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

March 7, 2024

Ms. Maegan McElwain, Administrator
Gill Odd Fellows Home of Vermont
8 Gill Terrace
Ludlow, VT 05149-1004

Dear Ms. McElwain:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **January 24, 2024.** Please post this document in a prominent place in your facility.

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

Sincerely,

Pamela M Cota RN
Pamela M. Cota, RN
Licensing Chief

Enclosure

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 ______	C 01/24/2024

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

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E 000	Initial Comments An unannounced on-site re-certification survey was conducted by the Division of Licensing and Protection on 1/22 -1/24/24 including Emergency Preparedness Requirements for 42 CFR Part 483 requirements for Long Term Care Facilities. The result of the Emergency Preparedness Survey identified no regulatory violations.	E 000		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and 2 complaint investigations, including report #22484 and #22407 from 1/22/24 through 1/24/24 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide reasonable accommodations of needs and preferences related to a mattress for 1 of 26 residents sampled. (Resident #7). Findings include: Per telephone interview on 1/23/24 at 8:38 AM with Resident #7's family member he/she has been advocating for Resident #7 to receive an air	F 558	The facility failed to provide reasonable accommodation of resident needs and preferences. This has the potential to affect all residents residing in the facility. DON has no "stipulations" regarding air mattresses. If not related to skin, therapy would determine risk vs benefit due to decrease in bed mobility, entrapment risk, increase risk of falling from bed, etc. We were not aware of the ongoing request of the overlay since the second mattress replacement, nor have we ever received a grievance over their interpretation of our refusal to accommodate. The resident received her air overlay on 1/30/24. Continued	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: JReichert
TITLE: Director of Nursing
(X6) DATE: 02/21/2024

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

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F 558	Continued From page 1 mattress because of the resident's back pain, but the facility refuses to provide one. The family member stated the reason provided is that the resident does not qualify for an air mattress as he/she can move in bed independently and that Resident #7 does not have any open skin. The family member states that she has told them that s/he is willing to pay for the air mattress and the facility just needs to work with her/him to get it. During an interview on 1/23/24 at 9:09 AM Resident #7 was observed sitting in a recliner chair in his/her room. Resident #7 stated that s/he sleeps in the chair all the time because his/her bed is not comfortable. Resident #7 also said that when s/he requested a new mattress the facility did provide one however, the new mattress still hurts his/her back. S/he is unable to turn in bed because of the mattress. During the interview this surveyor applied pressure to the mattress and it sunk down to the point that the bed frame could be felt. On 1/23/24 review of Resident # 7 record reveals that on 4/15/23 resident #7 was sent to the Emergency room for evaluation of severe back pain and right hip pain after he/she had fallen a week prior. The resulting diagnosis possible compression fracture of the Thoracic vertebra 11 (a fracture of the mid-back area). Per interview on 1/23/24 at 1:45 P.M. with a Licensed Nurse Assistant Resident #7 does sleep in his/her recliner, and occasionally will try to get into the bed but it doesn't last long because it is too uncomfortable. During a phone interview on 1/23/24 at 3:05 P.M. Resident #7's physician said that they recall that	F 558	Accommodations available at the facility will be reviewed at next month's resident counsel meeting, and discussed at each quarterly/annual care plan meeting with residents and their families. The DON and Administrator will ensure the residents are receiving reasonable accommodations as requested. This will be a topic of QAPI for the next 6 months. We are in substantial compliance as of 2/22/24. **Tag F 558 POC accepted on 3/7/24 by S. Freeman/P. Cota**	

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F 558	Continued From page 2 the Director of Nursing (DON) had stipulations in regards to providing an air mattress for Resident #7. The Physician does agree that an overlay air mattress may help to relieve the pain and he/she will discuss this with the DON. The Physician confirmed that the overlay air mattress is appropriate for Resident #7.	F 558		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in	F 626	The facility failed to accept a resident back after being transferred to an acute care facility for evaluation. Resident was sent out for posing a risk to other residents in the building by attempting to trip them, flipping over a dining room table in a room full of residents, and removing a walker from another resident (not his/her walker) and throwing it down the hall that was occupied by staff and other residents. At that time, allowing him to remain in the facility put other residents in the building in danger as was listed on the discharge/transfer notice provided to the wife and hospital. This was not a refusal to let him come back, as evidenced by his readmission to the facility on 9/29/23. Administrator, DON, and Medical Director, felt the risk to other residents to be too great on the day he was sent out. A tag is preferred to another resident getting injured. The discharge/transfer policy has been Updated. This will be reviewed at QAPI. Resident's being sent out will have The right to return to the next Available bed. We are in compliance as of 2/22/24. **Tag F 626 POC accepted on 3/7/24 by S. Freeman/P. Cota**	

