VERMONT

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

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

May 21, 2024

Ms. Jennifer Combs-Wilber, Administrator
Green Mountain Nursing and Rehabilitation
475 Ethan Allen Avenue
Colchester, VT 05446-3312

Dear Ms. Combs-Wilber:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **March 28, 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
	475040	A. BUILDING _____ B. WING _____	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN MOUNTAIN NURSING AND REHABILITATION	475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446

(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 onsite, unannounced survey of the facility's emergency preparedness program on 3/27/2024 through 3/28/2024 during a recertification survey. The following deficiencies were identified:	E 000	**Preparation and submission of this Plan of Correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and submitted solely because of requirements under state and federal laws.**	
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive	E 004	E004 It is the policy of Green Mountain Nursing & Rehabilitation to develop and maintain an emergency preparedness plan that addresses emerging infectious diseases. No residents and/or staff were affected by this alleged deficient practice. All residents/and/or staff have the potential to be affected by this alleged deficient practice. The facility does have a EP Plan evidenced by; The EP plan for infectious diseases is not located in the Red Emergency Binder developed by our Maintenance Supervisor. It is located in the OP & P binder as noted below. The Red Emergency Binder is not the sole contents of documentation of our EP program/plan. The Red binder contains procedures for staff. Further EP policies and procedures are located in the facility Operational policies & procedures(OP&P). The full EP OP&P to include The Red binder was reviewed 12/2023, annual approval of adoption on January 17th 2024 by QAPI committee. If policies stand as read, no changes are made.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Jones-Wilbur	LNHA	04/29/2024

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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E 004	Continued From page 1 emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and maintain an emergency preparedness plan that addressed emerging infectious diseases. This deficient practice could affect all occupants. Findings include: Per review of the facility's emergency management plan, last reviewed in 12/2023, with the Maintenance Supervisor on 3/28/24 at 10:55 AM, the facility's emergency management plan did not include hazards related to emerging infectious diseases such as influenza, COVID-19, or any other infectious diseases. The Maintenance Supervisor confirmed that the emergency management plan did not address emerging infectious diseases. This finding was reviewed with the Administrator on 3/28/2024 at 12:45 PM and s/he was unable to provide evidence that the emergency management plan addressed emerging infectious diseases prior to the exit conference approximately 6 hours later	E 004	Infectious diseases is specified in the OP & P binder under Disaster & Emergency Response pgs 63-65 and Disaster & Emergency Preparedness pgs 45-47 with further information in the infection control and prevention operational policy & procedure binder. Information beyond The Red Emergency Binder was not allowed to be utilized during interview as evidence of plan/program, as in previous survey visits. Per CMS Pub 100-07 State Operations Manual dated 4/16/2021, Surveyors should also consider the volume of documentation provided by the facility and working with the facility when reviewing the Emergency Preparedness Program as facilities have the flexibility to determine how to format the documentation of their program. It is recommended, but are not requiring, facilities to develop a crosswalk as applicable for where their documents are located. For instance, if their emergency plan is located in a binder, specify this for surveyors. If there are policies and procedures to specific standards/requirements, identify where these are located. Administrator did identify policies and procedures are in different areas to include computer. To ensure this alleged deficient practice does not occur, and procedure stays consistent with facility adopted policies we are taking the following measures: For convenience of reviewing and access, the EP policies and procedures will be consolidated. A QAPI evaluation /plan has been implemented under the supervision of the Administrator, QAPI team and/or designee to analyze and investigate processes to ensure procedures, protocols and best practices are in place. QAPI team will continue to review and approve policies and procedures annually and as needed. **Completion Date: 5/11/2024**	

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E 004	Continued From page 2 that evening.	E 004	Tag E 004 POC accepted on 5/20/24 by S. Stem/P. Cota	
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only.	E 015	It is the policy of Green Mountain Nursing & Rehabilitation to ensure emergency preparedness policies and procedures address all requirements for the provision of subsistence needs for staff and residents, whether they evacuate or shelter in place. The facility EP Plan/ program does include OP&P that addressed the following provisions of substance needs for staff and residents if they were to evacuate or shelter in place in an emergency: food, water for staff, medical and pharmaceutical supplies, temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; and sewage and waste disposal. Evidenced by The Red book pages pgs 84-91 extreme weather to include but not limited to hypothermia tx and heat stroke tx, Pharmaceutical EP plan developed by Health Direct Pharmacy, adopted and added to The Red book by facility on 3/15/2024 prior to 3/25/2024 survey date. Sewage/Waste disposal policy located in OP&P Disaster and Emergency Preparedness page 43, Safe storage of food and provisions policy is located in Food Storage Operations Policy & Procedure as well as Emergency Supplies Planning in the Emergency Disaster and Preparedness O P&P pgs 23 Information beyond The Red Emergency Binder developed by maintenance supervisor was not allowed to be utilized during interview as evidence of plan/program as in previous survey visits.	

