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

November 1, 2021

Ms. Theresa Southworth
Gill Odd Fellows Home
8 Gill Terrace
Ludlow, VT 05149-1004

Dear Ms. Southworth:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **September 30, 2021.** Please post this document in a prominent place in your facility.

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

Sincerely,

Pamela M. Cota, RN
Licensing Chief

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475052	A. BUILDING _____ B. WING _____	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GILL ODD FELLOWS HOME	8 GILL TERRACE LUDLOW, VT 05149

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The Division of Licensing and Protection conducted an annual emergency preparedness survey during the recertification survey, completed on 9/30/2021. The following regulatory deficiencies were cited as a result:	E 000		
E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.	E 006	E006- Each resident in the building has the potential to be effected by the facilities lack of a detailed response plan. We have completed an all inclusive emergency response and preparedness plan which will be updated and reviewed at least annually. **TAG E 006 POC Accepted on 11/1/21 by K. Ruffe/P. Cota**	10/28/21

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

Theresa Southworth | Nursing Home Administrator | 10/27/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 006	Continued From page 1 (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to establish an emergency program that is based on and includes a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. Findings include:	E 006		

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E 006	Continued From page 2 Per record review, the facility's emergency program did not include a documented risk assessment. Per interview on 9/29/2021 at approximately 11:30 AM, the Administrator confirmed that the facility did not use a risk assessment that met the regulation criteria during the formulation of the emergency program and could not provide documentation of such a risk assessment.	E 006		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not	E 007	E 007- Each resident in the building has the potential to be effected by the facilities lack of a detailed response plan. Our emergency plan has identified the persons at risk and the services the facility has the ability to provide during an emergency and the ability to continue operations. This includes delegations of authority and succession. The emergency plan will be reviewed and updated at least annually. **TAG E 007 POC Accepted on 11/1/21 by K. Ruffe/P. Cota**	10/28/21

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E 007	Continued From page 3 limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to address the patient/client population and the types of services the facility has the ability to provide in an emergency in the emergency plan. Findings include: Per record review, the facility's emergency plan did not include any information regarding the patient/client population and the types of services the facility has the ability to provide in an emergency. Per interview on 9/29/2021 at approximately 11:30 AM, the Administrator confirmed that the facility had not identified or included these elements in the emergency plan.	E 007		
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness	E 018	E 018- Each resident in the building has the potential to be effected by the facilities lack of a detailed response plan. We have developed a system to track the location of on-duty staff and sheltered patients in Gill Home's care during an emergency. We have also developed a way to document the name and location of a receiving facility if the residents must be relocated. Policy and procedure created for safe evacuation of residents and staff to ensure medical documentation and medication is preserved. This will be reveiwed and updated at least annually.	10/28/21

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E 018	Continued From page 4 policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.	E 018	**TAG E 018 POC Accepted on 11/1/21 by K. Ruffe/P. Cota**	

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E 018	Continued From page 5 (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a system to track the location of on-duty staff and sheltered patients in the facility's care during an emergency. Findings include: 1. Per record review, the facility's emergency plan did not include a system to track the location of on-duty staff and sheltered patients in the facility's care during an emergency.	E 018		

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E 018	Continued From page 6 Per interview on 9/29/2021 at approximately 11:30 AM, the Administrator confirmed that the facility had not developed or included such a system in the emergency plan.	E 018		
E 020 SS=C	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCIs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following:	E 020	E 020- Each resident in the building has the potential to be effected by the facilities lack of a detailed response plan. We have developed a plan to safely evacuate residents and staff, which includes consideration of care and the treatment needs of the evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. This plan will be reviewed and updated at least annually. **TAG E 020 POC Accepted on 11/1/21 by K. Ruffe/P. Cota**	10/28/21

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E 020	Continued From page 7 (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop policies and procedures regarding safe evacuation from the facility that includes transportation. Findings include: 1. Per record review, the facility's evacuation policy and procedure did not include information regarding methods or processes for transporting residents in the event of a facility evacuation. Per interview on 9/29/2021 at approximately 11:30 AM, the Administrator confirmed that the facility had not developed or included information regarding methods or processes for transporting	E 020		