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F 626	Continued From page 3 § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to accept a resident back after being transferred to an acute care facility for evaluation for 1 of 26 residents sampled. (Resident #33). Findings include: Per the record review Resident #33 was admitted to the facility on 9/13/2023 for Long Term Care with diagnoses of Parkinson's and Dementia with Psychotic disturbance. Progress notes written between 9/19/23- 9/21/23 reveal that Resident #33 began exhibiting aggressive behaviors, was placed on 1:1 supervision for safety, and was then transferred to the hospital on 9/21/23. A review of the hospital Discharge summary dated 9/29/23 reveals that Resident #33 was seen in the emergency department (ED) and the initial workups was "unremarkable." The facility refused to allow Resident #33 to return and s/he stayed in the ED for a week. A Social Services progress note written on 9/19/23 states that the Director of Social Services (DSS) spoke to Resident #33's spouse and explained that the facility could not always provide 1:1 supervision and that if the behaviors continued s/he may be discharged home. On 9/21/23 Resident #33 was transferred to the hospital with aggressive behaviors. A progress note written on 9/21/23 by the Director of Nursing	F 626		

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F 626	Continued From page 4 (DON) states "the resident had been on 1:1 supervision most of the night. The resident was kicking LNAs and trying to trip people as they walked by ... Resident threw [his/her] walker across the hallway which luckily did not make contact with another resident..." Another progress note written on 9/21/23 by the DON reveals that although the resident was not exhibiting and behaviors for a few hours at the hospital emergency department the DON refused to allow Resident #33 to return to the facility. Per an interview with the Director of Nursing (DON) on 1/24/24 at 9:33 AM her/his understanding of Resident #33 before admission to the facility was that behaviors were not a problem for him/her. However, a hospital discharge summary found in the resident's record dated 9/13/23 (original date admitted to the facility) reveals under the hospital summary " ...overnight and this morning patient required an as-needed dose of (PRN) Seroquel (Seroquel is an anti-psychotic medication used to treat certain mental health mood disorders) for impulsive behavior and requires frequent re-direction would suggest scheduled evening dose of Seroquel with additional PRN (as needed) dose" indicating that Resident #33 did have behaviors prior to admission. Therefore, the facility staff should have known there was a potential for behaviors. The DON confirmed that Resident #33 was on 1:1 monitoring when he/she flipped the table over and that no other residents were harmed during this event. The DON said that transferring Resident #33 was the only way his/her behavior could be managed by the facility. The DON confirmed that Resident #33 was not allowed to return to the facility based off his/her behaviors at the time of transfer, not per his/her current	F 626		

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F 626	Continued From page 5 condition. A review of the Facility Assessment Tool (a facility assessment is a required document used to evaluate the facility's capabilities to provide services to the residents in the facility) Part 2 reveals that the facility has the ability to care for residents with Mental Health issues and Behaviors including "Managing the medical conditions and medication-related issues causing psychiatric symptoms and behaviors, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD and other psychiatric diagnoses."	F 626		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision.	F 636	The facility failed to comprehensively Assess a resident's physical needs related To requiring a CPAP machine. The above has the potential to affect Any resident that has equipment Brought in after admission. As part of the admission packet, We have added that the charge Nurse on duty must be made aware of Any equipment that is brought in by Family following admission and that Such equipment will not be able to be Used until cleared for safety hazards by The maintenance department. Staff have been in-serviced regarding Notifying the DON, social services, and Maintenance of such equipment. The DON and Maintenance Director or Designee will monitor that this is being Consistently Followed. This will be a Topic of QAPI for the next 6mo or Longer. We are in compliance as of 2/22/24.	

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F 636 Continued From page 6

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

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

F 636

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F 636	Continued From page 7	F 636		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to comprehensively assess a resident's physical needs related to requiring a Continuous Positive Airway Pressure Machine (CPAP) for 1 of 26 residents sampled. (Resident #188). Findings include:

During an interview with Resident #188 on 1/22/23 5:12 P.M. a Continuous Positive Airway Pressure Machine (CPAP) was noted on the resident's bedside table. (This is a machine that uses mild air pressure to keep breathing airways open while you sleep. The air pressure delivered is determined by the pressure setting on the device.). Resident #188 stated that he/she wears his/her CPAP at night, and the nursing staff does not assist him/her with the CPAP. He/she stated s/he puts it on, turns it on, and removes it him/herself.

Per record review Resident #188 has a diagnosis of sleep apnea (A potentially serious sleep disorder in which breathing repeatedly stops and starts.) requiring the use of the CPAP. A physician's order is in place for "CPAP at night and for naps every evening and night shift document refusals to wear or frequent removal." The Admission comprehensive assessment/ Minimum Data Set (MDS) with Assessment Reference Date (ARD) (This is a 7-day look back period where the facility gathers the information to be entered into the MDS) of 1/16/24 Section O Special treatments, procedures, and programs the use of a CPAP is coded "NO". Indicating the resident does not use a CPAP.

