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

August 17, 2021

Mr. Mike Rivers, Administrator
Crescent Manor Care Ctrs
312 Crescent Blvd
Bennington, VT 05201-0170

Dear Mr. Rivers:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **June 9, 2021.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475033	A. BUILDING _____ B. WING _____	C 06/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESCENT MANOR CARE CTRS	312 CRESCENT BLVD 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 annual emergency preparedness survey on 6/9/21. The following regulatory deficiencies were cited as a result:	E 000		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach.	E 004	1. No residents were affected by this alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. 3. A comprehensive review and update of the Emergency Preparedness plan was completed on 7/6/21 by the Administrator, and Education Nurse. 4. The Administrator, Education Nurse were educated by the Regional Administrator on 7/6/2021 regarding the requirement to review the Emergency Preparedness Plan at least annually. 5. The Administrator or designee will bring the emergency plan to the quarterly QA meetings and review/discuss necessary updates with Department Heads. These updates will be assigned to Department heads and reviewed at the following QA meeting and on an ongoing basis. 6. The Administrator will review the entire emergency plan on an annual basis and sign it has been updated. 7. The Regional Administrator/ designee will audit the Emergency Preparedness Manual quarterly for two quarters and as necessary thereafter to ensure the plan has been updated at least annually. The Administrator will present the results of the audit to the QAPI committee at least quarterly. The QAPI committee consists of The Medical Director or his designee, Executive Director, Director of Nursing, Infection Preventionist, Environmental Services, Social Worker, MDS Coordinator and Dietary Manager to ensure compliance is achieved and sustained. Responsible Person: Administrator Completion Date: 7/6/21	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mike Rivers	Administrator	07/08/2021

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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E 004	Continued From page 1 * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that the emergency preparedness plan is reviewed and updated at least annually. Findings include: Per record review of the emergency preparedness plan, the plan was last updated on May 28th, 2019. Per interview on June 9th, 2021 at approximately 9:30 am, the facility Administrator confirmed that the facility has not reviewed or updated the emergency preparedness plan since May of 2019 and that the facility is not in compliance with this regulation.	E 004	**TAG E 004 POC Accepted on 8/17/21 by P. Cota**	
E 013 SS=C	Development of EP Policies and Procedures CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b).	E 013		

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E 013	Continued From page 2 (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2	E 013	1. No residents were affected by this alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. 3. A comprehensive review and update of the Emergency Preparedness plan was completed on 7/6/21 by the Administrator. 4. The Regional Administrator educated the Administrator, and Education Nurse on 7/6/2021 regarding the requirement to review and revise the Emergency Preparedness Plan at least annually. 5. The Regional Administrator or designee will audit the Emergency Preparedness Plan Manual quarterly for two quarters and as necessary thereafter to ensure the plan has been updated at least annually. The Administrator will present the results of the audit to the QAPI committee at least quarterly. The QAPI committee consists of The Medical Director or his designee, Executive Director, Director of Nursing, Infection Preventionist, Environmental Services, Social Worker, MDS Coordinator and Dietary Manager to ensure compliance is achieved and sustained. Responsible person: Administrator Completion date: 7/6/21	

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E 013	Continued From page 3 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that emergency preparedness policies and procedures are reviewed and updated at least annually. Findings include: Per record review of the emergency preparedness policies and procedures, the policies and procedures were last updated on May 28th, 2019. Per interview on June 9th, 2021 at approximately 9:30 am, the facility Administrator confirmed that the facility has not reviewed or updated the emergency preparedness policies and procedures since May of 2019 and that the facility is not in compliance with this regulation.	E 013	**TAG E 013 POC Accepted on 8/17/21 by P.Cota**	
E 034 SS=C	Information on Occupancy/Needs CFR(s): 483.73(c)(7)	E 034		

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E 034	Continued From page 4 §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to include a means of providing information about the facility's occupancy, needs, and its ability to provide assistance to the	E 034	1. No residents were affected by this deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. A comprehensive review and update of the Emergency Preparedness plan was completed on 7/6/21 by the Administrator including Section 19: Notifications and Communications Plan. 4. The Administrator and Education Nurse were educated on the need to develop and maintain an emergency preparedness communications plan that complies with Federal, State and local laws that must be updated at least annually (E034), and section 19 of the Emergency Preparedness Plan: Notifications and Communication. 5. The Administrator or designee will review the Emergency Preparedness Plan Manual quarterly for two quarters and as necessary thereafter to ensure the Emergency Preparedness Communications/ Communication Plan is updated at least annually. 6. The Administrator will present the results of the audit to the QAPI committee at least quarterly. The QAPI committee consists of The Medical Director or his designee, Executive Director, Director of Nursing, Infection Preventionist, Environmental Services, Social Worker, MDS Coordinator and Dietary Manager to ensure compliance is achieved and sustained. Responsible person: Administrator Completion date: 7/6/21	

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E 034	Continued From page 5 authority having jurisdiction, the incident command center, or designee in the communication plan. Per record review of the emergency preparedness communication plan, there is no evidence that the facility has a means of providing information about occupancy, needs, or the facility's ability to provide assistance as required. Per interview on June 9th, 2021 at approximately 12:00 pm, the facility Administrator confirmed that the facility is not in compliance with this regulation.	E 034	**TAG E 034 POC Accepted on 8/17/21 by P.Cota**	
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined	E 035	1. No residents were affected by this alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. 3. A letter was provided to cognitive residents and/or family representatives summarizing the Emergency Preparedness Plan which included bullet-points highlighting the major sections of the plan via in-person delivery or standard mail. Included in the letter is notification that the complete Emergency Preparedness plan is available for review. 4. The Administrator will send additional letters and/or emails to family members as needed, to apprise them of any significant changes to the emergency plan. 5. The Administrator, and Education Nurse were provided education by the Regional Administrator on 7/6/2021 regarding the "LTC Sharing Plan with Patients" requirement that a method for sharing information from the emergency plan with residents [or clients] and their families or representatives at least annually (E035) is included in the Emergency Preparedness Plan.	

