VERMONT

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

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

June 27, 2024

Wanda King, Administrator
Fairwinds Residential Care Home
108 Mechanic Street
North Bennington, VT 05257

Dear Ms. King:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 22, 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.

If you have any questions, please feel free to contact me at (802) 585-0995.

Sincerely,

Carolyn Scott, LMHC, MS
State Long Term Care Manager
Division of Licensing & Protection

PRINTED: 05/16/2024
FORM APPROVED

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0031	A. BUILDING: _____ B. WING _____	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWINDS RESIDENTIAL CARE HOME	108 MECHANIC STREET NORTH BENNINGTON, VT 05257

(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) COMPLETE DATE
R100	Initial Comments: An unannounced onsite relicensure survey was conducted on 4/22/24 by the Division of Licensing and Protection. Regulatory deficiencies were identified. Findings inlcude:	R100		
R101 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.1. Eligibility 5.1.a The licensee shall not accept or retain as a resident any individual who meets level of care eligibility for nursing home admission, or who otherwise has care needs which exceed what the home is able to safely and appropriately provide. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the Manager failed to apply for a level of care variance to retain a resident requiring nursing home level of care. Per observation Resident #1 activities of daily living include, wheel chair pushed by another, as primary mode of transportation, physical assist with eating at all meals, and physical assist with transfers The Resident Assessment completed on 4/10/23 indicates the resident requires total dependence with transfer, lifted manually, total dependence with locomotion, toileting, dressing and grooming. The facility filled out a variance form in early March, including a provider letter dated 3/5/24, the variance has not been submitted to the	R101		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wanda J. King — TITLE: Owner — (X6) DATE: 5/22/24

6/15/24
6/25/24

Division of Licensing and Protection

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R101	Continued From page 1 licensing agency. On a site visit on 3/18/24 the manager indicated a level of care variance to retain Resident #1 is going be submitted. The variance indicates Resident #1 requires full assist with dressing, grooming and eating, transfer with physical assist with one staff with, another staff standing by for safety. Per interview on 4/22/24 at 2:45 PM the Manager confirmed the variance form created in early March '24 has not been submitted to the licensing agency. The manager indicated Resident #1 to have an appointment in 2 days from date of survey and would obtain the signature from the provider for the variance. The manager acknowledged Resident #1 has had a decline in wellness for the last 6 months and has been receiving full care giver assist for several months and physical assist with eating has increased in the "last few weeks." The manager confirmed a policy is developed for the RN and LPN to perform assessments and plans of care, however the policy does not include a process for identifying level of care, and initiating level of care variances when indicated. This deficient practice is a potential for more than minimal harm, as the RCH is responsible to identify residents care needs and receive approval from the licensing agency to render nursing home level of care.	R101		
R145 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs	R145		

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R145	Continued From page 2 as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on record review and staff interivew the nurse failed to ensure plans of care were updated to identify resident care needs, along with including individualized nursing interventions for 1 out of 4 residents (Resident #3). Per observation through the course of survey, Resident #3, required prompt and cue for activities of daily living and meal reminders. Resident #3 wandered throughtout the home in varying rooms, the staff provided Resident #3 redirection to common areas of the home. Per record review Resident #3 was admitted to the RCH on 3/25/24, the plan of care did not identify the diagnosis Alzheimer's, with nursing interventions to support Resident # 3 in engagement, wandering behaviors and redirection. Per interview on 4/22/24 at 11:30 AM the Manager confirmed the plan of care developed for Resident #3, does not include individualized nursing interventions to support Resident #3 with memory impairment. The facility policy and procedures titles Charting Policy, section H. The LPN will be responsible for developing the care plan. The LPN will update the care plans if changes have been made to the residents orders. The RN will be responsible for	R145		