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E 015	Continued From page 3 The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures addressed all requirements for the provision of subsistence needs for staff and residents, whether they evacuate or shelter in place. This deficient practice could affect all occupants. Findings include: Per review of the facility's emergency management plan, last reviewed in 12/2023, with the Maintenance Supervisor on 3/28/24 at 10:55 AM, the facility's emergency management plan did not include policies and procedures that addressed the following provisions of substance needs for staff and residents if they were to evacuate or shelter in place in an emergency: food, water for staff, medical and pharmaceutical supplies, temperatures to protect resident health and safety and for the safe and sanitary storage of provisions; and sewage and waste disposal.	E 015	Per CMS Pub 100-07 State Operations Manual dated 4/16/2021, Surveyors should also consider the volume of documentation provided by the facility and working with the facility when reviewing the Emergency Preparedness Program as facilities have the flexibility to determine how to format the documentation of their program. It is recommended, but are not requiring, facilities to develop a crosswalk as applicable for where their documents are located. For instance, if their emergency plan is located in a binder, specify this for surveyors. If there are policies and procedures to specific standards/requirements, identify where these are located. Administrator did identify policies and procedures are in different areas to include computer. No residents and/or staff were affected by this alleged deficient practice. All residents and staff on duty have a potential to be affected by this alleged deficient practice. To ensure this alleged deficient practice does not occur, and procedure stays consistent with facility adopted policies we are taking the following measures: For convenience of reviewing and access, the EP policies and procedures will be consolidated. A QAPI evaluation /plan has been implemented under the supervision of the Administrator, QAPI team and/or designee to analyze and investigate processes to ensure procedures, protocols and best practices are in place. QAPI team will continue to review and approve EP policies and procedures annually and as needed. **Completion Date: 5/11/2024** **Tag E 015 POC accepted on 5/20/24 by S. Stem/P. Cota**	

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E 015	Continued From page 4 The Maintenance Supervisor stated that the facility had a plan for the above but did not have it written down. S/He confirmed that the emergency management plan did not address the above provisions. This finding was reviewed with the Administrator on 3/28/2024 at 12:45 PM and s/he was unable to provide evidence that the emergency management plan addressed all the requirements for the provision of subsistence needs for staff and residents prior to the exit conference approximately 6 hours later that evening.	E 015	E 018 It is the policy of the facility to develop a system to track the location of on-duty staff and sheltered patients in the facility's care during an emergency. No residents and/or staff were affected by this alleged deficient practice. All residents and staff could potentially be affected by this alleged deficient practice. The facility does have a tracking mechanism to track the location of on-duty staff and sheltered patients in the facility's care during an emergency. This is policy is located under Planning for	
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), §485.542(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 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	E 018	Evacuations in the EP OP&P pages 32-36, Resident tracking is within the PCC EHR which is backed up q 15 minutes. EHR is the most accurate method of resident tracking. Staff/ visitor tracking is identified in Accushield Staff/ Visitor facility tracking log in program as well as paper log by main entrance should visitor not be able to navigate Accushield program, Additionally staff are tracked with department schedules . The plan was updated when EHR was implemented and further updated when Accushield systems was implemented during 2020. To ensure this alleged deficient practice does not occur, and procedure stays consistent with facility adopted policies we are taking the following measures: For convenience of reviewing and access, the EP policies and procedures will be consolidated. The plan has been reviewed to delete the information that was missed on the original update. Plan will continue to have EHR/Online Tracking software as a system.	

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E 018	Continued From page 5 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. (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	E 018	A QAPI evaluation /plan has been implemented under the supervision of the Administrator, QAPI team and/or designee to analyze and investigate processes to ensure procedures, protocols and best practices are in place. QAPI team will continue to review and approve EP policies and procedures annually and as needed. **Completion Date: 5/11/2024** **Tag E 018 POC accepted on 5/20/24 by S. Stem/P. Cota**	

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E 018	Continued From page 6 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. This deficient practice could affect all occupants. Findings include: Per review of the facility's emergency management plan, last reviewed in 12/2023, with the Administrator on 3/28/2024 at 9:04 AM, the plan had contradicting procedures for tracking residents during an emergency. The plan stated that tracking would be managed through the electronic medical record system. Later in the plan, it explained that tracking would be done by using a census list that is posted daily at each nursing station. The Administrator confirmed that during an emergency, residents should be tracked using the electronic medical record. Per interview on 3/28/24 at 10:55 AM, the Maintenance Supervisor explained that residents should be tracked using the census sheet, contradicting the Administrator's earlier response.	E 018		

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E 020	Continued From page 7	E 020	E 020 It is the policy of the facility to develop policies and procedures regarding safe evacuation from the facility that includes transportation. No residents and/or staff were affected by this alleged deficient practice. All residents and staff have a potential to be affected by this alleged deficiency. The facility does have procedures regarding safe evacuation from the facility that includes transportation. Located in The Red EP book pg 63 Transportation for facility-wide evacuations due to disaster, this plan includes two Phases , Phase 1 transport of ambulatory and lower acuity residents and Phase 2 higher acuity residents, local companies with phone numbers are included in plan. Also located in facility OP&P Disaster & Emergency Preparedness page 32. Information beyond The Red Emergency Binder developed by maintenance supervisor was not allowed to be utilized during interview as evidence of plan/program as in previous survey visits. Per CMS Pub 100-07 State Operations Manual dated 4/16/2021, Surveyors should also consider the volume of documentation provided by the facility and working with the facility when reviewing the Emergency Preparedness Program as facilities have the flexibility to determine how to format the documentation of their program. It is recommended, but are not requiring, facilities to develop a crosswalk as applicable for where their documents are located. For instance, if their emergency plan is located in a binder, specify this for surveyors. If there are policies and procedures to specific standards/requirements, identify where these are located. Administrator did identify policies and procedures are in different areas to include computer.	
E 020 SS=F	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), §485.542(b)(3), §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) and REHs at §485.542(b)(3):] Safe evacuation from the [RNHCI or ASC or REHs] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of			