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E 035	Continued From page 6 is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to include a method for sharing information from the emergency preparedness plan with residents and their families or representatives in the communication plan. Per record review of the emergency preparedness communication plan, there is no evidence that the facility has a method for sharing information from the emergency preparedness plan with residents' families as required. Per interview on June 9th, 2021 at approximately 12:30 pm, the Nurse Educator confirmed that the facility is not in compliance with this regulation.	E 035	6. The Regional Administrator or designee will audit the Emergency Preparedness Plan to ensure the policy for a method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives is current quarterly for two quarters and as needed. 7. The Administrator will present the results of the audit to the QAPI committee at least quarterly. The QAPI committee consists of The Medical Director or his designee, Executive Director, Director of Nursing, Infection Preventionist, Environmental Services, Social Worker, MDS Coordinator and Dietary Manager to ensure compliance is achieved and sustained. Responsible person: Administrator Completion date: 7/6/21	
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in	E 036	**TAG E 035 POC Accepted on 8/17/21 by P.Cota**	

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E 036	Continued From page 7 paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the	E 036	1. No residents were affected by this alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. 3. A comprehensive review and update of the Emergency Preparedness plan and testing program was completed on 7/6/21 by the Administrator. 4. The Administrator and education Nurse were educated by the Regional Administrator on 7/6/2021 regarding the requirement to review the Emergency Preparedness Plan and Testing Program at least annually. 5. The Administrator or designee will audit the Emergency Preparedness Manual quarterly for two quarters and as necessary thereafter to ensure the Emergency Preparedness Plan and Testing Program has been updated at least annually. The Administrator will present the results of the audit to the QAPI committee at least quarterly. The QAPI committee consists of The Medical Director or his designee, Executive Director, Director of Nursing, Infection Preventionist, Environmental Services, Social Worker, MDS Coordinator and Dietary Manager to ensure compliance is achieved and sustained. Responsible person: Administrator Completion date: 7/6/21	

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E 036	Continued From page 8 emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that the training and testing program is reviewed and updated at least annually. Findings include: Per record review of the emergency preparedness training and testing program, the program had not been updated since May of 2019. Per interview on June 9th, 2021 at approximately 9:30 am, the facility Administrator confirmed that the facility has not reviewed or updated the emergency preparedness training and testing program since May of 2019 and that the facility is not in compliance with this regulation.	E 036	**TAG E 036 POC Accepted on 8/17/21 by P.Cota**	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:	E 039		

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E 039	Continued From page 9 (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):]	E 039	1. No residents were affected by this alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. 3. A facility table-top exercise to test the emergency plan was conducted on 7/7/2021. 4. The Administrator, DON, and Education Nurse were educated by the Regional Administrator on regarding the requirement to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures (E039). 5. The Administrator or designee will audit the Emergency Preparedness plan quarterly for two quarters and as needed thereafter to ensure the facility is has conducted exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures consistent with the requirements of E039. The Administrator will present the results of the audit to the QAPI committee at least quarterly. The QAPI committee consists of The Medical Director or his designee, Executive Director, Director of Nursing, Infection Preventionist, Environmental Services, Social Worker, MDS Coordinator and Dietary Manager to ensure compliance is achieved and sustained. Responsible person: Administrator Completion date: 7/6/21	

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E 039	Continued From page 10 (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or	E 039	**TAG E 039 POC Accepted on 8/17/21 by P.Cota**	

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E 039	Continued From page 11 (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or	E 039		

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E 039	Continued From page 12 (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of	E 039		

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E 039	Continued From page 13 the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that	E 039		

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E 039	Continued From page 14 requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.	E 039		

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E 039	Continued From page 15 (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not	E 039		

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E 039	Continued From page 16 limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.	E 039		

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E 039	Continued From page 17 *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to conduct exercises to test the emergency plan at least twice per year. Per review of the emergency preparedness plan exercise records for the year 2020, the facility had no record of conducting a second annual exercise as required. Per interview on June 9th, 2021 at approximately 12:00 pm, the facility Administrator confirmed that the facility had not conducted a second annual exercise to test the emergency preparedness plan during the year 2020 and that the facility is not in compliance with this regulation.	E 039		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced onsite annual recertification survey 6/7/21 - 6/9/21. A violation at F880 was cited at the immediate jeopardy level	F 000		

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F 000	Continued From page 18 without corresponding substandard quality of care. The jeopardy was not removed at the time of exit, but the facility has submitted an immediate corrective action plan to the survey agency since the survey exit date. The following regulatory deficiencies were cited as a result of the recertification survey:	F 000		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656	1) Residents affected by the alleged deficient practice: On 6/9/2021 The MDS Nurse/designee initiated a care plan to address the risks associated with anticoagulants for resident #28. On 6/9/2021 The MDS nurse/designee initiated a skin integrity care plan for resident #64. On 6/8/2021 The Registered Dietician/ designee initiated a care plan to address the nutritional status for resident #56. On 6/8/2021 The MDS nurse/designee revised the care plan for resident #17 to remove the Wanderguard alarm. 2) Residents with the potential to be affected by the alleged deficient practice: The DON/designee audited resident records on 7/7/21 to review/revise resident care plans to update skin integrity, elopement, anticoagulant risks and nutritional care plans to reflect the residents' current status.	

