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

February 8, 2024

Mr. Isaac Spilman, Administrator
Elderwood At Burlington
98 Starr Farm Rd
Burlington, VT 05408-1396

Dear Mr. Spilman:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **January 11, 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

PRINTED: 01/24/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475030	A. BUILDING _____ B. WING _____	C 01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERWOOD AT BURLINGTON	98 STARR FARM RD BURLINGTON, VT 05408

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E 000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 12/19/2023. 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 12/17/23 through 12/21/23 and 12/26/23 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. During the recertification survey, the survey team identified substandard quality of care as a result of a violation at 483.25(b)(1)- F 686. An unnanounced, onsite extended survey was conducted from 1/9/2024 through 1/11/2024 due to the determination of substandard quality of care. The following deficiencies were identified:	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550	See Attached **Tag F 550 POC accepted on 2/8/2024 by S. Stem/P. Cota** DocuSigned by: Isaac Spilman 4CF6A02596A04E9...	

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

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 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to treat those residents reliant on wheelchairs with dignity by failing to clean the wheelchairs. The facility has 80 residents who utilize wheelchairs. Findings include: On December 19, 2023, at approximately 9:00 AM Resident #5 was sitting in his/her power wheelchair waiting to leave the facility for an outing. The base of the wheelchair housing the motorized mechanisms was noted to have a coating of sticky, dusty grime, this coating was	F 550		

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F 550	Continued From page 2 noted along all flat surfaces of the chair. The posterior view of the backrest was noted to have an approximately 2 inch streak of a dark colored smeared sticky substance on the top edge. A unit Licensed Nurses Aid in the area at the time confirmed the chair was unclean. Further observations of wheelchairs in resident rooms, in hallways, or being used by residents revealed similar dusty, dirty surfaces, one with what appeared to be hair or thread wound around 2 of the spokes on the left large back wheel. Per facility policy entitled "Wheelchair, Geri-Chair Inventory, Maintenance, Cleaning", with an approval date of 10/12/2018, "The Supervisor of Maintenance will cooperate with Housekeeping staff to ensure that wheelchairs are cleaned on a regularly scheduled basis." At 9:30 AM the Director of Maintenance confirmed the wheelchairs were not clean and was unaware of any scheduled cleaning. On December 20, 2023, at approximately 1 PM the Director of Nursing confirmed there was no schedule or process to routinely clean wheelchairs.	F 550		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any	F 553	See Attached **Tag F 553 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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other factors related to the effectiveness of the plan of care.
(iii) The right to be informed, in advance, of changes to the plan of care.
(iv) The right to receive the services and/or items included in the plan of care.
(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

§483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-
(i) Facilitate the inclusion of the resident and/or resident representative.
(ii) Include an assessment of the resident's strengths and needs.
(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.
This REQUIREMENT is not met as evidenced by:
Based on interviews and record review, the facility failed to schedule timely care plan meetings and facilitate the inclusion of the resident's representatives to attend the meeting.

Findings include:

Per record review, Resident # 65 has resided at the facility since 09/15/2021 with a diagnosis of vascular dementia.
Per an interview on 12/18/2023 at 10:44 AM with a family member, s/he explained that Resident #65 was cognitively impaired due to dementia and often declined to participate in the meetings. S/he made decisions regarding financial and medical issues. Her/his work schedule needed to have advance notice to allow for attendance. The

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F 553	Continued From page 4 meetings were canceled often or not scheduled at all. Per record review, a care plan meeting was held on 3/23/2023 and 10/27/2023; there was no evidence of a care plan meeting between March and October. A review of Resident 65's care plan shows the following under Cognitive Skills: "I am significantly Impaired, and my son makes decisions regarding my financial needs and medical care related to vascular dementia." Per interview on 12/26/2023 at 10:08 AM with two social work department members, they could not produce documentation of a care plan meeting scheduled between the dates of 3/23/23 and 10/27/23. Both confirmed that the interdisciplinary team should confer after the quarterly assessment or if there is a significant change in the resident's condition. Additionally, there is no documentation of an invitation to the resident's representative to attend the care plan meeting. Per an interview with the unit manager on 12/26/2023, at 11:05 AM, s/he stated that care plan meetings were often canceled for various reasons. S/he confirmed that care plan meetings should be scheduled and attended by the Interdisciplinary team and that it was important for Resident #65's designated family member to participate.	F 553		
F 554 SS=E	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that	F 554	See Attached **Tag F 554 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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this practice is clinically appropriate.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and record review, the facility failed to determine whether it is clinically appropriate for residents to self-administer medications for 2 of 35 residents (Resident #31 and #81). Findings include:

Per facility policy titled "Medication Administration Methods," last revised on 7/12/23, "A medication must never be left at bedside or be out of sight of the nurse administering the medication. The nurse must watch each resident take the medication, and ensure the medication is swallowed, unless the resident has an order for self-administration of medications."

1. Per observation on 12/19/23 at 10:53 AM Resident #31 was lying in their bed in their room. On his/her bedside table was a respiratory inhaler labeled "Trelegy Ellipta Aerosol Powder." Resident #31 explained that the nurse left it there this morning but s/he also has another inhaler that s/he keeps in the room all the time. Resident #31 then revealed a respiratory inhaler labeled "Albuterol Sulfate" from a cup on his/her bedside table.

Record review reveals that Resident #31 has diagnoses that include chronic obstructive pulmonary disease (COPD) and physician orders that include "Trelegy Ellipta Aerosol Powder Breath Activated 200-62.5-25 MCG/INH (Fluticasone-Umeclidin-Vilant) 1 puff inhale orally in the morning for COPD Rinse mouth after use and spit," with a start date of 6/15/23, and "Albuterol Sulfate HFA Aerosol Solution 108 (90 Base) MCG/ACT 2 puff inhale orally three times a

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day for COPD/post COVID syndrome," with a start date of 12/1/23. Resident #31's does not have a physician order to self-administer medications and there is no evidence in his/her medical record that an assessment has been completed to determine if it is clinically appropriate for him/her to self-administer medications.

Per interview on 12/19/23 at 10:59 AM, the Unit Manager (UM) stated that there is nothing in Resident #31's care plan or orders for him/her to be able to self-administer medications. The UM confirmed that the medications should not have been left in his room.

2. Per observation on 12/20/23 at 2:04 PM Resident #81 was lying in their bed in their room. On his/her bedside table was a respiratory inhaler labeled "Albuterol Sulfate."

Per record review Resident #81 has diagnoses that include COPD and physician orders that include "Albuterol Sulfate HFA Aerosol Solution 108 (90 Base) MCG/ACT 2 puff inhale orally every 4 hours as needed for wheezing start date," with a start date of 11/17/23. Resident #81's does not have a physician order to self-administer medications and there is no evidence in his/her medical record that an assessment has been completed to determine if it is clinically appropriate for him/her to self-administer medications.

Per interview on 12/20/23 at 2:08 PM, the UM confirmed that Resident #81 did not have an order for self-administering medications and s/he has had the inhaler in his/her room for a while. Per interview on 12/20/23 at 2:09 PM, the

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F 554	Continued From page 7 Director of Nursing confirmed that residents should not have medications in room or self-administer meds without an order.	F 554		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance	F 578	See Attached **Tag F 578 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to ensure accurate advanced directive choices were indicated for 1 of 35 sampled residents (Resident #7). Findings include:

Record review reveals that Resident #7 has two conflicting code statuses in their medical record and facility documentation. Their most recent COLST form (clinician orders for life sustaining treatment), entered into Resident #7's electronic medical record (EMR) on 7/20/23, reveals that Resident #7 gave informed consent for a DNR (do not attempt resuscitation) and no intubation or ventilation interventions. This was signed by the Attending Physician. This COLST form is also in a binder located at the nursing station with the unit's residents' most up to date COLST forms. Physician orders and the resident profile banner in the EMR do not reveal a DNR order; instead, the code status order that appears in the EMR is "CPR/Full Code," created on 6/14/23. The unit assignment sheet that nursing staff use on a daily basis also indicates that Resident #7 is a full code.

A 7/17/23 linterdisciplinary team meeting note completed by the former Social Services Director reveals the following, "Code status: CPR/Full Code, [Resident #7] requesting to change to

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F 578	Continued From page 9 DNR." Per interview on 12/20/23 at 8:52 AM, a Registered Nurse said that Resident #7 is a full code and knows this because it is on the assignment sheet and on the banner in Resident #7's EMR. On 12/20/23 at 8:49 AM, the Unit Manager confirmed that staff should follow the COLST and the orders in the EMR are wrong and that Resident #7 should be a DNR according to their COLST.	F 578		
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems.	F 636	See Attached **Tag F 636 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
Based on record review the facility failed to use the data collected using the Resident Assessment

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Instrument (RAI) process, specifically the Minimum Data Set (MDS) assessment, as part of an ongoing process to develop a comprehensive care plan, to provide the appropriate care and services and to modify the care plan for 1 of 35 Resident's sampled (Resident # 28). Additionally, the facility failed to accurately code the MDS assessment, due to lack of accurate review of records and/or lack of actual assessment of the resident's wounds by the RN MDS coordinator, for 3 of 35 Resident's sampled (Residents #47, #99, and #1). Findings include:

1. Resident #28 has a score of 14 out of 15 on the Brief Interview for Mental Status assessment indicating a high level of cognitive function. Section D regarding mood on the MDS assessment includes questions asking if the resident has been feeling down or depressed, have little interest or pleasure in things, or feeling badly about themselves. If so, how many days during the past two weeks? A review of this section and the related questions in the assessments done in January, April, July, and August of 2023 revealed that Resident #28 had the following responses:

January 31, 2023- Down/depressed 12-14 days.
April 21, 2023- Little interest/pleasure in things 12-14 days, down/depressed 12-14 days.
July 6, 2023- Little interest/pleasure in doing things 12-14 days, feeling bad about yourself 2-6 days.
October 6, 2023- Little interest/pleasure in doing things 2-6 days, feeling down/depressed 2-6 days.

There is no evidence in the resident's record to indicate the medical provider had been made

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aware of the resident's expressed persistent depressed state. A review of the care plan entries specific to behavior/mood revealed a revision on 1/31/23 indicating 2 staff being present for care needs related to Resident #28's behaviors towards healthcare and staff. There is no evidence of revision to the care plan under behavior/mood or activities/leisure or in any other section to reflect the results of the responses noted during the MDS assessments.

2. Per observation of Resident #47 on 12/17/23 at 5:10 PM, the resident is sitting in a wheelchair at a table in a common area. S/he is sitting on the edge of his/her wheelchair, s/he appears to be tired, as s/he is on and off napping in the wheelchair leaning back. The resident is non-interviewable related to his/her level of cognitive loss.

Per medical record review of Resident #47 s/he has had 16 falls since admission on September 25, 2023. Two of these falls were witnessed and 14 were unwitnessed.

Review of the Minimum Data Set (MDS) with an assessment reference date (ARD) of 9/30/23, section J 1800 of the MDS is coded as no falls for this period. Further medical record review of fall history reveals that the resident has documentation of a fall on 9/29/23, indicating that the MDS was incorrectly coded.

During an interview on 12/21/23 12:02 PM via phone the Registered Nurse (RN) MDS Coordinator confirmed that the fall should have been coded on the MDS but was not.

3. Per observation of Resident #99 on 12/18/23 at

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9:58 am, the resident was in bed with his/her feet visible, and the surveyor observed a bandage on the resident's left foot. In an interview with the resident at this time s/he stated, "My toe was amputated, I have diabetes."

Per medical record review, Resident #99 had a left foot first-toe partial amputation on 6/15/23. A review of weekly skin assessment forms revealed that on 6/18/23 section B nursing documentation states "Surgical site Left Great toe was surgically removed. No signs or symptoms of infection currently." A weekly skin assessment dated 8/31/23 revealed measurements for the surgical incision as a length of 8.0 centimeters (cm) and 1 cm in width. The next weekly skin assessment that was completed was dated 10/2/23 (32 days after the 8/31/23 assessment). There were no measurements documented, the assessment does indicate in the description section "the wound bed is red, the peri-wound {area around the wound} is normal, wound edges are defined, overall wound progression is unchanged, treatment orders reviewed no changes".

A review of resident #99's MDS annual assessment with an ARD date of 10/1/23 reveals section M 1040 E. under surgical wounds is dashed (-) this indicates information is not available to support coding of the surgical wound. The assessment is supposed to be an actual assessment and not just based on documentation.

A review of progress notes for the period of 9/1/23 to 10/1/23 revealed that no progress notes related to Resident 99's Left foot 1st toe amputation were documented.

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During a phone interview conducted on 12/21/23 the RN MDS coordinator confirmed that section M 1040E was dashed because there was no information documented during the reference period. The MDS coordinator did not assess the resident's wound, only looked at documentation. S/he also confirmed that the weekly skin assessment dated 10/2/23 does reflect that the surgical wound was still open and was not healed.

4. Per observation on 12/19/23 of Resident #1, s/he was in bed with feet uncovered. It was noted that there was a wound dressing on his/her Left heel.

A review of resident # 1's Physician orders revealed that the resident has pressure ulcers on his/her left heel and on his/her sacrum, both were present on admission on 4/22/22.

Per review of MDS quarterly assessment Section M skin M 0300 titled "current number of unhealed pressure ulcers/injuries at each stage" all areas in this section are dashed, indicating the information was not available during the ARD look back period 10/4/23 to 10/10/23. The MDS coordinator is a RN and is qualified to do real-time assessments when there is a lack of information.

Per review of resident #1 weekly skin assessments for the dates of 10/4/23 to 10/10/23, there were no assessments completed during this time. The weekly skin assessments that were done in closest proximity to these dates were on 8/29/23 which revealed a stage III pressure ulcer (a stage III pressure ulcer is an ulcer that has full thickness tissue loss) to the left heel and an unstageable pressure injury to the sacrum, (an

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F 636	Continued From page 15 unstageable pressure ulcer is when the wound bed is covered with dead tissue so that it cannot be fully assessed). The next completed weekly skin assessment was dated 10/25/23 with documentation of Left heel stage III, Sacrum unstageable, and a new wound on the right lower rear leg documented as a stage III pressure ulcer. A review of Resident #1 progress notes reveals that there are no progress notes related to his/her pressure ulcers from 10/1/23 to 10/10/23. During an interview with the RN MDS the coordinator on 12/21/23 via phone, s/he confirmed that the MDS quarterly assessment ARD 10/10/23 was coded with dashes for section M 0300 as there was no documentation to support conditions of the pressure ulcers.	F 636		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders.	F 655	See Attached **Tag F 655 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to develop and implement a baseline care plan within 48 hours of admission that included the minimum healthcare information necessary to properly care for the resident for 1 of 35 sampled residents (Residents #50). Findings include:

Per record review, Resident #50 was admitted to the facility on 11/20/23 for rehabilitation services following a below-knee amputation (BKA) with diagnoses that include diabetes, osteomyelitis (bone infection), and severe kidney disease. A

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F 655	Continued From page 17 11/20/23 form titled "Braden Scale for Predicting Skin Ulcers," (a tool used to identify the level of risk a resident has for developing pressure ulcers), reveals that Resident #1 is "at risk." A 11/20/23 skin assessment form reveals that Resident #50 has four skin issues: two moisture associated skin damage areas, an abrasion, and a surgical incision. Vital signs reveal that Resident #50 experienced 10 out of 10 pain within the first 48 hours of admission (11/21/23). While a baseline care plan summary was provided to Resident #50 on 11/22/23, the baseline care plan did not address the following: nutrition, pain, safety, skin integrity, amputation status, diabetes, and renal failure. Care plans were created for these areas on 12/15/23, 25 days after admission. Per interview on 12/26/23 at approximately 8:30 AM, the Unit Manager confirmed that Resident #50 did not have a baseline care plan for skin, in addition to other required areas.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	F 656	See Attached **Tag F 656 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§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 observations, interviews, and record review, the facility failed to develop a Comprehensive person-centered care plan for 2 of 35 sampled residents (Resident #111 and #88). Findings include:

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1. Per record review, Resident #111 was admitted to the facility on 10/12/2023 with diagnoses that include multiple sclerosis, muscle weakness, and abnormalities of gait and mobility.

Per interview on 12/18/23 at 9:08 AM, Resident #111 expressed that s/he was sad. S/He got teary three times during the interview and cried twice. S/He talked about wanting to commit suicide prior to being admitted to the facility. When asked if anyone had hurt her at the facility, s/he replied "no" but became very upset; his/her voice became louder and s/he began to cry again, as if asking him/her about getting hurt was a trigger for him/her.

Record review reveals that Resident #111 showed symptoms of depression prior to the creation of the comprehensive care plan.

Resident #111's admission MDS (Minimum Data Set; a comprehensive assessment used as a care-planning tool) dated 10/17/23 reveals that s/he reported that s/he has little interest or pleasure in doing things nearly every day and feels down, depressed, or hopeless nearly every day.

A 10/17/23 social service note reveals "Resident answered "Yes" and "1-day" to the last PHQ-9 [patient depression questionnaire] questions, 'Thoughts that you would be better off dead, or of hurting yourself in some way?'. There was no plan, intent or further thoughts of hurting self, noted by resident upon this writer further asking. Resident identified that things have been more tough for her and knowing she was coming to a rehab at first was hard for her to cope with."

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A 10/22/23 progress note reveals "Resident declines to work with pt at times as well, stating she is not feeling up to it or is feeling sad."

A 11/1/23 social service note reveals that they received permission to make a referral for therapy services. Per a 10/27/23 IDT care conference note, a care conference to discuss Resident #111's comprehensive care plan took place on 11/6/23. There was no mention of Resident #111's mood in this note.

A 11/30/23 therapy assessment and plan of care note reveals that Resident #111 has a "Positive trauma history but patient refused further screening," and "Patient scored in the severe range for depression and within the mild range for anxiety."

Per review of Resident #111's comprehensive care plan, there is not a care plan focus or any interventions related to his/her mood and depression.

Per interview on 12/20/23 at 10:15 AM, the Director of Nursing confirmed that Resident #111 does not have a mood/behavior health care plan and should.

2. Per record review, Resident # 88 has resided at the facility since 9/4/2021 with the diagnosis of legal blindness. Per his Minimum Data Set (MDS) [a tool used to measure a resident's health status], Resident #88's ability to see in adequate light is severely impaired.

Per interview on 12/18/2023 at 1:32 PM, Resident #88 indicated s/he wished staff were more aware

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of his blindness; when asked for an example, s/he stated staff often walk in without knocking or announcing themselves at the door. Sometimes, they move her/his furniture around, causing him/her to run into it. "They do not seem aware of what a blind person needs to survive."

On 12/19/2023 at approximately 12:24 PM, an LNA was observed delivering a lunch tray to Resident # 88, entering the room without announcing her/him self, and continuing to speak to a coworker in the hall. The lunch tray was left on the bedside table a few feet from the resident.

An interview on 12/19/2023 at approximately 1:08 PM with an LNA, where s/he indicated s/he did not know how to act around a person who is blind and often "forgot" to speak to the resident before entering or give an indication of entering the room.

A record review of Resident # 88's care plan indicates a focus on visual function initiated on 09/04/21 and revised on 11/15/21, interventions that include documenting visual status/changes and updating MD as needed. Educate resident /family regarding visual function and instruct to report any changes in vision and medications as ordered. There is no evidence of a person-centered approach with preference and goals related to Resident #88's visual impairment and environment.

An interview on 12/21/23 at 10:34 PM with the Unit Manager confirmed that Resident 88's care plan does not reflect his/her personal preferences related to communication or managing an environment responsive to individual vision concerns.

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F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to review and revise care plans for 4 residents of 35 sampled residents (Resident #24, Resident #28, Resident #69 Resident #47) and failed to develop or revise resident's care plans after each assessment and with the required team for 9 of 37 sampled residents (Residents #7, #31, #111, #99, #1, #43, #50, #107, and #21).	F 657	See Attached **Tag F 657 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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Findings include:

1. Per record review Resident #47's care plan reveals two separate activities focus problems. #1 states "I have the potential for alteration in activities related to Parkinson's, heart disease, lumbar fracture, osteoarthritis, anxiety disorder, and artificial knee joint." The goal states "I will interact with others on a daily basis and have positive social experiences. I will interact with family and friends via visits, mail, and phone calls." Interventions include My faith is: Catholic. Religious Services Attendance - Mass." The 2nd Activities focus problem states "Activities-Leisure: I have potential barriers related to my leisure activities of choice related to cognitive skills .... Goals include "I prefer to attend Small Group activities of my interest. [Resident #47] will maintain and increase leisure activities of his/her interest in peer group settings. Interventions include Bingo and trivia, cooking and baking cookies, individual card games including solitaire, music, and easy-listening jazz, the resident enjoys doing crossword puzzles, reading mystery books, and playing cards and checkers."

Per observations made throughout the survey between 12/17/23 and 12/20/23 Resident # 47 was observed sitting in their wheelchair at various times in the nursing unit common area. During these observations, Resident #47 was not engaged in activities.

On 12/17/23 at 5:10 p.m. Resident #47 is sitting in a wheelchair at a table in a common area leaning back in the wheelchair and napping on and off.
On 12/18/23 from 2:30 p.m. to 3:15 p.m. Resident #47 was sitting at a table with other residents not

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interacting or talking with them.
On 12/19/23 at 4:00 p.m.- 4:45 p.m. S/he was sitting by him/herself in their wheelchair in a corner area of the common area no interactions with staff or other residents were noted.
On 12/20/23 at 9:41 am to 11:00 a.m. S/he was seen in the common area sitting at a table with her/his eyes closed. Resident #47 was not offered activities during that time.

Per review of Resident #47 activity attendance record from November 13, 2023, to December 18, 2023, reveals that Resident #47 attended activities only 13 days out of a possible 36 days. One of Resident #47 activity interventions is Catholic Mass there is no record during that period that S/he was offered or that S/he attended Mass

2. Review of Resident #24's record reveals on 12/18/23 s/he was transferred to the emergency room for a nosebleed that had persisted for 25 minutes. The resident reported to the emergency room provider that "s/he lives in a dry place and has had previous episodes of epistaxis (nosebleed)". The care plan for Resident #24 does not reflect a review or revision regarding the lack of humidity or related dehydration or proclivity for epistaxis. On 12/20/23 at approximately a unit Licensed Practical Nurse confirmed that the care plan had not been updated to reflect the hydration concern.