Per an interview with the Director of Nursing

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F 636	Continued From page 8 (DON) on 1/24/24 at 2:12 p.m. completing the resident MDS is part of his/her job, he/she confirmed that the CPAP is not coded on the Admission MDS, therefore the MDS does not accurately reflect Resident #188's status.	F 636		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655	The facility failed to develop a baseline Care plan that allows for the facility to Implement care for each resident that includes Instructed needed to provide effective and Person centered care within 48hrs. This has the potential to affect any resident Admitting to the facility. Baseline care plan assessment has been Updated to include asking about skin integrity, and Then if ‘yes’, is it pressure and if so, where? And see orders for instruction.” 02 and CPAP needs have been added to The ICP to meet the requirement. All ICP (interim care plans) will be Reviewed by DON and departments with 48hrs of admission and a topic to be reviewed at QAPI for the next 6months. In compliance as of 2/22/24. **Tag F 655 POC accepted on 3/7/24 by S. Freeman/P. Cota**	

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F 655	Continued From page 9 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to develop a baseline care plan within 48 hours of admission for 2 of 26 residents in the sample (Residents #188 and #237) related to a continuous positive airway pressure (CPAP) (a machine that uses mild air pressure to keep breathing airways open while you sleep) device (Resident #188), and a baseline care plan that included instructions needed to provide effective care related to a pressure ulcer (Resident # 237). Findings include: 1. During an interview with Resident #188 on 1/22/24 5:12 PM a CPAP machine was noted on the bedside table. Resident #188 said that he/she wears his/her CPAP at night and that the nursing staff does not assist him/her with it. Resident #188 stated s/he puts it on his/herself, turns it on, and removes it him/herself. He/ She also stated it has not been cleaned since he/she has been in the facility which has been about 2 weeks. Per record review Resident #188 was admitted to the facility on 1/9/24 with a diagnosis of sleep apnea (A potentially serious sleep disorder in	F 655		

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which breathing repeatedly stops and starts.) requiring the CPAP. A physician's order states "CPAP at night and for naps every evening and night shift document refusals to wear or frequent removal." There is no physician's order or instructions noted for a cleaning schedule for the CPAP. Resident #188's care plan initiation date of 1/9/24 reveals that the use and care of the CPAP is not on the baseline care plan.

Per interview on 1/24/24 at 1:01 p.m. with a Registered Nurse (RN) he/she does not know how to access the care plan to look to see if the CPAP is on the baseline care plan. The RN stated "I do not deal with the CPAP, I have not looked at it or applied it."

During an interview with a second RN on 1/24/24 at 1:17 p.m. the baseline care plan was reviewed, the RN confirmed the CPAP is not on Resident #188's baseline care plan.

During an interview on 1/24/24 at 2:12 p.m. the Director of Nurses (DON) also confirmed the use or care of the CPAP is not on the baseline care plan.

2. Per record review, Resident #237 was admitted to the facility on 1/11/24 with the following diagnoses: unstageable pressure ulcer (an ulcer with the base completely obscured by dead tissue) of the left heel, and chronic osteomyelitis (a serious infection of the bone) of the left ankle and foot.

Per record review a hospital discharge summary dated 1/11/2024 indicates a chronic unstageable left heel ulcer with wound care instructions to leave open to air while dry and stable, may paint

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F 655	Continued From page 11 with Betadine daily. If drainage occurs, apply a border dressing (a type of protective dressing) and change it every third day and as needed. A review of Resident #237's baseline care plan reveals no mention of a left heel wound. During an interview on 1/24/2024 at approximately 1:40 PM the Director of Nursing confirmed there was no mention of Resident #237's pressure ulcer in the baseline care plan. The facility failed to create a care plan that included instructions needed to provide effective care for the pressure ulcer.	F 655		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that professional standards of practice were followed for 3 of 26 residents in the sample. (Resident #36) related to assessment and monitoring after a choking episode, and (Resident # 188 and Resident #7) related to safe administration and monitoring of diabetic medications and blood glucose monitoring. Findings include: 1. Per record review Resident #36 experienced a choking episode which required oropharangeal suctioning. A SBAR (Situation, Background, Assessment, Request form) Note written by the Registered	F 658	The facility failed to meet the professional standards of quality by not following up by monitoring a resident that had an aspiration episode. A new policy has been drafted to include a note every shift for 3 days, monitoring of oxygen level and lung sounds for the same time period. This has the potential to affect everyone in the building that is at risk for aspiration. ' Any aspiration episode is to be reported to the DON and MD, and a report made in risk management. This will be reviewed at each QAPI meeting. In compliance as of 2/22/24. The facility failed to meet the professional standards of quality by not care planning for a CGM. Resident has had an order for glucose Monitoring since her admission date. She receives both scheduled and sliding Scale insulin, which would not be possible Without a subsequent order to monitor Glucose to determine coverage needed. Continued..	