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F 656	Continued From page 19 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to develop a comprehensive care plan for 4 of 22 applicable residents (Residents # 28, 56, 64, 17). Findings include: 1. Per review of the clinical record, there is no plan of care to address Resident # 64's needs related to skin integrity. Resident # 64 was admitted in September 2020 with multiple self-inflicted scratches and skin tears. Record review indicates this behavior has continued throughout the admission. There is no care plan to address potential for alteration in skin integrity nor is there a care plan to address the actual skin wounds. On 06/09/21 at 8:52 AM, the Unit Manager confirmed that there is no care plan in place to address needs for potential for alteration in skin integrity nor to address actual skin injuries since admission. The Unit Manager stated that there should be a care plan in place to address these needs. 2. Per record review, Resident #17 has a diagnosis of dementia and has a history of	F 656	3.Measures/ Systemic Change: On 7/8/2021, The Director of Nurses educated the interdisciplinary team on initiating, reviewing and/or revising care plans routinely to reflect the residents' current status. On 7/8/2021, The Nurse Educator or Director of Nurses will educate began educating the nursing staff on initiating, reviewing and/or revising care plans routinely to reflect the residents' current status. The Nurse Educator or DON will review/revise existing policies in order to ensure care plans reflect resident's condition/status. New clinical staff will be educated on the care plan process in orientation. 4.Monitor Corrective Actions On 7/13/2021 The MDS Nurse/ designee will audit 10 resident records, including new admissions, to ensure accuracy and completeness of the CCP on a weekly basis. Any discrepancies will be documented and given to the DON on a monthly basis for correction. Once 100% compliance is achieved, the MDS Nurse or designee will conduct 10 record reviews a month x 4 and then randomly thereafter. The MDS Nurse will present the results of the audit to the QAPI committee monthly. The QAPI committee consists of The Medical Director or his designee, Executive Director, Director of Nursing, Infection Preventionist, Environmental Services, Social Worker, MDS Coordinator and Dietary Manager to ensure compliance is achieved and sustained. Responsible Person: DON/Designee Completion Date: July 31, 2021.	

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F 656	Continued From page 20 attempted elopements (leaving the facility unaccompanied and without staff knowledge). On 7/10/2019, Resident #17 was care planned for high risk for elopement. On 8/4/2020 an intervention was added for this care plan focus that states, "WanderGuard [a device that alarms when a resident crosses a certain boundary] placed on left wrist for [his/her] safety." This intervention was revised on 5/25/2021 per the care plan. Per observation on 6/8/2021 at 2:45 pm, Resident #17 was not observed to have any device on either wrist. This was confirmed by an RN per interview on 6/8/2021 at 2:45pm who was observing Resident #17 at the same time. The RN stated they do not remember seeing a wander alarm on Resident #17 as far back as he/she could remember. Per interview on 6/8/2021 at 3:00 pm, the Memory Unit Coordinator stated that they don't recall seeing a wander alarm on Resident #17 for as long as they have worked at the facility, which is approximately one month. The Memory Unit Coordinator confirmed that this intervention is not being implemented and should be removed from the care plan. 3. Per record review, Resident # 28 has a Physicians order for Warfarin Sodium (an anticoagulant medication used to prevent blood from clotting) 5.5 mg daily for atrial fibrillation (an irregular and often rapid heart rate that can increase the risk of developing blood clots). Resident #28 does not have a care plan in place that addresses the use of, nor the risks associated with anticoagulation therapy. During an interview on 06/09/2021 at 2:07 PM the Director of Nursing confirmed that Resident #28's	F 656	**TAG F 656 POC Accepted on 8/17/21 by P.Cota**	

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F 656	Continued From page 21 care plan should address the use of anticoagulation therapy. 4. Per record review, there is no care plan to to address Resident #56's ongoing weight loss. The resident has the following diagnoses: Dysphagia, Oropharyngeal Phase; Dementia without behavioral disturbance; Noninfective Gastroenteritis and Colitis, Unspecified; Major Depressive Disorder, Recurrent, unspecified. The resident lost 18.5 pounds, which is 15.23% of her/his body weight within the previous 90 days. On 2/11/21 her/his weight was 121.5 and on 5/13/21 her/his weight was documented as 103.0. She/he is significantly below her/his IBW (Ideal Body Weight), per a dietician assessment that revealed her/his BMI to be 18.8 and her/his IBW is documented as being between 131 and 159 pounds. An annual FCC2 Mini Nutritional Assessment was completed on 4/5/21and the dietician scored the resident at an 8.0. The legend at the bottom of this assessment revealed that an 8.0 mean at risk of malnutrition. At the time of this assessment the residents weight is documented as being 115.9 pounds, moderate decrease in food intake, weight loss between 1 and 3 kg (2.2 pounds to 6.6 pounds), the resident has severe dementia or depression, and the residents BMI is 21 to less than 23. On 5/6 the FCC2 Mini Nutritional Assessent was completed as a quarterly assessment and scored as a 3.0. The legend at the bottom of this assessment revealed that an 3.0 means the resident is malnourished. At the time of this assessment the residents weight is documented as being 105.4 pounds, severe decrease in food intake, weight loss greater than 3 kg (6.6	F 656		