3. A review of Resident #28's record reveals on 12/5/23 Resident #28 stated roommate "made the room smell like mold", and on 12/12/23 Resident #28 called the roommate a "fat slob". The care plan for Resident #28 did not reflect a review or update until 12/17/23 after Resident #28

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was reported by a Licensed Nurse Assistant to have thrown a full cup of fluid and utilized verbally abusive language towards the roommate necessitating a room change. On 12/19/23 at approximately 2:30 a unit Registered Nurse confirmed the care plan had not been updated following the first two documented incidents.

4. A review of Resident #69's record reveals s/he was admitted in July of 2023 and on 10/20/23 was transitioned to hospice care. The care plan for Resident #68 contains a focus area for discharge planning stating "I require a short-term stay related to a rehabilitation need". On 12/19/23 at approximately 11 AM the Unit Manager confirmed the care plan had not been revised to reflect the change in goals of care.

5. Per record review of the 30 total assessments that occurred for Residents #7, #31, #111, #99, #1, #43, #50, #107, and #21 between 1/1/23 and 12/25/23, the following was revealed:

The facility could not produce evidence that the interdisciplinary team met to evaluate and/or update residents' care plans following 8 of the 30 assessments reviewed. There was no evidence that a care conference was held after Resident #99's 10/1/23 assessment, Resident #1's 1/27/23, 2/28/23, or 7/10/23 assessments, Resident #43's 2/25/23, 4/24/23, or 10/22/23 assessments, and Resident #107's 10/24/23 assessment.

The facility could not produce evidence that all the required IDT members (Interdisciplinary team; attending physician, a registered nurse (RN), a nurse aide, and a food and nutrition service staff member, resident, and resident's representative)

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F 657	Continued From page 26 were in attendance or provided input in the development and revision of the care plan for 22 of the 22 care conferences reviewed. There was no evidence that all members attended the care conference or had provided information regarding the resident's care plan based on the review of the resident's recent assessment for Resident #7's 1/3/23, 4/1/23. 7/2/23, and 10/2/23 assessments; Resident #31's 1/5/23, 4/4/23, 7/5/23, and 10/5/23 assessments; Resident #111's 10/17/23 and 12/14/23 assessments; Resident #99's 3/14/23, 7/1/23, and 12/23/23 assessments; Resident #1's 4/14/23 and 10/10/23 assessments; Resident #43's 7/18/23 assessment; Resident #50's 11/26/23 assessment; Resident #107's 7/31/23 assessment; and Resident #21's 1/1/23, 4/3/23, 7/4/23, and 10/4/23 assessments. Per interview on 11/9/24 at 1:11 PM, the newly appointed Social Services Director explained that the previous Social Service Director was recently let go and s/he is unable to speak about the system they used to ensure that care plans were being created and revised, either at care plan meetings or by providing input for the care plan meetings. S/He confirmed that there was no other evidence of additional care plan meetings for the residents listed above missing care plan meetings. S/He confirmed that based on the documentation, resident's care plans were not created or revised by the required IDT members.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 658	See Attached **Tag F 658 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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must-
(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to provide services that meet professional standards of quality related to the Social Services for 1 of 35 residents sampled (Resident # 28). Findings include:

Per record review on 12/5/23 Resident #28 stated thier roommate "made the room smell like mold", and on 12/12/23 Resident #28 called the roommate a "fat slob". On 12/17/23, Resident #28 was reported by a Licensed Nurse Assistant to have thrown a full cup of fluid at and utilized verbally abusive language towards the roommate, necessitating a room change.

During an interview on 12/22/23 at 12:00 PM with the facility's Social Service team, they were asked about the behaviors displayed by Resident #28 towards his/her roommate. The Social Service team admitted they were not aware of the behavior that had occurred precipitating the room change 4 days earlier. They were not aware that the care plan for Resident #28 had been revised on 12/17/23 to state "monitor/document/report to the Medical Provider of danger to self and others as needed" indicating a significant psycho-social concern. And when asked how this resident with a pre-existing history of "alteration in mood, behaviors and psychosocial wellbeing related to ...bipolar disorder, dissociative identity disorder anxiety, reltlessness and agitation", was paired with a roommate whose careplan included an entry for potential for victimization, Social Services responded "this is a lack of us reviewing care plans, we were unaware of some of these

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F 658	Continued From page 28 things...when we move people we go off of how they present and how we see them". The Journal of Health & Social Work, Volume 40, Issue 3, Published August 2015 entitled Resident-to Resident Aggression in Nursing Homes: Social Worker involvement and collaboration with Nursing Colleagues identifed "assessment approaches including gathering information, applying knowledge of causal factors determining appropriate interventions, applying preventive approaches, and delivering psychosocial interventions", as Social Service responsibilities within a Nursing Home. Per the interview on 12/22/23 these professional approaches were not implemented.	F 658		
F 677 SS=E	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 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to ensure residents who are unable to carry out activities of daily living receive the necessary services to maintain good personal hygiene for 3 of 35 sampled residents (Residents #111, #7, and #269). Findings include: 1. Per record review, Resident #111 was admitted to the facility on 10/12/2023 with diagnoses that include multiple sclerosis, muscle weakness, and abnormalities of gait and mobility. Per Resident #111's MDS (Minimum Data Set; a comprehensive assessment used as a	F 677	See Attached **Tag F 677 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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care-planning tool) dated 10/17/23, s/he requires supervision or touching assistance for showering.

Per interview on 12/18/23 at 8:40 AM, Resident #111 expressed that she would like to get showered more.

Per review of Licensed Nursing Assistant (LNA) documentation, there are zero documented showers for Resident #111 in October 2023, zero showers in November 2023, and only 2 showers are documented in December 2023.

2. Per record review, Resident #7 has diagnoses that include spastic quadriplegic cerebral palsy (a physical disability that causes muscle rigidity that affects all four limbs and often a person's torso, facial, and oral muscles). Resident #7's care plan reveals that s/he is totally dependent for staff support for showering. LNA tasks reveal a shower schedule of "Monday Days and Thursday Evenings."

Per review of LNA documentation, there are zero documented showers for Resident #7 in October 2023, zero showers in November 2023, and only 3 showers are documented in December 2023.

3. Per record review, Resident #269 was admitted to the facility on 12/4/2023 with diagnoses that include crystal arthropathy (joint disorder), muscle weakness, and abnormalities of gait and mobility. Per Resident #269's MDS dated 12/10/23, s/he is dependent on staff for toileting and showering.

Per interview on 12/18/23 at 8:40 AM, Resident #269 stated that s/he has not had care yet this morning and their brief is soiled. S/He stated that

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F 677	Continued From page 30 s/he asked for help before breakfast and the aide told her that s/he couldn't help until later that morning. Resident #269 stated that s/he would like to be up and dressed much before now as s/he has therapy shortly. S/He explained that this is normal when they are short staffed. Resident #269 also reported that s/he has not had a shower since s/he was admitted. Per review of LNA documentation, there are zero documented showers for Resident #269 in December 2023. Per interview on 12/21/23 at 2:55 PM, the Regional Nurse Consultant stated that they do not have additional evidence of showers for Residents #111, #7, and #269 beyond what is documented in the LNA documentation.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on Interview, observations, and record review, the facility failed to provide activities that support each resident's physical, mental and psychosocial well-being for 1 of 35 sampled	F 679	See Attached **Tag F 679 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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residents (Resident #65).

Findings include:

Per record review, Resident #65 has resided in the facility since 9/15/21 and has diagnoses that include vascular dementia, memory deficit related to a cerebral infarct (stroke), and cognitive communication deficit. A review of his/her care plan reveals that s/he yells or calls out to staff for attention.

Resident #65's care plan states, "I prefer social and entertainment activities involving music, happy hour, parties, outdoor parties, and socials." In an observation of Resident # 65 on 12/18/2023 at 9:12 AM, the resident was heard yelling, "Help, help, help." staff were observed entering the room several times for such calls over the next few hours.
An interview with a family member on 12/18/2023 at 10:51 AM revealed concerns that the facility was not adequately attempting to engage Resident # 65 in less isolating activities.

An interview with the charge nurse on 12/18/2023 at approximately 11:30 AM, s/he stated, "This is kind of what s/he does; s/he is better when out of his/her room." S/he says the activity department is responsible for getting residents to participate in activities.

On 12/19/2023 at 10:34 AM, an activities staff member was observed inviting residents from a common area to a Holiday Trivia event; they did not go to resident rooms or inquire from nursing staff who might attend.

An interview with the Activity Director on

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F 679	Continued From page 32 12/20/2023 at 9:29 AM, s/he indicates Resident #65 often declines activities; s/he states residents receive calendars every month with all the activities. S/he explains that if a resident declines an activity seven times, a 1:1 is offered. She confirms that Resident #65 has not received a 1:1 since early November, even though s/he has not attended activities, as they do not have the staff to provide the interventions or to reach out to residents if they are in their rooms. S/he states they rely on nursing staff to update residents and offer activities. S/he agrees Resident # 65 would benefit from more person centered interventions and one to one to assist resident to attend activities.	F 679		
F 686 SS=H	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide safe and effective skin and wound care consistent with facility policy and professional standards of practice for preventing	F 686	See Attached **Tag F 686 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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and treating existing pressure ulcers for 7 of 37 sampled residents (Residents #50, #7, #1, #99, #43, #21, and #107), resulting in new or worsening pressure ulcers for all 7 residents. Findings include:

Facility policy titled "Pressure Ulcer, Pressure Injury & Other Skin Conditions: Initial Assessment, Care Planning, Ongoing Evaluation and Management (HAM, LIV, SS, WAV, WMS [facility name initails]) SNF," last revised on 2/27/2023 reveals the following under procedures:

"Care Plan Development & Implementation: a baseline care plan will be developed by the IDT [interdisciplinary team] within 48 hours of admission identifying appropriate interventions to stabilize, reduce or remove underlying risk factors to prevent or treat skin conditions. The individualized care plan will be reviewed and revised as needed to meet the skin care needs of the resident based on assessment and risk factors. Medical providers are part of the IDT and will discuss, review, monitor and assess the progress of ulcers, pressure injuries or other skin conditions during routine visits and when necessary.

Ongoing assessment of existing pressure ulcers, pressure injuries & other skin conditions will be conducted weekly by facility staff and/or a consultant who specialized in wound management. Progress, treatment, and care plan interventions are reviewed at that time and will be documented in the medical record. Wound consultant progress notes will be scanned into the medical record and may be used as the source document to meet the requirement of a

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weekly assessment.

The assessment will include characteristics of the wound and surrounding tissue such as but not limited to presence of epithelial or granulation tissue, measurements, stage, presence of exudates, necrotic tissue such as eschar or slough and evidence of erythema or swelling around the wound. Staging of a pressure ulcer or pressure injury will be conducted according to professional standards of practice. Documentation also includes signs and symptoms of pain and intervention for pain related to the wound or treatment."

Appendix F: Wound Care & Skin Product Formulary Guide, dated 2/19/2020, reveals the following formulary products for MASD: "Thera Calazinc Body Sheild Cream (zinc product) and Dema Med Skin Protectant (aluminum hydroxide product); guidelines for use, Apply QS [every shift] & PRN [as needed] or as directed by MD order; considerations, Nurse to apply."

1. Per record review, Resident #50 was admitted to the facility on 11/20/23 for rehabilitation services following a below-knee amputation (BKA) with diagnoses that include diabetes, osteomyelitis (bone infection), hypertension, and severe kidney disease. A 11/20/23 form titled "Braden Scale for Predicting Skin Ulcers," a tool used to identify the level of risk a resident has for developing pressure ulcers, reveals that Resident #50 is "at risk."

Review of an initial wound assessment dated 11/20/23 reveals that Resident #50 has an abrasion on his/her lower left leg 2.5 cm x 0.2 cm. There are 3 other skin conditions identified on this

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assessment: MASD (Moisture-associated skin damage, which can contribute to the formation of a pressure injury since the tissue has been compromised) on the groin, MASD on the coccyx, and a surgical incision on the right knee. There is no documentation of the size of these conditions.

A second wound assessment dated 11/30/23 reveals that Resident #50 has a left lower leg abrasion that is 2.5 x 0.2 cm; a groin MASD that is marked "healed"; a coccyx MASD, 1 x 0.5 cm; and a right knee surgical incision, 16 x 0.1 cm.

A third wound assessment dated 12/11/23 reveals that Resident #50 has groin MASD, no measurement; coccyx MASD, no measurement; and no assessments of abrasion or surgical incision from the previous assessment.

Record review reveals that Resident #50 did not have a baseline care plan within 48 hours of admission related to his/her risk for impaired skin or for the skin conditions present on admission. The following care plan focus was created 25 days after admission "SKIN INTEGRITY: I am at risk for impaired skin integrity related to 5 (or more) medications, Activity Intolerance, Deconditioning, Diabetes, Hx [history] of Pressure Ulcers, Immobility, Incontinence, Overall Physical Condition," initiated on 12/15/23. It does not address the actual condition of Resident #50's skin. "Apply/administer treatments and barrier creams, as ordered," created 12/15/23.

Per review of physician order and the medication and treatment administration records, Resident #50 does not have physician orders for any wound treatment or barrier creams and there is no evidence in their medical record that any

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wound treatment or barrier creams were provided.

Per review of a 12/21/23 transfer form, Resident #50 was transferred to the emergency room on 12/21/23.

Review of a 12/21/23 hospital admission note reveals on physical exam Resident #50 has a "purplish/erythematous (redness of the skin) ulcer per imaging," and has a wound consult planned related to Resident #50's "sacral pressure wound." The note includes a small photograph of Resident #50's sacrum and coccyx area that is approximately 6 inches by 4 inches and dark purplish red. It is difficult to determine if the area is open based on just the photo.

Review of a 12/22/2023 hospital wound care note reveals the following, "Healing fungal rash notes to sacrum extending down bilateral buttocks. Superficial ulceration to left buttock and left coccyx, etiology likely moisture and friction. Linear, full thickness wound in gluteal cleft. Difficult to determine primary etiology as linear distribution tends to be due to moisture and friction however wound is located directly over coccyx so could likely have a pressure component. All wounds present on admission."

Per interview on 12/26/23 at approximately 8:30 AM, the Unit Manager stated that it is very difficult to get a sense of the current status of the skin and current wounds with the skin assessment form that is used in the EMR (electronic medical record). S/He was unable to find any wound care orders for Resident #50 and confirmed that Resident #50 did not have a baseline care plan for skin and should have.

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2. Per record review, Resident #1 has diagnoses that include diabetes, end stage renal disease requiring dialysis, malnutrition, and a history of pressure ulcers. A 7/10/23 MDS (Minimum Data Set; a comprehensive assessment used as a care-planning tool) assessment reveals that Resident #1 is at risk for developing pressure ulcers.

Review of an 8/29/23 wound assessment reveals that Resident #1 has a stage 3 pressure left heel pressure ulcer that measures 3.9 cm length x 3.0 cm width x 0 cm depth. Review of a 10/25/23 wound assessment reveals that Resident #1's stage 3 pressure left heel pressure ulcer now measures 4.5cm length x 4.0 cm width x 0 cm depth, an increase from the previous 8/29/23 wound assessment. There are no weekly skin assessments completed between the two assessments above.

Review of Resident #1's physician orders reveals the following order for his/her heel wound, "Clean left heel wound with NS [normal saline], pat dry, skin prep around wound edges X2, apply solosite [wound gel] soaked gauze to WOUND BED ONLY and cover with two 4x4 gauze, apply tubigrip [bandage] daily until wound resolves. every evening shift for WOUND CARE," with a start date of 7/24/23. Per Resident #1's Treatment Administration Record, this order is not marked as complete for the time between 8/29/23 and 10/25/23 9 times during September 2023 and 4 times during October 2023.

Per phone interview on 12/26/23 at 11:23 AM, the MDS Coordinator confirmed that Resident #1 did not have all their wound assessments completed

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weekly for their actual pressure ulcers and should have.

3. Per record review, Resident #99 has diagnoses that include diabetes, peripheral vascular disease, difficulty walking, and need for assistance with personal care. Resident #99 had a left great toe amputation on 6/15/23.

Per record review, Resident #99 has the following care plan "I am at risk for impaired skin integrity related to Diabetes and immobility, I have a left first toe partial amputation," revised on 6/19/23 with interventions that include, "monitor skin daily and report any signs of skin breakdown," and "conduct systemic skin inspection weekly and as needed. Document findings."

Review of an 8/31/23 wound assessment reveals that Resident #99 has an unresolved, unchanged surgical incision from the left toe amputation site that measures 8 cm x 1 cm.

Review of a 10/2/23 wound assessment reveals that Resident #99 continues to have an unresolved, unchanged surgical incision from the left toe amputation site. There are no measurements of this wound in this wound assessment.

There are no weekly wound assessments from 9/1/23 through 10/1/23 in Resident #99's medical record. According to the facility's policy and professional standards, there should have been a minimum of four wound assessments during this time.

Review of Resident #99's physician orders reveals the following order, "Diabetic foot check q

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(every) day, report s/sx [signs and symptoms] of skin breakdown to MD [physician]. every evening shift every 7 day(s) for diabetes -Start Date 09/23/2023." Resident #99's Treatment Administration Record for September, October, November, and December 2023 reveal that diabetic foot checks were only completed only once a week.

Per record review, a 12/1/23 progress notes state, "writer was informed by resident in the AM that the three toes on the left foot (excluding little toe) were hurting and resident was concerned with getting an infection; toes were red and warm to touch," and "Writer spoke with therapy regarding getting a bed extender for resident's bed; writer sees that resident is touching the foot of bed and it may be contributing to pressure on the resident's toes."

Per a Physician note dated 12/1/23, Resident #99 was seen for left foot pain. The provider describes examination of the left toe to have a small amount of scab that the patient notes has improved. This note does not assess the wound completely; there are no measurements or documentation that the pervious incision has fully healed.

Record review reveals the following physician order, "Apply telfa [cotton pad] and kerlix [gauze] to left foot every other day until steri stips fall off. every evening shift every Wed, Sun for Wound care," with a start date of 9/10/23. This is marked as complete as scheduled on the TAR on all but three days scheduled (missing 9/20/23, 10/4/23, and 11/29/23). The continuation of wound care implies that the wound has not healed and still needs treatment.

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A Physician progress note dated 12/13/23 reveals " ...Patient has a stage 3 (full thickness skin loss) non-inflamed ulcer over his/her distal amputated first toe ...." The note indicates that the patient's pain in his/her left foot is consistent with cellulitis will be treated with Keflex. The infected toe is Resident #99's left toe and his/her great left toe has an ulcer. A 12/13/23 wound assessment reveals a stage 2 pressure ulcer (Partial-thickness skin loss) on Resident #99's left great toe 1 cm x 0.5 cm in size and his/her left second toe has an area of trauma.

There are no weekly wound assessments of this area between 10/2/23 and this note dated 12/13/23 in Resident #99's medical record. According to the facility's policy and professional standards, there should have been a minimum of ten wound assessments during this time since the last skin assessment.

During a phone interview on 12/21/23 at 12:02 PM with the MDS Registered Nurse Coordinator, he/she confirmed that the weekly skin assessments were not completed consistently for Resident #99.

Per interview on 12/26/23 at 10:35 AM, the Regional Nurse Consultant reviewed Resident #99's weekly skin assessments and was unable to produce skin assessments of Resident #99's left toe wound for the missing weeks mentioned above.

4. Per record review, Resident #7 has diagnoses that include spastic quadriplegic cerebral palsy (a physical disability that causes muscle rigidity that affects all four limbs and often a person's torso,

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facial, and oral muscles), and is at risk for developing pressure ulcers according to a 10/2/23 MDS (Minimum Data Set; a comprehensive assessment used as a care-planning tool). Resident #7 has the following care plan focus, "I am at risk for fungal infections and/or impaired skin integrity related to Deconditioning, Immobility, Overall Physical Condition, Poor Nutritional Status," created on 3/3/2020.

A 11/17/23 progress note reveals "Writer was made aware of unstageable pressure area [full thickness tissue loss in which the base of the ulcer is covered by slough (non-viable tissue) and/or eschar (dry, non-viable tissue) in the wound bed] on residents right buttock. ... Resident states pressure area is painful. New tx [treatment] order to apply santyl [an ointment that removes dead tissue from wounds so they can start to heal] everyday shift and cover with allevyn [brand] foam dressing." Resident #7's care plan was revised to include the following focus, "I have an alteration in skin integrity r/t decreased mobility. Unstageable pressure area on right buttock," created on 11/17/23 with an intervention for "Assess and document status of wound/skin site(s) weekly and as needed," created on 11/17/23.

Review of an initial wound assessment (Skin Assessment form in the electronic medical record) dated 11/17/23 reveals that Resident #7 has an in-house acquired unstageable pressure ulcer on the right buttock that is 3 cm X 2 cm in size. This assessment does not include characteristics of the necrotic tissue.

There are no weekly wound assessments or

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evidence that progress, treatment, and care plan interventions were reviewed for the existing pressure ulcer from 11/18/23 through 12/14/23 in Resident #7's medical record. According to the facility's policy and professional standards, there should have been a minimum of three wound assessments during this time.

Review of a 12/15/23 skin assessment form reveals that Resident #7 has a stage 3 pressure ulcer (full thickness skin loss) on the right buttock that is 3 cm x 2.8 cm in size. This assessment does not include characteristics of the wound and surrounding tissue. While it was expected that treatment would expose at least a stage 3 pressure ulcer following treatment, the wound did increase in size. There is no evidence that a medical provider was informed of the change of status of Resident #7's pressure ulcer. Because of this, there is no evidence in Resident #7's medical record that progress, treatment, and care plan interventions were reviewed at the time of the 12/15/23.

There are no weekly wound assessments or evidence that progress, treatment, and care plan interventions were reviewed for the existing pressure ulcer from 12/16/23 through 12/26/23 in Resident #7's medical record. According to the facility's policy and professional standards, there should have been a minimum of one wound assessment during this time.