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E 020	Continued From page 8 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. This deficient practice could affect all occupants. Findings include: Per review of the facility's emergency management plan, last reviewed in 12/2023, with the Maintenance Supervisor on 3/28/24 at 10:55 AM, the facility's emergency management plan did not include policies and procedures that addressed transportation during an evacuation. The Maintenance Supervisor confirmed that the emergency management plan did not address transportation during an evacuation. This finding was reviewed with the Administrator on 3/28/2024 at 12:45 PM and s/he was unable to provide evidence that the emergency management plan addressed transportation during an evacuation	E 020	To ensure this alleged deficient practice does not occur, and procedure stays consistent with facility adopted policies we are taking the following measures: For convenience of reviewing and access, the EP policies and procedures will be consolidated. A QAPI evaluation /plan has been implemented under the supervision of the Administrator, QAPI team and, or designee to analyze and investigate processes to ensure procedures, protocols and best practices are in place. QAPI team will continue to review and approve EP policies and procedures annually and as needed. **Completion Date: 05/11/2024** Tag E 020 POC accepted on 5/20/24 by S. Stem/P. Cota	

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	475040	A. BUILDING _____ B. WING _____	03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN MOUNTAIN NURSING AND REHABILITATION	475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446

(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 020	Continued From page 9 prior to the exit conference approximately 6 hours later that evening.	E 020	E 022 It is the policy of the facility to develop policies and procedures for staff to shelter in place during an emergency. No residents and/or staff were affected by this alleged deficient practice. All residents and/or staff have the potential to be affected by this alleged deficient practice. The facility does have Disaster and Emergency Preparedness OP&P that include addressing staff when sheltering in place. This is addressed under Emergency Supplies and Planning pg 23, Disaster and Emergency Response OP&P Emergency Procedure Shelter in Place pg 26-30. Information beyond The Red Emergency Binder developed by maintenance supervisor was not allowed to be utilized during interview as evidence of plan/program as in previous survey visits. Per CMS Pub 100-07 State Operations Manual dated 4/16/2021, Surveyors should also consider the volume of documentation provided by the facility and working with the facility when reviewing the Emergency Preparedness Program as facilities have the flexibility to determine how to format the documentation of their program. It is recommended, but are not requiring, facilities to develop a crosswalk as applicable for where their documents are located. For instance, if their emergency plan is located in a binder, specify this for surveyors. If there are policies and procedures to specific standards/requirements, identify where these are located. Administrator did identify policies and procedures are in different areas to include computer.	
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), §485.542(b)(4), §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		

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GREEN MOUNTAIN NURSING AND REHABILITATION	475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446

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E 022	Continued From page 10 failed to develop policies and procedures for staff to shelter in place during an emergency. This deficient practice could affect all occupants. Findings include: Per review of the facility's emergency management plan, last reviewed in 12/2023, with the Maintenance Supervisor on 3/28/24 at 10:55 AM, the facility's emergency management plan did not include policies and procedures that addressed sheltering in place during emergencies for staff. The Maintenance Supervisor confirmed that the emergency management plan did not address sheltering in place during emergencies for staff. This finding was reviewed with the Administrator on 3/28/2024 at 12:45 PM and s/he was unable to provide evidence that the emergency management plan addressed sheltering in place during emergencies for staff prior to the exit conference approximately 6 hours later that evening.	E 022	To ensure this alleged deficient practice does not occur, and procedure stays consistent with facility adopted policies we are taking the following measures: For convenience of reviewing and access, the EP policies and procedures will be consolidated. A QAPI evaluation /plan has been implemented under the supervision of the Administrator, QAPI team and/or designee to analyze and investigate processes to ensure procedures, protocols and best practices are in place. QAPI team will continue to review and approve EP policies and procedures annually and as needed. **Completion Date: 5/11/2024** **Tag E 022 POC accepted on 5/20/24 by S. Stem/P. Cota**	
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), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d)	E 036	**E 036** It is the policy of the facility to develop a emergency management plan that includes policies and procedures that address the facility's emergency preparation training and testing program and review annually. No residents and/or staff were affected by this alleged deficient practice. All residents and staff have a potential to be affected by this alleged deficient practice. The facility does have a policy and procedure that addresses emergency preparation training and testing that is reviewed annually. This is located in the Facility Assessment list of trainings reviewed annually most recently Dec 20th 2023. The OP&P policies section Disaster & Emergency Preparedness pgs 14,36,47 address training. Information beyond The Red Emergency Binder developed by maintenance supervisor was not allowed to be utilized during interview as evidence of plan/program as in previous survey visits.	

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E 036	Continued From page 11 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 requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training,	E 036	Per CMS Pub 100-07 State Operations Manual dated 4/16/2021, Surveyors should also consider the volume of documentation provided by the facility and working with the facility when reviewing the Emergency Preparedness Program as facilities have the flexibility to determine how to format the documentation of their program. It is recommended, but are not requiring, facilities to develop a crosswalk as applicable for where their documents are located. For instance, if their emergency plan is located in a binder, specify this for surveyors. If there are policies and procedures to specific standards/requirements, identify where these are located. Administrator did identify policies and procedures are in different areas to include computer. To ensure this alleged deficient practice does not occur, and procedure stays consistent with facility adopted policies we are taking the following measures: For convenience of reviewing and access, the EP policies and procedures will be consolidated. A QAPI evaluation /plan has been implemented under the supervision of the Administrator, QAPI team and/or designee to analyze and investigate processes to ensure procedures, protocols and best practices are in place. QAPI team will continue to review and approve EP policies and procedures annually and as needed. **Completion Date: 5/11/2024** **Tag E 036 POC accepted on 5/20/24 by S. Stem/P. Cota**	