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E 020	Continued From page 8 residents during evacuation in the policy and procedure for evacuation.	E 020		
E 022 SS=C	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) §403.748(b)(4), §416.54(b)(3), §418.113(b)(6)(i), §441.184(b)(4), §460.84(b)(5), §482.15(b)(4), §483.73(b)(4), §483.475(b)(4), §485.68(b)(2), §485.625(b)(4), §485.727(b)(2), §485.920(b)(3), §491.12(b)(2), §494.62(b)(3). (b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	E 022	E 022- Each resident in the building has the potential to be effected by the facilities lack of a detailed response plan. We have developed a policy and procedure in our emergency plan to address shelter in place for patients, staff, and volunteers who remain at the Gill Home. We will review and update the plan at least annually. **TAG E 022 POC Accepted on 11/1/21 by K. Ruffe/P. Cota**	10/28/21

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E 022	Continued From page 9 failed to develop policies and procedures for sheltering in place during an emergency. Findings include: 1. Per record review, the facility's emergency plan did not include policies and procedures for sheltering in place during an emergency. Per interview on 9/29/2021 at approximately 11:30 AM, the Administrator confirmed that the facility had not developed or included policies or procedures for sheltering in place in the emergency plan.	E 022		
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) §403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information,	E 023	E 023- Each resident in the building has the potential to be effected by the facilities lack of a detailed response plan. We have a system of medical documentation (Point Click Care) that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. We will review and update this plan at least annually. **TAG E 023 POC Accepted on 11/1/21 by K. Ruffe/P. Cota**	10/28/21

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E 023	Continued From page 10 protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop policies and procedures for maintaining a system of medical documentation that preserves patient information. Findings include: 1. Per record review, the facility's emergency plan did not include policies and procedures for maintaining a system of medical documentation that preserves patient information during evacuation or an emergency. Per interview on 9/29/2021 at approximately 11:30 AM, the Administrator confirmed that the facility had not developed or included policies or procedures for maintaining a system of medical documentation during an emergency in the emergency plan.	E 023		
E 024 SS=C	Policies/Procedures-Volunteers and Staffing	E 024		

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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
E 024	Continued From page 11 CFR(s): 483.73(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated	E 024	E 024- Each resident in the building has the potential to be effected by the facilities lack of a detailed response plan. We have created a policy and procedure that covers the use of volunteers in an emergency or other emergency staffing strategies, including the process and role of integration of State and Federally designated healthcare professionals to address surge needs during an emergency. This plan will be reviewed and updated at least annually. **TAG E 024 POC Accepted on 11/1/21 by K. Ruffe/P. Cota**	10/28/21

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E 024	Continued From page 12 health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop policies and procedures for the use of volunteers in an emergency or other emergency staffing strategies. Findings include: 1. Per record review, the facility's emergency plan did not include policies and procedures for the use of volunteers in an emergency or other emergency staffing strategies. Per interview on 9/29/2021 at approximately 11:30 AM, the Administrator confirmed that the facility had not developed or included policies or procedures for the use of volunteers in an emergency or other emergency staffing strategies in the emergency plan.	E 024		
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the	E 026	E 026- Each resident in the building has the potential to be effected by the facilities lack of a detailed response plan. Gill Home has developed a policy and procedure related to the role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This plan will be reviewed and updated at least annually. **TAG E 026 POC Accepted on 11/1/21 by K. Ruffe/P. Cota**	10/28/21

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E 026	Continued From page 13 following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop policies and procedures regarding the facility's role under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. Findings include: 1. Per record review, the facility's emergency plan did not include policies and procedures regarding the facility's role in the provision of care and treatment at an alternate care site identified by emergency management officials under a waiver declared by the Secretary. Per interview on 9/29/2021 at approximately 11:30 AM, the Administrator confirmed that the facility had not developed or included policies or procedures for the facility's roles under any waivers declared by the secretary.	E 026		