Review of Resident #7's physician orders reveal the following, "Santyl External Ointment 250 UNIT/GM (Collagenase) Apply to Right Buttock topically every evening shift for Wound Care," with a start date of 11/18/2023, and "Right Buttock: Cleanse with NS, pat dry. Apply Santyl

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nickel thick to wound bed only. Cover with alleyvn foam dressing. every evening shift for Wound Care," with a start date of 11/18/2023. While the first order for Santyl is documented as complete in Resident #7's MAR, the second treatment order, which describes how the Santyl ointment is to be applied, and what type wound care is to be used, including cleaning and dressings, is not marked as complete for 12/6/23, 12/8/23, 12/12/23, 12/15/23, 12/17/23, 12/18/23, and 12/26/23.

Per interview on 12/21/23 at approximately 9:30 AM, the Unit Manger confirmed that the above wound treatment orders were not documented as administered for Resident #7 for the above times. S/He indicated that s/he was unsure why there were no wound assessments completed between the 11/17/23 and the 12/15/23 assessments.

5. Record review reveals that Resident #107 was admitted to the facility on 7/25/23 and has diagnoses that include diabetes, obesity, and abnormalities of gait and mobility. Per Resident #107's MDS dated 7/31/23, s/he requires a mix of partial, substantial. and complete assistance for most ADLs excluding eating, is at risk for developing pressure ulcers, and does not have any unhealed pressure ulcers at the time of the assessment.

Review of an admission skin assessment dated 7/25/23 skin reveals that Resident #107 has only a surgical incision on their chest which was present on admission. No other skin conditions are identified.

There are no weekly skin assessments or wound assessments for the existing surgical incision

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from 7/26/23 through 8/21/23 in Resident #107's medical record. According to the facility's policy and professional standards, there should have been a minimum of three wound assessments during this time.

Review of Resident #107's MAR shows a physician order for "Left Heel: skin prep every shift for Deep Tissue injury [closed wound where the tissues beneath the surface have been damaged]," with a start date of 8/10/23. There is no evidence that this wound was assessed when it was first discovered.

An 8/22/23 skin assessment reveals that Resident #107 has an in-house acquired left heel pressure ulcer that measures 3 cm x 4 cm x 0 cm. There is no staging information or date for when this wound was acquired.

Review of an 8/26/23 skin assessment reveals that Resident #107 has a newly identified in-house acquired pressure ulcer on the left lower leg. There is no staging information or measurements of this wound.

Review of an 8/29/23 skin assessment reveals that Resident #107's left lower leg is now being documented as an abrasion that measures 3.5 cm x 1 cm x 0 cm and the left heel is measured to have the same area and is still not staged.

Record review reveals that between 8/30/23 and 10/11/23 Resident #107 was missing two wound assessments and two wound assessments did not have the completed information.

Review of a 10/12/23 skin assessment reveals that Resident #107's left lower leg abrasion has

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worsened to an unstageable left calf pressure ulcer that measures 4 cm x 3 cm x 1 cm and their left heel has worsened to a suspected deep tissue pressure injury that measures 2.5 cm x 1.5 cm x 0 cm. The following weekly wound assessments reveal that on 11/6/23 the pressure injury to Resident #107's heel increased in size to 5.5 cm x 3.5 cm x 0 cm, and on 11/16/23, Resident #107's left calf pressure ulcer has worsened to a stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle) that measures 3.9 cm x 3.1 cm x 2.8 cm.

Resident #107's care plan was not revised to reflect his/her actual skin conditions related to his/her calf until 11/2/23, 68 days after it was first assessed, and heel until 11/2/23, 72 days after it was first assessed.

Per interview on 1/10/24 at 4:07 PM, the Director of Nursing confirmed that Resident #107 had incomplete and missing wound assessments and their care plan was not revised to reflect existing wounds when they were first identified.

The facility wound management policy was requested on 1/9/24 at 10:20 AM. On 1/9/24 at approximately 3:00 PM, both the Director of Nursing and the Asisstant Director of Nursing were unable to produce an up to date wound management policy.

On 1/11/24 at 8:10 AM, when asked to produce the current wound policy, the Unit Manager was only able to find a policy that was not applicable to the facility's wound assessment procedure. The policy that was available referred to using a photograph system to document wound progress

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which had stopped being used in the Spring of 2023.

On 1/11/24 at 3:07 PM, the Chief Nursing Officer confirmed that the facility policy titled "Pressure Ulcer, Pressure Injury & Other Skin Conditions: Initial Assessment, Care Planning, Ongoing Evaluation and Management (HAM, LIV, SS, WAV, WMS) SNF," last revised on 2/27/2023, was the wound policy that the facility should be using for wound management even though the title does not include the facility's initials.

6. Record review reveals that Resident #43 has diagnoses that include diabetes, peripheral vascular disease, and reduced mobility. Per Resident #43's MDS dated 10/11/23, s/he is dependent on staff for all ADLs, is at risk for developing pressure ulcers, and does not have any unhealed pressure ulcers at the time of the assessment. Resident #43 has the following care plan focus, "I have an alteration in skin integrity r/t pressure injury on right foot r/t impaired mobility," initiated on 11/2/23 with interventions to "apply treatments as MD/NP orders and assess and document status of wound/skin site(s) weekly and as needed," initiated on 11/2/23.

Review of a 11/6/23 skin assessment reveals that Resident #43 has an in-house acquired stage 2 right foot pressure ulcer measuring 1 cm x 1.5 cm x 0.1 cm and wound progress is described as "improving."

Review of a 11/15/23 skin assessment reveals that Resident #43's stage 2 right foot pressure ulcer measuring 1.1 cm x 1.7 cm x 0.1 cm and wound progress is described as "worsening."

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There are no weekly wound assessments for the existing pressure ulcer from 11/16/23 through 11/29/23 in Resident #43's medical record. According to the facility's policy and professional standards, there should have been a minimum of one wound assessment during this time.

Review of a 11/30/23 skin assessment reveals that Resident #43's right foot wound is now a stage 3 pressure ulcer measuring 6.5 cm x 4.5 cm x 0.5 cm and wound progress is described as "worsening."

Review of Resident #43's physician orders reveal the following, "Medihoney Wound/Burn Dressing External Gel (Wound Dressings) Apply to Right Lateral Foot topically every day shift for Wound Care," started on 11/9/23 and discontinued on 11/15/23. Per the MAR, this order is not marked as complete for 2 of the 7 days ordered (11/14/23 and 11/15/23). There are orders for cleaning or dressing the right foot wound in the MAR or TAR from 11/9/23 through 11/15/23. "Medihoney Wound/Burn Dressing External Gel (Wound Dressings) Apply to Right Lateral Foot topically every day shift for Wound Care Cleanse with wound cleanser, pat dry. Apply medihoney to wound bed only. Cover with allevyn foam dressing," with a start date of 11/16/23. Per the MAR, this order is not marked as complete for 3 of the 15 remaining days in November (11/18/23, 11/20/23 and 11/29/23).

Per interview on 1/10/24 at 4:07 PM, the Director of Nursing confirmed that Resident #43 had incomplete and missing wound assessments and their care plan was not revised to reflect existing wounds when they were first identified.

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Per interview on 1/11/24 at 8:51 AM, the Regional Nurse Consultant confirmed that Resident #43's treatment orders for their right foot wound from 11/9/23 through 11/15/23 did not include instructions for cleaning and dressing the wound and should have.

7. Record review reveals that Resident #2 has diagnoses that include diabetes, severe obesity, and abnormalities of gait and mobility. Per Resident #2's MDS dated 10/4/23, s/he is dependent on staff for all ADLs excluding eating, is at risk for developing pressure ulcers, and does not have any unhealed pressure ulcers at the time of the assessment. Resident #2 has the following care plan focus, "I am at risk for impaired skin integrity related to Diabetes, Incontinence, decreased mobility with hemiplegia [paralysis on one side of the body] s/p cva [status post stroke] and obesity related to skin folds," revised on 4/29/21, with interventions that include, "Appy/administer treatments and barrier creams, as ordered, and conduct systemic skin inspections weekly and as needed. Document findings," initiated on 6/10/19.

Review of a 11/24/23 skin assessment reveals that Resident #2 has a newly identified in-house acquired stage 2 pressure ulcer on the right buttock that measures 0.2 cm x 0.3 cm x 0.1 cm.

There are no weekly wound assessments for the existing pressure ulcer from 11/26/23 through 12/12/23 in Resident #2's medical record. According to the facility's policy and professional standards, there should have been a minimum of two wound assessments during this time.

Review of a 12/13/23 skin assessment reveals

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F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 688	See Attached **Tag F 688 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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failed to provide range of motion rehabilitation services for 2 of 35 sampled residents (Resident #81 and #43). Findings include:

1. Per record review Resident #81 has diagnoses that include acute transverse myelitis (inflammation of the spinal cord; symptoms may include pain), anxiety, and lower back pain.

Per interview on 12/19/23 at 10:45 AM, Resident #81 stated that s/he is concerned that staff are not doing ROM (range of motion) exercises with him/her. S/He explained that his/her goal is to "at least do some stretches" and s/he has declined in his/her ROM. S/He revealed that s/he had been told by staff that they have to be trained to do the exercises with him/her and there are not enough trained staff to do the ROM with him/her.

Resident #81 has the following care plan focus "RANGE OF MOTION: I have limitations or I am at risk for limitations in my ROM related to progressive weakness neurological," created 4/3/21, with the following intervention, "NURSING REHAB: Passive ROM - Lower Extremities (specify) While patient is in bed flex left knee as far as it will go toward chest. Hold for 5 seconds then let leg down to be so knee is straight," created 3/23/23. This ROM intervention also appears on the Kardex (a quick reference of care plan interventions) and is documented in the LNA's (Licensed Nursing Assistant) POC (point of care; electronic documentation system for LNAs). This was not documented as being done in POC on 10 occasions in October 2023, 20 occasions in November 2023, and 26 occasions in December 2023.

2. Per record review, Resident #43 has

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F 688	Continued From page 51 diagnoses that include reduced mobility, stiffness of other specified joint, cognitive communication deficit, and need for assistance with personal care. Resident #43 has the following care plan focus "RANGE OF MOTION: I have limitations or I am at risk for limitations in my ROM related to decreased mobility, schizophrenia," initiated on 9/15/2019, with the following intervention "NURSING REHAB: Passive ROM - Upper and Lower Extremities. Incorporate during bathing and dressing," revised on 03/23/2023. This ROM intervention also appears on the Kardex and is documented in the LNA's POC. This was not documented as being done in POC on 20 occasions in October 2023, 18 occasions in November 2023, and 17 occasions in December 2023. Per interview on 12/26/23 at 11:08 AM, the Unit Manager confirmed that Residents #81 and #43 were not receiving nursing rehab services per their care plans. S/He explained that ROM is an LNA task but they need to be trained and is unsure about who has been trained to work with specific residents.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689	See Attached **Tag F 689 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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F 689	Continued From page 52	F 689		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance to prevent accidents for 2 of 35 sampled (Resident #5 & #47). Findings include:

1. On 12/18/23 at 2 PM Resident #5's room was noted to be very warm, it was also noted that a cord from the oxygen concentrator was resting on top of the heat vent along the wall. The heater was hot to touch and the cord was very warm and spongy. The Director of Maintenance was paged and using an infrared thermometer gun the heat vent temperature was measured to be 108 degrees fahrenheit. The Director of Maintenance confirmed the cord was very warm should not be resting on top of the heat vent and immediately moved it.
2. Per observation of Resident #47 on 12/17/23 at 5:10 p.m., the resident is sitting in a wheelchair at a table in a common area. S/he is sitting on the edge of his/ her wheelchair, s/he appears to be tired as s/he is on and off napping in the wheelchair leaning back. The resident is not interviewable related to his/her level of cognitive loss.

Per record review of Resident #47 on 12/17/23 resident has a diagnosis of Dementia and Parkinson's disease. Parkinson's is a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves; it can affect balance and gait.
Record review reveals that Resident #47 has had a total of 16 falls since admission on September

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F 689	Continued From page 53 25th, 2023 Per the incident report review, Resident # 47 has fallen on the following dates 9/29/23 16:11 (4:11 p.m.) residents' room unwitnessed, 10/1/23 13:50 (1:50 p.m.) Residents' room unwitnessed 10/14/23 12:10 p.m. Residents' room unwitnessed 10/29/23 13:30 (1:30 p.m.) residents' room unwitnessed, 11/1/23 15:30 (3:30 p.m.) residents' room unwitnessed, 11/7/23 09:53 (9:53 a.m.) hallway witnessed, 11/17/23 18:01 (6:01 p.m.) Activity room unwitnessed 11/29/23 18:40 (6:40 p.m.) Other resident room unwitnessed 12/1/23 07:30 (7:30 a.m.) residents' room unwitnessed 12/1/23 1630 (4:30 p.m.) common area witnessed 12/5/23 19:30 (7:30 p.m.) bathroom near the dining room unwitnessed 12/723 23:45 (11:45 p.m.) residents' room unwitnessed 12/7/23 23:45 (11:45 p.m.) next to bed unwitnessed 12/9/23 13:00 (1:00 p.m.) Resident room unwitnessed 12/13/23 13:10 (1:10 p.m.) Residents room unwitnessed 12/16/23 18:30 (6:30 p.m.) nurse station unwitnessed 14 falls were unwitnessed, and 2 falls were witnessed.	F 689		

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F 689	Continued From page 54	F 689		

A review of Resident #47 Morse Fall Assessment scale completed on 9/25/23, the score was 60 indicating a high fall risk and on 10/22/23 the score was 65, again indicating a high fall risk. The Morse Fall Scale is a rapid and simple method of assessing a patient's likelihood of falling.

Per a review of resident #47 care plan there is a problem focus that states:
"Safety: I am at risk for falls related to Alteration in mental status, Hx (history) of falls, and poor memory. Goal: My safety will be maintained as evidenced by the absence of major injury through the next review. Interventions include the following: Provide a safe environment; encourage resident to be out of room activities during the day, do not leave alone in the bathroom"
Further review of Resident #47 record reveals the following rehab screens were completed related to Resident #47

10/30/23 Rehab Screen Section B Comments
"Resident had unwitnessed fall 10/29 in his/her room with injury and ED visit. Pt attempts to stand alone but needs physical assistance to do so safely and without falling, so increased supervision is recommended. Also, recommend bringing the resident to preferred activities or providing activities to do on the unit to engage the resident and redirect attention from self-transferring."
Resident number #47's current and resolved care plan interventions were reviewed and there is no intervention for increased supervision.

11/1/23 The rehab screen states "Resident fell OOB (out of bed) after he/she sat up on the edge of the bed and tried to put his/her shoes on. S/he

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F 689	Continued From page 55	F 689		

had flexed forward at the hip and tried to put his/her shoe on and then fell forward. due to frequent self-transfers with poor awareness of his/her limitations, she may be appropriate for a motion sensor alarm."
Review of Resident #47's current and resolved care plan interventions there is no intervention for the assessment of or application of a motion sensor alarm on the care plan.

11/21/23 Rehab Screen states "Resident had a fall while sitting in his/her wheelchair (WC) and reaching for an object on the floor and fell out of the WC. Recommend keeping him/her in line of site as much as possible. Offer frequent toileting, taking to activities as much as possible, and keep his/her room free of items on the floor.".
Review of Resident #47's current and resolved care plan interventions there is no intervention for keeping Him/her in line of sighe as much as possible or to offer frequent toileting, on the fall care plan.

Per an interview on 12/20/23 at 3:15 p.m. with the Licensed Practical Nurse (LPN) Unit Manager reveals that all falls are reviewed in the morning team meeting and whichever discipline that is responsible for the intervention for the fall is responsible for putting the intervention in the resident's care plan.

An interview with the Director of Nurses (DON) on 12/20/23 at 1:02 p.m. reveals that the facility does not write a progress note or otherwise document in the resident record, every time the IDT (Interdisciplinary team) discusses a resident's fall. S/he states they do discuss the falls at every am meeting with the IDT members that are in the meeting.

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F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the	F 690	See Attached **Tag F 690 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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F 690	Continued From page 57	F 690		

facility failed to ensure that 1 of 7 sampled residents (Resident #31) with an indwelling catheter receives the appropriate care and services to prevent urinary tract infections to the extent possible. Findings include:

Record review reveals that Resident #31 has diagnoses that include benign prostatic hyperplasia (enlarged prostate) and obstructive and reflux uropathy (blockage and reflux of the urinary system). A MDS (Minimum Data Set; a comprehensive assessment used as a care-planning tool) dated 10/5/23 reveals that Resident #31 has an indwelling catheter. Resident #31's care plan states "INDWELLING URINARY CATHETER: I require an indwelling urinary catheter use r/t Urinary Retention," revised on 12/28/22. Interventions include "Foley Catheter care every shift and as needed," revised on 11/3/23, and "Urinary Output: Empty urine & Record every shift," initiated on 9/12/2023. Physician orders include: "Urinary Output - verify documentation in POC and notify provider if output is < 100ml per shift every shift for Urinary Output documentation," with a start date of 6/14/2023.

While catheter care is an intervention on the care plan, it is not an order that appears on Resident #31's treatment administration record (TAR) or on Licensed Nursing Assistants' (LNA's) POC (point of care; electronic documentation system for LNAs). There is no evidence in Resident #31's medical record that catheter care was performed at any point in November 2023 or December 2023.

Per review of the November and December 2023 TAR, staff failed to document that urinary output

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F 690	Continued From page 58 was checked as ordered by the physician for Resident # 31. Urinary output was not documented in the TAR on 13 occasions in November 2023 and 22 occasions in December 2023. Per review of Resident #31's census information, Resident #31 was transferred to the hospital on 12/18/23 and returned to the facility on 12/19/23. A 12/19/23 progress note reveals that returned from the Emergency Department with a hernia and cystitis (urinary tract infection; UTI). Resident #31 had the following physician order, "Ciprofloxacin [antibiotic] HCl Tablet 250 MG Give 1 tablet by mouth every morning and at bedtime for UTI for 3 days," with a start date 12/19/23. On 12/26/23 at approximately 1:45 PM, the Director of Nursing confirmed that urinary output was not being monitored as ordered by the physicians. S/He was unable to find orders for catheter care on the TAR or on the POC for LNA staff or evidence that catheter care was completed.	F 690		
F 691 SS=D	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the	F 691	See Attached **Tag F 691 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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F 691	Continued From page 59	F 691		

facility failed to ensure that 1 applicable resident (Resident #7) a urostomy receives care consistent with the comprehensive person-centered care plan and professional standards of practice. Findings include:

Per record review, Resident #7 has diagnoses that include spastic quadriplegic cerebral palsy (a physical disability that causes muscle rigidity that affects all four limbs and often a person's torso, facial, and oral muscles) and a history of bladder cancer requiring a urostomy (a surgically created opening to allow urine to exit the body). Measuring urinary output, providing urostomy care every shift, and changing the urostomy drainage bag can reduce the risk for developing the complications such as infection, stomal (opening in the body) problems and skin irritation in addition to alerting staff to other serious complications.

Resident #7's care plan reveals the following focus: "ELIMINATION: I have an alteration in bladder/bowel elimination r/t [related to] Bladder Cancer with Ileal Conduit [urinary diversion created from the small intestine to allowing urine to drain from the kidneys and exit the body] and urostomy," initiated on 2/19/2022. Interventions include "LNAs [licensed nursing assistants] to Document urinary output in POC [point of care; electronic documentation system for LNAs] every shift," created on 2/27/2020, and "Urostomy bag with Catheter to be changed out when bag or tubing changes color. AND/OR Thursdays after shower," created 2/19/2020.

A physician order dated 6/14/23 states, "Urinary Output - verify documentation in POC and notify provider if output is < 100ml per shift every shift

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F 691	Continued From page 60	F 691		

for Monitoring to ensure patency and adequate output." This was not documented as being done on the POC on 19 occasions in October 2023, 35 occasions in November 2023 and 49 occasions in December 2023. Urinary output was also recorded on the treatment administration record (TAR). Review of the TAR shows urinary output was not documented on 9 occasions in October 2023, 14 occasions in November 2023 and 20 occasions in December 2023. A side by side comparison of these two documentation reveals that there was no documentation of urinary output 4 times in October, 11 times in November, and 17 times in December.

A physician order dated 6/14/23 states, "urostomy care qshift [every shift] and prn [as needed] every shift [as needed every shift] for urostomy care." This was not documented as being done on the TAR on 4 occasions in October 2023, 3 occasions in November 2023, and 7 occasions in December 2023.
A physician order dated 9/4/23 states, "change urostomy drainage bag every week every evening shift every 3 day(s) for ostomy care." This was not documented as being done on the TAR on 2 occasions in October 2023 and 3 occasions in December 2023.

Per interview on 12/20/23 at 4:37 PM, the Unit Manager, while review Resident #7's medical record, confirmed that there was no additional evidence that the above orders were complete.

Babakhanlou R, Larkin K, Hita AG, Stroh J, Yeung SC. Stoma-related complications and emergencies. Int J Emerg Med. 2022 May 9;15(1):17. doi: 10.1186/s12245-022-00421-9. PMID: 35534817; PMCID: PMC9082897.

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F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must 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 observation, interview, and record review the facility failed to maintain acceptable parameters of nutritional status as evidenced by failing to obtain weights as ordered, failing to consistently document resident meal intakes and meal refusals, and failing to update the physician of refusal of weights for one of the 35 residents sampled (Resident #92). Findings include: Per observation of Resident #92 on 12/18/23 at 11:43 am s/he was sitting in the common area in a wheelchair. S/he was thin, his/her face appeared drawn, and their clothes were loosely fitting. Resident #92 is not interviewable due to	F 692	See Attached **Tag F 692 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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cognitive decline and inability to understand questions, with a BIMS (Brief Interview Mental Status) score of 10.

Record review reveals Resident #92 had a significant weight loss of 10.66% in 6 months. His/her weight on 6/13/23 was 178.2 pounds and on 12/14/23 their weight was 159.6, a total loss of 18.6 pounds. Further record review reveals there is no documentation from the Physician that addresses the resident's significant weight loss.

Resident # 92's Nutrition care plan with a review start date of 10/31/23 has a focus of "Resident has a potential for alteration in nutrition status d/t [due to] CHF [congestive heart failure], depression, significant weight loss, history of refusals of weekly weights at times." With interventions that include encouraging meal completion, monitoring meal intakes and meal patterns as needed, monitoring weights as ordered, and informing medical of significant changes.