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E 036	Continued From page 12 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 that is based on all required elements of the emergency management plan, including the risk assessment and communication plan, or ensure it was reviewed annually. This deficient practice could affect all occupants. Findings include: Per review of the facility's emergency management plan, last reviewed in 12/2023, with the Maintenance Supervisor on 3/28/24 at 10:55 AM, the facility's emergency management plan did not include policies and procedures that addressed the facility's emergency preparation training and testing program. The Maintenance Supervisor confirmed that there is no training about the facility's communication plan because the facility does not have a communication plan. Lastly, s/he indicated that the training program itself is not reviewed annually. This finding was reviewed with the Administrator on 3/28/2024 at 12:45 PM and s/he was unable to provide evidence that the emergency management plan included policies and procedures that addressed the facility's emergency preparation training and	E 036		

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E 036	Continued From page 13 testing program prior to the exit conference approximately 6 hours later that evening.	E 036	E 037	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness	E 037	It is the facilities policy to develop an emergency management plan that includes policies and procedures that addresses the facility's emergency preparation training and testing program. No residents and/or staff were affected by this alleged deficient practice. All residents and staff have a potential to be affected by this alleged deficient practice. The facility does have a policy and procedure that addresses emergency preparation training and testing that is reviewed annually. This is located in the Facility Assessment list of trainings reviewed annually most recently Dec 20th 2023. The OP&P policies section Disaster & Emergency Preparedness pgs 14,36,47 address training. Staff are trained annually on EP within the facility evidenced attendance sheets of those who attend. To ensure this alleged deficient practice does not occur, and procedure stays consistent with facility adopted policies we are taking the following measures: New staff/volunteers will be given/ reminded of emergency preparation training. HR will monitor attendance to verify trainings have been completed.	

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E 037	Continued From page 14 policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.	E 037	A QAPI evaluation has been initiated under the supervision of Administrator and HR Director to evaluate attendance of new staff/volunteers relating to emergency preparation training. HR director will report findings to the QAPI team monthly for the first three months and then quarterly thereafter. **Completion Date: 5/11/2024** Tag E 037 POC accepted on 5/20/24 by S. Stem/P. Cota	

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E 037	Continued From page 15 *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency	E 037		

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E 037	Continued From page 16 preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and	E 037		

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E 037	Continued From page 17 procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least 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 that ensured all new staff and volunteers received initial training in emergency preparedness policies and procedures. This deficient practice could affect all occupants. Findings include: Per review of the facility's emergency management plan, last reviewed in 12/2023, with the Maintenance Supervisor on 3/28/24 at 10:55 AM, the facility's emergency management plan did not include policies and procedures that addressed the facility's emergency preparation training and testing program. The Maintenance Supervisor explained that s/he did test staff regularly on emergency management policies but explained that there was not initial training for all new staff or volunteers. This finding was reviewed with the Administrator on 3/28/2024 at 12:45 PM and s/he was unable to provide evidence that the emergency management plan included policies	E 037		

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E 037	Continued From page 18 and procedures that addressed the facility's emergency preparation training and testing program prior to the exit conference approximately 6 hours later that evening.	E 037		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is	E 039	It is the facilities policy to conduct exercises that test the emergency plan annually to include an analysis of the facility's response to an actual emergency. No residents and/or staff were affected by this alleged deficient practice. All residents and/or staff could potentially be affected by this alleged deficient practice. The facility utilized a "potential" natural gas leak with full community EMS response, the facility also conducted a workshop 12/4/2023 that was led by a facilitator(Town of Colchester Police Dept) included a group discussion using a narrated, clinically relevant emergency scenario (Civilian Responses to Active Situations, to include shooter due to shooting on facility street few weeks prior) and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. It was noted during survey that the facility was not able to utilize the workshop presented by Colchester Police Dept as an exercise.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN MOUNTAIN NURSING AND REHABILITATION	475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446

(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 039	Continued From page 19 not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:	E 039	To ensure this alleged deficient practice does not occur, and procedure stays consistent with facility adopted policies and procedures we are taking the following measures: The facility will participate in testing drills and provide further analysis to the exercises utilized to test the emergency plan. EP testing exercises will occur at a minimum every 6 months. An ongoing QAPI review will be completed under the supervision of the Administrator, Maintenance supervisor and/or designee to ensure facility is meeting EP testing and analysis guidelines, analysis documentation will be reviewed by QAPI team. **Completion Date: 5/11/2024** Tag E 039 POC accepted on 5/20/24 by S. Stem/P. Cota	

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E 039	Continued From page 20 (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

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E 039	Continued From page 21 (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

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E 039	Continued From page 22 (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and	E 039		

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E 039	Continued From page 23 maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.	E 039		

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E 039	Continued From page 24 *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:	E 039		

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E 039	Continued From page 25 (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:	E 039		

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E 039	Continued From page 26 (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to conduct exercises to test the emergency plan annually and failed to analyze the facility's response to an actual emergency. This deficient practice could affect all occupants. Findings	E 039		