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R145	Continued From page 3 reviewing them monthly and signing them on a monthly basis. The deficient practice is a potential for more than minimal harm for all facility residents, as the nurse is to develop plans of care to identify resident care needs, with individualized interventions plans to provide care and services to promote a resident's well being.	R145		
R146 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.9.c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the Nurse failed to ensure staff personnel are provided proper directions to provide care and services to 2 out of 4 residents (Resident #1, #3). Per observation Resident #1 required full caregiver assist with locomotion via pushed wheelchair, physical assist with transfers with stand by assist of additional staff for safety, full assist with eating at meals. Staff confirmed Resident #1 is provided full assist by 1 staff with dressing, grooming, and hygiene. Per record review Resident #1 Resident Assessment completed on 4/10/23 section G.1 Physical Functioning: Activities of Daily living	R146		

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R146	Continued From page 4 (ADLs) the RN assessed the Resident #1 to require total dependence in transfers, locomotion, dressing, toilet use, personal hygiene, and bathing. The Resident Assessment Instructional Guide indicates Total Dependence is full staff performance of activity during entire seven day period. The nurse developed a plan of care for Resident #1 that is limited to identifying diagnosis and interventions for each diagnosis and medications to be administered. The plan of care does not include direction to staff of how to provide assistance with activities of daily living, assistance at meals and transfers, and weight monitoring. Per interview on 4/22/24 at 2:00 PM the Manager confirmed staff are to reference the plan of care developed by the RN as direction to ensure proper care and services are provided as assessed by the RN. The manager confirmed the plan of care does not identify individualized care interventions to provide care and services to Resident #1. Resident #3 was admitted to the facility on 3/25/24. Through observation Resident #3 required frequent prompt, que, redirection and monitoring for safety. The resident wandered through the home, where staff would provide assistance to him/her, redirect to common areas. Per Resident #3 medical history notes, the resident has diagnosis of Alzheimer's Dementia, Hyperlipidemia, Asthma, Arthritis of hands, MRSA. Per appointment visit note on 8/3/23 to address memory impairment, the provider states "MoCA (Montreal Cognitive Assessment) was attempted, the testing was stopped after	R146		

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R146	Continued From page 5 becoming frustrated. Unable to follow one-step commands, has a paucity of verbal output but is able to produce coherent sentences." The plan of care developed by the RN does not include Alzheimer's diagnosis with nursing interventions for staff to reference to provide individualized nursing care and support with memory impairment. The facility policy titled Charting Policy, section H. (I) a working care plan has been placed in each residents folder in the daily notes. Staff will be responsible for reading each care plan and signing off on the back page of each care plan. Per interview on 4/22/24 at 12:40 PM the Manager confirmed Resident #3 was admitted to the RCH on 3/25/24, with a diagnosis of Alzheimer's Disseae. The manager confirmed the plan of care developed for Resident #3 does not provide direction to staff of interventions to support Resident #1 care needs of memory impairment. The Manager confirmed a policy is not developed to account for nursing overview to include the instruction and supervision of direct staff. The deficient practice is a potential for more than minimal harm to facility residents as nursing overview emcompasses the requirement of the nurse to ensure care personnel are provided direction and supervision, through utilizing the plans of care that include nursing interventions to support the health care needs of the residents.	R146		
R150 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (7)	R150		

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R150	Continued From page 6 Assure that symptoms or signs of illness or accident are recorded at the time of occurrence, along with action taken; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview progress notes for 1 out 4 Residents (Resident #2) did not include documentation of occurrences and follow up care to meet resident care needs. The facility policy titled "Charting Policy" states Staff will be responsible for documenting in the daily notes. (iii) the nurse (RN or LPN) is responsible for documenting the information on the individual's chart and in the nurses's notes. Per record Review Resident #2 had sustained fall on 2/2/24, this was identified by a office visit summary visit note dated 2/4/24. The document indicates Resident #2 was seen for a fall follow up with injury. The note indicates symptoms started 2 days ago, "falling backwards hit his/her back on the bathtub, bruising." The facility policy titled Emergency Plans for Residents, Illness or Injury section C. Resident Falls states "..to document in daily notes along with what occurred so the supervisor can fill out an incident report." Per the daily note log (a communication notebook, not apart of the resident record which is utilized by care staff to communicate to the nurses and manager) on 2/2/24 on the day time shift care staff (0630-1430), noted Resident #2 sustaining a fall in the bathroom, stating "S/he fell backwards onto the side of the tub hit right side,	R150		