Review of meal intakes for 11/27/23 through to 12/22/23, for 25 meals there were no meal intake amounts documented. There was also no documentation that these meals were refused.

An Occupational Therapy note dated 11/28/23 states "Resident in bed on writer's arrival to a room for skilled OT interventions. Resident breakfast meal set out next to bed on tray table untouched ..."
Occupational Therapy progress notes revealed on 12/14/23 "Post ADL care (activities of daily life which includes washing and dressing) resident breakfast tray was at his/her bedside untouched was reheated resident sat up in a wheelchair and

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F 692	Continued From page 63	F 692		

ate 100% of breakfast."

During an interview on 12/21/23 at 11:19 AM the Registered Dietitian (RD) confirmed that Resident #92's care plan interventions state to monitor meal intakes and adjust meal patterns, and the meal intake document was not complete as directed. The RD stated that the facility is unable to adjust meal patterns if there is no documentation to support which meals Resident #92 is taking well and which meals s/he is refusing. As a result, meal intake and patterns have not been evaluated for Resident #92.

A review of Resident # 92 physician orders reveals an order dated 6/14/23 to obtain weights weekly and as needed. Documentation of weekly weight are documented in both the Weight/Vital Sign section of the Electronic Medical Record (EMR) and the Electronic Medication Administration Record (EMAR) and should indicate if the weight was done and if not the reason that the weight was not obtained on the MAR.

On the following dates, there were no weekly weights documented as obtained and no documentation as to why the weights were not obtained; 6/21/23, 7/4/23, 7/25/23, 8/23/23, 9/5/23, 10/2/23, 10/3/23 and on 10/10/23.

On 8/15/23, 9/12/23, 10/24/23, and 11/21/23 documentation is in place that the resident refused weight but there is no documentation that a reapproach attempt for the weight was made. On 9/19/23 the EMAR stated "N/A" with no follow-up documentation as to what N/A means. A 9/26/23 nursing progress note states "refused" with no follow-up documented. A Nutritional

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service note dated 9/26/23 states "...have requested re wt. (weight) from nsg (nursing)... will follow trends." There is no reweight found in the medical record.

During an interview on 12/21/23 at 11:46 AM with the Director of Nursing (DON) Resident #92's weights and physician progress notes were reviewed. The DON confirmed that the Physician has not addressed Resident #92's weight loss.

Per facility policy titled Weight monitoring in long-term care SNF
Department: Dining/dietary/Nutrition Services, Nursing.
POLICY:" Any residents with a significant weight gain or loss will be placed on a specific weighing schedule... The weighing frequency of a resident will be determined by an attending Physician order or at the discretion of designated supervisory nursing staff and the Dietitian. All weights will be recorded and maintained in the Medical Record/computerized system.

PROCEDURE #6 section a). "Refusals- A resident has the right to refuse to be weighed. The resident's refusal is documented in the Nursing Progress Notes by a licensed nurse. The resident is approached to be weighed within 72 hours following the refusal. If a second request for weighing is refused the approach and resident's refusal is documented in the Nursing Progress Notes by a licensed nurse. The Physician/NP(Nurse Practitioner) /PA(Physician Assistant) is notified if indicated."

During an interview on 12/21/23 at 12:51 PM the Licensed Practical Nurse (LPN) Unit Manager confirmed that the expectation is that when a

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F 692	Continued From page 65 resident refuses a weight the nurse would reapproach and document the outcome of the reapproach "especially with this resident (resident #92)" due to the frequency of refusals. The Unit Manager also confirmed that the weights and reapproaches for refusal of weights are not documented as they are expected to be.	F 692		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to provide respiratory care consistent with professional standards of practice and per medical orders for 2 of 35 sampled residents (Resident #23 & Resident #66). Findings include: 1. Resident #23 has diagnoses that include pericarditis (inflammation around the heart), and congestive heart failure (failure of the heart to provide sufficient blood flow caused by an impairment of the heart's pumping function). On 11/10/23 the following order was placed - "BiPap-Apply at HS (bedtime), monitor placement and usage. Remove in AM. Settings BIPAP auto titrate IPAP max 24 EPAP min 4 PS 8 with 3 L bleed. At bedtime for SOB (shortness of	F 695	See Attached **Tag F 695 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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breath)/COMFORT O2 (oxygen) at 3 L (liters per minute), 15 tube type, ramp 4 time 0:05".

These settings are highly complex therefore on 12/21/23 at 10:15 AM the Surveyor and the Unit Manager viewed the machine (Dream Station) together to allow the Unit Manager to demonstrate how the settings are applied. The Unit Manager was unable to provide an explanation or a demonstration of the settings. During this observation, the Unit Manager reviewed several settings producing several readouts including a pressure reading of 12 and a 3-night summary readout which displayed 2 gray bars and 0.0 hours. It was noted that the machine stood alone without being connected to supplemental oxygen despite the order including "oxygen at 3 L for SOB/COMFORT".

On 12/22/23 at 8:30 AM the Surveyor called the company Health System Services listed on the machine as the provider of the Dream Station and spoke with a Customer Service Representative in the respiratory therapy department. The serial number of the machine was provided along with the medical order regarding the settings and the 3-night summary. Per the Representative, this was not a BiPap machine it was a C-Pap machine which provides continuous pressure and could not be set to the prescribed settings. Per the Representative, the 3-night summary of 0.0 meant the machine "had not been used or had not been used correctly for the past 3 nights". On 12/26/23 at approximately 2 PM the Director of Nursing (DON) was advised of the concerns regarding this machine and its use, the DON referenced being well-versed in ventilation products, and with the Surveyor viewed the machine. At this time DON confirmed

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F 695	Continued From page 67 this was not the prescribed machine and therefore was not providing the prescribed respiratory support. 2. Resident #66 has diagnoses that include chronic obstructive pulmonary disease (COPD is a lung disease characterized by limited airflow) and a medical order for supplemental oxygen to be administered at 3 liters/min via nasal cannula related to COPD. On 12/18/23 at 1:45 PM Resident #66 was noted to be in the dining room without supplemental oxygen and when asked about their use of this supplemental oxygen they replied that they only needed it "at night". On 12/20/23 at 2PM Resident #66 was noted to be sitting on a bench outside of the activity area again without supplemental oxygen, at this time Resident #66 appeared to be short of breath with an observed respiratory rate of 24 breaths per minute. A unit Licensed Practical Nurse applied a pulse oximeter to Resident #66 which revealed a heart rate of 102 beats per minute and an oxygen saturation level of 91%. The care plan for Resident #66 was consulted and noted to contain a focus area for "alteration in respiratory status related to COPD" with interventions including- "oxygen at all times" as well as "administer oxygen per Medical Doctor/Nurse Practitioner order". At 2:20 PM on 12/20/23, the Unit Manager confirmed that Resident #66 was not receiving supplemental oxygen as ordered.	F 695		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice,	F 697	See Attached **Tag F 697 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to provide pain management to a resident experiencing pain for 1 of 35 sampled residents (Resident #7) related to not providing pain medication per physician orders and not administering pain medication that met professional standards of practice resulting in Resident #7 having significant, untreated pain.
Findings include:

Per record review, Resident #7 has diagnoses that include spastic quadriplegic cerebral palsy (a physical disability that causes muscle rigidity that affects all four limbs and often a person's torso, facial, and oral muscles), polyneuropathy (nerve damage which can cause symptoms including pain and trouble swallowing), dysphagia (difficulties swallowing), and anarthria (loss of speech).

Resident #7's 10/2/23 Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) dated 10/2/23 reveals that s/he shows indicators of pain daily and is assessed to have a BIMS of 15 (brief interview for mental status; a cognitive assessment score indicating cognitive intactness). Resident #7's care plan states that "I have pain or have the potential in an alteration in my comfort r/t [related to] history of bladder and breast Cancer, Chronic Physical Disability r/t spastic CP [cerebral palsy], quadriplegia, polyneuropathy and bilateral knee pain " created on 3/3/2020, with a goal that "My pain will be managed daily," created on 3/3/2020. Interventions include "Provide medication as

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ordered," created on 2/23/2023, and "Assess characteristics of pain: location, severity on a scale of 0-10, type, frequency, precipitating factors, alleviating factors and vital signs or Non-verbal indications of pain as needed," created on 12/29/2021.

Physician orders reveal that Resident #7 has orders to receive "oxyCODONE HCl Oral Solution 5 MG/5ML (Oxycodone HCl) Give 5 ml by mouth three times a day for pain," which began on 2/20/23. Per review of Resident #7's MAR (Medication Administration Record) for November 2023 and December 2023, and confirmed by MAR administration notes, Resident #7 did not receive their scheduled oxycodone twice on 11/16/23 (afternoon and evening), three times on 12/8/23 (morning, afternoon, and evening) and two times on 12/9/23 (morning and afternoon) because the medication was not available. There is no evidence in Resident #7's medical record that a physician was notified of the missed doses on 11/26/23 or 12/8/23 and was not notified until after the first missed dose on 12/9/23. On 12/21/23 at approximately 9:30 AM, the Unit Manager confirmed that neither s/he nor the physician were notified every time Resident #7 did not receive their oxycodone and should have been.

Pain assessments during the above periods reveal the following: On 11/16/23, at the time medications were due, Resident #7 had pain assessments of 0 for the afternoon and a 5 for the evening; on 12/8/23, at the time medications were due, Resident #7 did not have pain assessments documented (morning, afternoon, and evening) but additional pain assessments for that day were documented as a 0; on 12/9/23, at

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the time medications were due, Resident #7 did not have pain assessments documented (morning and afternoon) but additional pain assessments for those times were documented as a 0 and a 4. However, the accuracy of these pain assessments are questionable based on the following interviews and record reviews.

Record review and interview reveal that Resident #7 suffers greatly when his/her pain is not managed. Per interview on 12/21/23 at approximately 9:30 AM, the Unit Manager explained that Resident #7 is normally in pain. S/He explained that while Resident #7 is unable to communicate by speech, s/he can communicate clearly non-verbally. S/He explained that Resident #7's pain can be assessed with a numerical pain scale but sometimes staff use the PAINAD (an instrument for measurement of pain in noncommunicative patients).

Weekly psychological service progress notes dated from 10/20/23 through 12/8/23 indicate that Resident #7 had been working on coping skills related to feeling frustrated with communication and being able to verbalize his/her pain.

A 12/8/23 psychological services progress note "Patient was alert and fully oriented. Patient reported she was in a lot of pain and was feeling uncomfortable." This note was from a day where Resident #7's pain was only documented as a 0 for the entire day. A 12/15/23 clinical treatment therapy plan of care note reveals, "Patient reported depressive symptoms related to [his/her] situation, including pain. Ability to effectively communicate continues to be very frustrating for [him/her]" Assessments from this visit indicated

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that Resident #7 had severe anxiety disorder and moderate depression; an increase from the previous 8/11/23 assessment.

Per interview on 12/21/23 at 9:45 AM, Resident #7 indicated that s/he is in pain most of the time and the pain reaches a level of 10 often. S/he indicated that the pain medications do help a little but not completely. When asked about the two days in December when s/he did not receive her pain medication, s/he indicated that his/her pain was very bad.

Per interview on 12/21/23 at 2:55 PM, the Regional Nurse Consultant confirmed that Resident #7 was not administered his/her oxycodone as ordered and a physician was not notified of each of the missing medication administrations and should have been.

2. Per observation on 12/19/23 at approximately 10:00 AM, Resident #7 was lying in bed with a red substance dripping from his/her mouth onto a towel placed on his/her chest. An unknown amount of the red substance was collected on the towel. Resident #7 was unable to reposition his/herself in the bed. Per interview on 12/19/23 directly following this observation, the Registered Nurse (RN) caring for Resident #7 explained that the red substance was oxycodone and it was normal for it to be dripping out of his/her mouth because s/he has difficulty swallowing. The two pain assessments recorded before and after this observation were documented as a 7 out of 10 for severity (10 being the highest severity) at 8:36 AM and a 6 out of 10 at 2:12 PM.

Per facility policy titled "Medications Administration Methods," last modified on

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F 697	Continued From page 72 7/12/2022, and professional nursing standards, when administering medications, the nurse must watch each resident take the medication and ensure the medication is swallowed unless the resident has an order for self-administration. Per interview on 12/20/23 at 2:27 PM, the Unit Manager stated that Resident #7 is normally in pain. S/He confirmed that the nurse administering the medication should have stayed with Resident #7 to make sure that the pain medication was administered all the way. Reference: Open Resources for Nursing (Open RN); Ernstmeyer K, Christman E, editors. Nursing Skills [Internet]. Eau Claire (WI): Chippewa Valley Technical College; 2021. Chapter 15 Administration of Enteral Medications. Available from: https://www.ncbi.nlm.nih.gov/books/NBK593215/	F 697		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician;	F 710	See Attached **Tag F 710 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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F 710	Continued From page 73 §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on observstion, interview, and record review, the facility failed to ensure that the medical care of each resident is supervised by a physician for 1 of 35 sampled residents (Resident #92). Findings include: Per observation of Resident #92 on 12/18/23 at 11:43 a.m., s/he was sitting in the common area in a wheelchair. S/he was thin, his/her face appeared drawn, and their clothes were loosely fitting. Resident #92 is not interviewable due to cognitive decline and inability to understand questions, with a BIMS (Brief Interview Mental Status) score of 10. Record review reveals Resident #92 had a significant weight loss of 10.66% weight loss in 6 months. His/her weight on 6/13/23 was 178.2 pounds and on 12/14/23 their weight was 159.6, a total loss of 18.6 pounds. Further record review reveals that no documentation from the Physician addresses the resident's significant weight loss. Per the interview with the Director of Nursing (DON) on 12/21/23 at 11:46 a.m. DON reviewed Resident #92 Physician progress notes, and the DON confirms that the MD has not addressed Resident #92's weight loss.	F 710		
F 711 SS=E	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3)	F 711	See Attached **Tag F 711 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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F 711	Continued From page 74 §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policies, the facility failed to ensure that a physician reviewed the total program of care during the required regulatory visits for 9 of 37 sampled residents (Residents #7, #31, #111, #99, #1, #43, #50, #107, and #21). Findings include: Facility policy titled, "Attending physician Medical Services Responsibilities- Burlington," last modified on 4/28/23 states "Documentation of mandated visits must include documentation showing evidence that the provider reviewed the total plan of care ..." Per record review of 40 physician notes for the above 9 residents between 6/1/23 and 1/9/24, which were provided by the facility to this surveyor, a majority of them did not contain evidence that the physician reviewed the resident's total program of care, including the resident's progress and problems in maintaining	F 711		

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or improving their physical, mental and psychosocial well-being and decisions about the continued appropriateness of the resident's current medical regimen. Many of the visit notes (18 of the 38) are handwritten on a one page template that contains several sections to fill out. The information in these sections are not entirely filled out in any of these notes and some are illegible.

There is not a consistent way to determine which visits are acute visits and which visits fulfill the regulatory requirements for physician visits and the review of the resident's total program of care.

5 of the 9 residents reviewed for physician visit requirements had skin issues that worsened over time while at the facility and had a regulatory visit following the onset of the skin issue. Of these 5 residents, 4 did not have documentation that the attending physician had reviewed their skin issues at their visit.

Resident #50's physician notes from 11/27/23 and 12/12/23 does not address that s/he has moisture associated skin damage on his/her coccyx or its progress, that s/he does not have treatment for the MASD and does not have a care plan for skin integrity or wounds.

Resident #99's physician note from 10/3/23 does not address that s/he has a wound on his/her toe or its progress. A box next to "skin" is checked, indicating that Resident #99's skin is intact, with no rashes, no lesions, and no erythema.

Resident #21's physician note from 1/4/23 does not address that s/he has a pressure ulcer on his/her buttock.

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F 711	Continued From page 76 Resident #107 physician note from 9/2/23 does not address that s/he has pressure ulcers on his/her calf and heel or their progress and does not have a care plan for skin integrity or wounds. Per interview on 12/26/23 at 3:47 PM, the Attending Physician/Medical Director stated that s/he was unaware of documentation requirements for regulatory visits and was not aware that the facility had a policy about these requirements. On 1/9/24 at approximately 2:20 PM, s/he explained that s/he gets a list of required visits from the front office when s/he arrives at the facility. S/he explained that at these visits s/he tries to review the total program of care for each resident, including skin, but sometimes it is not possible to review everything if the resident has an acute medical issue. Per interview on 1/9/24 at approximately 3:00 PM, the Director of Nursing confirmed that there is not a consistent way to determine if visits are regulatory or acute in nature. S/He confirmed that provider notes completed by the Attending Physician/Medical Provider did not meet regulatory requirements for reviewing and documenting resident's total program of care.	F 711		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by	F 725	See Attached **Tag F 725 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident and staff interviews, and record review, the facility failed to ensure there are a sufficient number of skilled licensed nurses, nurse aides, and other nursing personnel to provide care and respond to each resident's basic needs and individual needs as required by the resident's diagnoses, medical condition, or plan of care, impacting all residents of the facility. Findings include:

1. Staff schedules reveal that there is frequently not enough staff working to consistently meet the needs of the residents.

Review of facility direct care staff schedules and PPD (direct care staff to resident ratios) for October, November, and December 2023 reveals

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that the facility failed to maintain required Vermont minimum staffing levels to allow for 2.0 hours of direct care per resident per day (PPD) on a weekly average by Licensed Nursing Assistants (LNAs) for 7 of the 8 sampled weeks and failed to maintain required minimum staffing levels to allow for 3.0 hours of direct care per resident per day (PPD) on a weekly average, including nursing care, personal care, and restorative nursing care for 4 of the 8 sampled weeks.

Per an interview on 12/26/23 with the Director of Nursing s/he stated they were aware that the direct care PPD as referenced above did not meet the staffing requirements.

2. Resident interviews reveal that there are not enough staff to meet their needs.

Record review shows that Resident #269 requires a two person assist for ADLs (activities of daily living). Per interview on 12/18/23 at 8:40 AM, Resident #269 stated that s/he has not had care yet this morning and their brief is soiled. S/He stated that s/he asked for help before breakfast and the aide told her that s/he couldn't help until later that morning. Resident #269 stated that s/he would like to be up and dressed much before now as s/he has therapy shortly. S/He explained that this is normal when they are short staffed. Resident #269 also reports that s/he has not had a shower since s/he was admitted.

Record review shows that Resident #52 requires a mix of supervision, partial, moderate, and complete assistance for most ADLs. Per interview on 12/18/2023 at 10:30 AM, Resident #52 expressed concerns about losing his/her

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independence and relying on staff who were inattentive and rough with his/her care needs. S/He stated that it frequently takes staff forever to answer his/her call bell and by the time they do come in, it is too late and s/he has soiled him/herself.

Record review shows that Resident #51 requires a mix of supervision, partial, and moderate assistance for ADLs. Per interview on 12/19/23 at 7:55 AM, Resident #51 stated that it takes a long time for his/her call light to be answered. S/He explained that sometimes no one comes at all and the nights are the worst for when s/he needs help.

Record review shows that Resident #64 requires a mix of supervision and partial assistance for most ADLs. Per interview on 12/19/23 at 9:17 AM, Resident #64 expressed concern that there are not enough staff. S/He explained that when they are short staffed, it can take a long time or sometimes s/he won't get what s/he needs at all, especially when it comes to meals.

Record review shows that Resident #81 requires a two person assist for ADLs. Per interview on 12/19/23 at 10:45 AM, Resident #81 stated that it can be hours before s/he gets help with his ADLs when they are short staffed. S/He explained that there are not trained staff to do his/her range of motion exercises with him/her.

3. Staff interviews reveal that there is frequently not enough staff to consistently meet the needs of the residents.

Per interview on 12/18/23 at 9:25 AM, a LNA indicated that there are not enough staff related

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F 725	Continued From page 80 to how many residents need total care. S/He explained that 8 of his/her assigned 10 residents needed total care for ADLs. Per interview on 12/26/23 at approximately 10:45 AM, the Unit Manger explained that the LNA that was assigned to the unit for the day shift was moved to a different unit to work and s/he was taking on the responsibilities of the LNA that day. Per interview on 12/26/23 at 11:40 AM, the Unit Manager, who was working on a medication cart, explained that s/he could often be assigned to a medication cart instead of working in his/her role as the unit manager. S/He explained that when this happens, his/her job duties, such as keeping up with resident care plans, can fall behind. S/He also stated that when the unit is short staffed sometimes ADL care, like showers, does not happen. Per interview on 12/26/23 at 11:27 AM, a Licensed Nursing Assistant indicated that there are not enough aides on the unit because there are so many residents that require two person assistance. S/He explained that residents who require a two person assist might have to wait a while until two staff are free at the same time and when two staff are with one resident, many other residents have to wait a long time for assistance.	F 725		
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest	F 726	See Attached **Tag F 726 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).

§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
Based on interview, staff education record review, and the facility assessment, the facility failed to ensure that licensed nurses and licensed nursing assistants were assessed for competency and skill sets to provide care and respond to each resident's individualized needs. This has the potential to affect all residents.

The facility's Facility Assessment (an assessment that determines what resources are necessary to care for the residents competently during both day-to-day operations and emergencies), last

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reviewed 10/2/2023, reveals under section 3 titled "Facility Resources Needed to Provide Competent Resident Support and Care Daily and During Emergencies" a chart that lists the required staff competencies required to provide the level and types of care needed for the resident population, both initially and annually. Per this chart, licensed nurses use the Nurse Competency Skills Evaluation which lists 9 pages of skills licensed nurses are required to demonstrate. This list includes skills such as handwashing, safe medication administration, Treatment Administration Record (TAR) documentation, CPAP and BiPAP use (wearable machines to treat sleep apnea), catheter care, urostomy (urinary diversion) management, identification of advanced directives, developing, revising and reading the care plan, and pain evaluations. Per this chart, LNAs (interchangeable with CNA; certified nursing assistant) use the CNA Competency Skills Evaluation which lists 7 pages of skills LNAs are required to demonstrate. This list includes skills such as wearing masks, catheter care, measuring urinary output, how to document in POC (point of care; electronic documentation system for LNAs), and showering.

Per review of 11 sampled employee education records, 5 of the 7 sampled LNAs and 4 of the 4 licensed nurses did not have documentation of the competency evaluation required to demonstrate that they had the necessary skills to provide care needed.