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E 034	Continued From page 14	E 034	E 034- Each resident in the building has the potential to be effected by the facilities lack of a detailed response plan. We have developed a policy and procedure describing our means of providing information about Gill Home's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This plan will be reviewed and updated at least annually.	10/28/21
E 034 SS=C	Information on Occupancy/Needs CFR(s): 483.73(c)(7) §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility		**TAG E 034 POC Accepted on 11/1/21 by K. Ruffe/P. Cota**	

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E 034	Continued From page 15 failed to develop a communication plan that includes a means of providing information about the LTC facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction, the incident command center, or designee. Findings include: 1. Per record review, the facility's communication plan did not include a means of providing information about the LTC facility's occupancy, needs, or its ability to provide assistance in an emergency to the appropriate parties. Per interview on 9/29/2021 at approximately 11:30 AM, the Administrator confirmed that the facility had not developed or included information regarding how the facility would provide information about the facility's census, needs, or ability to provide assistance in an emergency in the communication plan.	E 034		
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every	E 035	E 035- Each resident in the building has the potential to be effected by the facilities lack of a detailed response plan. We have developed a plan for sharing information from the emergency plan, that the facility has determined is appropriate, with residents and their families or representatives. We will review and update this plan at least annually. **TAG E 035 POC Accepted on 11/1/21 by K. Ruffe/P. Cota**	10/28/21

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E 035	Continued From page 16 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a communication plan that includes a method for sharing information from the emergency plan, as appropriate, with residents and/or families and representatives. Findings include: 1. Per record review, the facility's communication plan did not include information regarding communicating appropriate aspects of the emergency plan to residents and families/representatives. Per interview on 9/29/2021 at approximately 11:30 AM, the Administrator confirmed that the facility does not provide residents or families/representatives with information about the emergency plan.	E 035		
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE	E 036	E 036- Each resident in the building has the potential to be effected by the facilities lack of a detailed response plan. We have developed an emergency preparedness training and testing program that is based on the risk assessment, incorporated policies and procedures, and the communication plan. The training and testing program will be reviewed and updated at least annually.	10/28/21

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E 036	Continued From page 17 at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the	E 036	**TAG E 036 POC Accepted on 11/1/21 by K. Ruffe/P. Cota**	

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E 036	Continued From page 18 requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and maintain an emergency program training and testing program that is based on an all-hazards risk assessment. Findings include: 1. Per record review, the emergency program did not show evidence of a risk assessment that was executed using an all-hazards approach. Review of the the facility's current training and testing program showed that there was no documented plan for training or testing staff for all applicable emergencies outside of COVID-19 and fire emergencies. Per interview on 9/29/2021 at approximately 11:30 AM, the Administrator confirmed that the facility did not use an all-hazards approach risk assessment to determine which emergencies were appropriate for training and testing of staff and does not have a training program that encompasses all emergencies applicable to the	E 036		

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E 036	Continued From page 19 facility.	E 036		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an onsite, unannounced recertification survey from 9/27/2021 to 9/30/2021. The following regulatory deficiencies were cited as a result:	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow it's policies and procedures to ensure each resident's right to be free from abuse as evidenced by the facility failing to follow their process for reporting injuries of unknown origin for two of 16 sampled residents (Resident #10 and Resident #19). Findings include: 1. Per record review, Resident #10 has a	F 600	F600- Each resident in the building has the right to be free of abuse, neglect, and exploitation. The nurse failed to notify the DON of what she/he documented as "injury of unknown origin." All nurses have been re-educated regarding our abuse policy, when to notify the DON, when to notify the administrator, and clarification regarding injury of unknown origin. Any new injury that the origin cannot be determined will be documented as injury of unknown origin and reported to DON which will then make reports to the state authorities. In the case of resident #10 and #19, the injuries were looked into and both have explanations. Neither experienced injuries of unknown origin. This will be monitored by the DON on an ongoing basis and will be a topic of discussion at QAPI for the next 6 months. **TAG F 600 POC Accepted on 11/1/21 by K. Ruffe/P. Cota**	10/31/21

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F 600	Continued From page 20	F 600		

diagnosis of dementia and scored a 2 on their most recent Brief Interview of Mental Status test (meaning severe cognitive impairment). Per the record, four bruises on Resident #10's left forearm/hand were first observed on 9/24/2021. Per a nursing note on 9/24/2021 at 5:40 PM, "Skin/Wound Note Text: Resident has three purple bruises on left forearm with diffuse redness surrounding area and one purple bruise on top of left hand."