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R150	Continued From page 7 and is complaining of being sore. S/he can take deep breaths with no problem, was given Tylenol to help with discomfort." A daily log note written on 2/3/24 states "Woke up sore. Resident #2 said his/her back hurt sat in his/her chair with heating pad, Tylenol given." On 2/4/24 a daily note states " Resident #2 didn't want to get up but did. AM care done, staff took Resident #2 to express care for his/her back." In review of Resident #2 progress notes, a note was not documented to account for the fall occurrences, by the nurse or manager. Per interview on 4/22/24 at 1:10 PM the Manager confirmed Resident #2 record does not include documentation for accounting for the residents fall at time of the occurrence. The Manager noted incident reports are filled out to communicate occurrences such as falls. The manager confirmed an incident report is not available, and believes "one was not filled out" to account for Resident #2 fall. Further, the Manager confirmed a progress notes does not account for provided follow up nursing by the overseeing Registered Nurse (RN). The Manager identified the utilization of the "Daily Notes" communication book by care staff, and was unable to provide further information, for the Resident record to not be updated by the nurse to account for the fall and/or the follow up care the care staff initiated for Resident #2 and the summary visit from Express care. The Manager confirmed the nurse is notified of all fall or illness occurrences. Additionally, Resident #2, was hospitalized on 11/17/23-11/20/23 due to loss of balance, related to medication administrations of Bactrim DS (antibiotic), the record does not include reasoning for the antibiotics use and/or a progress note for	R150		

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R150	Continued From page 8 the fall at time of occurrence with admission to the hospital. A progress note authored by the RN, on the date of discharge, 11/20/23, accounts for the hospitalization, and use of Bactrim DS related to the fall and medications changes of Lisinopril from 20 mg to 10 mg once daily by mouth. The progress note further states "Will monitor for any change in status." The next progress note written on 12/1/24 documents, "Resident #2 was seen at Dr Office 11/29/24, with provider, follow up for being hospitalized." the note further states "S/He now has a yeast rash on inner Left leg." The progress notes do not demonstrate follow up care and/or monitoring the RN implemented after the hospitalization as indicated in the note written on 11/20/24, nor does the record include observations of skin issues documented by the manager and/or the nurse. The facility policy titled Charting Policy states Staff will be responsible for documenting in the daily notes. (iii) the nurse (RN or LPN) is responsible for documenting the information on the individual's chart and in the nurses's notes. Per interview on 4/2/24 at 1:20 PM the Manager confirmed Resident #2 was hospitalized in November. The Manager confirmed the record does not include interventions to account for "monitoring" as the RN indicated in the progress note on 11/20/23. The Manager further confirmed, the resident record, does not include nursing overview of monitoring of changes in skin conditions. The deficient practice is potential for more than minimal harm for facility residents as the resident record is to include and account for occurrences of accidents and illness at the time occurred, as a chronologically history to be utilized by the health	R150		

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R150	Continued From page 9 care team, to aide in establishing care needs, identifying problems areas, and account for monitoring of improving or worsening signs and symptoms.	R150		
R151 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.9.c (8) Ensure that the resident's record documents any changes in a resident's condition; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the Nurse failed to ensure documentation to identify changes in condition related to the dietary care needs for Resident #1. Per record review Resident #1 progress notes entries written by then RN, on 8/1/23 states "No Change in status, appetite good and needs assistance with feeding rarely. Recognizes familiar faces, ambulates poor, stands and pivots 1-2 people needed." The next entry on 8/30/23 states "No change in status, staff reports no change in status, Resident is my old neighbor and still seems to recognize me, s/he smiles and takes my hand." The next entry with an illegible date, states "Continues needing assistance with care and feeding and daily care, Non-verbal. No change in status." The next entry on 10/1/23 states "appetite good..", the next entry on 11/2/23 indicates "No change in status." The progress note dated 1/2/24 states "No change in status." the following progress notes dated 2/28/24 indicates "No change in status" and on 3/1/24	R151		