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F 656	Continued From page 22 pounds), severe dementia or depression and a BMI of 19 to less than 21. This resident has an ADL care plan that includes: "Eating: Assistance varies Set-up to dependent to dine at meal. I have a dining NRP. At times, I prefer to be fed. I required additional time to dine." This piece of the care plan was last updated on 3/23/21. There is care plan for for Nursing Rehab/Restorative that reveals, "Eating/Swallowing Program #1 to maximize safety and independence at meals. 1.) Encourage out-of-bed seating (TV room or Main Dining Room whe open) as tolerated. 2) Cut-up all foods into bite-size pieces. 3) Remove items for tray and place within [Resident #56's] reach. 4) Monitor for pocketing. Alternate textures (e.g., ground meat and potatoes) and/or solid/liquids to clear residue. 5) Provide 1:1 assistance with meals as tolerated 6.) Provide pureed French toast as an alternative if I refuse my meal." This part of the care plan was last updated on 4/15/21. Interview on 6/8/21 at approximately 1:30 PM, with the dietician revealed that she/he was aware of this residents weight loss and that staff know that the resident requires someone to feed her/him for all meals. The dietician confirmed that she/he has not completed a care plan to address this residents weight loss.	F 656		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's	F 692		

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F 692	Continued From page 23 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, it was determined that the facility failed to maintain acceptable nutritional supports to residents at risk and who had significant weight loss for 1 of 20 residents in the survey sample (Resident #56). Findings include: Review of the electronic medical record (EMR), revealed that Resident #56 was admitted to the facility in June 2020. The resident has had a significant avoidable weight loss while in the facility. The resident has the following diagnoses: Dysphagia, Oropharyngeal Phase; Dementia without behavioral disturbance; Noninfective Gastroenteritis and Colitis, Unspecified; Major Depressive Disorder, Recurrent, unspecified. The resident lost 18.5 pounds, which is 15.23% of her/his body weight within a 90 day period. On 2/11/21 her/his weight was 121.5 and on 5/13/21 her/his weight was documented as 103.0. She/he is significantly below her/his IBW (Ideal	F 692	1.Residents affected by the alleged deficient practice: On 6/8/2021 The registered Dietician/designee reviewed the resident #56 's medical record, review and revised a nutritional support and care plan to address the resident's weight loss. 2.Potential for Those Residents to be Affected: All residents with a compromised nutritional intake have a potential to be affected by this alleged deficient practice. On 7/7/21 The Registered Dietician/designee reviewed residents at moderate to high risk for weight loss to ensure there is a plan in place to effectively deal and/or promote weight gain and prevent altered nutritional status. 3.Measures/ Systemic Change: On 7/7/2021, The Regional Nurse Consultant and Nurse Educator met with the dietician to discuss the specific responsibility of the position, including but not limited to: Accurately monitoring and tracking resident weights, providing intervention to prevent weight loss, addressing weight loss in the CCP. 4.Monitor: On 7/14/2021 The dietician/ designee will begin to audit 10 resident records which may include newly admitted residents to assure appropriate interventions are in place to reflect the resident's current nutritional status weekly x4 then monthly x3 then randomly thereafter. The dietician will present the results of the audit to the QAPI committee at least monthly. The QAPI committee consists of The Medical Director or his designee, Executive Director, Director of Nursing, Infection Preventionist, Environmental Services, Social Worker, MDS Coordinator and Dietary Manager to ensure compliance is achieved and sustained. Responsible Person: Dietician Correction Date: 7/13/21	

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F 692	Continued From page 24 Body Weight), per a dietician assessment that revealed her/his BMI to be 18.8 and her/his IBW is documented as being between 131 and 159 pounds. An annual FCC2 Mini Nutritional Assessment was completed on 4/5/21and the dietician scored the resident at an 8.0. The legend at the bottom of this assessment revealed that an 8.0 means at risk of malnutrition. At the time of this assessment the residents weight is documented as being 115.9 pounds, moderate decrease in food intake, weight loss between 1 and 3 kg (2.2 pounds to 6.6 pounds), the resident has severe dementia or depression, and the residents BMI is 21 to less than 23. On 5/6/21 the FCC2 Mini Nutritional Assessent was completed as a quarterly assessment and scored as a 3.0. The legend at the bottom of this assessment revealed that an 3.0 means the resident is malnourished. At the time of this assessment the residents weight is documented as being 105.4 pounds, severe decrease in food intake, weight loss greater than 3 kg (6.6 pounds), severe dementia or depression and a BMI of 19 to less than 21. This resident has an ADL care plan that includes: "Eating: Assistance varies Set-up to dependent to dine at meal. I have a dining NRP. At times, I prefer to be fed. I required additional time to dine." This piece of the care plan was last updated on 3/23/21. There is care plan for for Nursing Rehab/Restorative that reveals, "Eating/Swallowing Program #1 to maximize safety and independence at meals. 1.) Encourage out-of-bed seating (TV room or Main Dining Room whe open) as tolerated. 2) Cut-up	F 692	**TAG F 692 POC Accepted on 8/17/21 by P.Cota**	

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F 692	Continued From page 25 all foods into bite-size pieces. 3) Remove items for tray and place within [Resident #56's] reach. 4) Monitor for pocketing. Alternate textures (e.g., ground meat and potatoes) and/or solid/liquids to clear residue. 5) Provide 1:1 assistance with meals as tolerated 6.) Provide pureed French toast as an alternative if I refuse my meal." This part of the care plan was last updated on 4/15/21. Interview on 6/8/21 at approximately 1:30 PM, with the dietician, revealed that she/he was aware of this residents weight loss and that staff know that the resident requires someone to feed her/him for all meals. The dietician confirmed that she/he has not completed a care plan to address this residents weight loss and didn't realize she/he needed to do a seperate care plan for weight loss. See also F656.	F 692		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.	F 756	1)Residents affected by the alleged deficient practice: Resident #27 was not affected by this deficient practice. The MD immediately reviewed and reconciled the drug regimen. 2)Potential for residents to be affected by the alleged deficient practice: All residents who receive as needed psychotropic drugs have the potential to be affected by this alleged deficient practice. The DON will ensure no residents have open-ended or prn psychotropic medication orders. 3) Measures/ Systemic Change: The Administrator, Medical Director and the DON will meet and review with the Pharmacy Consultant those residents who receive psychotropic medications to ensure that prn orders have a stop date and are reconciled. The Medical Director will educate all physicians on addressing recommendations by the Pharmacist Consultant and discuss the regulation prohibiting open-ended prn orders for psychotropic medications.	