Per review of the facility's policy on abuse prevention under the section for identification of abuse situations, the policy states "A. the administrative staff and nursing supervisors of the facility will monitor the residents for suspicious markings ... that may constitute abuse. Any suspicion of abuse will be reported to the Directors of Nursing immediately. The reporting staff member will also write a detailed summary of the allegations or suspicion." Under the section for investigation of abuse situations, the policy states, "in the event of resident abuse, the DON (director of nursing) will review the nursing report to determine if a pattern exists with the victim or aggressor, or an injury occurred. These incidents will be reported to the Department of Licensing and Protection/Adult Protective Services."

Per interview on 9/28/2021 at approximately 3:30 PM, the DON described the facility's procedure and expectations of staff when injuries of unknown origin are discovered. The DON stated that staff who discover a new wound or bruise without awareness of the origin are to report the finding to a nurse (if not already a nurse). The nurse then completes an incident report in the Risk Management System. The nurse is also expected to contact the DON and the physician to

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F 600	Continued From page 21	F 600		

report the finding as soon as possible. The DON would then investigate the circumstances surrounding the new wound/bruise to determine if the wound was suspicious for possible abuse. If determined to be suspicious for abuse, a report would be made by the DON to the appropriate agencies. During this interview, the DON confirmed that the incident report was started but the report was incomplete and that the DON had no evidence of being contacted about the bruises.

Per observation/interview on 9/29/2021 at approximately 1:00 PM, Resident #10 showed this surveyor their left forearm. There were 3 circular purple bruises larger than a quarter on Resident #10's forearm. When asked how they obtained the bruises, Resident #10 stated, "I don't know."

Per interview on 9/29/2021 at approximately 4:00 PM, the DON confirmed that they had not investigated the circumstances surrounding the new bruises to determine if they were suspicious for abuse, as they were not made aware of them.

2. Per record review, two linear bruises with an open area were noted on Resident #19's right calf on 9/1/2021. Per a nursing note on 9/1/2021 at 12:24 AM, "Note Text: Dried blood noted to resident's sheet by lower extremities. R) lateral calf noted to have 2 'lines' of red bruising, small opening to end of top 'line'. Area not raised, not scabbed, no pain noted. Etiology unknown." A second nursing note on 9/1/2021 at 9:00 AM states, "Skin/Wound Note Text: Bruising/scraping noted right lower leg. Will Monitor and report."

Per interview on 9/28/2021 at approximately 3:30

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F 600	Continued From page 22 PM, the DON described the facility's procedure and expectations of staff when wounds of unknown origin are discovered. During this interview, the DON confirmed that there is no incident report on record in the Risk Management System for Resident #19's bruises. The DON also confirmed that they were not aware of the bruising and could provide no evidence of being notified of it. Per interview on 9/29/2021 at approximately 4:00 PM, the DON confirmed that they had not investigated the circumstances surrounding the new bruise to determine if it was suspicious for abuse, as they were not made aware of it.	F 600		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656	F656- The items have been care planned for the mentioned residents after a thorough review. Upon review of the 24 hour report provided by PCC, it does not list behavior notes which are generated by the question on the TAR, "Is the resident displaying behaviors this shift?" These notes are not part of the routine report. In order to see these notes, you must go to the resident's chart, choose progress note, and read the notes. Going forward we will have the nurses document not in the TAR where they answer the question on behaviors, but in a separate behavior progress note which will show on the 24 hour report. This will make more staff aware of any potential behaviors in need of care planning. Nursing staff have also been educated regarding their role in care planning items as they arise, that a care plan is a living, breathing, plan that is to change with the resident. The clinical coordinator will be tasked with the monitoring of the notes and will pass on any items found that requires planning. This will be an ongoing review at each care plan meeting which take place quarterly and with any significant change in status.	10/31/21