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R151	Continued From page 10 "Appetite good assistance as needed." The facility policy titled Charting Policy states Staff will be responsible for documenting in the daily notes. (iii) the nurse (RN or LPN) is responsible for documenting the information on the individual's chart and in the nurses's notes. Per interview on 4/22/24 at 1:00 PM the Manager, confirmed the resident has had a decline in wellness in the last 6 months, requiring physical assistance with eating and drink at meals, and modifying foods for safe consumption. The Manager confirmed the progress notes written by the Nurse do not account for the changes in care needs of Resident #1 and confirmed the record does not indicate the primary care provider has not been updated on dietary support required for the resident, along with the modifying of food(s) practice the home initiated. This deficient practice is a potential for more than minimal harm as resident's changes in condition are to be observed and assessed to identify the appropriate nursing care interventions and services and coordinate care with primary care providers to maintain wellness	R151		
R153 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.9.c (10) Monitor stability of each resident's weight; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the	R153		

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R153	Continued From page 11 RN failed to ensure nursing overview of weight monitoring was provided for 1 out or 4 residents (Resident #1). Per record review of Resident #1 record, routine weights were not documented to account for Resident #1 monitoring. Per interview on 4/22/24 at approximately 1:00 PM, the manager confirmed the record does not include weights monitoring for Resident #1. Through the course of the interview, the Manager identified due to Resident #1 functional status, the resident is unable to stand independently on the scale to obtain weights. The Manager noted, weights are accounted for through provider appointments for Resident #1. The Manager confirmed the RN is aware of the inability to obtain weights, and confirmed alternative monitoring (such as girth measurement) was not being provided. The Manager indicated the homes practice is to obtain weights on a monthly basis, or references a weight obtained through a provider visit. A policy is not established to identify the homes practice in weight monitoring. This deficient practice a risk for more than minimal harm for all facility residents, and nursing overview encompassing weight monitoring to identify potential health related outcomes from weight changes.	R153		
R154 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.9.c (11) Implement assistive therapy as necessary to maintain or improve the resident's functional	R154		

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R154	Continued From page 12 status, with consultation from a licensed professional as needed; and This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the RN failed to ensure nursing overview was provided for 1 out of 4 residents (Resident #1) requiring for dietary support. Per observation during the lunch meal at approximately 12:00 PM, Resident #1 received full feeding assist from staff. The resident required staff to provide physical assistance with eating and drinking throughout the meal. Staff confirmed the resident requires physical assistance and foods to be prepared for safe consumption. Per record review, the record did not account for the required assistance from staff. Documentation within the progress notes by the RN do not identify the care needs for dietary support, documentation to account for communication to a provider of the support, or request for referrals with assistive therapies for evaluation of Resident #1. Per review of the facility policies, a policy was not established to identify the nurse's procedural process of nursing overview in coordination of care and services with providers and communication with providers of Resident care needs. Per interview on 4/22/24 at 12:45 PM the Manager, confirmed the observation of support provided to Resident #1 during meals, to include physical assist with eating and drinking, foods being cut to a size for safe consumption or	R154		

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R154	Continued From page 13 preparation of finger foods for the resident to attempt in self-feeding. The Manager confirmed the RN was made aware of the changes in Resident #1 dietary support needs. The manager identified the RN provides nursing overview to include establishing care needs within the RCH, coordination with providers to provide updates of changes in condition or initiate services to aide in residents functional status. The Manager confirmed the record does not demonstrate the RN initiated communication with the provider with the dietary changes and/or communication to obtain referrals for assistive therapies for Resident #1. This deficient practice is a risk for more than minimal harm to all facility residents as nursing overview is to include monitoring of functional status of residents and implement assistive therapies with primary care providers to maintain or improve a resident's functional status and establish care needs to support the resident's functional status.	R154		
R160 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.a Each residential care home must have written policies and procedures describing the home's medication management practices. The policies must cover at least the following: (1) Level III homes must provide medication management under the supervision of a licensed nurse. Level IV homes must determine whether the home is capable of and willing to provide assistance with medications and/or administration	R160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0031	A. BUILDING: _____ B. WING _____	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRWINDS RESIDENTIAL CARE HOME	108 MECHANIC STREET NORTH BENNINGTON, VT 05257