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F 756	Continued From page 26 (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the physician acted upon a pharmacy medication recommendation for 1 or 20 residents (Resident #27). Findings include: Per record review, it was revealed that a drug regimen review was conducted for resident #27 on 3/29/21 with the following recommendation: "Currently has an active order for Hydroxyzine prn [as needed] without specified stop date. Please note that CMS [Centers for Medicare and Medicaid] guidelines do not allow maintaining open ended orders for PRN psychotropic's on medication profiles. Please evaluate and	F 756	4.Monitor: On 7/30/2021, The DON/designee will audit 50% of residents on psychotropic drugs and on a monthly basis to ensure there are no open-ended prn orders. The DON will report these audit results to the Medical Director and report the results at the QA Meeting. The Unit Managers will audit the monthly pharmacy medication revisions to ensure the resident's medication charts are reviewed. Any omissions will be immediately reported to the DON/Pharmacist. The QAPI committee consists of The Medical Director or his designee, Executive Director, Director of Nursing, Infection Preventionist, Environmental Services, Social Worker, MDS Coordinator and Dietary Manager to ensure compliance is achieved and sustained. Responsible Person: DON Completion Date: 7/31/21 **TAG F 756 POC Accepted on 8/17/21 by P.Cota**	

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F 756	Continued From page 27 consider discontinue Hydroxyzine prn and change to standing dose of 50 mg [milligrams] qd [every day], if appropriate." The physician failed to follow up on the above recommendation. Review of the policy and procedure, titled, "Medication Monitoring Medication Regimen Review and Reporting", dated 09.08 Section 8.1, under "PROCEDURES" #6 reads, "Resident-specific MRR [Medication Regimen Review] recommendations and findings are documented and acted upon by the nursing care center and/or physician." Interview on 6/8/21 at approximately 2 PM, with the Unit Manager, revealed that she/he had a call out to the doctor regarding the pharmacists recommendation that the physician had not responded to. The Unit Manger confirmed that Resident #27 does use this PRN medication daily.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758	1.Residents affected by this alleged deficient practice: Resident #27 was not affected by this deficient practice. The MD immediately reviewed and reconciled the drug regimen. 2.Residents that could be affected by the alleged deficient practice: All residents who receive as needed psychotropic drugs have the potential to be affected by this alleged deficient practice. 3.Measures/ Systemic Change: On 7/8/2021, The Pharmacist educated the medical director, nurse practitioner, DON and the Nurse Educator on the ordering of prn psychotropic medications.	

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F 758	Continued From page 28 §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 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, it was determined that the facility failed to ensure PRN (as needed) orders for psychotropic drugs were limited to 14 days for 1 resident in a sample size of 20 residents (Resident #27). Findings include:		The medical director will review and revise the policy on ordering of psychotropic meds prn to ensure that the information clearly states there must be a stop date no later than 14 days after the order. The medical director will review the policy with all attendings. The Nurse Educator/DON will review and educate all nurses on the revised policy and procedure re: the ordering of psychotropic medications. 4.Monitor: The DON/ designee will audit 10 resident records weekly for four weeks to ensure prn psychotropic drug orders have an appropriate stop date. Audits will continue on a monthly basis then randomly thereafter. The DON will present the results of the audit to the Medical Director. The Medical Director will present the audit results to the QAPI committee at least monthly. The QAPI committee consists of The Medical Director or his designee, Executive Director, Director of Nursing, Infection Preventionist, Environmental Services, Social Worker, MDS Coordinator and Dietary Manager to ensure compliance is achieved and sustained. Responsible Person: Medical Director Completion Date: 7/31/21	

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F 758	Continued From page 29 Record review of Resident #27's medical record revealed several Pharmacy Medication Record Reviews (MRR) with the following recommendation: "Currently has an active order for Hydroxyzine prn without a specified stop date. Please note that CMS [Centers for Medicare and Medicaid] guidelines do not allow maintaining open ended orders for PRN psychotropic's on medication profiles. Please evaluate and consider discontinue Hydroxyzine prn and change to standing dose of 50 mg [milligrams] qd [every day], if appropriate." The last MRR with these recommendations was made on 3/29/21 and has not been acknowledged by the ordering physician as of this survey date. The original order for this PRN medication is dated 5/31/2019. Interview on 6/8/21 at approximately 2 PM with the Unit Manager, who confirmed that this order has been a long standing PRN order and that the resident does use this PRN every day. She/he stated that she/he has a call out to the ordering physician regarding this medication and is hoping to receive clarification specific to its long term use and perhaps making it a scheduled medication. There is no evidence in the medical record that a Gradual Dose Reduction (GDR) has been attempted for this resident since her admission to this facility on 10/26/18. Interview on 6/8/21 at approximately 2:30 PM with the DON (Director of Nursing) regarding the long standing use of this PRN medication and no evidence of a GDR revealed that the DON was also unable to find supporting evidence of a GDR or rationale for the continued PRN order for this medication.	F 758	**TAG F 758 POC Accepted on 8/17/21 by P.Cota**	