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E 039	Continued From page 27 include: Per review of the facility's emergency management plan testing documentation, with the Maintenance Supervisor on 3/28/24 at 10:55 AM, no evidence could be found that a second annual exercise to test the emergency plan had been conducted or any documentation that the facility analyzed its response to an actual emergency. The Maintenance Supervisor explained that the facility did not do any additional drills or exercises in the past year on top of the actual event where the facility had to activate the emergency plan due to a potential gas leak. S/He explained that there was no analysis of the response done by the facility following the potential gas leak. This finding was reviewed with the Administrator on 3/28/2024 at 12:45 PM and s/he was unable to provide evidence that the emergency management plan that demonstrated that a second annual exercise to test the emergency plan had been conducted or any documentation that the facility analyzed its response to an actual emergency prior to the exit conference approximately 6 hours later that evening.	E 039		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey from 3/25/2024 through 3/28/2024 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following deficiencies were identified:	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean,	F 584		

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F 584	Continued From page 28 comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 584	It is the policy of the facility to provide the residents with a home-like environment during meals. No residents were negatively affected by this alleged deficient practice. All residents have the potential to be affected by this alleged deficient practice. Effective 3/25/2024 plates were brought to the kitchen for staff to utilize for resident meals, extra boxes of china are stored in the basement storage. Paper products are to be utilized only as part of infection prevention procedures and/or residents plan of care. To ensure that the alleged deficient practice does not occur, dietary staff are reminded to go to the basement storage area to look for supplies, if supplies are out of stock staff must order from vendor immediately to prevent paper product usage. A QAPI evaluation has been initiated under the supervision of Dietitian and dietary supervisor to evaluate, audit and report findings to the QAPI team monthly for the first three months and then quarterly thereafter. Audits to be submitted to QAPI team for review. **Compliance date: 5/11/2024** Tag F 584 POC accepted on 5/20/24 by S. Stem/P. Cota	

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F 584	Continued From page 29 Based on observation and interview the facility failed to provide the residents with a home-like environment during meals. Findings include: On 3/25/24 at 12:35 pm, an observation of the lunch meal in the main resident dining room revealed 6 of 12 residents had their meal delivered on paper plates, this included 2 residents who had puree diets, a puree diet is food that is blended to a soft almost liquid like consistency. Regarding the residents that had the pureed diet, the plates were noted to be wet appearing as the liquid from the food was making the plate soft, effecting the strength of the plate. It was observed that the other residents in the dining room had regular plates. An interview on 3/25/24 at 12:30 pm with the Registered Dietitian (RD) revealed that the facility has had a shortage of plates for about a month and some residents have been using paper plates during that time. An interview on 3/25/24 at 4:40pm with the facility administrator revealed that the administrator went into the storage area that morning and found 2 cases of regular plates. S/he confirmed that the facility had been using paper plates for the past month and the plates had not been found until today.	F 584		
F 623 SS=F	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and	F 623		

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F 623	Continued From page 30 the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:	F 623	It is the policy of the facility to issue transfer/ discharge notices to residents and/or their representatives at the time a resident is transferred to the hospital. Resident #21,39,52,167 were readmitted to facility following acute hospital stay. All residents who transfer/discharge to the ER have a potential to be affected by this alleged deficient practice. To ensure residents and/or representatives are notified of transfer/discharge notice, staff nurse will review transfer/discharge notice with resident and/ or representative and obtain signature if medical condition permits. If resident is not medically stable notice must be sent to ER with resident/EMS team. Resident Family Services Coordinator to follow up with resident representative, staff nurse and RFSC will document in progress note. The Administrator will provide education and supervision as needed to staff responsible for distributing bed-hold notices. A QAPI evaluation has been initiated under the supervision of Administrator, DNS and Resident Family Services Coordinator. Audits to be completed weekly for 30 days, then monthly for 30 days then quarterly on going. Audits to be submitted to QAPI team for review. **Completion Date: 5/11/2024** Tag F 623 POC accepted on 5/20/24 by S. Stem/P. Cota	

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F 623	Continued From page 31 (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.	F 623		

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	475040	A. BUILDING _____ B. WING _____	03/28/2024

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F 623	Continued From page 32 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to notify the resident and resident representative of a transfer to the hospital and the reason for transfer to the hospital in writing for 4 of 27 residents sampled (Resident #21, Resident #39, Resident #52, and Resident #167). Findings include: 1. Per record review Resident #21 was discharged to the hospital on 12/5/23 and was readmitted to the facility on 12/21/23. S/he was again discharged to the hospital on 1/29/24 and readmitted on 1/31/24. There is no documentation in the electronic medical record or the paper medical record that Resident # 21 or his/her representative received a discharge/transfer notice. Per an interview on 3/26/24 at 12:43 pm the Registered Nurse (RN) Unit Manager (UM) confirmed that there is no documentation that supports that a discharge/transfer notice was given to Resident # 21 or the resident representative on either of the two discharges dates to the hospital. 2. Per record review Resident #39 was sent to the hospital on 3/24/24 for evaluation and	F 623		

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F 623	Continued From page 33 treatment due to sudden onset of pain. There is no documentation in the electronic medical record or the paper medical record that Resident #39 or his/her representative was provided a transfer/discharge notice. Per an interview on 3/27/24 at approximately 2:15 PM the Registered Nurse (RN) Unit Manager (UM) confirmed that there is no documentation that supports that the written notification of transfer to the hospital was given to Resident #39 or the resident representative. 3. Per record review Resident #52 was sent to the hospital on 12/28/23 for evaluation and treatment due to a fall. There is no documentation in the electronic medical record or the paper medical record that Resident #52 or his/her representative was given transfer/discharge notice. Per interview on 3/27/24 at approximately 2:15 PM the Registered Nurse (RN) Unit Manager (UM) confirmed that there is no documentation that supports that a discharge/transfer notice was given to Resident #52 or the resident representative. 4. Per interview on 3/25/24 at approximately 1:30 PM, Resident #167 stated that they have been transferred to the hospital twice since their initial admission to the facility on 2/8/2024, and they do not recall ever having been given a notice of transfer prior to transfer or discussing one with staff.	F 623		