Per interview on 12/26/23 at 11:27 AM, an LNA explained that s/he is a contracted staff and no one has gone over competencies with her/him since she became employed at the facility.

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F 726	Continued From page 83 Per interview on 12/26/23 at 4:17 PM, the Staff Educator explained that there hadn't been a staff educator at the facility until very recently when s/he took the position; before that, the role had been vacant for 8 months. S/He is unsure what systems were in place for tracking and filing competencies prior to his/her arrival.	F 726		
F 755 SS=G	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755	See Attached **Tag F 755 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Per interview and record review, the facility failed to provide medications as ordered by the prescriber to meet the needs of each resident for 4 of 35 sampled residents (Resident #7, #52, #102, and #81). Findings include:

1. Per record review, Resident #7 has diagnoses that include spastic quadriplegic cerebral palsy (a physical disability that causes muscle rigidity that affects all four limbs and often a person's torso, facial, and oral muscles), polyneuropathy (nerve damage which can cause symptoms including pain and trouble swallowing), dysphagia (difficulties swallowing), and anarthria (loss of speech).
Resident #7's 10/2/23 Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) dated 10/2/23 reveals that s/he shows indicators of pain daily. A 10/16/23 progress note indicates that Resident #7 has difficulties with oral secretions.

Physician orders reveal that Resident #7 has orders to receive "oxyCODONE HCl Oral Solution 5 MG/5ML (Oxycodone HCl) Give 5 ml by mouth three times a day for pain," which began on 2/20/23. Per review of Resident #7's MAR (Medication Administration Record) for November 2023 and December 2023, and confirmed by MAR administration notes, Resident #7 did not receive their scheduled oxycodone twice on 11/16/23 (afternoon and evening), three times on 12/8/23 (morning, afternoon, and evening) and

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two times on 12/9/23 (morning and afternoon) because the medication was not available. There is no evidence in Resident #7's medical record that a physician was notified of the missed doses on 11/26/23 or 12/8/23 and was not notified until after the first missed dose on 12/9/23. On 12/21/23 at approximately 9:30 AM, the Unit Manager confirmed that neither s/he nor the physician were notified every time Resident #7 did not receive their oxycodone and should have been.

Physician orders reveal that Resident #7 has orders to receive "Scopolamine Transdermal Patch 72 Hour 1 MG/3DAYS (Scopolamine) Apply 1 patch transdermally every 72 hours for Secretions and remove per schedule," which began on 10/17/23. Per review of Resident #7's MAR (Medication Administration Record) for October through December 2023, and confirmed by MAR administration notes, Resident #7 did not receive their scheduled scopolamine patch 9 out of the 21 scheduled times through 12/22/23 (10/29/23, 11/4/23, 11/13/23, 11/19/23, 11/22/23, 12/4/23, 12/13/23, 12/19/23, and 12/22/23) because the medication was not available. There is no evidence in Resident #7's medical record that a physician was notified of the missed doses. As a result, Resident #7 experienced significant, untreated pain. See F760 for more information.

Per interview on 12/21/23 at 2:55 PM, the Regional Nurse Consultant confirmed that Resident #7 was not administered his/her oxycodone and scopolamine as ordered and a physician was not notified of each of the missing medication administrations and should have been.

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2. Per record review, Resident #52 was admitted to the facility on 11/9/23 with diagnoses that include post-traumatic stress disorder (PTSD), traumatic brain injury with impulsive behaviors, anxiety disorder, bipolar disorder, and psychotic disorder (other than schizophrenia).

Resident #52 had a physician order for "Invega Sustenna Suspension 234 MG/1.5ML (Paliperidone Palmitate; an atypical antipsychotic) Inject 1.5 ml intramuscularly one time a day every 28 day(s) for PTSD/BIPOLAR DISORDER," with an order date of 11/9/2023 and a start date of 11/13/2023. Per Resident #52's MAR, and confirmed by a 12/11/23 progress note, Resident #52 was scheduled to have this medication administered on 12/11/23, 28 days following the 11/13/2023 administration, but it was not administered because the medication was not available. As a result, Resident #52 was at increased risk for increased behavioral and mental health symptoms. See F760 for more information.

A physician note dated 12/14/23 reveals "[S/He] admits [his/her] depression has been a bit worse lately ... At times, [s/he] has thoughts of suicide, but denies any active plan." This note "continue paliperidone palmitate injection 234 mg IM monthly." This note does not address that Resident #52 did not receive their dose three days prior (12/11/23) when it was scheduled to be administered.

Per interview on 12/21/23 at 11:30 AM, the Unit Manager stated that s/he was unaware that Resident #52 did not receive his/her Invega Sustenna as ordered and should have been notified. Per interview on 12/21/23 at 2:55 PM,

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the Director of Nursing was unaware that Resident #52 was not administered his/her Invega Sustenna as ordered. After bringing this medication omission to the facility's attention, the facility obtained the medication from the pharmacy and a new physician order. Resident #52 was administered the medication on 12/23/2023, twelve days after the scheduled order.

3. Per record review Resident #102 has diagnoses that include diabetes requiring daily insulin. A 12/11/23 Endocrinology consult note shows a new medication order for Ozempic related to diabetes management.

Resident #102 has a physician order for "Ozempic (0.25 or 0.5 MG/DOSE) 2 MG/3ML Solution pen-injector INJECT 0.25MG SUBCUTANEOUSLY EVERY MORNING FOR 7 DAYS; INJECT 0.5MG SUBCUTANEOUSLY EVERY MORNING FOR 7 DAYS;INJECT 1MG SUBCUTANEOUSLY EVERY MORNING FOR 7 DAYS," with a start date of 12/14/23. Per Resident #102's MAR and confirmed by a 12/14/23 progress note, Resident #102 did not receive their Ozempic on 12/14/23 because the medication was available. This order was discontinued on 12/19/23 and a new order for Ozempic was placed with a start date of 12/20/23. Per Resident #102's MAR, s/he received his/her first does of Ozempic, 6 days after the initial start date. There is no evidence in Resident #102's medical record that a physician was notified of the missed dose between 12/14/23 and 12/18/23.

4. Per record review Resident #81 has diagnoses that include acute transverse myelitis

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F 755	Continued From page 88 (inflammation of the spinal cord; symptoms may include pain), anxiety, and lower back pain. Physician orders reveal that Resident #81 has orders to receive "New Age Naturals Advanced Hemp Gummies 100 MG Give 1 gummy by mouth three times a day for pain / anxiety," which began on 11/17/23. Per review of Resident #81's MAR for December 2023, and confirmed by MAR administration notes, Resident #81 did not receive their scheduled hemp gummies 1 time on 12/9/23, 1 time on 12/20/23, 3 times on 12/21/23, 3 times on 12/22/23, 3 times on 12/23/23, and 1 time on 12/24/23 because the medication was not available.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons	F 757	See Attached **Tag F 757 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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stated in paragraphs (d)(1) through (5) of this section.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to keep each resident's drug regimen free from unnecessary drugs for 1 of 35 sampled residents (Resident #23). Findings include:

Resident #23 received 5 doses of an antibiotic unnecessarily.
Per record review Resident #23 returned from a hospital stay related to a pericardial effusion (abnormal fluid accumulation around the heart) on 12/9/23. Included with the discharge orders were:
1. "Prednisone 40 mg (a steroid medication) continue this dose until directed to taper, duration to be determined at cardiology outpatient follow up."
2. "Sulfamethoxazole-Trimethoprim Oral Tablet 800-160 mg (an antibiotic) Give one tablet by mouth in the morning every Mon, Wed, Fri for PPX (prophylaxis) while on long-term prednisone taper."

During a review of the medical record, there was no documentation endorsing a cardiology follow-up appointment had occurred thus no prednisone taper had been ordered. An analysis of the medication administration record (MAR) revealed the resident continued to receive Prednisone 40 mg and on 12/9/23 (Saturday) the Sulfamethoxazole-Trimethoprim 800-160 mg had been put on the MAR and was given to the resident on 12/11, 13, 15, 18 and 20, 2023. The Unit Manager was interviewed on 12/20/23 at approximately 11 AM. s/he confirmed there had not yet been a follow-up with cardiology therefore

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F 757	Continued From page 90 the antibiotic should not have been started and given to Resident #23 on the 5 occasions noted.	F 757		
F 760 SS=G	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 interview and record review, the facility failed to ensure 2 of 35 sampled residents (Residents #7 and #52) are free from significant medication errors related to missed medication administration. As a result, Resident #7 experienced significant, untreated pain and Resident #52 was at increased risk for increased behavioral and mental health symptoms. Findings include: 1. Per record review, Resident #7 has diagnoses that include spastic quadriplegic cerebral palsy (a physical disability that causes muscle rigidity that affects all four limbs and often a person's torso, facial, and oral muscles), polyneuropathy (nerve damage which can cause symptoms including pain and trouble swallowing), dysphagia (difficulties swallowing), and anarthria (loss of speech). Resident #7's 10/2/23 Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) dated 10/2/23 reveals that s/he shows indicators of pain daily and is assessed to have a BIMS of 15 (brief interview for mental status; a cognitive assessment score indicating cognitive intactness). Resident #7's care plan states that "I have pain or have the	F 760	See Attached **Tag F 760 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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potential in an alteration in my comfort r/t [related to] history of bladder and breast Cancer, Chronic Physical Disability r/t spastic CP [cerebral palsy], quadriplegia, polyneuropathy and bilateral knee pain " created on 3/3/2020, with a goal that "My pain will be managed daily," created on 3/3/2020. Interventions include "Provide medication as ordered," created on 2/23/2023.

Physician orders reveal that Resident #7 has orders to receive "oxyCODONE HCl Oral Solution 5 MG/5ML (Oxycodone HCl) Give 5 ml by mouth three times a day for pain," which began on 2/20/23. Per review of Resident #7's MAR (Medication Administration Record) for November 2023 and December 2023, and confirmed by MAR administration notes, Resident #7 did not receive their scheduled oxycodone twice on 11/16/23 (afternoon and evening), three times on 12/8/23 (morning, afternoon, and evening) and two times on 12/9/23 (morning and afternoon) because the medication was not available. There is no evidence in Resident #7's medical record that a physician was notified of the missed doses on 11/26/23 or 12/8/23 and was not notified until after the first missed dose on 12/9/23. On 12/21/23 at approximately 9:30 AM, the Unit Manager confirmed that neither s/he nor the physician were notified every time Resident #7 did not receive their oxycodone and should have been.

Pain assessments during the above periods reveal the following: On 11/16/23, at the time medications were due, Resident #7 had pain assessments of 0 for the afternoon and a 5 for the evening; on 12/8/23, at the time medications were due, Resident #7 did not have pain assessments documented (morning, afternoon,

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and evening) but additional pain assessments for that day were documented as a 0; on 12/9/23, at the time medications were due, Resident #7 did not have pain assessments documented (morning and afternoon) but additional pain assessments for those times were documented as a 0 and a 4. However, the accuracy of these pain assessments are questionable based on the following interviews and record reviews.

Record review and interview reveal that Resident #7 suffers greatly when his/her pain is not managed. Per interview on 12/21/23 at approximately 9:30 AM, the Unit Manager explained that Resident #7 is normally in pain. S/He explained that while Resident #7 is unable to communicate by speech, s/he can communicate clearly non-verbally. S/He explained that Resident #7's pain can be assessed with a numerical pain scale but sometimes staff use the PAINAD (an instrument for measurement of pain in noncommunicative patients).

Weekly psychological service progress notes dated from 10/20/23 through 12/8/23 indicate that Resident #7 had been working on coping skills related to feeling frustrated with communication and being able to verbalize his/her pain.

A 12/8/23 psychological services progress note "Patient was alert and fully oriented. Patient reported she was in a lot of pain and was feeling uncomfortable." This note was from a day where Resident #7's pain was only documented as a 0 for the entire day. A 12/15/23 clinical treatment therapy plan of care note reveals, "Patient reported depressive symptoms related to [his/her] situation, including pain. Ability to effectively

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communicate continues to be very frustrating for [him/her]" Assessments from this visit indicated that Resident #7 had severe anxiety disorder and moderate depression; an increase from the previous 8/11/23 assessment.

Per interview on 12/21/23 at 9:45 AM, Resident #7 indicated that s/he is in pain most of the time and the pain reaches a level of 10 often. S/he indicated that the pain medications do help a little but not completely. When asked about the two days in December when s/he did not receive her pain medication, s/he indicated that his/her pain was very bad.

Per interview on 12/21/23 at 2:55 PM, the Regional Nurse Consultant confirmed that Resident #7 was not administered his/her oxycodone as ordered and there was no evidence that a physician was notified of each of the missing medication administrations and should have been.

2. Record review, interviews, and observations reveal that Resident #7 has trouble with oral secretions which began in October 2023. Due to Resident #7's diagnoses of spastic quadriplegic cerebral palsy and dysphagia, troubles managing oral secretions would put him/her at increased risk for aspiration and skin breakdown. A 10/16/23 progress note indicates that Resident #7 was having difficulty breathing. S/He had an oxygen saturation of 79% on room air, was tachycardic (fast heartrate), required oxygen, and suctioning due to mucus in his/her throat. The physician was made aware and Resident #7 was prescribed a scopolamine patch (used to reduce mucus and salvia production). A 12/19/23 nurse note states, "Resident presenting with secretions,

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congestion, and a non-productive cough." Per interview on 12/20/23 at 2:27 PM, the Unit Manager revealed that Resident #7 has trouble with oral secretions. On 12/21/23 at 9:45 AM, Resident #7 was observed having a weak, mucous cough. A 12/21/23 physician note states "[Resident #7] has difficulty with oral secretions."

Physician orders reveal that Resident #7 has orders to receive "Scopolamine Transdermal Patch 72 Hour 1 MG/3DAYS (Scopolamine) Apply 1 patch transdermally every 72 hours for Secretions and remove per schedule," which began on 10/17/23. Per review of Resident #7's MAR (Medication Administration Record) for October through December 2023, and confirmed by MAR administration notes, Resident #7 did not receive their scheduled scopolamine patch 9 out of the 21 scheduled times through 12/22/23 (10/29/23, 11/4/23, 11/13/23, 11/19/23, 11/22/23, 12/4/23, 12/13/23, 12/19/23, and 12/22/23) because the medication was not available. There is no evidence in Resident #7's medical record that a physician was notified of the missed doses.

Per interview on 12/21/23 at 2:55 PM, the Regional Nurse Consultant confirmed that Resident #7 was not administered his/her scopolamine as ordered and a physician was not notified of each of the missing medication administrations and should have been.

Per interview on 12/26/23 at approximately 1:45 PM, the Director of Nursing stated that s/he was unaware that Resident #7 did not receive his/her scopolamine patch on the above dates. S/He stated that s/he and the provider should have been notified because there was atropine (which can also be used to treat oral secretions)

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available in the facility and staff could have gotten an order for that while the medication was unavailable.

3. Per record review, Resident #52 was admitted to the facility on 11/9/23 with diagnoses that include post-traumatic stress disorder (PTSD), traumatic brain injury with impulsive behaviors, anxiety disorder, bipolar disorder, and psychotic disorder (other than schizophrenia).

Per interview and observation on 12/18/2023 at 10:30 AM, Resident #52 stated that s/he was on medications for his/her mood swings. S/He expressed concerns about losing his/her independence and relying on staff who were inattentive and rough with his care needs. During this interview Resident #52 expressed feelings of sadness and became weepy and for a few moments, s/he withdrew from the conversation in tears.

Resident #52 had a physician order for "Invega Sustenna Suspension 234 MG/1.5ML (Paliperidone Palmitate; an atypical antipsychotic) Inject 1.5 ml intramuscularly one time a day every 28 day(s) for PTSD/BIPOLAR DISORDER," with an order date of 11/9/2023 and a start date of 11/13/2023. Per Resident #52's MAR, and confirmed by a 12/11/23 progress note, Resident #52 was scheduled to have this medication administered on 12/11/23, 28 days following the 11/13/2023 administration, but it was not administered because the medication was not available.

A physician note dated 12/14/23 reveals "[S/He] admits [his/her] depression has been a bit worse lately ... At times, [s/he] has thoughts of suicide,

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F 760	Continued From page 96 but denies any active plan." This note "continue paliperidone palmitate injection 234 mg IM monthly." This note does not address that Resident #52 did not receive their dose three days prior (12/11/23) when it was scheduled to be administered. Per interview on 12/21/23 at 11:30 AM, the Unit Manager stated that s/he was unaware that Resident #52 did not receive his/her Invega Sustenna as ordered and should have been notified. Per interview on 12/21/23 at 2:55 PM, the Director of Nursing was unaware that Resident #52 was not administered his/her Invega Sustenna as ordered. After bringing this medication omission to the facility's attention, the facility obtained the medication from the pharmacy and a new physician order. Resident #52 was administered the medication on 12/23/2023, twelve days after the scheduled order.	F 760		
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	F 761	See Attached **Tag F 761 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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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:
Based on observation, interview, and record review, the facility failed to ensure that all drugs and biologicals are kept in locked compartments only accessible to authorized personnel for one applicable treatement cart; failed to ensure that medications and biologicals were removed from use when expired for 2 of 3 units; and failed to ensure medications were properly stored for 2 of 35 sampled residents (Resident #31 and #81). Findings include:

1. The facility's treatement cart was not kept locked or under direct observation of authorized staff in an area where residents could access it.

Per observation on 12/17/23 at 5:43 PM, a treatment cart in the common area of Unit A was observed unlocked making the items in the drawers accessible. There were noted to be prescription medication ointments in the unsecured drawers. At 5:43 PM the Licensed Practical Nurse (LPN) was notified that the cart was not locked. The LPN stated, "It's the other nurse's cart." The LPN walked away without locking the cart. At 6:03 PM the 2nd LPN on duty was shown that the treatment cart was not locked

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and the drawers where the precription medication ointments were accessible. The LPN confirmed that the cart should be locked and then s/he locked the treatment cart. Per interview with the Director of Nurses on 12/17/23 at 6:10 PM, s/he confirmed that the treatment cart should be locked at all times.

2. Expired medications and biologics were in circulation on 2 of the 3 units.

On 12/20/23 at 12:32 PM during an observation of the medication room on Unit A, there was noted to be a bottle of Oyster Shell Calcium (a medication that is given to supplement Calcium intake) that had an expiration date of 07/23/23. Per interview on 12/20/23 at 12:35 PM, the Medication Technician confirmed that the expired medication should not be in the medication room and it should be removed and destroyed.

On 12/20/23 at 1:33 PM, the medication storage room and a medication cart were observed alongside the Unit Manager. The following items were found to be expired and in circulation:
Approximately 6 blood collection sets, expired 4/13/23, in the medication room,
A nearly full box of red top flu collection tubes, expired 4/30/23, in the medication room,
A syringe, expired 6/2021, in the medication cart,
Assure Prisms Control Solution (used for checking blood glucose meters accuracy), expired 3/15/23, in the medication cart.

Per interview on 12/20/23 at 3:30 PM, the Director of Nursing (DON) confirmed that there should not be any expired biologics or medications in the medication room or on the medication carts.

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F 761	Continued From page 99 3. Medications were improperly stored in resident's rooms. Per observation on 12/19/23 at 10:53 AM Resident #31 was lying in their bed in their room. On his/her bedside table was a respiratory inhaler labeled "Trelegy Ellipta Aerosol Powder." Resident #31 explained that the nurse left it there this morning but s/he also has another inhaler that s/he keeps in the room all the time. Resident #31 then revealed a respiratory inhaler labeled "Albuterol Sulfate" from a cup on his/her bedside table. Per interview on 12/19/23 at 10:59 AM, the Unit Manager (UM) stated that there is nothing in Resident #31's care plan or orders for him/her to be able to self-administer medications. The UM confirmed that the medications should not have been left in his room. Per observation on 12/20/23 at 2:04 PM Resident #81 was lying in their bed in their room. On his/her bedside table was a respiratory inhaler labeled "Albuterol Sulfate." Per interview on 12/20/23 at 2:08 PM, the UM confirmed that Resident #81 did not have an order for self-administering medications but s/he has had the inhaler in his/her room for a while. Per interview on 12/20/23 at 2:09 PM, the Director of Nursing confirmed that residents should not have medications in room or self-administer medications without an order.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812	See Attached	

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F 812	Continued From page 100 §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 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 and interview, the facility failed to ensure that food is stored in accordance with professional standards for food service safety. The facility also failed to ensure that dishwasher temperatures were monitored to ensure proper sanitation. Findings include: On 12/17/23 at 4:10 p.m. during the initial tour of the kitchen, the following observations were made: 1. In the walk-in cooler observed a milk crate with 8 containers of egg nogg being stored directly on the floor. The facility cook confirmed the egg nogg should not be on the floor it should be on a shelf. 2. In the walk-in cooler a box of celery was	F 812	**Tag F 812 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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wilted, with soft and bendable stocks and the color of the celery was pale indicating that it is not suitable for eating. The facility cook confirmed the celery was spoiled and removed it from the walk-in cooler.

3. In the walk-in cooler a watermelon had mold and brown spots on the outer rind. The facility cook confirmed the watermelon was spoiled and removed it from the walk-in cooler.

4. In the walk-in cooler there were 6 half-gallon containers of half-and-half creamer with an expiration date of 12/8/23. The facility cook confirmed the half and half was expired and removed it from the walk-in cooler.

5. On the floor of the walk-in cooler was an unwrapped donut and other debris. The facility cook confirmed that this debris should not be on the floor, and it needed to be removed from the walk-in cooler.

6. In the walk-in freezer there was a tied bag with a frozen food item in it, that was not labeled and not dated. The facility cook confirmed that this item was not labeled or dated, and it should be removed from the walk-in freezer.

7. Both the walk-in freezer and walk-in cooler had boxes stacked to the ceiling. The facility cook confirmed that the boxes should not be stacked to the ceiling of the cooler.