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Continued From page 12

Nurse (RN) on duty on 9/21/2023 states "LNA (Licensed Nurse Assistant) brought resident to me, from Lunch room, to Nurse station. Resident was breathing rapidly and pointing to [his/her] mouth, unable to speak or cough. This RN obtained code cart and used suction and yankeur to clean mouth back of throat and illicit cough which produced chocolate milk. Resident immediately felt better". The progress note states that both the Director of Nursing and the Physician were notified however, there were no recommendations documented. There was no evidence of further assessment or monitoring to ensure the resident did not develop complications related to aspiration (food or fluid entering the airway and lungs by accident. This can lead to pneumonia and scarring of the lungs) and suctioning.

During an interview on 1/24/24 the Director of Nursing confirmed that Resident #36 should have been further assessed and monitored, but was not.

2. During an interview with Resident #188 on 1/22/23 at 5:12 P.M. a round object covered in bandage tape was observed on Resident #188's upper arm. Per Resident #188 the object on his/her arm was a continuous blood sugar monitor (A continuous glucose monitor (CGM) estimates what your glucose is every few minutes and keeps track of it over time. A tiny sensor is inserted under the skin on your abdomen or arms with an adhesive patch that helps it stay in place). She/he uses his/her cell phone to obtain blood sugar values and then he/she tells the nurses, stating this is how the nurses monitor his/her blood glucose level. The resident also stated that the nurses do not do blood glucose finger sticks.

F 658

This has the potential to affect everyone in the building that has a CGM device.
Any medical equipment that has been Brought in from home, is to be reported to the DON. If it is electric, it must be cleared by maintenance prior to use. Admission paperwork has been updated reminding families of the importance of making staff aware of new items brought in after the admission date.
This will be reviewed at each QAPI meeting.
In compliance as of 2/22/24.

Tag F 658 POC accepted on 3/7/24 by S. Freeman/P. Cota

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The resident revealed that the glucose monitor has tape over it because it has been in his/her arm for a while. She/he is unable to recall how long exactly, but at least since before he/she was originally admitted to the hospital, and he/she does not want it to fall out.

Per record review a physician order states Lispro (a short-acting insulin)16 units three times a day with meals and Lantus (a long-acting insulin) 50 units subcutaneously at bedtime. There is no physicians order for glucose monitoring. There is also no order for the CGM device that the resident has in his/her right upper arm. A care plan focus problem states: "Resident has Type 2 diabetes Goal: Resident will not experience complications from diabetes through the review date" interventions include monitoring blood sugar as ordered, and notifying MD of blood glucose levels outside of ordered parameters. There are no interventions in place related to the CGM device.

According to American Diabetes Association the following professional standard related to the CGM device;
1. "When prescribing a device, ensure that people with diabetes/caregivers receive initial and ongoing education and training ...". https://diabetesjournals.org/
2. "For safety you may sometimes need to compare your CGM glucose readings with a finger-stick test and a standard blood glucose meter"
"Disposable CGM sensors should be replaced every 7 to 14 days ..." https://www.niddk.nih.gov/
3. Calibrate the device with a fingerstick blood glucose reading https://my.clevelandclinic.org/

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Per interview on 1/24/24 at 1:01 PM with a Registered Nurse (RN) Resident #188 tells her/him what their glucose is before the RN gives Resident #188's insulin before meals. The RN confirmed that there is no order for glucose monitoring and no order for the CGM device. This RN also confirmed he/she has had no training or competency on the care or management of the CGM Device, she/he is unaware of any schedule to change the device.

During an interview on 1/24/24 at 1:17 P.M. a second RN confirmed there was no order for glucose monitoring for Resident #188 and this RN has had no training or competency on the CGM device.

Per interview on 1/24/24 at 2:12 PM the Director of Nursing (DON) stated "I didn't know she/he had that thing" (in reference to the CGM device). "We do not have a policy for them, we should be checking finger stick blood sugars with a glucometer." (a glucometer is a device for measuring the concentration of glucose in the blood, typically using a small drop of blood placed on a disposable test strip).

3. Per record review, Resident # 7 has a diagnosis of Diabetes Type 2. A review of Physician orders reveals an order for Novolog (short-acting insulin) 10 units three times a day with meals and an order for Levemir (long-acting insulin) twice a day. There is no order to check Resident #7's blood sugar.

