRN [as needed]". The intervention first appears in the Care Plan on 1/3/24 upon admission, then is repeated and marked as 'initiated' and 'created' on 1/4/24. After falls on 1/5, 1/11, & 1/14/24, the identical wording of the intervention is repeated and marked as a 'revision' to the Care Plan and dated 1/18/24. Per interview with the Director of Nursing [DON] on 3/20/24 at 10:47 AM, the DON confirmed that the facility failed to address accident hazards by failing to evaluate the effectiveness of the interventions regarding the grip strips and failed to attempt new interventions after each fall with in order to prevent future falls, some of which resulted in injury. 2. Per observation on 3/18/24 at approximately 3:00 PM, Resident #266 had multiple bruises on their face in varying degrees of healing. Per record review, Resident #266 was admitted to the facility on 3/11/24 after sustaining a significant fall at their Senior Living facility. Resident #266 sustained a fall on 3/12/24. As a result, the plan of care was updated to toilet Resident #266 every 2-3 hours. Resident #266 sustained a second fall on 3/17/24 in the nurse's	F 689		

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F 689 Continued From page 26 F 689

station after breakfast. As a result of this fall, the plan of care was updated to lay Resident #266 down for a nap after meals. This intervention was added to the care plan on 3/19/24.

Per observation on 3/20/24 at 12:15 PM, Resident #266 was being fed lunch by staff. At 1:00 PM, Resident #266 was observed sitting outside of the nurses station in their wheelchair, nodding off to sleep with eyes closed and head hanging downward. Resident #266's assigned Nurse and two LNAs (licensed nursing assistants) were observed walking by Resident #266 multiple times and verbally checking in with Resident #266 between 1:00 PM and 1:15 PM. At 1:15 PM, this surveyor asked Resident #266 if they were tired, and they replied "yes." At 1:18 PM, Resident #266 attempted to stand up out of their wheelchair and walk away. Resident #266 still had eyes half closed and their head down as if they were very sleepy. An LNA and Resident #266's assigned nurse came over and encouraged Resident #266 to sit back down. They did not attempt to determine Resident #266's reason for wanting to stand up unassisted.

After this observation, the nurse and the LNA were asked if Resident #266 should be in bed, as they appear tired. The LNA stated that Resident #266 sometimes gets laid down after meals but not all the time. Both the LNA and the Nurse confirmed that they were not aware that Resident #266's care plan includes that they be laid down in bed after meals. Resident #266 continued to stay up out of bed after this interaction and was given coloring materials. The Nurse and LNA were not observed to move Resident #266.

F 692 SS=D Nutrition/Hydration Status Maintenance F 692

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F 692

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CFR(s): 483.25(g)(1)-(3)

§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;

§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;

§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure that residents maintain acceptable parameters of nutritional status as evidenced by the facility failing to obtain weights as care planned and identify weight loss for 1 of 29 sampled residents (Resident #100). Findings include:

Facility policy titled "Weight Assessment Monitoring," last modified on 3/11/2022 states, "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/gain,

F 692

F692 Nutrition/Hydration Status Maintenance

1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

Resident #100 was evaluated by the MD for weight loss.

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 weight monitoring of all residents will be conducted. Schedules for weight monitoring will be adjusted 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?

The following policies: "Weight Assessment Monitoring", Weight Assessment Monitoring—Unintentional Loss", and "Weighing the resident." will be reviewed and updated as indicated.

Education will be provided to all nursing staff regarding weight monitoring procedures.

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weights may be continued weekly and reviewed by Interdisciplinary Care Team for appropriate intervention."

1. Record reveals that Resident #100 was admitted to the facility on 10/12/2023 and has diagnoses that include Alzheimer's disease, hypothyroidism, and dementia. Resident #100's nutrition care plan states that s/he "remain at risk for malnutrition in view of need for nutrition supplementation," created on 7/29/23 and has the following goal, "My weight will be stable within 125-135 lbs [pounds]," revised on 12/8/23. Interventions include, "Monitor my weights and labs as available," created on 7/29/23, and "Notify my MD of any significant weight changes PRN [as needed]," created on 7/29/2023. Resident #100's care plan includes interventions for monitoring, documenting, and reporting weight changes in relation to hydration status and thyroid medications.