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F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Per direct observation and staff interview, the facility failed to ensure that medications were stored and labeled properly and removed from use when expired. Findings include: 1. On 06/7/21 at 4:01 PM during observation of the South/West medication storage room, an open, unlabeled, multi dose vial of Influenza Vaccine was in the medication refrigerator. The Unit Manager who was present at the time of the	F 761	1 Residents affected by this alleged deficient practice: No residents were affected by this alleged deficient practice. The following was immediately corrected: • On 6/7/2021 The Director of Nurses/ designee discarded the undated Influenza vaccine from the South/West medication storage room. • On 6/7/2021, The DON/designee discarded the undated vial of Tubersol from the North Unit medication room. • On 6/7/2021, The DON/designee discarded the undated bottle of eye drops and reordered from the pharmacy. • On 6/7/2021, The DON/designee discarded the expired bottle of Fish Oil softgels. • On 6/7/2021, The nurses working the North Hall immediately locked the med cart when noted unlocked. • 2 Residents that have the potential to be affected by this alleged deficient practice. All residents have the potential to be affected by this alleged deficient practice. 3 Measures/ Systemic Change: The DON/designee will review/revise all the medication storage policies including but not limited to: • necessity of locking medication carts when not actively in use and being monitored • labeling all drugs when opened (including vials) • Checking all drugs in refrigerator, medication cart and medication storage area for expiration dates and discarding expired drugs.	

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F 761	Continued From page 31 observation, stated that s/he believed multi dose vials should be tabled with the date they were opened and discarded after 28 days of opening. S/he confirmed that the Influenza vaccine was not tabled with the date it was opened. During an interview with the Infection Control/ Staff Development Nurse on 6/7/2021 at approximately 4:15 PM s/he confirmed that multi dose vials should be tabled at the time they are opened and discarded after 28 days. 2. During the North Unit medication storage observation on 6/7/2021 at 4:23 PM the cart used to store medications was observed unlocked behind the nurse's station. The Charge Nurse confirmed that the cart was unlocked and stated that s/he did "not usually" keep the cart unlocked when unattended. On 6/7/2021 at 4:30 PM, during observation of the North Unit medication storage room, an opened multi dose vial of Tubersol (used to aid in diagnosis of tuberculosis) was not tabled with the date that it was opened. The Charge Nurse confirmed that the vial had not been dated when opened. During observation of the North Unit medication carts, there was an opened bottle of eye drops that were not tabled with a date they were opened, and an expired bottle of Fish Oil softgels. At the time of observation, the Charge Nurse confirmed that the eye drops were not tabled when opened and the Fish Oil was expired. S/he also confirmed that the unlabeled and expired medications should be removed from use. Per interview with the Director of Nursing on 06/09/21 08:26 AM there is no process in place or	F 761	On 7/1/21 the Nurse educator provided in-service to all nurses on the revised policies (above). Monitor: On 7/13/2021, The Nurse Supervisor/ designee will conduct weekly medication storage audits of mediation refrigerators and med storage areas (med carts) to ensure there are no expired meds, opened medications are dated/labeled and medication carts are locked. After 4 weeks monthly audits will be done for 3 months and then randomly. Noncompliance will be corrected immediately. The Nurse supervisor/designee will report findings to the DON. The DON will report findings to the QAPI committee at least monthly. The QAPI committee consists of The Medical Director or his designee, Executive Director, Director of Nursing, Infection Preventionist, Environmental Services, Social Worker, MDS Coordinator and Dietary Manager to ensure compliance is achieved and sustained. Responsible Person: DON Completion Date: 7/31/21	

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F 761	Continued From page 32 designated staff responsible to ensure that expired meds are removed and discarded from use. In the past the Unit Managers were responsible to do so and stated nurses should be checking the carts for expired medications and discarding them when expired. 3. On 6/7/21 at 3:20 PM while doing observations on the North side/hall (Dementia Unit), an unlocked medication cart was discovered, behind the nurses station. Several residents walked past the nurses station and 2 LNA's entered the nurses station while the medication cart was unlocked. The nurse responsible for this medication cart was in the dining room, which is adjacent to the nurses station at the time of this observation. The unlocked medication cart was not within her/his visual sight for at least 8 minutes - from the time it was discovered until the nurse returned to the medication cart. At 3:28 PM the nurse who was assigned to that cart, returned to the nurses station. On 6/7/21 at 3:29 PM, interview with the nurse responsible for the unlocked medication cart, who stated she/he usually locks her/his medication cart before leaving the nurses station and this is an infrequent occurrence.	F 761	**TAG F 761 POC Accepted on 8/17/21 by P.Cota** 1)Residents affected by this alleged deficient practice: No residents were affected by the alleged deficient practice. On 6/7/2021 the unlabeled liquid substance in the walk-in refrigerator was immediately discarded. On 6/7/2021 The thawing meats were immediately removed from the top shelf and placed on the low shelf with no foods underneath. On 6/7/2021 the tomatoes and bagged vegetables, which were underneath the thawing meat, were immediately discarded. On 6/7/2021 the 5 cabbages, which may have been rotting, were immediately discarded along with the flour.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812	On 6/8/2021 the 2 operating fans were turned off and removed until they could be properly and thoroughly cleaned or replaced. On 6/7/2021 the microwave oven in the south kitchen unit was immediately discarded and replaced. On 6/9/7 the refrigerator on the north unit was temporarily put out of service until proper temperature could be achieved. On 6/9/21 a new refrigerator was installed replacing the defective refrigerator	