During an interview on 1/23/24 at 8:45 AM Resident #7 stated "They do not check my blood sugar and I take insulin" The resident stated that this worries him/her. Resident #7 further stated

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F 658	Continued From page 15 that he/she has requested to have his/her blood sugars monitored and staff told him/her they would check his/her blood sugar in the in morning, but this is not happening. According to the American Diabetes Association "Blood glucose (blood sugar) monitoring is the primary tool you have to find out if your blood glucose levels are within your target range. This tells you your blood glucose level at any one time. It's important for blood glucose levels to stay in a healthy range. If glucose levels get too low, we can lose the ability to think and function normally. If they get too high and stay high, it can cause damage or complications to the body over the course of many years." https://diabetes.org/ During a phone interview on 1/23/24 at 3:05 PM with Resident # 7's physician confirmed that Resident #7 should have glucose monitoring in place. Per interview on 1/24/24 at 11:00 AM the DON confirmed that Resident #7's blood glucose had not been being monitored. The DON stated that s/he had spoke with the doctor yesterday and obtained orders for Blood sugar monitoring.	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689	The facility failed to ensure that resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Care plan of #33 has been updated Regarding resident wishes. Resident #12 and #33: Task has been added to LNA charting For them to sign off, Acknowledging Frequent checks during the shift for Safety. Staff will continue to monitor For unwanted visits and safety. Falls and wandering behaviors are monitored and will be ongoing topics of QAPI, they will also be brought Up at resident counsel for resident feed-Back. Next counsel meeting to be held In March. Results to be reported to DON. In compliance as of 2/22/24.	

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to ensure all residents have adequate supervision to prevent accidents for 2 of 26 residents sampled (Resident #33 and Resident #12). Findings include:

1. Per record review Resident #33 has diagnoses of dementia with psychotic disturbance and Parkinson's disease. A Brief Interview for Mental Status (BIMS) dated 9/13/23 revealed Resident #33's score of 9 (A BIMS score is a cognitive screening measure that evaluates memory and orientation.) A BIMS score of 9 indicates moderate cognitive impairment. Resident #33's care plan date initiated 9/14/23 has the following focus: "Resident is at risk for falls". The goal is "resident will not sustain an injury from falls through the review date" with interventions including close supervision for safety- impulsivity and frequent checks while in the room for safety. A review of LNA task documentation shows no documented evidence that staff is providing close supervision or frequent checks. Further record review reveals that Resident #33 had a hospital admission from 9/21/23 through 9/29/23 for behaviors the facility stated they could not manage. Resident #33 has had 20 falls since the original admission on 9/14/23 to present. All but one of these falls were unwitnessed, 19 took place in the resident's room at the bedside while he/she was unsupervised.

A nursing progress note written 1/19/24 states "Over the past month staff have attempted to encourage resident to spend time out of his/her room during the day for safety, closer supervision and to prevent falls, resident has not been

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agreeable to this and states 'you just want to babysit me'. Reminded that the measure is for safety and is an intervention we have been trying in an attempt to lessen his/her risk for fall or injury. He/she states that he/she 'does not care, and we cannot stop him/her'. The Wife is aware of the failed trial of this measure and of this wish to not be monitored or spend extra time out of his/her room. We have explained the right to fall, and our interventions lessen the risk of major injury. Staff will continue to monitor as allowed and respond quickly to any request." However, no care plan update regarding the Resident's wishes was found related to this note.

During observation on 1/22/24 at 11:40 AM Resident #33 was sitting in a wheelchair, self-propelling around the unit. When the resident stopped moving, he/she would make gestures as if he/she was trying to stand up, but was unable to. Staff noted to be walking by and did not respond or ask Resident #33 if he/she needed anything.

On 01/24/24 at 09:13 a.m., during an interview the Director of Nurses (DON) stated that staff does do frequent checks on the resident. However, the DON confirmed that the checks are not documented in the record and cannot provide evidence that close supervision or frequent checks have been done.

2. Per record review, Resident #12 was admitted to the facility on 5/16/2023 with diagnoses of vascular dementia and Alzheimer's disease and a brief interview for a mental status (BIMS) score of 6, indicating severe cognitive impairment.

Per record review, an incident note dated

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F 689	Continued From page 18 12/10/2023 indicates Resident # 12 was found lying on the floor in another resident's room with a bump on her/his head. A nursing note dated 11/15/2023 indicates Resident #12 constantly goes in and out of other residents' rooms, is not easily redirected, and requires constant supervision. On 1/22/24 at approximately 2:35 PM, Resident #12 was observed in a closed room going through its contents; an interview with a Licensed Nursing Assistant (LNA) at approximately 2:50 PM the same day revealed that they did not know where Resident #12 was. At 2:55 PM, Resident #15 shouted, "[s/he] is in here again." During an interview with Resident #15 on 1/22/2024 at approximately 11:34 AM, s/he stated that frequent uninvited visits to his/her room by Resident #12 were causing him/her to be nervous and upset. Often, Resident #12 would come into his/her room, rifling through her belongings, swearing and shouting at him/her, or shaking his/her fists when asked to leave. Per record review, Resident #15 has resided at this facility since 10/30/23, and his/her BIMS score is 15, indicating s/he is cognitively intact. On 1/25/24 at 11:40 AM, an interview with the Director of Social Services revealed that s/he was aware of resident concerns regarding Resident #12 going in other's rooms. S/he stated, "[s/he] goes in every room." On 1/25/24, at approximately 1:20 PM, the Director of Nursing confirmed the facility was not providing adequate supervision of Resident #12 to protect him/her and other residents from accidents.	F 689		