Record review reveals that Resident #100 was weighed on 1/1/2024, 2/3/2024, 2/5/2024, 3/8/2024, 3/11/2024, and 3/18/2024. There is no evidence in Resident #100's record that s/he had weekly weights taken between 1/1/24 through 2/3/204 and 2/5/2024 through 3/8/2023. Per Resident #100's documented weights, s/he weighed 126.4 pounds on 2/5/2024 and 105.8 pounds on 3/8/2024, five weeks after his/her last weight. This weight loss of 20.6 pounds indicates that s/he lost 16.3% of their body weight, making it a significant weight loss.

Per interview on 3/20/24 at 3:54 PM, the Unit Manager confirmed that Resident #100 should have been weighed weekly and was not.

F 692

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?

For the next four weeks, the DNS and/or designee will conduct weekly audits of all resident weight monitoring schedules. After four weeks, random audits will be conducted monthly for three months and then randomly thereafter. Audit results will be reported to the facility Safety-Quality Committee.

5. The dates corrective action will be completed.

Corrective Action will be completed by 05/09/2024.

Tag F 692 POC accepted on 5/23/24 by S. Freeman/P. Cota

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F 699 Continued From page 29

F 699 Trauma Informed Care
SS=D CFR(s): 483.25(m)

§483.25(m) Trauma-informed care
The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to create an individualized person-centered plan to render trauma informed care to a resident with a personal history of trauma for 1 of 29 residents (Resident #30). Findings include:

Per observation on 3/18/2024 at 4:18 PM, Resident #30 was seen lying in his/her bed, awake, with the covers pulled to his/her chin. S/He was crying in his/her bed; when asked if s/he was okay, Resident #30 appeared afraid and was weeping while s/he tried to explain concerns s/he had about his/her mother and father and their skin. S/He repeated incoherent phrases about the skin of her father and the skin of her mother and how s/he needed to get it to them and they would not be happy. When asked if s/he would be eating dinner in the dining room, s/he explained that s/he would very much like to go into the dining room. His/her voice was shaky when speaking and continued to weep while she spoke. Per observation on 3/19/2024 at 2:25 PM, Resident #30 was in bed crying. On approach, s/he appeared distressed and was sobbing about his/her father and his skin. S/He was alone in

F 699
F 699

F699 Trauma Informed Care

1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

The care plan for Resident #30 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?

An audit of all residents to identify those with a documented history of trauma will be conducted. Care plans will be 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?

The following policies: "Trauma Informed Care", "Plan of Care", "Interdisciplinary (IDT) Plan of Care (POC) Document", and " Care Plan Meeting" will be reviewed and updated as indicated.

Education will be provided to all staff regarding Trauma Informed Care.

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?

For the next four weeks, the DNS and/or designee will conduct weekly new admission trauma care plan audits. After four weeks, random audits will be conducted monthly for three months and then randomly thereafter. Audit results will be reported to the facility Safety-Quality Committee.

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F 699	Continued From page 30 his/her room. Per interview on 3/19/2024 at 3:34 PM, the Unit Manager (UM) and this surveyor observed Resident #30 in his/her bed crying about his/her father, his skin, and taking the skin to give to his/her mother. The Unit Manger explained that Resident #30 does have a history of trauma but is unsure about the specifics. The UM explained that the observed behavior for Resident #30 is typical. Record review reveals a behavioral health note dated 3/12/2024 states that Resident #30 screened positive for trauma. Resident #30 does have care plan interventions that address behavior but does not have a care plan focus, goals, or interventions that focus on his/her trauma or identifying, mitigating, or eliminating his/her triggers. Facility policy titled "Trauma Informed Care," last modified on 3/4/2024, states "Social Service personnel, in coordination with the interdisciplinary team, will work to develop a plan of care aimed at mitigating/ eliminating triggers. . . Resident specific interventions for a resident will be placed in the care plan upon admission and assessment. Care plans and interventions will be reviewed quarterly and more often as necessary." Per interview on 3/20/24 at 2:47 PM, Resident #30's Physician stated that the team, including the family, are not completely sure about the specifics of Resident #30's past trauma and the team has been talking about it for a while. The Physician explained that being alone was a trigger identified for Resident #30. S/He indicated that there used to be interventions in his/her care	F 699	5. The dates corrective action will be completed. Corrective action will be completed by 05/09/2024. **Tag F 699 POC accepted on 5/23/24 by S. Freeman/P. Cota**	