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(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.
This REQUIREMENT is not met as evidenced by:
Based on observations, resident and staff interview, and record review the facility failed to develop and implement a comprehensive care plan for two of 16 residents in the sample (Residents #3 and #19). findings include:

1. Per record review Resident #3 has a diagnosis of dementia with behavioral disturbance, impulsiveness, anxiety disorder, and major depressive disorder. S/he has a history of wandering throughout the facility, in and out of other resident's rooms, and getting into bed with her/his room mate on several occasions. A progress note dated 4/21/2021 5:00 AM states "found laying in roommates bed next to [her/his] roommate." A progress note dated 6/14/2021 4:22 AM states "...roommate yelling out 'come get

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this [girl/boy]'. Upon entering room, resident noted to be at roommates bedside attempting to pull down [her/his] pants to void on bed." A progress note dated 6/21/2021 4:49 AM states "Up OOB (out of bed) x1 to roommates bed and had a temper tantrum when staff asked [her/him] to get up and go back to [her/his] own bed." A progress note dated 8/19/2021 at 6:09 AM states "...overheard roommate yelling, upon entering room twice, resident noted to be over trying to get into roommates bed." A behavior note written on 9/2/2021 at 7:16 AM states "Continually up in hallway...then noted up sitting in chair on roommates side talking with her. Combative with LNAs x 2 during NOC, slapped one LNA across the face when being redirected from going in others rooms." A progress note dated 9/9/2021 at 6:28 "Continuous disrobing, pulling off adult brief, ambulating around nurses station, attempting to walk away, redirected back...Roommate heard yelling out at resident, [s/he] was attempting to get into bed with [her/him], again with nightgown pulled over her head and adult brief on the floor." A progress note written on 9/11/2021 at 7:50 PM "...awake, consistently wandering, poor safety awareness, bangs [her/his] walker into door ways, chairs, attempting to strip clothing off in hallway..." A progress note dated 9/13/2021 at 6:30 AM states "Noted to be up OOB, wandering again in hallway to lobby." A progress note written on 9/13/2021 at 5:55 AM states "Resident awake all NOC until approx 5am... when out of the room, [s/he] goes in others rooms, found in room 109, brief and pajama bottoms off... trying to get into roommates bed." A progress note written on 9/15/2021 at 7:26 PM states "[Resident #25] was yelling. LNA [Licensed Nursing Assistant] went into room to find [Resident #3] naked trying to sit on [Resident # 25's] bed." On 9/16/2021 at 3:19 a

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progress note states "Resident up several times during NOC. One time leaning over roommate with roommate shouting at [her/him] to go back to bed." A progress note dated 9/16/2021 6:32 AM stated "Up OOB at this time, attempting to get into roommates bed again. Staff heard roommate yelling for her to get into her own bed. Staff separated and redirected." On 9/19/2021 at 6:52 PM "[Resident] wandering in hallway....Five minutes later roommate ringing because {Resident #3] had tried to get in [her/his] bed." A progress note from 9/20/2021 at 6:47AM "Wakeful, wandering, disrobing at beginning of NOC (night) shift." A progress note dated 9/23/2021 4:33 AM states "...then up to roommates side attempting to get into bed with [her/him]. Roommate heard yelling at res (resident) to go to [her/his] own bed." An incident note dated 9/24/2021 at 3:41 AM states "[S/he] attempts to get in bed with [her/his] roommate when in [her/his] own room...Continual attempts to wander in hallway and enter other residents rooms. Unable to redirect." An Incident note dated 9/26/2021 at 6:09 AM states "Awake and wandering most of night."

Per review of Resident #3's care plan, there is no care plan that addresses wandering/intrusive behaviors or interventions instructing staff on what actions to take if Resident #3 is exhibiting wandering/intrusive behaviors.