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F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide respiratory care consistent with Professional standards of practice for 1 of 26 residents sampled. (Resident #188). During an interview with Resident #188 on 1/22/23 5:12 P.M. a Continuous Positive Airway Pressure Machine (CPAP) was noted on the resident's bedside table. (This is a machine that uses mild air pressure to keep breathing airways open while you sleep. The air pressure delivered is determined by the pressure setting on the device.) The resident turned the machine on and there were specific settings programmed into the machine. The resident stated his/her spouse brought the machine in from home. Resident #188 said that he/she wears his/her CPAP at night, and the nursing staff does not assist him/her with the CPAP. He/she stated he/she puts it on, turns it on, and removes it him/herself. He/She also states it has not been cleaned since he/she has been in the facility which has been about 2 weeks. Per record review Resident #188 has a diagnosis	F 695	The facility failed to provide respiratory care consistent with Professional standards of practice due to not having the settings of the CPAP in the orders or plan of care. This has the potential to affect all residents receiving this type of therapy/ Per policy, it should have been set to Default settings of 10cmH2O. Settings Were obtained from PCP in the Community and added to the orders. Cleaning schedule added to orders and Plan of care. Policy updated staff education Completed via handout for cleaning. Each resident that admits with orders for A CPAP/BIPAP/APAP, will be reviewed By DON to ensure plan of care is Consistent per policy. Number of Residents receiving this therapy will be Reviewed for compliance at QAPI times 6 months. In compliance as of 2/22/24. **Tag F 695 POC accepted on 3/7/24 by S. Freeman/P. Cota**	

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of sleep apnea (A potentially serious sleep disorder in which breathing repeatedly stops and starts) requiring the use of the CPAP. A Discharge Summary dated 1/8/24 for Resident #188 states the following "hospital course complicated by acute respiratory failure in the setting of altered mental status while on CPAP leading to aspiration pneumonia." Further review reveals the discharge summary does not give instructions for CPAP use. A physician's order for "CPAP at night and for naps every evening and night shift document refusals to wear or frequent removal" There are no orders for the CPAP settings that should be programmed into the machine.

There is no note in the record that indicates where this CPAP machine came from, hospital, home, or a rental company. There is no evidence in the record that the setting for the CPAP has been evaluated since he/she had the event of altered mental status while on CPAP that resulted in aspiration pneumonia. According to https://www.sleepfoundation.org "The right amount of pressure is critical to effective CPAP therapy, as pressure that is too low or too high can create adverse side effects. The pressure setting is crucial to treating sleep apnea and reducing CPAP pressure levels, as determined by a sleep specialist, are typically the lowest amount of pressure needed to keep the airway open ...." https://www.sleepfoundation.org

Per Review of the facility policy titled Policy and Procedure of CPAP and BIPAP Units during SNF(skilled nursing facility) Stay. Effective date 12/1/21. Under Policy section states "in the event that the ordering physician cannot be contacted, and the patient does not know their CPAP/BIPAP

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F 695	Continued From page 21 setting the machine will be set to default setting 10cmH2O for CPAP and 10/5cmH20 for BiPAP." This section also states "Every attempt will be made to obtain the specific settings from the physician." An interview with a Registered Nurse (RN) on 01/24/24 reveals that the nurse "does not deal with the CPAP", he/she has not looked at it or applied it and has had no teaching or competency on the CPAP machine, and as far as he/she knows there is no cleaning schedule for the machine. Per an interview with the RN Director of Nurses (DON) on 1/24/24 he/she confirms that the orders for the CPAP do not include the settings and the order should be inclusive of the settings. He/she also confirms that there is no cleaning schedule for the CPAP and that staff has not been assessed for competency related to the care and use of the CPAP machine.	F 695		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident	F 710	The facility failed to ensure that the physician evaluated and assessed a pressure ulcer. While the physician was aware and updated on wound progress, staff failed to provide the date of the update and MD failed to mention the wound in his Progress notes. This has the potential To affect all residents residing in the Facility. The MD visited on 1/30/24 And noted the pressure ulcer as present On admission and provided assessment. Going forward, nurse manager during MD Rounds will ensure that MD is updated On skin impairments and progress of Healing to ensure that it is mentioned In his progress notes. DON will review Notes upon receipt to ensure proper Documentation. Added to QAPI for review x 12 months. In compliance as of 2/22/24.	