During a review of dishwasher temperature records it was revealed that there were no temperature records for August, September, October, and November of 2023.
12/20/23 2:30 p.m. An interview with the Dietary

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F 812	Continued From page 102 Manager confirmed that the temperatures for the dishwasher had not been taken during the above time period.	F 812		
F 841 SS=F	Responsibilities of Medical Director CFR(s): 483.70(h)(1)(2) §483.70(h) Medical director. §483.70(h)(1) The facility must designate a physician to serve as medical director. §483.70(h)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, it was determined that the facility failed to ensure the Medical Director (MD) duties per the Medical Director Agreement and Medical Director facility policy were implemented to ensure resident care policies and services were provided to all residents that were consistent with current professional standards of practice on 3 of 3 resident units. Findings include: A document titled "Medical Director Agreement," signed by the facility on 5/31/23 revels the following services will be provided by the MD: "Minimum Qualification Standards and Performance Requirements of a medical Director 1.2.9.2 Review of the resident's overall condition and program of care at each visit, including medication and treatment 1.2.14 Process for accurate assessments, care planning, treatment implementation, and monitoring or care and services to meet resident needs.	F 841	See Attached **Tag F 841 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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1.3 Physician shall review and update resident care policies and procedures to reflect current standards of practice for resident care and quality of life.

Facility policy titled "Medical Director," last modified on 9/16/2019 states,
"The facility is responsible for obtaining the medical directors ongoing guidance in the development and implementation of resident care policies, including review and revision of existing policies.
The medical director has a key role in helping the facility to incorporate current standards of practice into resident care policies and procedures/guidelines to help assure that they address the needs of the residents by guiding, approving and helping to oversee the implementation of policies and procedures.
The medical director addresses issues related to the coordination of medical care identified through the facilities quality assessment and assurance committee and quality assurance program comma and other activities related to the coordination of care."

During a recertification survey concluded on 12/26/23, the survey team identified substandard quality of care related to pressure ulcers. Record review reveals that the MD was also the Attending Physician for all 7 Residents with identified skin issues. There was no evidence that the MD attended care plan meetings and/or contributed to the development and/or revision of these 7's Resident's plan after required assessments, and the MD did not review and document the total program of care for residents at required regulatory visits for 4 of the 5 residents requiring regulatory physician visits with identified skin

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issues, See F657, F686, and F711 for more information.

Per interview on 12/26/23 at 3:47 PM, the Medical Director explained that s/he has been an Attending Physician and the Medical Director for the facility since June 2023. When asked about skin and wound management, s/he was not sure how long the facility had been using a telehealth wound provider and was unaware of who was managing wounds prior to bringing on the telehealth wound provider. S/He indicated that s/he was unaware that the facility did not have an up to date wound management policy that was knowingly accessible to staff. The MD stated that s/he was unaware of documentation requirements for regulatory physician visits and was not aware that the facility had a policy about these requirements.

Per interview on 1/9/24 at approximately 2:20 PM, the Medical Director explained that s/he was not aware that the facility has any concerns with skin or wound management and was not aware that these issues were identified during the recertification survey just completed 2 weeks prior to the interview.

Per interview on 1/11/23 at 1:25 PM, the Director of Nursing indicated that the Medical Director should be aware of concerns with skin management because it is a topic at the quarterly QAPI (quality assurance and performance improvement) meetings and there has been a performance improvement plan related to skin management since s/he has become Medical Director. S/He explained that s/he has also met with the Medical Director weekly and has discussed the need for a wound provider prior to

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F 841	Continued From page 105 recently working with a telehealth wound provider that started around the beginning of December 2023. Per interview on 1/11/24 at 3:07 PM, the Chief Nursing Officer explained that policies are reviewed at a corporate level and if a facility recognizes that a policy needs to be updated, they bring a revised policy to the corporate team who will review it. S/He confirmed that the current Medical Director has never brought any policy revision requests, including skin and wound policies, to this team for review.	F 841		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.	F 849	See Attached **Tag F 849 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.

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(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The

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interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if

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F 849	Continued From page 109 any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to develop a coordinated plan of care for 1 sampled resident receiving hospice care (Resident #69). Findings include: Per record review, Resident #69 was initially admitted for a rehab stay but transitioned onto hospice care in October 2023. Per a review of the care plan, there is no evidence of coordination of care between the hospice and the facility. On 12/20/23 at 12:20 PM, the Unit Manager was interviewed regarding the collaborative process between the hospice and the facility. Per the Unit Manager, the Hospice Nurse meets with the Unit Manager to discuss the resident and puts notes into the resident's health record but there is no care plan collaboration or coordinated plan of care.	F 849		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880	See Attached **Tag F 880 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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F 880	Continued From page 110 §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: §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,	F 880		

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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 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 observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections as evidenced by the improper use of PPE (personal protective equipment) for 1 of 3 residents on precautions (Resident #50) and throughout the facility; failure to use proper hand hygiene during medication administration; and the failure to clean respiratory equipment (C-PAP and

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Bi-PAP) machines per orders and facility policy for 3 of 3 sampled residents (Residents #69, 5, & 23). Findings include:

1. Staff did not wear the appropriate PPE in the facility when there was active COVID-19 and influenza.

Per observation, on entry to the facility on 12/17/23 through 12/21/23 and 12/26/23, signs are posted to inform all entering of the use of facemasks facility wide.

Record review reveals that Resident #50 tested positive for influenza on 12/18/2023. Per observation on 12/18/23 at 3:04 PM, Resident #50 had a sign on his/her door and personal protective equipment outside of his/her room, notifying staff that Resident #50 is on droplet precautions (mask, gown, gloves, and eye protection). At this time, a Therapy Staff Member was observed going into Resident #50's room without eye protection to perform close contact therapy with Resident #50. This observation was brought to the Unit Manager's (UM) attention immediately. The UM then called the Therapy Staff Member away from Resident #50's bed and to the door where the UM explained that s/he should have eye protection on while being in Resident #50's room. The Therapy Staff Member responded that s/he was not aware that s/he needed to wear eye protection.

On 12/18/23 at approximately 3:15 PM and 12/20/23 at 12:11 PM, a Speech Therapist (ST) was observed in room 75 (room of Resident # 270 and #87), and at 8:34 AM in room 69, with their face mask hanging below their chin and not covering any part of their nose or mouth.

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F 880	Continued From page 113 Per interview on 12/20/23 at 12:12 PM, the Unit Manager stated that it is unacceptable for the above ST to not be wearing a face mask on the units and in a resident's room. Multiple staff were observed throughout 12/18/2023 through 12/19/2023 on all units, including the unit with active Covid-19 and influenza, without their face masks covering all of their mouth and nose. These observations took place on: 12/18/23 at 7:53 AM, 8:08, 8:21, 8:57, and 11:25 AM on Unit C (the unit with active Covid-19 and influenza), 10:55 AM on Unit B, and 11:20 AM on Unit A. 12/19/23 at 6:48 AM, 8:48 AM, and 9:29 AM on Unit B, 7:32 AM on Unit C, and 7:40 AM on Unit A. Per interview on 12/18/23 at 3:30 PM, the Infection Preventionist/Director of Nursing confirmed that all staff should being wearing facemasks, over their mouth and nose, when out on the units. 2. Per observation on 12/18/23 at 5:32 PM, a Registered Nurse (RN) was observed preparing medications for a resident in room 42 when s/he dropped a pill onto the medication cart and picked it up with his/her bare hands, placed it into a cup with other pills and brought it into room 42 for administration. Per interview following this observation, the RN confirmed that s/he did not follow the correct infection control practices for preparing and administering medications by touching the medication with his/her bare hands and then administering it.	F 880		

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3. Residents #69, #5, and #23 each have orders for the use of either C-Pap or Bi-Pap which are medical devices ordered to assist with airflow for individuals while they sleep. On 12/26, 27, and 28 these devices were viewed on the bedside tables in each room numerous times throughout the day without indication of having been cleaned.
Per record reviews an order to "clean tubing and mask with a solution of warm water and a mild detergent, rinse thoroughly and air day" was in place in each Resident's record. On 12/27/23, 3 Licensed Nursing Assistants (LNA's) were interviewed during the time between 10-10:30 AM regarding the process for cleaning these respiratory devices. Each LNA confirmed they were unaware of a need to clean these devices and had not ever done so. A unit Registered Nurse (RN) was interviewed on 12/27/23 at approximatley 10:45 AM as this task appeared on the Task Administration Record to be done daily and was signed off with few exception. Per the RN "I sign if off because I assume it's being done".
Per the facility policy entitled Bi-level Positive Airway Pressure (BiPAP) and Continuous Positive Airway Pressure (CPAP) the following steps are to be taken:
1. "Wipe outside of the device with a cloth slightly dampened with water and mild detergent. Let the device dry completely before plugging in the power cord."
2. "Clean and replace machine filter according to manufacturers specifications."
3. "Gently wash mask daily in a solution of warm water and a mild detergent or as specified in the manufacturer instructions. Rinse thoroughly. Air dry."
4. "Clean the tubing before first use and daily or as specified in the manufacturer instructions.

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F 880	Continued From page 115 Disconnect the flexible tubing from the device. Gently wash tubing in a solution of warm water and a mild detergent. Rinse thoroughly. Air dry. Check tubing for leaks periodically." During an interview with the Unit Manager on 12/27/23 at approximately 9:45 AM s/he stated they were unaware if these machines were cleaned or of any schedule to do so.	F 880		
F 883 SS=G	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 883	See Attached **Tag F 883 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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F 883	Continued From page 116	F 883		

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure that 3 eligible residents (Residents #50, #270, and #80) on one unit received the influenza vaccine. As a result, one unvaccinated resident (Resident #50) developed influenza and required hospitalization for dehydration and abnormal lung sounds, and two residents (Resident #270 and #87) were at increased risk for contracting influenza and/or developing influenza complications.

1. Per record review, Resident #50 was admitted

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to the facility on 11/20/23 with diagnoses that include diabetes and severe kidney disease. S/He was recently assessed at the emergency room related to elevated kidney function labs and a urinary tract infection according to a 12/16/23 emergency visit note. Resident #50 is considered high risk for influenza complications because of his/her diagnoses and nursing home admission.

An undated form titled "Vaccination Review: Consent/Declination Resident Form," entered into Resident #50's medical record with the effective date of 11/20/23, reveals that his/her vaccination history was assessed for influenza, Covid-19, and pneumococcal. The form indicates that s/he did not receive a 2023 influenza vaccine. Under "decision" to vaccinate, the choices "not eligible," "consented," and "declined" are all left blank. The resident, nor their representative, did not sign off that they were provided education or that they consented or declined the administration of the influenza vaccine. There is no evidence that Resident #50 received the influenza vaccine in his/her medical record or that s/he had a medical contraindication to receive the vaccine.

Per interview on 12/18/2023 at 9:07 AM, Resident #50 stated that s/he does not feel good at all and was needing to rest.

A 12/18/23 physician visit note reveals that Resident #50 was complaining of a scratchy throat which started late the night before/earlier that morning. A 12/18/23 progress note reveals that Resident #50 had a rapid flu test and was positive for influenza A.

A 12/21/23 physician note reveals the following: "HPI [history of present illness]: Patient seen

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because of continued illness with influenza. When I saw the patient [s/he] was sleeping [s/he] was arousable [s/he] was alert. But [s/he] had a hard time staying awake. The patient has not been eating or drinking. Despite the staff efforts to constantly come in and give [him/her] fluids. [S/He] does not feel like eating or drinking [s/he] has been feeling quite sick. No ear pain no eye symptoms mild stuffy nose no sore throat no difficulty breathing but [s/he] does have a persistent cough. [S/He] feels nauseated no abdominal pain no. The nausea is the main reason [s/he] cannot eat or drink anything at this time ... Physical Exam: This patient appears to be in mild to moderate distress. [S/He] was retching when I came in the room. After I woke [him/her]. It started within a few seconds. [S/He] does not have tenting but [his/her] mucous membranes are dry. [S/He] appears to be very tired. [S/He] is alert and oriented. Lungs have nonspecific coarse sounds throughout ...Assessments/Plans: Influenza due to identified novel influenza A virus with other manifestations ... Patient is dehydrated and also has abnormal lung sounds. And not able to take fluids we are not able to start an IV here. Patient will need to go to the ER [emergency room] for further evaluation and treatment."

A 12/21/23 transfer form reveals that Resident #50 was transferred to the emergency room on 12/21/23 for the following reason: "flu, n/v [nausea/vomiting], poor appetite, decreased fluid intake ... Additional Relevant Information: poor kidney function, ID [infectious disease] patient, dx [diagnosed] w/ FLU."

A 12/21/23 hospital admission note reveals the following: "Assessment: Resident #50 is a 60 y.o. [year old] [gender] with a PMHx [past medical

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history] significant for T2DM [type 2 diabetes mellites] c/b [complicated by] neuropathy [nerve damage], retinopathy [disease of the retina] and CKD4 [stage 4 kidney disease]. HTN [hypertension], Seizure disorder (on Keppra [seizure medication]), left TMA [transmetatarsal amputation; removal of part of the foot] (2019) and recent hospitalization (10/20-11/6) for osteomyelitis [bone infection] as a result of a burn with course complicated by shock secondary to GBS bacteremia [bloodstream infection] (now s/p [status post] right BKA [below knee amputation]), as well as type II NSTEMI [heart attack] who presents with 3-5 days of increased confusion, poor PO [by mouth] intake in the setting of new diagnosis FluA and ongoing treatment for a UTI [urinary tract infection] with cefpodoxime [antibiotic]. Patient likely with multifactorial toxic/metabolic encephalopathy [brain disease that alters brain function or structure] due to infection, dehydration, and buildup of metabolites [substance resulting from the metabolism of a drug] with [his/her] PTA [prior to admission] medication in the setting of poor renal [kidney] function." In addition, chest x-ray results reveal "possible pneumonia in the left lung base, very faint and appearance and visible only on the lateral view, therefore equivocal."

Per interview on 12/21/23 at 9:07 AM, the Director of Nursing/Infection Preventionist explained that Resident #50 did not receive an influenza vaccine because s/he was on antibiotics and staff have been instructed not to vaccinate residents that are taking antibiotics.

Per interview on 12/26/23 at approximately 9:30 AM, the Attending Physician stated that being on antibiotics is not a contraindication to receive

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vaccinations.

2. Record review reveals that Resident #270, who is 66 years old, was admitted to the facility on 12/6/23 with diagnoses that include cerebral infarction (stroke), diabetes, and asthma. Resident #270 is considered high risk for influenza complications because of his/her age, diagnoses, and nursing home admission. Resident #270 also resides on a unit at the facility where there is an active case of influenza.

An undated form titled "Vaccination Review: Consent/Declination Resident Form," entered into Resident #270's medical record with the effective date of 12/6/23, reveals that his/her vaccination history was assessed for influenza, Covid-19, and pneumococcal. The form indicates that s/he did not receive a 2023 influenza vaccine. Under "decision" to vaccinate, the choices "not eligible," "consented," and "declined" are all left blank. The resident, nor their representative, did not sign off that they were provided education or that they consented or declined the administration of the influenza vaccine. There is no evidence that Resident #270 received the influenza vaccine in his/her medical record or that s/he had a medical contraindication to receive the vaccine.

3. Per record review, Resident #87, who is 76 years old, was admitted to the facility on 11/21/23 with diagnoses that include COPD (Chronic Obstructive Pulmonary Disease), diabetes, heart disease, and kidney disease. Resident #87 is considered high risk for influenza complications because of his/her age, diagnoses, and nursing home admission. Resident #87 also resides on a unit at the facility where there is an active case of influenza.

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F 883	Continued From page 121 A form titled "Vaccination Review: Consent/Declination Resident Form," dated 12/14/23, reveals that Resident #87 vaccination history was assessed for influenza, Covid-19, and pneumococcal. The form indicates that s/he did not receive a 2023 influenza vaccine. Under "decision" to vaccinate, the choices "not eligible," "consented," and "declined" are all left blank. There is no evidence that Resident #87 received the influenza vaccine in his/her medical record or that s/he had a medical contraindication to receive the vaccine. Per interview on 12/26/23 at approximately 1:45 PM, the Director of Nursing/Infection Preventionist was unable to determine why Residents #270 and #87 did not receive the influenza vaccine by looking at their vaccination review forms.	F 883		
F 887 SS=E	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 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	F 887	See Attached **Tag F 887 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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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 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

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Healthcare Safety Network (NHSN).
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure that 3 eligible residents (Residents #50, #271, and #37) on one unit received the COVID-19 vaccine.

1. Per record review, Resident #50, who is 60 years old, was admitted to the facility on 11/20/23 with diagnoses that include diabetes and severe kidney disease. Resident #50 is considered high risk for COVID-19 complications because of his/her diagnoses and age.

An undated form titled "Vaccination Review: Consent/Declination Resident Form," entered into Resident #50's medical record with the effective date of 11/20/23, reveals that his/her vaccination history was assessed for influenza, COVID-19, and pneumococcal. The form indicates that s/he did not receive a 2023 COVID-19 vaccine. Under "decision" to vaccinate, the choices "not eligible," "consented," and "declined" are all left blank. The resident, nor their representative, did not sign off that they were provided education or that they consented or declined the administration of the COVID-19 vaccine. There is no evidence that Resident #50 received the COVID-19 vaccine in his/her medical record or that s/he had a medical contraindication to receive the vaccine.

Per interview on 12/21/23 at 9:07 AM, the Director of Nursing/Infection Preventionist explained that Resident #50 did not receive a COVID-19 vaccine because s/he was on antibiotics and staff have been instructed not to vaccinate residents that are taking antibiotics.

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Per interview on 12/26/23 at approximately 9:30 AM, the Attending Physician stated that being on antibiotics is not a contraindication to receive vaccinations.

2. Per record review, Resident #271, who is 78 years old, was admitted to the facility on 11/17/23 with diagnoses that include diabetes and severe kidney disease. Resident #271 is considered high risk for COVID-19 complications because of his/her diagnoses and age.

A form titled "Vaccination Review: Consent/Declination Resident Form," dated of 11/17/23, reveals that Resident #217's vaccination history was assessed for influenza, COVID-19, and pneumococcal. The form indicates that s/he did not receive a 2023 COVID-19 vaccine. Under "decision" to vaccinate, the choices "not eligible," "consented," and "declined" are all left blank. There is no evidence that Resident #271 received the COVID-19 vaccine in his/her medical record or that s/he had a medical contraindication to receive the vaccine. Resident #217 tested positive for COVID-19 on 11/28/23 and was currently no longer eligible for the vaccine.

3. Per record review, Resident #37, who is 90 years old, was admitted to the facility on 1/4/23 with diagnoses that include kidney disease, reduced mobility, and hypertension. Resident #37 is considered high risk for COVID-19 complications because of his/her diagnoses and age.

Per review of Resident #37's immunization tab in the electronic medical record, Resident #37 did not receive a 2023 COVID-19 vaccine; his/her

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F 887	Continued From page 125 last documented COVID-19 vaccine is 3/20/2022. There is no evidence that Resident #271 or their representative received the COVID-19 vaccine in his/her medical record or that s/he had a medical contraindication to receive the vaccine.	F 887		
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to maintain an effective pest control program that ensures the facility is free of pests. Findings include: 12/17/23 4:10 p.m. On the initial tour of the facility kitchen observed several fruit flies in all sections of the kitchen, including the food prep area, food storage areas, and dishwashing areas. Also during the initial tour observation of a blue light unit mounted on the wall in the kitchen had many trapped flies and fruit flies in the unit. An interview with the facility cook on duty during the initial tour confirms that the fruit flies come from the sink drains and that they need to contact the exterminator for control of these pests. On 12/17/23 at 6:26 p.m. observed during the supper meal tray pass, fruit flies came out of the tray cart that resident's meal trays were on waiting to be passed out. On 12/18/23 at 11:55 a.m. fruit flies were observed in the resident's dining room while the	F 925	See Attached **Tag F 925 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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F 925	Continued From page 126 lunch meal was being served. "Fruit flies are mainly attracted to extra ripe, fermenting fruits and vegetables. However, they are also drawn to things such as drains, garbage disposals, empty bottles and cans, trash bags, cleaning rags, and mops. Essentially, they are drawn to food waste and moist environments" https://www.arrowexterminators.com/learning-center/pest-library/flies/fruit-flies#:~:text 12/20/23 2:30 p.m. during an interview with the Kitchen manager, s/he confirms that fruit flies are a concern, s/he believes they come from the drains, and they are going to "bleach the drains" but an exterminator should also be contacted to resolve the fruit fly problem.	F 925		
F 949 SS=E	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility assessment, the facility failed to ensure that staff had effectively been trained in trauma informed care. Findings include: The facility's Facility Assessment (an assessment that determines what resources are necessary to care for the residents competently during both day-to-day operations and emergencies), last reviewed 10/2/2023, indicates that the facility is able to provide care and services for individuals	F 949	See Attached **Tag F 949 POC accepted on 2/8/2024 by S. Stem/P. Cota**	

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(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
F 949	Continued From page 127	F 949		

with psychiatric mood disorders that include post traumatic stress disorder (PTSD) and behaviors that needs interventions. Section titled "Education/In-services" describes the staff education and training necessary to maintain the level and the types of support and care needed for the resident population. Included in both the general orientation and the annual education program is the topic "behavior stress management."

The trauma informed care education that is incorporated into the general orientation includes 2 basic slides that describe the definition of trauma and general symptoms of trauma, depression, and PTSD. Two additional slides describe reporting general behavior symptoms and a description of using a behavior care path. The competencies for trauma informed care is included in the general orientation quiz; it is one true or false question that asks if behavioral health includes certain disorders.

Per review of the facility Resident Matrix (a Centers for Medicare and Medicaid [CMS] form completed by the facility, used to identify pertinent care areas) dated 12/17/23, 4 residents were identified as having PTSD/Trauma.