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R160	Continued From page 14 of medications as provided under these regulations. Residents must be fully informed of the home's policy prior to admission. (2) Who provides the professional nursing delegation if the home administers medications to residents unable to self-administer and how the process of delegation is to be carried out in the home. (3) Qualifications of the staff who will be managing medications or administering medications and the home's process for nursing supervision of the staff. (4) How medications shall be obtained for residents including choices of pharmacies. (5) Procedures for documentation of medication administration. (6) Procedures for disposing of outdated or unused medication, including designation of a person or persons with responsibility for disposal. (7) Procedures for monitoring side effects of psychoactive medications. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the Manager failed to ensure medication policies were established to account for disposing of outdated medications, stored within the medication cabinet available for use. Per interview on 4/22/24 at 2:30 PM the Manager confirmed the medications stored within the medication cabinet identified were expired. The manager confirmed a policy is not developed to establish a process in the monitoring of expired medications. The deficient practice has a potential for more than minimal harm, as policy and procedures are to be referenced by staff to carry out the	R160		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R160	Continued From page 15 expectations related to job descriptions as defined. See tag 176.	R160		
R176 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h (4) Medications left after the death or discharge of a resident, or outdated medications, shall be promptly disposed of in accordance with the home's policy and applicable standards of practice. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the Manager failed to ensure medications stored within the medication cabinet available for use were within appropriate use by dates and not expired. Per observation of the medication storage cabinet the follow medications were observed expired and available for use: Aspirin 325 mg tablets, 100 ct expired on 3/22 Acetaminophen 500 mg tablet 50 ct expired on 3/24 Aleve 220 mg 24 count bottle, expired 7/23 Aspirin 81 mg 100 count bottle expired 3/23 Acetaminophen 325 mg 100 cout bottle expired on 3/23 Tylenol 500 mg gel capsules, 100 count bottle expired 10/23	R176		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0031	A. BUILDING: _____ B. WING _____	04/22/2024

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R176	Continued From page 16 Allergy 10 mg tablets, 30 count package expired on 3/24 Per interview on 4/22/24 at 2:30 PM the Manager confirmed the medications identified were expired. The manager confirmed a policy is not developed to establish a process in the monitoring of expired medications. This deficient practice is a potential risk for more than minimal harm for all facility residents related to the potential negative impact on resident's health related care and maintenance aling with, the effectiveness of potential use of expired medications.	R176		
R200 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.15 Policies and Procedures Each home must have written policies and procedures that govern all services provided by the home. A copy shall be available at the home for review upon request. This REQUIREMENT is not met as evidenced by: Based on staff interview, the Manager failed to ensure policy and procedures were established to identify procedural processes for nursing overview. Per interviews occurring on 4/22/24 , the Manager referenced policies established and not established through interviews. The following policies were confirmed as not established: a.) Nursing overview, to identify procedural	R200		

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0031	A. BUILDING: _____ B. WING _____	04/22/2024

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R200	Continued From page 17 process of monitoring weights b.) Nursing overview to identify procedural process of communication with providers to facilitate assistive therapies c.) Assessments to include a procedural process of establishing level of care needs, in where a variance would be indicated. The deficient practices is a risk for more than minimal harm, as policy and procedures are referenced by the facility staff to ensure job related responsibilities are followed by the procedural process established and the home ensures all regulatory requirements are adhered to.	R200		

Fairwinds Residential Care Home
108 Mechanic Street
North Bennington,Vermont 05257
802-442-4067

PLAN OF CORRECTIONS FOR SURVEY DONE ON APRIL 22,2024

R(101) Resident Care and Home Services

5.1 Eligibility

1.Resident #1 a was in need of a variance which was applied for and denied. A letter has been drafted and sent to the family with a target date of transfer 8/1/2024.