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F 812	Continued From page 33 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Findings include: 1. During the initial kitchen tour on 06/07/21 at 11:14 AM, the following observations were made in the walk-in refrigerator: a. There is a 2 quart metal container containing an unknown liquid substance. The container is uncovered and unlabeled. b. There is thawing raw and cooked meats on the top shelf of a wire rack. There are uncovered tomatoes and bagged vegetables on the bottom shelf of the wire rack directly underneath the thawing meats. c. There are 5 cabbages on the bottom shelf of a wire rack that appear to be rotting. They are soft to touch and have extensive brown/black areas on the surface. 2. In the dry storage room there is a 1 cup scoop left inside the bulk flour bin, instead of being	F 812	2. Potential for those residents to be affected: All residents who eat facility prepared food have the potential to be affected. 3. Measures/ Systemic Change: On 6/14/2021 the Education Nurse or designee educate the Dietary Manager and dietary staff regarding: • The proper storage of produce, placement of food storage in refrigeration. • Proper refrigerator temperature, proper freezer temperatures, logging and reporting temperatures out of range. • Assessment of fresh produce, rotation of fruits vegetables and foods. • Proper storage of meats; frozen, thawing and storin g cooked meats. • Labeling of foods in the refrigerator / freezer. • Proper cleaning of microwave ovens. • Proper storage of scoops/utensils used in dry storage bulk products are properly stored. 3. Monitor: • The Dietary Manager or designee will conduct audits of all fresh produce to ensure freshness and safe use. • The Dietary Manager or designee will conduct audits to observe placement of foods in refrigerator to ensure meats are not thawing or leaking below onto other foods. • The Dietary Manager or designee will conduct audits of all unsealed food items to ensure proper labeling. Any items that have been opened and are not labeled will immediately be discarded. • The Dietary Manager or designee will conduct audits of all microwaved to ensure cleanliness. • The Dietary Manager or designee will conduct audits of all fans in the kitchen area to ensure cleanliness.	

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F 812	Continued From page 34 stored outside of the flour bin, potentially contaminating the flour. 3. There are 2 operating fans in the dishwasher room. The fans are blowing over clean dishware and are soiled with dust. 4. In the South Unit kitchenette, a microwave oven used daily is soiled inside with spilled foodstuffs. There is visible flaking paint and rust. The Maintenance Director stated that he/she was not aware of the oven's condition and stated that it should be replaced immediately. 5. Per observation on 6/8/21 - A refrigerator on the North Unit read 60 degrees Fahrenheit. This is confirmed by the Unit Charge Nurse at 11:19 AM The Food Service Director also confirmed this observation at 11:23 AM, and a pudding tested with a facility instant read thermometer was at 46.4 degrees Fahrenheit.	F 812	• The Dietary Manager or designee will conduct audits of the nursing station refrigerator temperature logs to ensure proper temperature are maintained. • The Dietary Manager will conduct audits of bulk items in dry storage to ensure scoops / utensils These audits will be conducted weekly for 4 weeks, then monthly for 3 months, then randomly thereafter. The Dietary Manager will present the results of the audit to the QAPI committee at least monthly. The QAPI committee consists of The Medical Director or his designee, Executive Director, Director of Nursing, Infection Preventionist, Environmental Services, Social Worker, MDS Coordinator and Dietary Manager to ensure compliance is achieved and sustained. Responsible Person: Dietary Manager Date of Completion: 7/31/21	
F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880	**TAG F 812 POC Accepted on 8/17/21 by P.Cota**	

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F 880	Continued From page 35 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880	**DPOC** 1.Residents found to be affected by this alleged deficient practice: No residents were affected by this alleged deficient practice. All glucometers were immediately cleaned per manufacturer's guidelines. Employees not wearing masks correctly were immediately directed to place their masks in proper position. 2.Residents at risk for this alleged deficient practice: • All residents who require monitoring of blood glucose levels or testing have the potential to be affected by this alleged deficient practice. All residents within 6 feet proximity of employees not wearing masks properly have the potential to be affected by this alleged deficient practice. 3.Measures/ Systemic Change: *Facilitated by the Nurse Consultant a root cause analysis was completed re: this deficient practice. Based on that analysis the following corrections were put in place.* • The Nurse Consultant educated all staff on the rationale for proper use of masks during COVID, proper mask placement, covering both nose and mouth and protecting vulnerable residents, employees, and families. -Education includes properly demonstrating the placement of a face mask. -Education includes reminding peers of correct placement of masks and 'helpful' tips to protect staff and residents. • Policy/procedures for the proper use of face masks were reviewed with all staff during education/demonstration sessions.	