Per observations on 9/27/2021 at 3:10 PM, Resident #3 was seen in room #103 sitting on Resident #8's bed. Resident #8 stated s/he "does that all the time but doesn't stay long." Resident #3 stood up from the bed and exited the room. At 3:21 s/he was observed wandering up and down the hall, in and out of other resident's rooms. On

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9/29/2021 at 12:55 PM this surveyor was in the activities room meeting with two other surveyors. Resident #3 opened the closed door of the activities room, entered the room, and wandered about the room. A registered nurse (RN) entered and began to redirect the resident out of the room. The RN stated that the resident "gets up all the time and that [s/he] just went to the bathroom and [the resident] had been in [her/his] room. Then [s/he] got up and came out of the room." The RN confirmed that Resident #3 frequently wanders throughout the unit.

During interview on 09/29/21 at approximately 4:30 PM the Director of Nursing Services (DNS) confirmed that Resident #3 was not currently care planned for wandering or intrusive behaviors. The DNS stated that s/he had not been aware of any issues or complaints regarding Resident #3's wandering or intrusive behaviors.

2. Per record review, Resident #19 has a diagnosis of myocardial infarction (heart attack), depressive disorder, dementia, and anxiety disorder. Minimum Data Set assessments from 2/24/21, 5/26/21, and 8/25/21 all confirm the presence of hallucinations and delusions for Resident #19. Per a progress note from 8/9/21 at 17:46, "Staff reports episodes of increased agitation and anxiety of late. Meals have been more challenging as [Resident #19] has been reaching for other residents' food and belongings. [Resident #19] also exhibited some inappropriate verbal exchanges. Staff has had to seat [Resident #19] at a different table at suppertime quite often in order to prevent [their] behaviors from effecting others." A progress note from 8/11/21 at 7:13 PM states, "[Resident #19] refused care tonight. [Resident #19] is undressed and punching at LNA (licensed nursing assistant)." A progress note

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F 656	Continued From page 27 from 8/13/21 at 7:48 states, "Resident answered phone in another residents room. Wandered in hall and tried to go into other rooms, redirected often." A progress note from 8/30/21 at 7:14 PM states, "Behavior Note: Aide reported resident being very aggressive. Yanked at [their] necklace, grabbing clothes, and swinging with [their] hand." Per review of Resident #19's care plan, there is no focus in the care plan for aggression/intrusive behaviors and interventions instructing staff on what actions to take if Resident #19 is exhibiting aggressive/intrusive behaviors. Per interview on 9/29/21 at approximately 10:30 AM, an LNA who regularly works with Resident #19 states that they were aware that Resident #19 has a history of intrusive/aggressive behaviors but is not aware of any plan for managing the intrusive/aggressive behaviors. Per interview on 9/29/21 at approximately 3:30 PM, the DON confirmed that Resident #19 was not currently care planned for intrusive/aggressive behaviors towards others despite remembering there being one for Resident #19 in the past.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657	F 657- Every resident in the building has the potential to be effected by lack of a comprehensive care plan which dictates the care of each resident in the building. The director of social services during the time of the missing conference and at the time of the survey is no longer employed at the Gill Home. We have hired a new director of social services and part of her ongoing orientation will be learning about the care plan meeting regulations and our processes. This orientation will be overseen jointly by the administrator and the DON. Education has been provided to nurses and therapy to update the care plan with new interventions as needed following a change. We have created a tracking tool to ensure a meeting is held within 7 days of the assessment. This will be a topic of QAPI for the next 6 months.	10/31/21

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F 657	Continued From page 28 (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 staff interview and record review the facility failed to review and revise the comprehensive care plan for two of 16 residents in the sample (Residents #3 and #10). Findings include: 1. Per record review, an annual multidisciplinary care conference was conducted on 12/21/2020. There is no documentation in Resident #3's medical record reflecting that a quarterly multidisciplinary care conference was held in March or June of 2021 as required. On 09/29/21 at 5:15 PM the Director of Nursing confirmed that there was no evidence that quarterly multidisciplinary care conferences were held for Resident #3 in March or June of 2021. 2. Per record review, Resident #10 sustained falls	F 657	**TAG F 657 POC Accepted on 11/1/21 by K. Ruffe/P. Cota**	