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F 623	Continued From page 34 Per record review, Resident #167 transferred to the hospital for evaluation of medical symptoms on 2/28/24 and 3/15/24. Both transfers resulted in hospital admissions. There was no evidence in the record that a transfer notice was ever provided to Resident #167 for either transfer. Per interview on 3/26/24 at approximately 12:45 PM, the Social Worker stated that nurses are expected to provide transfer notices to the resident/representative prior to transfer. Per interview on 3/26/24 at approximately 1:00 PM, Resident #167's nurse confirmed that they also could not locate any evidence of a transfer notice being completed for either of Resident #167's transfers out of the facility. Per interview on 3/26/24 at approximately 1:10 PM, the Unit Manager stated that there are blank copies of transfer notices in every resident's paper chart to use in the event of a transfer. Upon inspection of the blank transfer notices, it was discovered that the Administrator's signature is pre-signed on all of the copies. The Unit Manager confirmed that this is the case, even though the Administrator is not the person who is responsible for providing/discussing the transfer notices with the resident/representative. Per interview on 3/26/24 at approximately 1:30 PM, the Administrator confirmed that the facility's current practice for transfer notices does not meet the regulation.	F 623		
F 625 SS=C	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a	F 625		

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F 625	Continued From page 35 nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that residents or resident representatives received written notification of the facility bed hold policy on residents' discharge to the hospital for 4 of 27 residents sampled. (Resident #21, Resident #39, Resident #52, and Resident #167). Findings include: 1. Per record review Resident #21 was discharged to the hospital on 12/5/23 and was readmitted to the facility on 12/21/23. S/he was again discharged to the hospital on 1/29/24 and	F 625	It is the policy of the facility to issue bed hold notices to residents and/or their representatives at the time a resident is transferred to the hospital. Resident #21,39,52,167 were readmitted to facility following acute hospital stay. All residents who discharge to the hospital have a potential to be affected by this alleged deficient practice. To ensure residents and/or representatives are notified of bed hold, staff nurse will review bed hold notice with resident and/or representative and obtain signature if medical condition permits. If resident is not medically stable, notice must be sent to ER with resident/EMS team. Resident Family Services Coordinator to follow up with resident representative, staff nurse and RFSC will document in progress note. A QAPI evaluation has been initiated under the supervision of Administrator, DNS and Resident Family Services Coordinator. Audits to be completed weekly for 30 days, then monthly for 30 days then quarterly on going. Audits to be submitted to QAPI team for review **Completion Date: 5/11/2024** Tag F 625 POC accepted on 5/20/24 by S. Stem/P. Cota	

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F 625	Continued From page 36 readmitted on 1/31/24. There is no documentation in the electronic medical record or the paper medical record that the bed hold policy was given to the resident or the resident's representative. Per an interview on 3/26/24 at 12:43 pm with the Registered Nurse (RN) Unit Manager (UM) confirms that there is no documentation that supports that the written notification of the bed hold policy was given to Resident # 21 or the resident representative on either of the two discharges to the hospital. 2. Per record review Resident #39 was sent to the hospital on 3/24/24 for evaluation and treatment due to sudden onset of pain. There is no documentation in the electronic medical record or the paper medical record that a bed hold policy was given to Resident #39 or their representative. Per interview on 3/27/24 at approximately 2:15 PM the Registered Nurse (RN) Unit Manager (UM) confirmed that there is no documentation that supports that the written notification of the bed hold policy was given to Resident #39 or their representative. 3. Per record review Resident #52 was sent to the hospital on 12/28/23 for evaluation and treatment due to a fall. There is no documentation in the electronic medical record or the paper medical record that a bed hold policy was provided to Resident #52 or their representive. Per interview on 3/27/24 at approximately 2:15 PM the Registered Nurse (RN) Unit Manager	F 625		

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F 625	Continued From page 37 (UM) confirmed that the written notification of the bed hold policy was not provided to Resident #52 or their representive. 4. Per interview on 3/25/24 at approximately 1:30 PM, Resident #167 stated that they have been transferred to the hospital twice since their initial admission to the facility on 2/8/2024, and they do not recall ever having been given a bed hold notice prior to transfer or discussing one with staff. They said that having their bed held for them upon return was always a concern for them. Per record review, Resident #167 transferred to the hospital for evaluation of medical symptoms on 2/28/24 and 3/15/24. Both transfers resulted in hospital admissions. There was no evidence in the record that a bed hold notice was provided to Resident #167 for either transfer. Per interview on 3/26/24 at approximately 12:45 PM, the Social Worker stated that nurses are expected to provide bed hold notices to the resident/representative prior to transfer. Per interview on 3/26/24 at approximately 1:00 PM, Resident #167's nurse confirmed that they also could not locate any evidence of a bed hold notice being completed for either of Resident #167's transfers out of the facility. Per interview on 3/26/24 at approximately 1:30 PM, the Administrator confirmed that the facility's current practice for bed hold notices does not meet the regulation.	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		