2. The residents' needs have been met with caring and compassion from each and every staff member . Our Nurse R.N and L.P.N are overseeing the residents care 3x weekly and on an as needed basis . 4/23/24.

3.The R.N. and the L,p.n.will monitor the resident each week at least 3x weekly and as needed.Staff will be responsible for reporting a change in condition to both the R.N. and L.p.n. The nurse will assess the resident . The nurse will complete a change in condition assessment and an updated care plan . The change in condition will be documented in the nurses notes. 5/1/2025

4.If a variance is needed to retain a resident the nurse will assist the manager in applying for the variance in accordance with the licensing regulations. This will prevent further recurrence of keeping a resident that has resided in the home for a long time and exceeded our level of care.

5.A section is being added to our Charting policy to identify the need for a variance.The variance will be applied for within 2 weeks of identifying a need for a variance.This will allow time for the manager to obtain a letter from the family member as well as the signature and letter from the physician. The variance will then be submitted to the Dept. of licensing for approval.5/24/24.

6. A working care plan has been added to each resident's folder in the daily notes . The staff will be responsible for reading each care plan and sign off on the back page when completed , This will keep staff educated on the needs and changes of the residents Questions will be directed to the Nurse and Manager.4/24/2024.
7. The manager will be responsible for making sure the Nurse has updated the care plans and assessments ,as well as making sure staff has read and signed the working care plan this should prevent further mistakes from occurring .5/1/24.

Tag 101- Approved-6-27-24-LTCM

R145 V. Resident care and Home Services

5.9(2)
1. A new Care Plan was developed by the L.P.N. including the diagnosis of Alzheimer's and interventions to support Resident#3 in engagement,wandering behaviors.and redirection.5/9/2024.

2.The L.P.N developed the care plan and signed it on 5/9/2024. The R.N.reviewed and signed on 5/11/2024.

3.The Nurse and Manager will review the diagnosis together upon admission (While compiling information for the care plan)this should

prevent further mistakes from occurring and keep us in compliance with the licensing regulations.
4. The nurse and manager will also review together the diagnosis following a physician's appointment. The Nurse will add any new information to the care plans as changes occur.This will prevent further errors from occuring. 5/1/2024.

Tag 145- Approved-6-27-24-LTCM

R146 Resident Care and HomeServices

5.9c(3)

1.The L.P.N. revised resident #1's care plan to add new orders from the physician addressing the individual care needs that had not been addressed during our survey .5/23/2024

2.The R.N. charted and addressed the individual's care needs in the nurses notes on 5/1/24. The R.N. also reviewed and signed the care plan on 5/1/2024.
3.The manager will be responsible for notifying the nurse of any changes that may have occurred with a resident.The Manager or Nurse will be responsible for obtaining physicians orders needed to address the care needs as soon as intervention is needed for a resident .The charting will then be provided in the nurses notes by the L.P.N.and the R.N.5/1/2024
4.The nurse will provide the information to the staff ,to make sure there is an understanding of the changes and how to implement them.5/1/2024
5.The care plan will be updated and available to staff to review and sign acknowledging they have read the updated care plan.5/1/2024.
6. The manager will be responsible for making sure the staff has read the care plans and signed them.4/25/2024.

7. A new care plan was developed for resident #3 including the diagnosis for Alzheimers and interventions to support Resident #3
8.A new working care plan was placed in the residents folder and staff was required to read the care plan and sign. This practice will continue to maintain education for each resident.
9.A policy will be developed for Nursing overview to include instruction and supervision to direct care staff.6/5/2024. Tag 146- Approved-6-27-24-LTCM

R150 v.Resident Care and Home Services

5.9.c (7)
An incident or illness requiring an intervention or not, are documented and put in the residents chart.This was an oversight.Documentation has been provided by the manager and placed in #2's chart.

2. R.N and L.P.N. will continue to be notified of incidents and illnesses both will be responsible for charting and and following up with the manager to make sure an incident report has been filled out and placed in the residents chart under the accident and illness section of the residents chart.
3. The manager will be responsible for notifying the R.N. and L.p.n. of any incidents of falls or illnesses. The nurse will be responsible for assessing the resident and documenting the progress in the nurses notes.The manager will be responsible for filling out the incident report and checking the nurses notes to be sure all information is accurate . This will prevent further errors from reoccurring.