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without major injury on 1/31/21, 3/20/21, 6/27/21, and 7/10/21. Per review of the care plan, Resident #10 is care planned for "risk for falls." The following interventions are listed under this care plan focus:
- Send to ER (emergency room) for eval as need, post fall (entered 5/3/2019).
- Anticipate resident needs (entered 12/14/2018).
- Ensure appropriate footwear (entered 12/14/2018).
- Following a fall, complete neuros and vital signs per protocol (entered 12/14/18).
- Following a fall, notify the MD, Administrator, DON (director of nursing), and responsible party (entered 12/14/2018).
- Place call bell within reach when in the bathroom or room (entered 12/14/2018).
- Place personal items within reach while in bed (entered 12/14/18).
- PT/OT to screen (entered 12/14/18).
- Respond promptly to toileting requests (entered 12/14/18).
- Review medications for fall risks (entered 12/14/18).

There were no care plan interventions for falls added following any of the falls on 1/31/21, 3/20/21, 6/27/21, and 7/10/21.

Per interview on 9/29/21 at approximately 3:30 PM, a physical therapist/occupational therapist stated that following the falls on 1/31/21 and 6/27/21, Resident #10 was seen for PT/OT (physical/occupational therapy). The therapist provided documentation from these consults. Following these consults, the PT/OT team recommended and implemented some interventions for nursing to use with Resident #10 to help prevent further falls. The therapist

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F 657	Continued From page 30 confirmed that these nursing interventions did not make their way into the care plan and were only communicated via word-of-mouth and a message board within the electronic health record that expired after approximately 2 weeks. Per interview on 9/29/21 at approximately 4:00 PM, the DON confirmed that the care plan for falls had not been updated following any of Resident #10's falls in 2021.	F 657		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732	F 732- On 9/30/21, we revised our daily staffing matrix to include; facility name, date, the total number and the actual hours worked by category of direct care staff and resident census. This matrix is updated in real time to reflect and change in number of direct care staff or hours worked. During the week, this is the responsibility of the administrative assistant and her designee on the weekend. The DON will compare the matrix to the schedule daily while in the building and her designee will be tasked on days when the DON is not in the building. **TAG F 732 POC Accepted on 11/1/21 by K. Ruffe/P. Cota**	9/30/21

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F 732	Continued From page 31 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post the total number of staff directly responsible for patient care and actual hours worked on a daily basis. Findings include: 1. Observation of the facility's posting of staffing on 9/27/21 at approximately 4:00 pm showed that the posting displayed worked staffing hours for RNs, (registered nurses), LPNs (licensed practical nurses), and LNAs (licensed nursing assistants) for the dates of 9/24/21 through 9/28/21 across the day, evening, and night shift. The maximum resident census was also displayed for every day that had already passed. There was no information on the posting for the total number of personnel worked per shift or per day. Per observation of the facility's posting of staffing on 9/28/21 at approximately 9:30 AM, there had been no adjustments or changes made to the posted worked hours of staff on any of the posted dates. Per interview on 9/28/21 at approximately 1:00 PM, the DON (Director of Nursing) stated that the	F 732		

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F 732	Continued From page 32 staff posting is updated daily with any changes to the staffing hours, such as call outs or hiring of additional staff, by an office assistant on weekdays or the staff member who recieves word of a change in staffing on the weekends. The DON confirmed at this time that an LNA had called out of work for a day shift on 9/27/21 and 9/28/21 without being replaced, but it had not been updated in the staff posting. Per observation of the facility's posting of staffing on 9/28/21 at approximately 3:30 PM, adjustments had been made to the worked hours of staff on 9/24/21, 9/25/21, 9/26/21, 9/27/21, and 9/28/21. Per interview on 9/29/21 at approximately 3:00 PM, the DON confirmed that the staffing posting did not include total numbers of staff worked, nor had it been accurately posted and updated daily for the dates of 9/24/21, 9/25/21, 9/26/21, 9/27/21, and 9/28/21.	F 732		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758	F 758- All residents with orders for PRN psychotropic medications have the potential to be effected. The three residents mentioned have had their PRN ativan discontinued for non-use. We have developed an audit tool for 6 months, to track all PRN psychotropic medications, how often they are being used, and recorded stop date. The audit will be assigned to the nurse manager and due to the DON on a monthly basis. This will be a topic at QAPI for the next 6 months. **TAG F 758 POC Accepted on 11/1/21 by K. Ruffe/P. Cota**	10/31/21