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F 656	Continued From page 38 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (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.	F 656	It is the policy of the facility to develop a comprehensive care plan that is person centered and developed to meet the residents' preferences and goals. Resident #30 plan of care has been updated to reflect the right to refuse care. All residents have the right to refuse care and have the potential to be affected by this alleged deficient practice. To ensure this alleged deficient practice does not occur the facility has taken the following steps; Staff are reminded to care plan residents for the right to refuse care and document steps to encourage participation. A QAPI evaluation has been initiated under the supervision of DNS , ADON and/or designee. Audits to be completed weekly for 30 days, then monthly for 30 days then quarterly on going. Audits to be submitted to QAPI team for review. **Completion Date: 4/25/2024** Tag F 656 POC accepted on 5/20/24 by S. Stem/P. Cota	

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F 656	Continued From page 39 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to develop a comprehensive care plan that is person-centered and developed to meet the residents' preferences and goals for 1 of 23 residents in the sample (Resident #30). Findings include: 1. Resident #30 was admitted to the facility on 2/14/24 with diagnoses that include depression, demoralization, and apathy. Per interview on 3/25/2024 at approximately 2:00 PM with a family member of Resident #3, they revealed that they are concerned about how often the resident refuses care. This includes refusing to have a dressing changed on a wound on top of their head. When Resident #30 was at home, the family would reapproach until they could provide care, change the dressing and assist with bathing and dressing. Per observation on 3/26/24 at approximately 9:40 AM, Resident #30 was sitting in a recliner in his/her room. A Licensed Nursing Assistant (LNA) asked Resident #30 if they could assist resident with morning care. Resident #30 did not respond to several requests and pushed the LNA's hand away. An interview with the LNA a few minutes later, she/he stated "we just know to reapproach at another time" and that this resident refuses most care daily; it often takes several attempts before care of any care is received.	F 656		

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F 656	Continued From page 40 Per observation on 3/27/24 at approximately 10:00 AM, Resident #30 did not respond to the wound care practitioner requesting to change his/her wound dressing. The wound care nurse stated "this is often the case, and I know from experience to come back later", explaining that some days it took three or four attempts. A record review reveals that Resident #30's care plan does not contain any goals or interventions regarding refusal of care or reapproaching resident later. A policy titled "Care Plans, Comprehensive Person-Centered" with an "adoption date" of 3/21, page 1, # 7 states, "The comprehensive, person-centered care plan: a. Includes measurable objectives and timeframes. b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: c. (1) services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights, including the right to refuse treatment." #13 on page 2 states, "The resident has the right to refuse to participate in the development of his/her care plan and medical nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies." Per interview with the DON on 3/27/2024 at approximately 3:20 PM, s/he confirmed that Resident #30's care plan did not include documentation addressing his/her refusal of care.	F 656		
F 657 SS=E	Care Plan Timing and Revision	F 657		

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F 657	Continued From page 41 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that a resident's care plan was reviewed and revised for 2 of 27 residents sampled (Residents #6 and #1). Findings include: 1.Per record review Resident # 6 admitted to the facility in 2023 with diagnoses that include heart	F 657	It is the policy of Green Mountain Nursing & Rehabilitation to make every attempt to ensure that resident's care plans are reviewed and revised Residents # 1 & 6 plan of care has been updated on the following. Residents #6 plan of care was updated evidenced by updates 12/30/23 with fall & Tramadol order, 1/2/23 Tramadol change, 1/16/24 with change in Tramadol, 1/18/24 with change dc Tramadol, add Tylenol. Approaches remained consistent with residents on going goals of care therefore not changed. Resident #1 does have paper care plans initiated,G Tube plan of care under Focus of new G-Tube noting diagnosis for placement reason, goals , interventions and tasks. Focus of potential fluid deficit r/t GT feeding ,a 9/11/23 goal target date and ongoing updates evidenced by changes noted 8/19/23 for tube site tx for infection, 8/24/23 tube site tx change, 9/13/23, 3/12/24 change to receiving flushes and nectar thick liquids a SLP plan of care was initiated on 1/18/24 that outlines safety considerations. Located in the paper chart of the care plan section. All residents have the potential to be affected by this alleged deficient practice. To ensure this alleged deficient practice does not occur, and procedure stays consistent with facility adopted policies we are taking the following measures, staff are reminded of the plan of care updating policy, review of resident care plans are done when changes occur in resident conditions to identify if plan of care has been updated.	

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F 657	Continued From page 42 failure, rheumatic heart disease, chronic respiratory failure oxygen dependent, and receiving anticoagulants. On 12/30/23 Resident #6 fell onto the right side of his/her chest striking it off the footboard. Post fall documentation completed on 12/30/23 by a license nurse noted a "small bruise to the right side of chest with no other injury". Physician orders on 12/30/2023 at 11:54 am identified Resident # 6 as being in severe right rib pain related to fall. Per Green Mountain Nursing and Rehabilitation policy last reviewed 01/2021 Comprehensive Care Plan: "assessments of residents are ongoing and comprehensive care plans are revised as information about the resident's condition changes. Interdisciplinary team reviews and updates the care plan for the following reasons. A significant change in resident status, when the desired outcome is not met, and when the resident has been readmitted after hospitalization". Review of Resident #6's care plan revealed that the comprehensive care plan was not updated or revised timely to address the fall or the severe right rib pain, and none of the interventions listed in the above policy were implemented in the plan of care until 01/23/2024 An interview with the director of nursing on 3/28/24 at 138 PM confirmed that the care plan had not been updated for Resident # 6 until 01/23/24, 24 days after the fall and sustained injury. The Director of nursing confirmed that all residents comprehensive care plans should be updated when changes in resident's condition	F 657	A QAPI evaluation has been initiated under the supervision of DNS , ADON and/or designee. Audits to be completed weekly for 30 days, then monthly for 30 days then quarterly on going. Audits to be submitted to QAPI team for review. **Completion Date: 5/11/2024** Tag F 657 POC accepted on 5/20/24 by S. Stem/P. Cota	