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F 710	Continued From page 22 is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that the physician evaluated and assessed a pressure ulcer for 1 of 26 residents sampled. (Resident #33). Findings include: Per record review an Admit/Readmit Screener form written on 9/29/23 Section 3 Skin Integrity reflects that Resident #33 had a blister and reddened buttocks. There are no measurements documented for the blister and no measurement or description of the reddened buttocks documented on the form. A progress note written on 9/29/23 states " ...scratching marks noted in lower legs and knees. Red areas in buttocks and dry skin noted throughout the body". There is no note regarding the blister on the sacrum nor is there evidence that physician was made aware of the blister or reddened areas. Review of a Wound- Weekly Observation tool dated 10/5/23, the blister on the sacrum worsened to an open wound that measures 25 millimeters(mm) in width, 12 mm in length, and 2 mm in depth, the wound bed is 100% slough and there was a noted odor to the wound. In Section A. Communication 1a. Date Medical Doctor(MD) notified / last updated states "10/5/23." A verbal order for a wound treatment was documented at the time of notification. Wound-Weekly Observation tools documented on the following dates 10/5/23, 10/12/23, 10/19/23, 10/26/23,	F 710	**Tag F 710 POC accepted on 3/7/24 by S. Freeman/P. Cota**	

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11/2/23, 11/9/23, 11/16/23, 11/30/23, 12/7/23, 12/14/23, 12/28/23, 1/4/24, 1/11/24, and 1/18/24 under section A. Communication 1a. the date the MD notified/last updated continues to state "10/5/23" indicating the Physician has not been updated regarding the progress of the wound since the pressure ulcer was presented as an open wound. Physician progress notes dated 10/5/23, 11/21/23, and 12/19/23 reviewed revealed no documented evidence that the Physician assessed this wound in any of the 3 progress notes. The only reference to the skin in the 3 Physician progress notes is "s/he reports no rashes." Treatment of the pressure wound is not addressed in any of the Physician progress notes.

During an interview on 1/24/24 at 9:33 A.M. the Director of Nursing (DON) was informed that this surveyor was unable to find documentation that the Physician had evaluated and assessed Resident #33 pressure ulcer. The DON stated, "I know he/she is aware of it" however, he/she could not provide supporting documentation that the Physician has evaluated or assessed this pressure ulcer.

F 726 SS=F — Competent Nursing Staff
CFR(s): 483.35(a)(3)(4)(c)

§483.35 Nursing Services
The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in

F 726 (Plan of Correction):
The facility failed to ensure that licensed nurses and aides have the specific competencies and skill sets documented in their files necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. On 2/7/24, the facility purchased “Staff Competency Toolkit” from Briggs Health Care.

Continued..

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accordance with the facility assessment required at §483.70(e).

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

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

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to ensure that nursing staff were assessed for skills competency upon hire and annually, based on the care needs of the residents who reside in the facility. Findings include:

Per review of employee training and competency records, nursing staff did not have evidence of annual skills competency evaluations.

An employee record for a Registered Nurse (RN) who was hired on 11/20/23 had a Competency Checklist dated 12/7/23. This checklist lists various skills and offers instructions as follows:
1. Observe each skill below
2. Provide a Pass or fall rating
3. Place an N/A for any skill that doesn't applying

F 726

Education RN is working with staff to
Complete competencies during their
Usual working hours.
These competencies include hand
Washing, donning and doffing PPE,
Dementia, safe body mechanics,
Lifts, wound care, and medication
Administration, etc. On 2/13/24,
The facility purchased a LTC clinical
Procedures manual from which we
Can create more competencies if a
Educational need arises.
Plan in place to have 40% of staff
Competencies reviewed by 3/1/24.
Ongoing education and competency
completion will be an ongoing topic
of QAPI indefinitely.

Tag F 726 POC accepted on 3/7/24 by S. Freeman/P. Cota

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current resident population.
Any skill failed will need follow up.

This checklist was signed by the RN who assists with staff education on 12/7/2023. However, there were no actual competencies present in the file.

A Licensed Practical Nurse (LPN) hired on 2/4/2021 had competencies completed in 2023 for hand washing and IV's. However, there was no Competency Checklist completed, and there were no other competency reviews for 2023 in the file.

A Licensened Nursing Assistant hired on 6/3/2020 had a Competency Checklist signed by the RN who assists with staff education on 1/5/23. There was no evidence of completed competencies in the file.

A LNA hired on 3/17/2020 had a Competency Checklist completed on 1/5/2023 with no evidence of actual completed competencies.

Another LNA had a Competency Checklist completed on 9/26/23 with no actual competencies completed.

Per interview on 1/24/24 at 1:01 PM with a staff Registered Nurse (RN) the facility has not assessed him/her for competency including the use of a CPAP machine (a machine that uses mild air pressure to keep breathing airways open while you sleep. The air pressure delivered is determined by the pressure setting on the device), blood glucose monitoring, or blood draws.