4. Documentation provided by the hospital or Physician visit will be placed in the residents chart under Physicians orders.These will be reviewed and signed by the R.N. Any changes will be documented in the nurses by the R.N.and the staff will be responsible for

documenting in the daily notes .This will prevent further documentation errors from occurring.

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5. Upon readmission from a hospital stay .The R.N. and L.P.N. will be notified that the resident has returned to the facility ,both will be responsible for charting the resident's progress in the nurses notes. The R.N. and L.p.n will be responsible for completing a new assessment and an updated care plan . The staff and manager will continue to be responsible for charting changes and new orders in the daily notes.

6.The L.P.N will be responsible for following up on the illness or incident and charting as needed following the illness or injury.The L.p.n will monitor the resident when they are in the facility. The L.p.n.will keep progress notes in the nurses notes.
The R.N. will be notified and information provided to [redacted] so [redacted] can provide progress notes in the nurses notes as well. Documentation will be provided by the R.N.and placed in the nurses notes until the problem is resolved.

7.The manager will be responsible for reviewing the notes upon completion to be sure all information is accurate .This will prevent further errors from reoccurring.

8. The direct care staff is responsible for reporting any improving or worsening signs and symptoms to the manager and nurse. Documentation will be provided by the R.N. and L.P. N. in the individual's chart in the nursing notes upon receiving the information. Both nurses will continue to follow the residents progress and documentation will be added to the nurses notes .
9. The staff and manager will be responsible for charting the information that was provided to the nurse in the residents

Pronouns removed by DLP 6/26/24

chart.including that the nurse has been notified and updated on the residents condition.The nurse and manager will be responsible for educating direct care staff on how to proceed with care needs and identifying problem areas.

10. Continuing education will be provided to the staff on a monthly basis and as problems arise. This will assure that each staff member stays educated to be able to identify any new or worsening problems that arise with the residents.

11.Increased documentation and monitoring from both nurses and oversight from the manager will prevent further errors from occurring.

Tag 150 - Approved-6-27-24-LTCM

R151 V.Resident care and home services

5.9.c (8)

1.The R.N. and manager have met since our survey to ensure they will do more thorough and accurate charting on each resident.5/1/2024

The L.P.N. and manager will also be responsible for reviewing all nurses notes to be sure they are accurate and up to date.4/25/2024.

The manager and Staff will be responsible for documenting changes in orders from the physician ,in the daily notes.The L.P.N.and manager will be responsible for educating the staff on all care needs and changes.4/25/2024.

The L.P.N. documented in the nurses notes upon receiving new orders for Resident#1 which includes a modified diet and thickened liquids .The nurse will continue to monitor the residents progress and chart in the nurses notes. 4/25/2024

5.The R.N. documented on new orders for resident #1 which includes a modified diet and thickened liquids.The R.N. will continue to monitor the residents progress and chart in the nurses notes. 5/1/2024

6. All staff were made aware of the change in resident 1's orders on 4/25/2024 and again on 5/1/24.The L.P.N.will be responsible for educating the staff on the changes to the residents condition and orders.

The manager will be responsible for notifying both nurses of changes to a resident's order and reviewing the notes to ensure all nurses notes contain accurate and complete information.Both nurses will be responsible for reviewing Dr.s orders and adding new information to the assessments and care plans. If clarification on orders is needed the nurse will be responsible for contacting the physician .The nurses will then document in the nurses notes and sign the dr's orders. Both nurses will monitor each resident while on duty and chart their progress.This will prevent further documentation errors. 4/25/2024.

Tag 151- Approved-6-27-24-LTCM

R153 Resident Care and Home Services

5.9c (10)

1 . A. policy for obtaining weights will be written to include girth measurements by the R.N. if a weight is unobtainable.6/1/2024
2..Weights will be obtained on a monthly and charted on a monthly weight document which will be kept in the back of MAR 5/24/2024. Girth measurements will be done monthly on any resident unable to y obtain an accurate weight . .