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F 699	Continued From page 31 plan related to trauma informed care plan but they might have been accidentally removed due to other care areas becoming resolved. S/He confirmed that s/he should have interventions in her care plan about his/her trauma and identified triggers.	F 699	F758 Free from Unnecessary Psychotropic Meds/PRN use 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The medication regime for Resident #13, Resident #30, and for Resident #100 were reviewed by the consulting pharmacist and MD. Care plans for Resident, #13, #30, #100 were reviewed and updates were made 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? An audit of all residents receiving psychotropic medications will be completed. Medication regime reviews will be conducted 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? The following policies: "Psychotropic Medication Use", "Behavioral Health Emergency-CLR", "Medication Administration", "Pharmacy Drug Regime Review", and "Medication Reconciliation" will be reviewed and updated as indicated. Order templates were developed for behavioral monitoring were developed. Education will be provided to all nurses regarding medication monitoring and documentation. Education will be provided to all nursing staff regarding behavior monitoring and management.	
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a	F 758		

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F 758 Continued From page 32
diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure that residents who use psychotropic drugs receive gradual dose reductions (GDR), unless clinically contraindicated, in an effort to discontinue the drugs for 1 of 5 sampled residents (Resident #13); failed to ensure that there was a specific diagnosis/condition documented in the medical record for psychotropic medications for 1 of 5 sampled residents (Resident #100); and failed to ensure that residents who use psychotropic drugs are accurately monitored for behaviors and medication side effects (Residents # 13, #100, and #30). Findings include:

Facility policy titled, "Psychotropic Medication Use," last modified on 10/2/2022, states, "Psychotropic medications should only be given when necessary to treat a specific diagnoses and documented condition. . . GDR will be attempted

F 758
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?

For the next four weeks, the DNS and/or designee will conduct weekly random audits of medication, GDR status, and behavior documentation. After four weeks, random audits will be conducted monthly for three months and then randomly thereafter. Audit results will be reported to the facility Safety-Quality Committee.

5. The dates corrective action will be completed.

Corrective Action will be completed by 05/09/2024.

Tag F 758 POC accepted on 5/23/24 by S. Freeman/P. Cota

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using the following guidelines and limits (unless clinically contraindicated): 1. For all psychotropic medications: within the first year following admission or initiation of medication; attempt taper in 2 separate quarters with at least one month between attempts, Reevaluation should occur at least annually."

1. Record reveals that Resident #13 was admitted to the facility on 10/29/21 and has diagnoses that include major depressive disorder, schizophrenia, and drug induced subacute dyskinesia (movement disorder). Resident #13 has physician orders for "Escitalopram Oxalate [psychotropic; antidepressant] Tablet 20 MG Give 30 mg by mouth in the morning for Depression," with a start date of 05/05/2022, "fluphenazine Decanoate [antipsychotic] Solution Inject 50 mg intramuscularly at bedtime every 14 day(s) for schizophrenia, with a start date of 10/03/2022, " fluPHENAZine HCl [antipsychotic] Tablet 10 MG Give 1 tablet by mouth at bedtime for schizophrenia," with a start date of 10/27/2021, "fluPHENAZine HCl Tablet 10 MG Give 1 tablet by mouth in the afternoon for schizophrenia, with a start date of 10/27/2021, "fluPHENAZine HCl Tablet 10 MG Give 1 tablet by mouth in the morning for schizophrenia," with a start date of 10/28/2021, and "OLANZapine [antipsychotic] Tablet 2.5 MG Give 1 tablet by mouth at bedtime related to UNDIFFERENTIATED SCHIZOPHRENIA," with a start date of 7/11/2023.

a.) Review of Resident #13's pharmacist medication regimen review for the past year show that no recommendations were made by the pharmacist, including recommendations for a GDR. There is no evidence that a GDR was

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attempted in the past year in the medical record for any of the above medications, as required per regulations and facility policy.