During an interview on 1/24/24 at 1:17 PM the

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F 726	Continued From page 26 Registered Nurse who assists with the education of staff confirmed that staff are not assessed for proper medication administration on hire or annually. The RN stated "if they are experienced we just let them do it, we do not watch them." On 1/24/24 at 2:30 PM the RN also confirmed that s/he does not routinely do competencies with staff. The Checklist is reviewed and instruction is provided when needed. During an interview on 1/24/24 at 2:12 PM the Director of Nursing confirmed that the nurses had not been assessed for competency in the care and use of a CPAP machine or routine blood draws. During an interview on 1/24/24 at 4:30 PM the Director of Nursing confirmed that the facility has not implimented a fully intact competency evaluation process that includes the skills required to care for the residents who reside there.	F 726		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880	The facility failed to ensure proper infection control processes were followed during a pressure wound dressing change and cleaning of a Continuous Positive Airway Pressure Machine (CPAP). This has the Potential to affect all residents receiving Wound care as well as residents receiving This type of respiratory care. Wound care/Dressing policy reviewed with The nurse. Competencies have been Purchased that will be reviewed with each RN/LPN on staff, including demonstration. A cleaning schedule has been established For each of the residents using a BiPAP/ CPAP machine. This has been added to Their orders as well as their plan of care. Continued..	

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F 880	Continued From page 27 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880	CPAP policy has been updated and Education provided. Resident #188 is No longer residing at the facility. Nurses must sign off the cleaning Schedule on the TAR to verify task Completion. Policies and procedures have been added as an ongoing topic of QAPI indefinitely. In compliance as of 2/22/24. **Tag F 880 POC accepted on 3/7/24 by S. Freeman/P. Cota**	

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F 880	Continued From page 28 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure proper infection control processes were followed for 2 of 26 residents sampled. (Resident #33) during a pressure wound dressing change and cleaning of a Continuous Positive Airway Pressure Machine (CPAP) for (Resident #188) Findings include: 1. During an observation on 1/23/24 at 2:10 p.m. of a dressing change to a pressure ulcer on Resident #33's sacral area, the Registered Nurse (RN) removed the dirty dressing from the wound with a gloved hand laying the dirty dressing on the bed covers. The RN did not remove her/his gloves, did not sanitize her/his hands, and did not apply clean gloves after removing the dressing. S/he then handled the medicated ointment tube and applied ointment to her/his gloved finger and applied the ointment that was on her/his gloved finger to Resident #33's open wound. The RN picked up the clean dressing and applied it to the resident's sacral area. S/he picked up the dirty dressing on the bed covers, removed her/his gloves, and disposed of the dirty dressing and gloves, and washed his/her hands.	F 880		

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During an interview with the RN who performed the dressing change directly after the observed procedure, the RN confirmed that S/he should have removed Her/his gloves and sanitized Her/his hands between removing the old dressing and applying the ointment and new dressing. The RN also confirmed that the old dressing should not have been laid on the bed covers, but should have been disposed of at that time of removal.

2. Per record review Resident #188 has a diagnosis of Sleep Apnea requiring the use of a CPAP machine. A physician's order states "CPAP at night and for naps every evening and night shift document refusals to wear or frequent removal." There is no physician's order or instructions given for a cleaning schedule for the CPAP equipment.

Per interview with Resident #188 on 1/22/24 5:12 PM he/she wears his/her CPAP at night. The resident stated that nursing staff does not assist him/her with the CPAP. He/she stated that s/he puts it on, turns it on, and removes it him/herself. He/ She also stated that the CPAP equipment has not been cleaned since he/she has been in the facility which has been about 2 weeks.

According to FDA.gov, regarding recommendations for cleaning a CPAP machine "All types of CPAP machines need to be cleaned regularly so that these germs and contaminants do not grow inside of your equipment and make you sick. Dust and dirt can also cause problems with the machine, making it more likely to break or need replacement." (https://www.fda.gov/). Along with the FDA recommendations sleephealthsolutionsohio.com; provides the following information; "CPAP equipment

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F 880	Continued From page 30 manufacturers recommend regular cleanings. They advise washing out the mask, tubing and CPAP humidifier chamber at least once a week. Rinsing the mask and hose daily is also a good practice that helps keep them clean in the interim. Experts also recommend washing the parts out daily if you are sick. " (https://www.sleephealthsolutionsohio.com/) During an interview on 1/24/24 at 1:01 PM with a Registered Nurse (RN) who cares for Resident #188 s/he stated that s/he "does not deal with the CPAP", he/she has not looked at it or applied it and has had no teaching or proven competency on the CPAP machine. As far as he/she knows there is no cleaning schedule for the machine. During an interview on 1/24/24 at 1:17 PM a second RN confirmed that there was no cleaning schedule for Resident #188's CPAP. During an interview on 1/24/24 at 2:12 PM the Director of Nursing (DON) confirmed that there is no cleaning schedule for the CPAP equipment. The DON also confirmed that nursing staff have not been required to prove competence regarding the use or care of a CPAP machine.	F 880		