3.The R.N. will do the Girth Measurements and document in the nurses notes on a monthly basis.
4. Staff will be responsible for obtaining weights on all residents and documenting on the monthly weight document as well as in the daily notes .
5.Staff is responsible for notifying the manager and the nurse if they feel there is a significant weight loss or gain.
6. The R.N, L.P.N or the Manager will be responsible for contacting the physician if there is a significant gain or loss. All staff will be made aware of the changes . The nurse will be responsible for documenting in the nurses notes .The staff and manager will be responsible for documenting in the daily notes.5/1/2024.

Tag 153- Approved-6-27-24-LTCM

R154 Resident care Home and Services
5.9.c(11)1.
1. A policy is being established for the procedural process for nursing overview.The policy will include monitoring of functional status of residents and implement assistive therapies with primary care providers to maintain or improve a resident's functional status and establish care needs to support the residents functional status.6/5/2024.

2. Orders were obtained from the physician for a modified diet and for thick it be added to the liquids.4/24/24

3. A new assessment was completed and signed by the R.N.and L.p.n. to reflect the need for a modified diet ,thickened liquids and the need for staff assistance the at mealtimes.4/25/24

4.A new care plan was completed and signed by the R.N.and L.p.n. to include the modified diet ,thickened liquids and staff assistance at meal times as needed. on 5/22//2024.

5.Documentation was provided in the nurses notes by the L.P.N to add the new orders for the modified diet and thickened liquids and staff assistance with meals as needed on 4/25/2024.Documentation was provided by the R.N. to include the new orders for a modified diet and thickened liquids,and staff assistance with meals as needed .5/1/2024

6.The R.N.and L.p.n.will continue to monitor the residents progress and document in the nurses notes. If assistive therapies are needed the nurse will contact the physician to obtain those orders.5/1/2024

7..With a completed policy in place the manager will be responsible for making sure the nursing overview is being implemented as needed to ensure the safety and welfare of the residents.The nurses will be responsible for increased documentation in the nurses notes ,following up with the physicians and physicians orders, and increased monitoring of each resident and documentation of their progress. The nurses will also be responsible for educating staff on direct care of the residents and their changing needs. 6/5/24
This should prevent further translation and documentation errors.6/5/2024

Tag 154- Approved-6-27-24-LTCM

R160 Resident Care and Home Services

5.10 Medication Management

1. A procedure was added to our Policies For Medication Management to include a policy for identifying expired medications and a policy for disposing of expired and unused medications.5/20/2024

2.The manager and a designated staff member will be responsible for checking the med cabinet weekly to make sure there are no expired meds being stored in the med cabinet.4/25/2024
3. If expired meds are identified the Nurse and manager will dispose of them immediately.4/22/2024

4.The nurse and manager will sign and date a document stating the name of the medication , the amount and the date and time the medications were disposed of.4/22/2024

Tag 160- Approved-6-27-24-LTCM

R176 V. Resident Care Home and Services

5.10 Medication Management

5.10h(4)

1 All over the counter expired medications were promptly disposed of by the L.P.N. and the manager at 3:20pm on 4/22/2024.

2.The manager and a designated staff member will check the med cabinets on a weekly basis to make sure there are no expired medications being kept in the med cabinet.This policy will ensure that this error will not reoccur and we will continue to stay in compliance with our regulations.

3. A procedure was added to the policies for medication management to include a policy for identifying and disposing of expired and unused medications.5/20/2024.

Tag 176- Approved-6-27-24-LTCM

R 200 V.Resident Care and Home Services

5.15 Policies and Procedures

1.We are continuing to write all policies and procedures of services and practices provided by our home.6/5/2024

2.These will include but not be limited to:

(a)Nursing overview,to identify procedural process of monitoring weights

(b)Nursing overview to identify the procedural process of communication with providers to facilitate assistive therapies.

(c)Assessments to include a procedural process of establishing Level of care needs,in where a variance would be indicated.6/5/2024.

Tag 200- Approved-6-27-24-LTCM

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