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F 758	Continued From page 33 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility failed to ensure that PRN (as needed) psychotropic medications were not prescribed for longer than 14 days without documented rationale	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475052	A. BUILDING _____ B. WING _____	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 34	F 758		

in the resident's medical record and indicate the duration for the PRN order for three of 16 residents in the sample (Residents #8, #26, and #19). Findings include:

1. Per record review Resident #8 has an active order for Lorazepam (Ativan) Tablet 0.5 milligrams (an anti-anxiety medication) - give 1 tablet by mouth every 12 hours as needed for anxiety/restlessness for 99 months. Per pharmacy review dated 8/1/2021 "[Resident] is on 1. Paxil 10mg po qd. 2. lorazepam 0.5mg po qd (daily) and PRN (as needed) q (every) 12 hrs. Recommendation: Please address a GDR (gradual dose reduction) of above combination." The Physicians response includes "I decline the recommendation(s) above because GDR is CLINICALLY CONTRAINDICATED for this individual as indicated below. Continued use is in accordance with the current standard of practice and a GDR attempt at this time is likely to impair this individuals function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder as documented below. Resident has depression related to dementia, loss of function, home, and death of husband." However, review of Resident #8's medication administration record (MAR) reflects that the PRN Ativan was not administered during the months of April, May, June, July, or August of 2021. There is also no rational documented in the record as to why the length of the PRN Ativan was ordered for 99 months exceeding the 14-day as-needed psychotropic medication limit (per regulation).

Per interview with the Director of Nursing (DON) on 09/29/21 at 1:02 PM confirmation was made that the PRN Ativan orders are written for 99

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F 758	Continued From page 35	F 758		

months. The DON stated that this is because "The doctor didn't feel there would be an end date, so instead of having us chasing [her/him] and the residents missing doses going into withdrawal [s/he] stated 99 months as the end date."

2.) A review of Physician Orders for Res. #26 reveals an order dated 3/16/21 for 'Ativan [an anti-anxiety medication] topical gel 1 milligram/milliliter every 4 hours as needed [PRN] for Anxiety, Agitation related to Emotional Lability, Violent Behavior.' Review of the Order Summary lists the Start date as 3/16/21 and the End date as "indefinite".
Review of the Pharmacy Monthly Medication Review dated 7/6/21 reveals a recommendation to the physician which includes "provide stop date for PRN Ativan GEL- Thank you." The Physician's response includes "I accept the recommendation(s) above with the following modifications: Ativan stop date, 99 months."
Additionally, review of Res. #26's Medication Administration Record [MAR] from date of order on 3/16/21 to the date of the survey on 9/29/21 reveals the PRN Ativan order not used once.
Review of the Treatment Administration Record [TAR] from date of the medication order on 3/16/21 to the date of the survey on 9/29/21 reveals behaviors monitored every day, 3 times a day/each shift. The TAR records behaviors one time on one date [7/7/21], and the PRN Ativan was not used.
3. Per record review, Resident #19 has an active order for "Ativan Tablet 0.5 milligrams (an anti-anxiety medication) - give 0.5 tablet by mouth every 6 hours as needed for anxiety/restlessness for 99 months)." There is no rationale

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F 758	Continued From page 36 documented in the record as to why the length of this order exceeds the 14-day as-needed psychotropic medication limit (per regulation). Per review of Resident #19's medication administration record (MAR), no Ativan was administered on an as-needed basis during the months of August and September 2021. Per review of Resident #19's medication regimen reviews done by the facility's pharmacist in the prior 3 months, there was no recommendation from the pharmacist in regard to the Ativan order.	F 758		