Per interview on 3/20/24 at 2:47 PM, Resident #13's Physician confirmed that there should have been a GDR attempt made in the past year and was not.

b.) Per observation on 3/18/24 at 4:47 PM, Resident #13 was sitting in was wheelchair in the dining room. S/He was fidgeting, had repetitive right foot movements, tongue rolling, and a tremor in his/her left hand. Resident #13 was observed again during breakfast and lunch on 3/19/2024 and 3/20/2024 with similar tremors and repetitive movements. After breakfast on 3/20/2024 at approximately 9:30 AM, the Unit Manager was bringing Resident #13 from the dining room to the bathroom and explained that Resident #13 was feeling anxious.
Per interview on 3/19/2024 at 8:52 AM, Resident #13's Representative explained that s/he visits Resident #13 frequently and has observed Resident #13's tremors are happening regularly and have been getting worse.

Record reveals that Resident #13 has the following care plan focuses and interventions related psychotropic medications:
"[Resident #13] is at risk for a mood problem r/t [related to] Disease Process secondary to Schizophrenia and depression," revised on 2/27/2024 with an intervention to, "Administer medications as ordered. Monitor/document for side effects and effectiveness," created 8/15/2018.
"[Resident #13] has an alteration in neurological status (movement disorder/chronic tremors) r/t

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chronic use of psychoactive medications and PTSD [post-traumatic stress disorder]. Tremors worsen when [s/he] feels that others are watching [him/her]," revised on 2/27/2024 with an intervention to "Give medications as ordered. Monitor/document for side effects and effectiveness," created 3/3/2022.
"[Resident #13] uses antidepressant and psychotropic medications r/t behavior management, depression, and schizophrenia," revised on 6/29/2020 with an intervention to, "Monitor/record occurrence of behavior symptoms and document per facility protocol," revised on 6/15/2023.
Per review of progress notes from January 1, 2024, through March 20, 2024, staff documented about potential side effects from medications 3 times (twice possible medication side effects, once that s/he had no medication side effects) and documented about behaviors 1 time (that s/he did not have behaviors). This does not reflect the observations or interviews made during the recertification survey about Resident #13's behaviors or medication side effects.

2. Record reveals that Resident #100 was admitted to the facility on 10/12/2023 and has diagnoses that include Alzheimer's disease and dementia. Resident #100 has a physician order for "Risperidone 0.25 MG Give 1 tablet by mouth in the morning for psychosis history," with a start date of 10/20/2023.

a.) A pharmacist medication regimen review dated 10/16/2023 states that Resident #100 is "Recently admitted on Risperidone with no clear diagnosis to support current use. Please consider obtaining a psychological workup along with performing a medical workup as soon as possible

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to assess for underlying causes of behaviors, Should the workups and nursing behavioral monitoring reveal no significant behaviors or identification of a chronic psychiatric condition, please consider implementing a tapering schedule and/or discontinue Risperidone." A box next to this recommendation is checked "Disagree," and a handwritten response states "psychosis history."

A pharmacist medication regimen review dated 1/7/2024 states that Resident #100 is "Currently receiving allow dose of Risperidone (Risperdal) for a diagnosis other than an approved chronic psychiatric condition. Please evaluate continued need and efficiency. Consider discontinue, if appropriate." A box next to this recommendation is checked "Agree, will do," and a handwritten response states "diagnosis psychosis."

No changes were made to Resident #100's diagnoses or changes to the physician order for Risperidone after either of the medication evaluations above. As of 3/20/24, Resident #100 did not have a documented diagnosis that Risperidone would be necessary to treat.

Per interview on 3/20/2024 at approximately 4:30 PM, the Director of Nursing confirmed that there was no evidence that the physician followed the recommendations in the medication regime reviews listed above.

b.) Per observation and interview on 3/18/24 at 3:44 PM, Resident #100 is in bed. S/He is talking about people that are not in the room and is describing things hanging from the ceiling by the door that do not exist. Shortly after, at 4:24 PM, Resident #100 is seen in his/her wheelchair in the

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common area. S/He is swearing at the surveyors and appears to be significantly agitated.

Record reveals that Resident #100 has the following care plan focuses and interventions related psychotropic medications:
"[Resident #100] uses psychotropic medications r/t disease process secondary to delusional disorder, dementia and CVA [stroke]. Noted to sundown and have hallucinations at times," revised on 10/23/2023, with interventions that include, "Monitor/document/report PRN [as needed] any adverse reactions of PSYCHOTROPIC medications," created on 7/28/2023, and "Monitor/record occurrence of for target behavior symptoms," revised on 9/11/2023.
"[Resident #100] is at risk for depression," revised on 10/20/2023, with interventions that include, "Monitor/document/report PRN any s/sx [signs/symtoms] of depression," created on 8/16/2023.