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F 880	Continued From page 36 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and review of facility policies, the facility failed to ensure infection control measures were carried out to maintain resident safety from the spread of potential infections. This is cited at the Immediate Jeopardy severity level. Findings include: 1. Per observation on 06/09/21 at 11:00 AM, during a medication administration pass, a staff nurse checked the blood glucose of a resident prior to giving insulin using a device called a glucometer, which is used for multiple residents and utilizes a sample of resident blood to obtain a blood glucose level. S/he returned to the medication cart, removed the test strip from the glucometer and placed the device in the top drawer of the cart without cleaning the device. After a few more medications were delivered to other residents, the nurse proceeded to use the same, potentially contaminated glucometer to check the blood glucose level of another resident, without cleaning the glucomter prior to or after the procedure, and once again placed the potentially contamiated glucometer in the cart. Per interview on 06/09/21 at 11:20 AM with the	F 880	• All licensed nursing staff were educated on the necessity of cleaning glucometer after each resident and the risk of improper cleansing poses to residents. • Every nurse required to demonstrate the proper cleaning technique of glucometers. • Review revised Glucometer cleaning policy with special emphasis on frequency on cleaning with all licensed nurses. • The Nurse Educator will provide competency evaluations on glucometer cleaning for every licensed staff person. 4.Monitor: On 6/14/2021, The DON/designee will conduct daily rounds throughout the building to ensure that all employees are wearing face masks correctly. Any inconsistencies will be immediately corrected. Results of daily audits will be reported to DON weekly. Audits will continue until masks are no longer needed or there is 100% compliance. The Nurse Educator 'designee will conduct random blood glucose meter cleaning audits on every shift to ensure the practice meet the professional standards. Audits will continue on a weekly basis until 100% compliance is observed and then monthly x 30 days. Deficiencies will be corrected immediately with further education and progressive discipline as required. The DON will present the results of the audits to the QAPI committee at least monthly. The QAPI committee consists of The Medical Director or his designee, Executive Director, Director of Nursing, Infection Preventionist, Environmental Services, Social Worker, MDS Coordinator and Dietary Manager to ensure compliance is achieved and sustained. Responsible Person: DON Completion Date: 7/31/21	

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F 880	Continued From page 37 staff nurse, s/he stated that the glucometer is a shared device for all residents and that the test strip is what comes in contact with the resident's blood and not the device itself, therefore the device does not need to be disinfected after each use. S/he stated that the device is cleaned with Cavi-wipes prior to each shift. These Cavi-wipes were found at the nurses' station and not at the medication cart. A review of the facility policy: Crescent Manor Rehabilitation Policy and Procedure Blood Glucose Monitoring by Resident (06/25/2018) specifies if meter is dirty, use a moist dampened cloth to remove debris. This policy also pertains to monitoring by residents who are cognitively able to perform self-glucose testing with their own glucometers and not to those who require assistance. The residents observed during the medication pass required assistance and did not have their own glucometers. Review of the ASSURE PRISM blood Glucose Monitoring System manufacturer instruction/user manual indicates on page 38 that the meter should be cleaned and disinfected after use on each patient. On page 39 it states to use Clorox Healthcare, Bleach Germicidal Wipes, Dispatch, Hospital Cleaner Disinfectant, Towels with Bleach, CaviWipes 1 and PDI Super Sani-Cloth Germicidal Disposable Wipes with contact times listed. The Center for Disease Control (CDC) indicates the following: Blood glucose meters are devices that measure blood glucose levels. -Whenever possible, blood glucose meters should be assigned to an individual person and	F 880	**TAG F 880 POC Accepted on 8/17/21 by P.Cota**	

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F 880	Continued From page 38 not be shared. -If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected, then it should not be shared. https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html Per interview on 06/09/21 at 1:30 PM the nurse educator/infection preventionist confirmed facility wide use of this glucometer. S/he also indicated that s/he was not aware that the meters needed to be cleaned between each person. After discussion re: glucometer manual instructions and the CDC guidance, s/he acknowledged that this is a breach of the infection control process. 2. On 6/7/21 at approximately 3:20 PM while doing observations on the North side/hall (Dementia Unit) a staff nurse was observed sitting behind the nurses station wearing her surgical mask under her/his nose. On 6/8/21 at approximately 1:45 PM a staff nurse was observed in the nurses station on the South side/hall wearing her/his surgical mask under her/his nose. This same nurse was observed at the medication cart, at 2:24 PM on the South side/hall wearing her/his surgical mask under her/his nose and again, this staff nurse was observed to be wearing her/his surgical mask under her/his nose at 2:30 PM. On 6/8/21 at 2 PM 2 staff (unknown disciplines) were noted to be wearing their surgical masks under their chin and 2 other staff (unknown	F 880		

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F 880	Continued From page 39 disciplines) were observed to be wearing their masks under their noses. On 6/8/21 at approximately 2:05 PM an interview with the staff nurse on the South side/hall, who had been observed at 1:45 PM wearing her/his mask under her/his nose was asked for the full names of the 4 staff members observed wearing their masks either under their nose or under their chin, as well as her/his full name. The staff nurse confirmed that the 4 other staff members were LNA's (Licensed Nurses Aides). The staff nurse explained that she/he was having a hard time keeping the mask up on her/his nose as it kept sliding down. It was noted the metal bar at the top of the mask had not been form fitted to her/his nose. The staff nurse confirmed that appropriate use of the masks was to wear them over the nose and the mouth. On 6/8/21 at approximately 2:40 PM a conversation with the DON (Director of Nursing) specific to the South hall/Unit, while sitting at the nurses station, it was noted that the DON was wearing her/his mask under her/his nose throughout the conversation. On 6/9/21 at 9:15 AM on the South side/hall outside of room 24, an LNA was gathering linen from the linen cart and was noted to be wearing her/his mask under her/his nose. Interview on 6/9/21 at approximately 9:17 AM with this LNA revealed that she/he has been taught that the mask is only effective if worn to cover the nose and mouth. On 6/9/21 at approximately 1:30 PM, a staff member was noted to wearing her/his mask	F 880		

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F 880	Continued From page 40 under her/his nose while working at the linen cart on the South side/hall outside of room 26. Interview on 6/9/21 at approximately 1:32 PM with a staff nurse on the South side/hall, confirmed that the person at the linen cart was a laundry person and she/he should be wearing her/his mask over her/his nose and mouth. On 6/9/21 at 1:30 PM an interview with the Nurse Educator/Infection Preventionist regarding the wearing of mask, she/he confirmed that masks are to be worn to cover the nose and mouth and are required to be worn throughout the facility regardless of vaccination status.	F 880		