While all staff have reviewed the 4 slides that constitute as the facility's trauma informed care in the general orientation once initially hired, it is apparent that these slides are not adequate as multiple staff are either unable to demonstrate knowledge of trauma informed care or state that they have not received trauma informed care education from the facility. On 12/26/23 at approximately 10:40 AM, a LNA (Licensed Nursing Assistant) stated that s/he has not had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475030	A. BUILDING _____ B. WING _____	C 01/11/2024

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ELDERWOOD AT BURLINGTON	98 STARR FARM RD BURLINGTON, VT 05408

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F 949	Continued From page 128 training specific to trauma informed care. On 12/26/23 at 11:27 AM, a LNA stated that s/he has not had trauma informed care training. On 12/26/23 at 12:05 PM, an LNA stated that s/he does not know what trauma informed care is. On 12/26/23 at 12:10 PM, an LNA stated that s/he does not know what trauma informed care is. On 12/26/23 at 12:30 PM, an LPN (Licensed Practical Nurse) stated that s/he has not had trauma informed care training from the facility. On 12/26/23 at 4:17 PM, the Staff Educator confirmed that the trauma informed care training that is included in the general orientation is the only current trauma informed care offered to staff and it is not sufficient education for staff to meet the needs of residents that have a history of trauma.	F 949		

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S321 SS=F	7.13 (d)(2) QUALITY OF CARE - STAFFING LEVELS 7.13 (d)(2) The facility shall provide staffing information to the licensing agency in a manner and on a schedule prescribed by the licensing agency. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to maintain the required minimum staffing levels to allow for 2.0 hours of direct care per resident per day (PPD) on a weekly average by Licensed Nursing Assistants (LNAs) for 7 of the 8 sampled weeks and failed to maintain required minimum staffing levels to allow for 3.0 hours of direct care per resident per day (PPD) on a weekly average, including nursing care, personal care, and restorative nursing care for 4 of 8 sampled weeks. Findings include: Per review of the daily nursing PPD hours, the average direct care PPD by LNA staff was below the required 2 hours per day minimum during the following weeks in October, November, and December 2023: 10/21/23 -10/28/23 = 1.93 11/1/23 -11/7/23 = 1.88 11/8/23 -11/14/23 = 1.82 11/15/23 -11/21/23 = 1.74 11/22/23 -11/28/23 = 1.5 12/1/23 -12/7/23 = 1.43 12/8/23 -12/14/23 = 1.5 Per review of the daily nursing PPD hours, the average direct care PPD by direct care staff, including nursing care, personal care, and	S321	See Attached **Tag S321 POC accepted on 2/8/2024 by S. Stem/P. Cota** DocuSigned by: Isaac Spilman 4CF6A02596A04E9...	

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S321	Continued From page 1 restorative nursing care, was below the required 3 hours per day minimum during the following weeks in November and December 2023: 11/15/23 -11/21/23 = 2.9 11/22/23 -11/28/23 = 2.6 12/1/23 -12/7/23 = 2.77 12/8/23 - 12/14/23 = 2.74 Per an interview on 12/26/23 with the Director of Nursing s/he stated they were aware that the direct care PPD as referenced above did not meet the staffing requirements.	S321		

F550

The corrective action for Resident #5 found to be affected by this alleged deficient practice was the wheelchair was cleaned 12/ 20 /23 immediately and placed on a monthly wheelchair cleaning schedule
To identify other resident potentially affected by this alleged deficient practice the facility conducted an audit of all wheelchairs and cleaned them if they were found to be soiled.
To ensure that the alleged deficient practice does not recur all staff will be educated on the wheelchair cleaning policy and schedule. All wheelchairs currently in use in the facility will be placed on a weekly cleaning schedule.
The corrective action will be monitored through weekly cleanliness audits of all wheelchairs for four weeks then monthly audits of all wheelchairs for a minimum of three months or until substantial compliance is achieved. The audits will be reported to the Quality Assurance Committee at the monthly meetings.
The corrective action for this deficient practice will be completed by 2/14/24
The Administrator/Designee is responsible for this corrective action.

F553
The corrective action for Resident#65 found to be affected by this alleged deficient practice, a careplan meeting will be conducted with resident/resident representative present to participate in the care planning meeting**.**
To identify other residents potentially affected by this alleged deficient practice an audit of all residents care conference schedules was conducted, all residents affected by this alleged deficient practice will have a careplan meeting with resident/resident representative present**.**
To ensure that the alleged deficient practice does not recur the social work department will be educated on Resident Care Plan Review Sessions policy**.** Each resident/resident representative will be contacted by the social work department at the minimum on a quarterly basis, with the care planning meeting date and time, every effort will be made to schedule care conference via a method of communication(ie phone, video conference, in person) and at a time that will allow for resident representative to be present.
The corrective action will be monitored weekly for four weeks them monthly for a minimum of three months through random audits of careplan meeting schedule review, social work notes for notification of resident/resident representative of care plan meeting, and resident/resident representative response to attend care conference meeting to ensure substantial compliance is maintained. The audits will be reported up to the Quality Assurance Committee at scheduled meetings.
The corrective action for this deficient practice will be completed by 2/14/24 The Director of Social Work/Designee is responsible for this corrective action.

F554

The corrective action for Residents #31 and #81 found to be affected by this alleged deficient practice was both residents were assessed for self-administration of medication and found to be unable to perform self-administration, education was provided to the nurse/nurses

who left the meds at bedside.
To identify other residents potentially affected by this alleged deficient practice a Med pass audit will be conducted on all units with each nurse to ensure medication pass is performed as per policy, any deficient practice observed will be corrected immediately.
To ensure that the deficient practice does not recur all nurses will be educated on the medication administration policy and medication self-administration policy**.**
The corrective action will be monitored through monthly medication pass audits on each unit across all shifts for a minimum of three months to ensure substantial compliance is maintained. The monthly audits will be reported to the quality assurance committee at scheduled meetings.
The corrective action for this deficient practice will be completed by 2/14/24
The Director of Nursing/Designee is responsible for this corrective action.

F578

The corrective action to Resident #7 found to be affected by this alleged deficient practice was immediate correction of code status orders in PCC to match the COLST on 12/21/23.
To identify other residents potentially affected by this alleged deficient practice a full house audit of COLST and code status orders in PCC was conducted on 12/21/23. Residents code status's verified and corrected as needed.
To ensure that the alleged deficient practice does not recur all nurses and social work staff will be educated on the advanced directives policy. An audit of all new admission COLST/CODE status will be reviewed at the baseline care plan meeting. All long-term care residents will have their COLST/CODE status reviewed at a minimum at each regulatory visit to ensure accuracy.
This corrective action will be monitored through weekly audits for four weeks then monthly for three months for a minimum of three months to ensure substantial compliance is maintained. The audits will be reported to the Quality assurance committee at the scheduled meeting.
The corrective action for this alleged deficient practice will be completed by 2/14/24. The Director Social Work/designee is responsible for this corrective action

F636

The corrective action for resident #28 found to be affected by this alleged deficient practice was review and revision of the careplan to reflect a behavior/mood care plan focus, the physician was alerted to the depressed state of the resident and med changes made as appropriate. Resident #47's MDS will be corrected to reflect accurate documentation regarding falls. Resident #99 & Resident #1 there is no corrective action both MDS's were appropriately dash filled related to the lack of wound assessment in the look back period**.**
To identify other residents potentially affected by this alleged deficient practice an audit of all MDS's submitted for the past 6 months will be conducted for accuracy and any findings requiring correction will be corrected and resubmitted.
To ensure that the deficient practice does not recur all nurses will be educated on MDS Assessment Process Policy. A pre-submission meeting will be started weekly to review all MDS submissions for accuracy prior to submission.

The corrective action will be monitored through weekly audits to be conducted at the weekly presubmission meeting. This audit will be conducted weekly for four weeks then monthly for a minimum of three months to ensure that substantial compliance is maintained. The audits will be reported to the Quality assurance committee at the scheduled meeting. **The corrective action for this deficient practice will be completed by 2/14/24. The MDS coordinator will be responsible for this corrective action.**

F655

The corrective action for resident #50 found to be affected by this alleged deficient practice was a review and revision of the careplan to reflect the following care plan focuses: skin, nutrition, pain, safety, amputation status, diabetes, and renal failure. Additionally, the careplan was reviewed and revised to incorporate all current health conditions**.**
To identify other residents potentially affected by this alleged deficient practice an audit of all newly admitted resident's care plans admitted from 12/1/23 to present will be conducted by 2/2/24. Any findings will be corrected upon discovery.
To ensure that the deficient practice does not recur nursing, social service, activities, clinical dietary staff, and therapy staff will be educated on the baseline care plan policy. The baseline careplan will be established within 48 hours of admission. The baseline care plan will be reviewed with the resident/resident representative to establish goals of care.
The corrective action will be monitored through weekly audits of baseline careplan meetings and baseline care plan review for four weeks then monthly for a minimum of three months to ensure that substantial compliance is maintained**.** The audits will be reported to the Quality assurance committee at the scheduled meeting.
The corrective action for this alleged deficient practice will be completed by 2/14/24.
The Director of Social Services/designee is responsible for this corrective action.

F656

The corrective action for residents # 111 and #88 found to be affected by this alleged deficient practice was a review and revision of the plan of care to include mood/behavior focus for resident #111 and revision to resident #88 plan of care to include person centered interventions regarding approach related to blindness**.**
To identify other residents potentially affected by this alleged deficient practice a review of all active resident care plans will be conducted and any findings will be corrected upon discovery.
To ensure that the alleged deficient practice does not recur all nursing, social service, activities, clinical dietary staff, and therapy will be educated on the Care Planning IDT policy. All careplans will be reviewed as per regulation quarterly or with any significant change to ensure timely revisions and updated person-centered interventions.
The corrective action will be monitored by monthly care plan audits for a minimum of three months to ensure that substantial compliance is maintained. The audits will be reported to the quality assurance committee at the scheduled meeting**.**

The corrective action for this alleged deficient practice will be completed by 2/14/24. The Director of Nursing /designee is responsible for this corrective action.

F657

The corrective action for resident #47, #24, #69 found to be affected by this alleged deficient practice was a review and revision of the plan of care to include #47 (activity care plan), #24 (humidification plan), #69 (discharge plan of care). Resident #28 care plan had already been revised on 12/17/23. Resident #7, #31, #111, #99, #1, #43, #50, #107, #21 were scheduled for an IDT meeting and care plan review to be completed.
To identify other residents potentially affected by this alleged deficient practice a review of all active resident care plans was conducted by 1/5/24, and findings corrected upon discovery.
To ensure that the alleged deficient practice does not recur all nursing, social service, activities, clinical dietary staff, and therapy will be educated on the Care Planning IDT policy. All careplans will be reviewed as per regulation quarterly or with any significant change to ensure timely revisions and updated person-centered interventions**.**
The corrective action will be monitored by monthly care plan audits for a minimum of three months to ensure substantial compliance is maintained. The audits will be reported to the quality assurance committee at the scheduled meeting**.**
The corrective action for this alleged deficient practice will be completed by 2/14/24. The Director of Nursing/designee is responsible for this corrective action.

F658

The corrective action for resident #28 found to be affected by the alleged deficient practice was already addressed with the care plan revision on 12/17/23.
To identify other residents potentially affected by this alleged deficient practice an audit of all resident to resident altercations from 12/1/23 to present will be conducted by to ensure care plan review and revision was completed. Any findings will be corrected upon discovery
To ensure that the alleged deficient practice does not recur all staff will be educated on the abuse reporting policy. All allegations of resident-to-resident altercations and disruptive resident behaviors will be discussed with the IDT in morning meeting. Any resident-to-resident allegation or disruptive behaviors will have follow up from the social work team within 48 to 72 hours to evaluate psychosocial wellbeing for all involved
residents.
The corrective action will be monitored by weekly audits of any allegations of resident abuse or disruptive behaviors for four weeks then monthly for a minimum of three months to ensure substantial compliance is maintained. The audits will be reported up to the quality assurance committee at the schedule meeting.
The corrective action for this deficient practice will be completed by 2/14/24.The Director of Social Services/Designee is responsible for this corrective action.

F677

The corrective action for residents identified: Resident # 111 – The resident was interviewed, and it was determined that the resident's preference was to be showered 3 per week and the care

plan/tasks were updated. Resident #7 - Discharged on 12/31/23. **Resident #269 – On 12/18/23,** the resident's brief was changed, and they received care as planned. The resident was interviewed, and it was determined that the resident prefers bed baths weekly, preference was updated on 2/1/24. The care plan and LNA task documentation were updated**.**
To identify other residents potentially affected by this alleged deficient practice the facility will review shower preferences for every resident and update care plans and LNA tasks as appropriate.
To ensure that the alleged deficient practice does not recur all staff will be educated on the facilities policy title Bath, Tub/Shower which indicates that the residents preferences for showers will be care planned and honored.
The corrective action will be monitored by weekly shower audits for four weeks then monthly for a minimum of three months to ensure that substantial compliance is maintained. The audits will be reported to the quality assurance committee at the scheduled meeting.

The corrective action for this alleged deficient practice will be completed by 2/14/24. The Director of Nursing/Designee is responsible for this corrective action.

F679

The corrective action for residents identified: Resident #65's activity care plan was reviewed and revised as required, based on the residents' preferences on 2/1/24.
All residents have the potential to be impacted by this alleged deficient practice.
To ensure that the alleged deficient practice does not recur all activity staff will be educated on the facilities policy titled Activity Care Standards, which outlines providing ongoing programs of meaningful activities designated to meet in accordance with the assessment, interests, physical, cognitive, and psychosocial wellbeing of each resident**.**
The corrective action will be monitored by completing activity participation audits weekly for 4 weeks and then monthly for a minimum of three months to ensure that substantial compliance is maintained. The audits will be reported to the quality assurance committee at the schedule meeting**. The corrective action for this deficient practice will be completed by 2/14/24. The Director of Activities/Designee is responsible for this corrective action.**

F686

The corrective action for residents identified: #50: was assessed on 1/4/24 and treatment order updated, Resident #7: discharged from the facility on 12/31/23, Resident #1: was assessed on 12/28/23 and treatment order reviewed, Resident #99: was assessed on 1/4/24 and treatment reviewed and updated, #43: was assessed on 12/21/23 and treatment order updated, #21: was assessed on 1/17/24 and the wound was healed. #107: was assessed on 12/21/23 and treatment orders updated. Care plans were reviewed and updated if indicated for each resident. Resident #7: discharged from the facility on 12/31/23

All residents with skin alterations have the potential to be impacted by this alleged deficient practice. The facility will conduct skin evaluations on every resident to ensure all skin

conditions are accurately captured and documented by 2/10/24. Once identified, treatments and care plans will be reviewed and/or revised as required**.**

To ensure that the alleged deficient practice does not recur all nursing staff will be reeducated on the revised facilities policy titled: Pressure Ulcer, Pressure Injury & Other Skin Conditions: Initial Assessment, Care Planning, Ongoing Evaluation and Management (BUR, HAM, LIV, SS, WAV, WMS) SNF. Education will be focused on the following: Wound Risk Assessments, Care Planning, Interventions, Wound Assessments, Wound Documentation, Wound Treatments. Weekly wound rounds have been established to ensure treatment and services to prevent pressure ulcers are being followed.
The corrective action will be monitored by completing wound audits weekly then monthly for a minimum of three months to ensure that substantial compliance is maintained. The audits will be reported to the quality assurance committee at the schedules meeting**. The corrective action for this alleged deficient practice will be completed by 2/14/24. The Director of Nursing/ Designee is responsible for this corrective action.**

F688

The corrective action for resident's #81 and 43 is to educate all nursing staff assigned to their care, on their range of motion program.

All residents with a ROM program has the potential to be affected by this alleged deficient practice. The facility will conduct an audit to identify all residents with active ROM programs in place.

To ensure that this alleged deficient practice does not recur, all LNA staff will be re-educated on the Range of Motion Program for each resident. DOR will complete weekly audits of POC documentation will be completed to ensure that care is being provided as care planned**.**

The corrective action will be monitored through audits completed weekly for four weeks and then monthly of for a minimum of three months to ensure substantial compliance is maintained and all results will be reported to the Quality Assurance Committee at the scheduled meeting**.**

The corrective action for this alleged deficient practice will be completed by 2/14/24. The Director of rehab services/designee will be responsible for this corrective action.

F689

The corrective action for this alleged deficient practice included immediately removing Resident# 5's cord to her concentrator away from near the heat vent on 12/18/23. Resident # 47 has discharged from the facility on 1/16/2024.

All residents have the potential to be affected by this alleged deficient practice.

To ensure that this alleged deficient practice does not recur, an audit will be completed of all resident areas to ensure they are without potential hazards. A review of all residents falls within the last 30 days will be completed and therapy screens will be reviewed for recommended

interventions. The IDT will discuss each fall and proposed intervention, the care plans will be reviewed and updated as appropriate. The IDT will document the review and updates made in the resident record. Morse Scale assessments of all residents that were completed in the last week will be reviewed for fall risk and be care planned as appropriate.

To ensure this alleged deficient practice does not recur, the IDT team will review falls daily at morning team meeting, the care plan will be reveiwed and updates as needed, and a progress note will be enterred into the resident record.

This corrective action will be monitored through weekly audits of all falls to ensure that recommended interventions are reviewed with the IDT team and entered into the care plan as appropriate, and documentation of the IDT meeting is entered into the resident record. These audits will be conducted weekly for four weeks, then monthly for three months to ensure substantial compliance is maintained all results will be reported to the Quality Assurance Committee at the scheduled meeting**. The corrective action for this alleged deficiency will be completed by 2/14/24. The DON/designee will be responsible for this corrective action.**

F690

The corrective action for Resident #31, whos was found to be affected by this alleged deficient practice included adding a task to POC to include Foley output and to compete urinary catheter care every shift.

To identify other residents potentially affected by this alleged deficient practice, an audit of all residents with indwelling catheters will be completed to ensure a task for catheter care completion and for output is present in POC.

To ensure the deficient practice does not recur, Education will be provided to all nursing staff on completion of catheter care and on obtaining catheter output and documentation in POC.

This corrective action will be monitored by audits of the POC documentation with audits to be conducted weekly for four weeks and then monthly for three months to ensure substantial compliance is maintained and all results will be reported to the Quality Assurance Committee at the scheduled meeting**.**

The corrective action for this plan of correction will be completed by 2/14/2024. DON/Designee will be responsible for this corrective action.

F691

The Resident #7 affected by this alleged deficient practice discharged on 12/31/23.

To identify others potentially affected by this alleged deficient practice, an audit of all residents was completed on 1/30/24 to identify residents with urostomies, There were no additional residents identified.

To ensure that this alleged deficient practice does not recur, all nurses and LNAs will be re-educated on urostomy care, output collection, bag changes and appropriate documentation of same in the resident record. An audit will be completed weekly to ensure that care is being provided as ordered for any new admissions with Urostomies.

To monitor compliance of this corrective action, audit of all identified residents care record will be completed weekly for 4 weeks and then monthly for 3 months to ensure substantial compliance is maintained and all results will be reported to the Quality Assurance Committee at the scheduled meeting.

The corrective action for this alleged deficient practice will be completed by 2/14/24. The Director of nursing or Designee will be responsible for this corrective action.

F692

The corrective action for the resident #92 who was found to be affected, a review of his weights and nutritional status by the medical provider and dietitian was completed.

To identify other residents potentially affected by this alleged deficient practice, the weights of all residents will be reviewed for weight loss and unplanned weight loss of 5% will be reported to the provider for review.

To ensure that this alleged deficient practice does not recur, education will be provided to nursing staff on documentation of nutritional intake for all residents including refusals, recording weights as ordered into the medical record or refusals and reapproaching a resident if weight or meal is refused according to policy, timely reporting of weight changes to the provider and documentation of the same. Daily/weekly audits will be completed to review meal intakes for all residents and documentation of refusals and the provider will be updated as appropriate.

This corrective action will be monitored through weekly audits x4 and then monthly audits x3 months to ensure substantial compliance is maintained and all results will be reported to the Quality Assurance Committee at the scheduled meeting.

This corrective action will be completed by 2/14/24. The Dietitian/Director of Nursing or Designee will be responsible for this corrective action.

F695

The corrective action for resident #23 was a review of the record with pulmonologist and medical provider which was completed on 12/27/23. Resident #23 was restarted on CPap with CPap settings. Resident #66, oxygen orders were verified with the medical provider on 2/1/24.

To identify other residents potentially affected, an audit of all CPAP/BIPAP machines will be verified against the orders to ensure they are correct and an review of all resident oxygen orders will be completed and an audit completed to verify use. Any discrepancies will be brought to the providers attention and rectified.

To ensure this alleged deficient practice does not recur, all nurses will be educated on CPap and BiPap identification and use. All nurses will be educated on administration of oxygen per provider orders.

This corrective action will be monitored through audits of CPap/BiPap administration and oxygen Administration to be completed weekly x4 and then monthly x3 to ensure substantial compliance is maintained and all results will be reported to the Quality Assurance Committee at the scheduled meeting.

This corrective action will be completed on 2/14/24. The Director of Nursing /Designee will be responsible for this corrective action.

F697

Resident #7 discharged on 12/31/23.

To identify other residents potentially affected by this alleged deficient practice, all residents or resident representative will be assessed for resident acceptable level of pain. A review of the pain levels for the past 7 days for all residents will be reviewed and any residents who are found to have uncontrolled pain will be reviewed by the provider.

To ensure that this alleged deficient practice does not continue, all nurses will be educated on the Medication administration policy and the pain management policy.

This corrective action will be monitored through shiftly audits of the MAR for medications not given and weekly random audits for pain levels x4 weeks then monthly x3 months to ensure substantial compliance is maintained and all results will be reported to the Quality Assurance Committee at the scheduled meeting.

The corrective action for this alleged deficient practice will be completed by 2/14/24.

The Director of Nursing /designee will be responsible for this corrective action.

F710

The corrective action for the resident #92 who was found to be affected, has continued to refuse to have his weights obtained, he was seen by the medical provider on 1/17/24, 1/24/24

To identify other residents potentially affected by this alleged deficient practice, the weights of all residents will be reviewed for weight loss and unplanned weight loss of 5 % will be reported to the provider for review.

To ensure that this alleged deficient practice does not recur, education will be provided to nursing staff on reporting of weight changes to the provider. Weekly /monthly audits will be completed to review weights for all residents and unplanned weight changes of 5% or greater will be reported to the medical provider.

This corrective action will be monitored through weekly audits x4 and then monthly audits x3 months to ensure substantial compliance is maintained and all results will be reported to the Quality Assurance Committee at the scheduled meeting.

This corrective action will be completed by 2/14/24. The Director of Nursing or Designee will be responsible for this corrective action.

F711

The corrective action for this alleged deficient practice was an updated regulatory visit for those residents found to be affected, #31, #111, #99, #1, #43, #50, #107 and #21, to a reveiw of their total plan of care by a medical provider to include the residents progress and problems in maintaining or improving their physical , mental and psychological well-being and decisions about the continued appropriateness of their current medical regimen. Resident # 7 discharged on 12/31/23.

To identify other residents potentially affected, a review of regulatory visits for the last 30 days will be completed, and any residents found to be affected will have an updated regulatory visit conducted to review their total plan of care.