Per review of progress notes from January 1, 2024, through March 20, 2024, staff documented about potential side effects from medications 1 time (once that s/he had possible medication side effects) and documented about behaviors 15 times (that s/he did not have behaviors). This does not reflect the observations or interviews made during the recertification survey about Resident #100's behaviors.

3. Record reveals that Resident #30 was admitted to the facility on 11/9/2021 and has diagnoses that include dementia, anxiety, and major depressive disorder. S/He has a physician order for Mirtazapine (psychotropic, antidepressant) 22.5 mg once daily at bedtime for depression.

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Per observation on 3/18/2024 at 4:18 PM, Resident #30 was seen lying in his/her bed, awake, with the covers pulled to his/her chin. S/He was crying in his/her bed; when asked if s/he was okay, Resident #30 appeared afraid and was weeping while s/he tried to explain concerns s/he had about his/her mother and father and their skin. S/He repeated incoherent phrases about the skin of her father and the skin of her mother and how s/he needed to get it to them and they would not be happy. Per observation on 3/19/2024 at 2:25 PM, Resident #30 was in bed crying. On approach, s/he appeared distressed and was sobbing about his/her father and his skin. Per interview on 3/19/2024 at 3:34 PM, the Unit Manager (UM) and this surveyor observed Resident #30 in his/her bed crying about his/her father, his skin, and taking the skin to give to his/her mother. The UM explained that the observed behavior for Resident #30 is typical.

Per review of progress notes from January 1, 2024, through March 20, 2024, staff documented potential side effects from medications 0 times and documented behaviors 4 times (once that s/he did not have behaviors, and three times that she did). This does not reflect the observations or interviews made during the recertification survey about Resident #30's behaviors.

Per interview on 3/20/24 at 2:14 PM, the Unit Manager demonstrated how nursing staff do not have a place to document what medication side effects or behaviors a resident might be having in the medication administration record or treatment administration record, and explained that nursing staff should be putting in a progress note every time a resident has a behavior or a possible

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F 758	Continued From page 39 medication side effect. She explained that documenting behaviors used to be easier because there was a form in the electronic medical record that would give structure to documenting behaviors. The Unit Manager reviewed Resident #13, #100, and #30's progress notes and confirmed that behaviors were not accurately documented for all three and medication side effects were not accurately documented for Resident #30. (We start talking about 2 more residents here with no information about those - this may need to be copied to the end?) Per phone interview on 3/26/2024 at 11:30 AM, the Administrator and the Director of Nursing confirmed that they were unable to provide any additional evidence to show that staff were documenting medication side effects or behaviors for Residents #30, #13, and #100.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that residents are free from significant medication errors for one of 29 sampled residents (Resident #266) as evidenced by administration of an anticoagulant for a resident with a brain bleed. Findings include: Per resident #266's record, Resident #266 sustained a fall on 3/12/24 at approximately 5:40 PM. The fall was unwitnessed, and Resident	F 760	F760 Residents are Free of Significant Med Errors 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #266 has been discharged. 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 residents taking anticoagulant therapy was conducted. 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 following policies: "Fall Prevention and Protocol" and "Anticoagulant, Administration of Procedure-CLR" will be reviewed and updated as indicated. A "Return from ER visit" protocol will be developed. Education will be provided to all nurses regarding anticoagulant monitoring and the return from ER process.	