To ensure this alleged deficient practice does not recur, education will be provided to medical providers regarding regulatory visit requirements. Weekly audits will be completed to review the documented regulatory notes for compliance and any deficiencies will be rectified.

This corrective action will be monitored through weekly audits of the regulatory visits for compliance. Audits will be completed weekly X4 weeks and then monthly x3 months to ensure substantial compliance is maintained and all results will be reported to the Quality Assurance Committee at the scheduled meeting.

The corrective action for this alleged deficient practice will be completed by 2/14/24. The Director of Nursing/Designee will be responsible for this corrective action.

F725

The corrective action for this alleged deficient practice was review of the daily PPD for the last 30 days to ensure that the PPD was not less than 3.0.

To identify other potentially alleged deficient practice, a daily audit will be completed for the last 30 days to review the daily PPD.

To ensure this alleged deficient practice does not recur, an audit of the daily PPD will be completed daily. Supplemented staffing and shifting of responsibilities to areas of need will be implemented when indicated. (i.e. Nurses working as LNAs, therapist providing ADL care). Recruitment of staff will continue with weekly recruitment and retention IDT meetings. Facility will recruit for staff as needed to maintain staffing levels of no less than 3.0 daily.

The corrective action will be monitored through auditing of daily PPD daily for 4 weeks and then weekly for 3 months to ensure substantial compliance is maintained. Audits will be reported to the Quality Assurance Committee at the scheduled meeting.

The corrective action for this alleged deficient practice will be completed by 2/14/24. The Director of Nursing/Designee is responsible for this corrective action.

F726

The corrective action for this alleged deficient practice was a review of all licensed staff competencies.

All residents have the potential to be affected by this alleged deficient practice.

To ensure that this alleged deficient practice does not recur, all licensed staff will be educated, and appropriate competencies will be completed. All newly hired staff will not be allowed to work on the units until the competencies have been completed. A Nurse Educator will be hired to assist with and ensure that competencies are completed on hire and annually.

This corrective action will be monitored through audits of all newly hired staff competencies which will be reviewed for completion prior to assuming an assignment and all current staff competencies will be reviewed annually and completion verified. Audits will be completed weekly for 4 weeks and then monthly for 3 months to ensure substantial compliance is maintained and all results will be reported to the Quality Assurance Committee at the scheduled meeting.

This plan of Correction will be completed by 2/14/24. The Director of Nursing/designee will be responsible for the corrective action.

F755

The corrective action for residents # 7 and #52 who were found to be affected by this alleged deficient practice were discharged from the facility on 12/31/23 and 1/30/24 respectively. An audit was completed for Residents # 102 and #81 medications to ensure their medications were available for and being administered.

To identify other residents potentially affected by this alleged deficient practice, an audit will be completed for all residents to ensure that all medications are currently on hand. Pharmacy will be notified of any missing medications and all medications will be reordered immediately. The provider and DON will be notified immediately and if appropriate an alternate order obtained.

To ensure the alleged deficient practice does not recur, all nursing staff will be re-educated on the Medication Administration Reportable Problems Policy and Medications Held, Refused or Not Available Policy as well as re-ordering of medications and protocol to notify the pharmacy, Provider, unit manager, and DON of medications that are unavailable, and obtaining an alternate order from the provider as appropriate.

The corrective action will be monitored by shiftily audits of MAR/TARs for missing/unavailable medications and documentation of notification to the pharmacy to obtain the medication and notification of the provider to obtain new orders as appropriate. All deficiencies will be immediately rectified through receipt of medication or new order. Audits will be completed each shift x 4 weeks then daily X 3 months to ensure substantial compliance is

maintained and all results will be reported to the Quality Assurance Committee at the scheduled meeting.

The corrective action for this deficient practice will be completed by 2/14/24. The Director of Nursing is responsible for this corrective action.

F757

The corrective action for Resident # 23 who was affected by this alleged deficient practice was seen by the physician who started the Prednisone taper and antibiotic. A review of the medications was completed and prednisone taper began on 1/26/24. The resident is receiving the antibiotic as ordered.

To identify other residents potentially affected by this alleged deficient practice, an audit of all residents receiving antibiotics will be conducted to ensure they are necessary and being administered in accordance with physician orders.

To ensure this alleged deficient practice does not recur, random audits of antibiotic medication orders will be conducted, and all nurses will be educated regarding avoidance of unnecessary medications.

To monitor this corrective action, random audits will be conducted weekly times four weeks and then monthly times 3 months.

Results of these audits will be brought to the Quality Assurance Committee during scheduled meetings.

The corrective action will be completed by 2/14/24. The Director of Nursing or Designee will be responsible for this corrective action.

F760

The residents # 7 and #52 found to be affected by this alleged deficient practice were discharged from the facility on 12/31/23 and 1/30/24 respectively.

To identify other residents potentially affected by this alleged deficient practice, an audit will be completed for all residents to ensure that all medications are currently on hand. Pharmacy will be notified of any missing medications and all medications will be reordered immediately. The provider and DON will be notified immediately and if appropriate an alternate order obtained.

To ensure the alleged deficient practice does not recur, all nursing staff will be re-educated on re-ordering of medications and protocol to notify the pharmacy, Provider, unit manager, and DON of medications that are unavailable, obtaining an alternate order from the provider as appropriate, increased monitoring of pain and/or behavioral symptoms. All nursing staff will be re-educated on completing the appropriate pain assessment tool and required notification to the provider for unmanaged pain. All nursing staff will be re-educated on recognition of change in behavioral symptoms and required notification to the provider for changes.

The corrective action will be monitored by shiftily audits of MAR/TARs for missing/unavailable medications and documentation of notification to the pharmacy to obtain the medication and notification of the provider to obtain new orders as appropriate. All deficiencies will be immediately rectified through receipt of medication or new order, and residents monitored for increased pain or behavioral symptoms as appropriate. Audits will be completed Seach shift x 4 weeks then daily X 3 months to ensure substantial compliance is maintained and all results will be reported to the Quality Assurance Committee at the scheduled meeting.

The corrective action for this alleged deficient practice will be completed by 2/ 14/24. The Director of Nursing is responsible for this corrective action.

F761

The corrective action for this alleged deficient practice was locking of the cart. An audit was completed on 12/20/24 of all med rooms and carts and all expired medications and biologicals were removed if found. The medications for residents # 31 and # 81 were removed from the bedside and residents will be assessed for appropriateness for self-administration. If appropriate, orders will be obtained, and care plan will be updated and residents will be educated on storage and reporting of use.

To identify other residents potentially affected by this alleged deficient practice, an audit of resident's rooms will be completed to identify if any medications left at the bedside and remove for those not assessed for self-administration. If appropriate, residents will be assessed for sef-administration of medication, orders obtained from the provider and care plan updated.

To ensure the deficient practice does not recur, all nurses will be re-educated on Medication storage and self- administration of medication policy.

The corrective action will be monitored by Weekly random audits will be completed to ensure medications are properly stored, unsupervised carts are locked, and no medications are left at the bedside as appropriate. Audits will be completed weekly x4 then monthly x3 to ensure substantial compliance is maintained and all results will be reported to the Quality Assurance Committee at the scheduled meeting**.**

The corrective action will be completed by 2/14/24. The Director of Nursing or designee will be responsible for this plan of correction.

F812

The corrective action for this alleged deficient practice was to remove the milk crate(s) off the floor, the celery, watermelon, and creamers were immediately thrown out, the debris on the floor was removed, the frozen food item was thrown out and the stacked boxes were re-stacked

to an appropriate height. The dishwasher temperature will be obtained daily to ensure it is within range.

To identify additional areas of potential deficient practice, a compliance audit was completed of storage areas, to include audit of food conditions and labeling of opened/perishable foods, and food expiration dates.

To ensure this alleged deficient practice does not recur all food service staff will be educated on food storage.

This corrective action will be monitored by daily audits for food storage, food quality, expiration dates, and temperature logs for the dishwasher daily x 30 days then weekly x 3 months to ensure substantial compliance is maintained and all results will be reported to the Quality Assurance Committee at the scheduled meeting.

The corrective action for this alleged deficient practice will be completed by 2/14/24. The Director of Dietary/Designee will be responsible for this plan of correction.

F841

The corrective action for this alleged deficient practice is the review of the regulatory requirements for medical directors, the Medical Director Agreement, Medical Director facility Policy, and wound management policy with the Medical Director. A review will be completed of the total plan of care and care plan for the 7 residents identified by the Medical Director/Attending Physician and IDT and updated as appropriate.

To Identify other residents potentially affected by the same alleged deficient practice, an audit will be completed of all residents plan of care documentation for the past 30 days to ensure that regulatory requirements to include a contribution by the MD into the development and/or revision of the care plans and a review and documentation of the total plan of care were completed. Any deficient findings will be addressed immediately.

To ensure that this alleged deficient practice does not recur, policy updates will be reviewed at scheduled Quality Assurance meetings and recommendations for revisions will be brought to the policy procedure committee for review and update.

This corrective action will be monitored through audits of documented regulatory visits and care conference meetings to ensure that regulatory requirements are met weekly for 4 weeks then monthly for 3 months to ensure substantial compliance is maintained and all results will be reported to the Quality Assurance Committee at the scheduled meeting**.**

The corrective action for this alleged deficient practice will be completed by 2/14 /24. The Director of Nursing or designee will be responsible for this plan of correction.

F849

Resident #69 discharged on 1/25/24.

To identify other residents having the potential to be affected by the same alleged deficient practice, A review of the plan of care for all residents receiving Hospice services will be completed in collaboration with the hospice provider and the plan of care will be updated as appropriate to ensure it reflects coordinated care between the two providers.

To ensure that this alleged deficient practice does not recur, IDT members who are designated to work with hospice representatives will be educated on the collaborative process. A review of the plan of care in collaboration with the hospice provider will be completed weekly or with any significant change to ensure it reflects the most current plan of coordinated care.

This corrective action will be monitored through weekly audits of the plan of care for 4 weeks then monthly for 3 months to ensure substantial compliance is maintained and all results will be reported to the Quality Assurance Committee at the scheduled meeting.

The corrective action for this corrective will be completed by 2/14 /24. The Director of Nursing or designee is responsible for this plan of correction.

F880 Infection Prevention & Control Plan of Correction

Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

PPE Usage

The Therapy Staff Member and the Speech Therapist identified using PPE improperly were verbally counseled at the time of observation and will be formally reeducated on the proper use of PPE.

Hand Hygiene

The RN observed practicing improper hand hygiene and improper handling of medications was verbally counselled and will be formally reeducated on proper hand hygiene during medication administration.

Respiratory Equipment

Resident #69, Resident #5, and Resident #3's Treatment Administration Records were revised to include new orders and direction to licensed nurses to ensure respiratory equipment are properly cleaned per the facilities policy. Orders now include

the following:

• Apply CPAP or BIPAP at bedtime, monitor placement and usage at appropriate settings and remove in AM.

• Check tubing for leaks every shift while in use.

• Wipe the outside of the device with a cloth slightly dampened with water and a mild detergent, clean tubing, and mask with a

solution of warm water and a mild detergent, rinse thoroughly and air dry.

• Clean & Replace filter (Q7 for an external filter or Q30 days of an internal filter) and as needed.

Identifying other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

PPE Usage

All residents requiring transmission-based precautions have the potential of being impacted by the same deficient practice of improper PPE use.

Hand Hygiene

All residents receiving medication have the potential of being impacted by the same deficient practice of staff failing to perform proper hand hygiene during medication administration.

Respiratory Equipment

All residents requiring the use of a CPAP or BIPAP have the potential of being impacted by the same deficient practice of not properly cleaning these respiratory devices. Those residents were identified, and new Treatment Administration Records were revised to include

new orders and directions to licensed nurses to ensure respiratory equipment are properly cleaned per the facilities policy. Orders now

include the following:

• Apply CPAP or BIPAP at bedtime, monitor placement and usage at appropriate settings and remove in AM.

• Check tubing for leaks every shift while in use.

• Wipe the outside of the device with a cloth slightly dampened with water and a mild detergent, clean tubing, and mask with a

solution of warm water and a mild detergent, rinse thoroughly and air dry.

• Clean & Replace filter (Q7 for an external filter or Q30 days of an internal filter) and as needed.

Measures that will be put in place or systemic changes will be made to ensure that the deficient practice does not recur.

The facilities QAPI team conducted a RCA on 1/25/24 discussing the lack of proper PPE use, breaches in infection control during medication administration and the lack of cleaning of respiratory equipment. The below measures were developed as a result of that analysis and identification of contributing factors.

PPE Usage

All staff using PPE at the facility will be re-educated on proper procedures and use of PPE to prevent the spread of infection.

The training will review the facility policy titled, “Transmission Based Precaution Levels (Type of Infectious Condition, Techniques and Documentation)” and demonstrate the correct sequence for applying and removing personal protective equipment (PPE)including basic face mask wearing.

Hand Hygiene

The facilities policy titled “Medication Administration Methods” was revised on 1/25/24 to include medications that will not be handled with bare hands.

All nurses with responsibilities of administering medications will be reeducated on the facilities policy and will receive training on proper infection control procedures and hand hygiene requirements when administering medications which include, handwashing before and after administering medications to a resident and that medications are not to be handled with bare hands to prevent the spread of infectious organisms.

Respiratory Equipment

The electronic medical record system’s batch orders for CPAP and BIPAP will be revised to include exact cleaning directions.

All nurses responsible for entering nursing orders into the electronic medical record system will be educated on the use of batch orders for order entry. All nurses with the responsibility for the maintenance of and monitoring of respiratory equipment will be

reeducated on the facility policy titled “Bi-level Positive Airway Pressure (BiPAP) and Continuous Positive Airway Pressure (CPAP)” and education about cleaning of all respiratory equipment to ensure a sanitary environment to prevent the spread of infectious organisms.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur.

PPE Usage

Three Transmission-Based Precautions Healthcare Personnel (HCP) Observation Tools will be completed weekly x 60 days to ensure the deficient practice will not recur.

Hand Hygiene

Three Infection Control Medication Administration Observations will be completed weekly x 60 days to ensure the deficient practice will not occur**.**

Respiratory Equipment

A new audit tool will be created to monitor the following items: Proper nursing orders are present in the medical record, documentation is present indicating cleaning has been done, equipment observations for cleanliness and staff interviews and/or observations to ensure staff

competency and knowledge of proper cleaning procedures. This audit tool will be completed monthly for every resident who requires the use of a CPAP or BIPAP x 90 days**.**

Date of correction and the title of the person responsible for correction

The Director of Nursing is responsible for the plan of correction by 2/14/24. Corrective measures and results of auditing will be reported to the QAPI at the scheduled meeting.

F880DPOC

Training Plan & Outline

Tag: F880 Infection Prevention & Control

PPE Usage

All staff using PPE at the facility will be re-educated on proper procedures and use of PPE to prevent the spread of infection.

The training will review the facility policy titled, "Transmission Based Precaution Levels (Type of Infectious Condition, Techniques and Documentation)" and demonstrate the correct sequence for applying and removing personal protective equipment (PPE) including basic face mask wearing.

Materials:

• Transmission Based Precaution Levels (Type of Infectious Condition, Techniques and Documentation)

• CDC's applying and removing personal protective equipment (PPE) worksheet.

Hand Hygiene

The facilities policy titled "Medication Administration Methods" was revised on 1/25/24 to include medications that will not be handled with bare hands.

All nurses with responsibilities of administering medications will be reeducated on the facilities policy and will receive training on proper infection control procedures and hand hygiene requirements when administering medications which include, hand washing before and after administering medications to a resident and that medications are not to be handled with bare hands to prevent the spread of infectious organisms.

Materials:

• Medication Administration Methods Policy

Respiratory Equipment

The electronic medical record system's batch orders for CPAP and BIPAP will be revised to include exact cleaning directions.

All nurses responsible for entering nursing orders into the electronic medical record system will be educated on the use of batch orders for order entry. All nurses with the responsibility for the maintenance of and monitoring of respiratory equipment will be reeducated on the facility policy titled “Bi-level Positive Airway Pressure (BiPAP) and Continuous Positive Airway Pressure (CPAP)” and education about cleaning of all respiratory equipment to ensure a sanitary environment to prevent the spread of infectious organisms.

Materials:

• Bi-level Positive Airway Pressure (BiPAP) and Continuous Positive Airway Pressure (CPAP)

Instruction Methods:

• Power Point outlining key points

• In-person conducted by the Director of Nursing, or her designee

Date of Completion

• 2/14/24

F883

The corrective action for resident # 50, #270, and # 87 was a review of their vaccination record to verify eligibility for the Influenza Vaccination. Resident #270 and/or resident representative were educated regarding the risk and benefits of receiving the vaccination. Resident #270 declined vaccination on1/4/24.. Documentation of education and declination was entered in the resident record. Resident #87 discharged on 12/29/23. Resident #50 discharged on 1/22/24.

To identify other residents having the potential to be affected by the same alleged deficient practice, an audit of all resident Influenza Vaccination status was completed on 2/1/24. For any residents identified, education will be provided to each resident and/or their representative regarding the risk and benefit of vaccination for Influenza. Consents or declinations will be obtained for all residents for vaccination and vaccination will be completed for all residents who consented by 2/14/24. Documentation of education, consent or declination and vaccination administration will be entered into each resident record.

To ensure that this alleged deficient practice does not recur, all nurses will be re-educated on protocols for vaccination. The nurse manager/designee will audit the record for vaccination status on all new admissions. For those who are eligible for vaccination, education will be provided to the resident and/or responsible party regarding the risk and benefit for vaccination, consent or declination will be obtained, if consented to, vaccination will be administered and documentation of education, consent or declination and administration will be entered into the resident record.

This corrective action will be monitored through an audit of all new admissions vaccination status within 7 days of admission weekly for 4 weeks then monthly for 3 months to ensure

substantial compliance is maintained. Audits will be reported the Quality assurance committee at the scheduled meeting

The corrective action for this plan of correction will be achieved by 2/14 /24. The Director of Nursing /Designee is responsible for this plan of correction.

F887

The corrective action for resident # 50, #271, and # 37 was a review of their vaccination record to verify eligibility for the Covid 19 immunization. Resident #37 and/or resident representative was educated regarding the risk and benefits of receiving the immunization. Consent/Declination was obtained for immunization. Documentation of education, consent or declination and immunization administration was placed in each residents record. Resident #50 discharged on 1/22/24. Resident #271 discharged on 12/19/23.

To identify other residents having the potential to be affected by the same alleged deficient practice, an audit of all resident Covid19 immunization status will be completed. For any residents found to be affected, education will be provided to each resident and/or their representative regarding the risk and benefit of immunization for Covid 19. Consents or declinations will be obtained for all residents for immunization and immunizations will be completed for all residents who consented by 2/14/24. Documentation of education, consent or declination and immunization administration will be entered into each resident record.

To ensure that this alleged deficient practice does not recur all nurses will be re-educated on protocols for immunization. The nurse manager/designee will audit the record for immunization status on all new admissions. For those who are eligible for immunization, education will be provided to the resident and/or responsible party regarding the risk and benefit for immunization, consent or declination will be obtained, if consented to, immunization will be administered and documentation of education, consent or declination and administration will be entered into the resident record.

This corrective action will be monitored through an audit of all new admissions immunization status within 7 days of admission weekly for 4 weeks then monthly for 3 months to ensure substantial compliance is maintained. Audits will be reported the Quality assurance committee at the scheduled meeting.

The corrective action for this plan of correction will be achieved by 2/14/24. The Director of Nursing /Designee is responsible for this plan of correction.

F925

The corrective action for this alleged deficient practice was extermination services provided on 12/21/23.

To identify other areas of potential deficient practice, an audit of facility drains, garbage storage, garbage disposal areas, areas that store empty bottles or cans, areas that store cleaning

rags, mops and other moist environments will be inspected and any identified areas will be scheduled for exterminated immediately.

To ensure that this alleged deficient practice does not recur, education will be provided to dietary and housekeeping staff regarding notification to administrator of need for pest control. Weekly audits will be conducted for flies in the drains, kitchen areas, dining rooms and tray carts**.**

This corrective action will be monitored by weekly audits for flies in all areas of the drains kitchen, dining room and tray carts, for 4 weeks and then monthly for 3 months to ensure substantial compliance is maintained. Audits will be reported the the Quality assurance committee at the scheduled meeting**.**

The corrective action for this deficient practice will be completed by 2/14/ 24. The Administrator / Designee is responsible for this plan of correction.

F949

The corrective action for this plan of correction is education for all staff on Trauma Informed Care.

To identify other areas of alleged deficient practice, an audit will be completed for all staff education related to trauma informed care. Training will be assigned as indicated.

To ensure that this alleged deficient practice does not recur, additional trauma informed care education will be provided within 30 days of hire and annual education will be assigned for all current and new staff on trauma informed care.

This corrective action will be monitored through monthly audits of training modules to ensure completion of trauma informed care trainings. Any staff who are identified as not having completed initial and annual training will not be allowed to provide any hands-on care until training is completed. Audits will be conducted for 4 weeks and then monthly for 3 months to ensure substantial compliance is maintained. Audits will be reported to the Quality assurance committee at the scheduled meeting**.**

The corrective action for this deficient practice will be completed by 2/14/24. The Director of Human Resources/designee is responsible for this corrective action.

S-321

The corrective action for this alleged deficient practice was review of the daily PPD for the last 30 days to ensure that the PPD was not less than 3.0.

To identify other potential deficient practice a daily audit will be completed to review the projected daily PPD to identify where supplemental staffing is needed.

To ensure this alleged deficient practice does not recur, an audit of the daily PPD will be completed daily. Supplemented staffing and shifting of responsibility to areas of need will be

implemented when indicated. (i.e. Nurses working as LNAs, therapist providing ADL care). Recruitment of staff will continue with weekly recruitment and retention IDT meetings. Facility will recruit for staff as needed to maintain staffing levels of no less than 3.0 daily.

The corrective action will be monitored through auditing of daily PPD daily for 4 weeks and then weekly for 3 months to ensure substantial compliance is maintained. Audits will be reported to the Quality Assurance Committee at the scheduled meetings.

The corrective action for this plan of correction will be completed by 2/14/24. The Director of Nursing /Designee is responsible for this corrective action.