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F 760	Continued From page 40 #266 was sent to the Emergency Room for evaluation. Per a nursing progress note from 3/13/24 at 7:32 AM, the Emergency Room nurse called to report that the Resident has a brain bleed that was 3mm in diameter, and that they were unable to determine if it was a result of the fall or not. Per a documented secure conversation note on 3/13/24 at 11:52 AM, Resident #266's physician sent a message at 7:14 AM stating "[Resident #266] has a small intracranial hemorrhage (brain bleed), stable on second CT (cat scan) 6 hours later. We'll be holding anticoagulation...". In the same documented secure conversation note there is an additional message from the facility NP sent at 11:52 AM that states, "unfortunately it looks like [Resident #266] did receive [their] apixaban (an anticoagulant medication that makes bleeding easier) dose this morning. I have placed it on hold moving forward." Per Resident #266's orders, the anticoagulant medication "apixaban 5 mg - give 1 tablet by mouth every morning and at bedtime" was ordered on 3/11/24 and was not placed on hold until 3/13/24 at 11:43 AM. The scheduled AM dose on 3/13/24 is marked as administered. Per interview on 3/13/24 at approximately 1:00 PM, the Director of nursing confirmed that Resident #266 was given a dose of anticoagulant medication against MD recommendations despite Resident #266 having a diagnosed brain bleed.	F 760	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? For the next four weeks, the DNS and/or designee will conduct weekly audits of all residents on anticoagulant therapy and ER visits. After four weeks, random audits will be conducted monthly for three months and then randomly thereafter. Audit results will be reported to the facility Safety-Quality Committee. 5. The dates corrective action will be completed. Corrective action will be completed by 05/09/2024. **Tag F 760 POC accepted on 5/23/24 by S. Freeman/P. Cota**	
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies	F 887	F887 COVID Immunizations 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #6 has been discharged. 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? Education in the form of VIS sheets will be provided to all residents and/or their POA regarding COVID immunizations.	

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	475029	A. BUILDING ______ B. WING ______	C 03/27/2024

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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F 887	Continued From page 41 and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19	F 887	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 following policies: "Infection Prevention and Control Program & Antibiotic Stewardship Policy", " Immunization Universal Policy", " Immunization Record Protocol Policy", " Coronavirus (COVID-19) Policy", and " Coronavirus (COVID-19) Vaccine Administration Procedure" will be reviewed and updated as indicated. Vaccine consent was standardized to include documentation of vaccine education. 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? For the next four weeks, the IP and/or designee will conduct weekly audits of all vaccine administration. After four weeks, random audits will be conducted monthly for three months and then randomly thereafter. Audit results will be reported to the facility Safety-Quality Committee. 5. The dates corrective action will be completed. Corrective action will be completed by 05/09/2024. **Tag F 887 POC accepted on 5/23/24 by S. Freeman/P. Cota**	

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F 887	Continued From page 42	F 887		

vaccine due to medical contraindications or refusal; and
(vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:
(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;
(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and
(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to ensure that each resident's medical record contains documentation that indicates that the resident or resident's representative was provided education regarding the benefits and potential side effects of the COVID-19 immunization before receiving the vaccine for 1 of 5 sampled residents (Residents #100). The facility also failed to ensure that each eligible resident receives the COVID-19 vaccine for 1 of 5 sampled residents (Resident #6).
Findings include:

1. Per record review, resident #100 received the Fall 2023 COVID-19 immunization on 3/20/2024. There is no evidence in the record that Resident #100 or their representative was provided education regarding the benefits or side effects of the immunization.

Per interview on 3/20/24 at approximately 4:30 PM, the facility's Infection Preventionist confirmed that no documentation could be located in the

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F 887	Continued From page 43 record to validate that Resident #100 was provided education regarding the benefits or side effects of the immunization prior to vaccination. 2. Per record review, resident #6 was not provided the Fall 2023 COVID-19 immunization. There is no evidence in the record that Resident #6 or their representative was provided education regarding the benefits or side effects of the immunization or that the Resident or representative had signed consent to receive or not receive the immunization. Per interview on 3/20/24 at approximately 4:30 PM, the facility's Infection Preventionist confirmed that there was no signed consent to either give the COVID-19 immunization to Resident #6, or that Resident #6 or their representative had refused the immunization. They stated this was because Resident #6 was currently in the process of obtaining a Power of Attorney (POA) and that they needed that sorted out before obtaining consent because Resident #6 does not have the capacity to consent. Per further record review, Resident #6 signed consent for the Fall 2023 influenza vaccine on 10/31/23 themselves and received the vaccine the same day. Per review of communications between the facility and their immunization provider, the facility received COVID-19 vaccinations on 11/2/2023, two days after Resident #6 signed consent to receive the Fall 2023 influenza vaccine. Per interview on 3/20/24 at approximately 5:00 PM, the Infection Preventionist confirmed that Resident #6 could have signed consent for the	F 887		

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F 887	Continued From page 44 Fall 2023 COVID-19 immunization at the same time as the influenza immunization and received the COVID-19 immunization when the facility received the vaccines.	F 887		