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F 657	Continued From page 43 occur. 2. Per record review, Resident # 1 was admitted to facility on 6/14/2012 with diagnoses of Lou Gehrig's disease (ALS), paraplegia, expressive aphasia (the lack of ability to communicate using voice), and dysphagia (difficulty swallowing due to disease or other injury). Resident #1 is dependent for all his/her care, and has contractures of both his hands that limit use. Resident #1 requires assistance for mobility and all transfers. On 05/25/2023 Resident #1 was transferred to the hospital with an infection and admitted until 06/05/2024. A Physician's Transition of Care Report dated 06/05/2023 reveals that Resident #1 was admitted to the University of Vermont Medical Center related to sepsis, (an infection in the blood) on 05/25/23. During Resident # 1's hospital stay a G-tube was inserted to be used for all medications and nutrition. Hospital discharge orders written on 06/05/2024 reflect all medications and nutrition to be given through the g-tube. Per Green Mountain Nursing and Rehabilitation policy last reviewed September 2022, Gastrostomy and jejunostomy sites will have a physician order to care for the site, care plan will be reviewed and updated for any special needs of the resident. Documentation of the g-tube site will include, when care was performed, how the resident tolerated care of the site, and assessment of the area. Documentation of the care will be completed by the licensed nursing staff and include date, time, and signature.	F 657		

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F 657	Continued From page 44 According to the facility's policy Comprehensive Care Plan last updated 01/2021 assessments of residents are ongoing and comprehensive care plans are revised as information about the resident's condition changes. Interdisciplinary team reviews and updates the care plan for the following reasons. A significant change in resident status, when the desired outcome is not met, and when the resident has been readmitted after hospitalization. Review of Resident#1's care plan revealed no evidence that a comprehensive plan was developed for Resident #1's G-tube, and none of the interventions listed in the policies were implemented in the plan of care. Director of Nursing confirmed during interview on 3/28/2024 at 2:30 PM all Resident's comprehensive care plans should be updated at the time there is a change in resident's condition.	F 657		
F 661 SS=E	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.	F 661		

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F 661	Continued From page 45 (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy, the facility failed to prepare a discharge summary that included a final summary of the resident's status and a post discharge plan of care for 1 applicable resident (Resident #64) and did not have a system in place to prepare a discharge summary that included all the required elements for any resident with the potential for discharge, putting residents with the potential for discharge at risk for more than minimal harm. Findings include: Facility policy titled "Discharge Summary and Plan," adopted on 9/2022, states that when a resident's discharge is anticipated, a post-discharge plan and a discharge summary will be developed, provided to the resident, and filed in the resident's medical record. The policy indicates that the discharge summary should include a summary of the resident's status at the time of discharge by including a description of the resident's: a. current diagnosis; b. medical history; d. current laboratory, radiology,	F 661	It is the policy of the facility to prepare a discharge summary that included a final summary of the resident's status and a post discharge plan. No residents who discharged were adversely affected by this alleged deficient practice. All residents who discharge have a potential to be affected by this alleged deficient practice. To ensure this alleged deficient practice does not occur staff will be reminded of the discharge summary process, the facility policy & procedure will be reviewed, discharge summary evaluation in EHR PCC will be implemented for all future anticipated discharges. Paper copies may remain until PCC has Green Mountain Discharge Summary activated. Copies of discharge summary evaluation will be reviewed and given to discharging resident and/or representative. A QAPI review will be completed under the supervision of the DON/ADON and/or designee to monitor implemented practices. Audits to be completed weekly for 30 days, then monthly for 90 days then quarterly on going. Audits to be submitted to QAPI team for review. **Completion Date: 5/11/2024** **Tag F 661 POC accepted on 5/20/24 by S. Stem/P. Cota**	

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F 661	Continued From page 46	F 661		

consultation, and diagnostic test results; physical and mental functional status; ability to perform activities of daily living including bathing, dressing and grooming, toilet use, eating, and using speech, language, and other communication systems, and the ability to form relationships, make health care decisions, and participate in activities; sensory and physical impairments; nutritional status and requirements including weight and height, nutritional intake, and eating habits, and preferences; special treatments or procedures; mental and psychosocial status; discharge potential; dental condition; activities potential, rehabilitation potential, and cognitive statusc. The post discharge plan should include: " a description of the resident's stated discharge goals; the degree of caregiver/support person availability, capacity and capability to preform required care; how the IDT will support the resident or representative in the transition to post-discharge care; what factors make the resident vulnerable to preventable readmission; and how those factors get addressed."

Per record review, Resident #64 was admitted to the facility on 11/15/2023 for therapy related to a fractured femur and discharged home on 12/31/2023.

A request was made to the Resident Family Service Coordinator (RFSC) on 3/27/2024 to provide this surveyor with Resident #64's discharge summary and post-discharge plan. On 3/27/2024 at approximately 2:00 PM, the RFSC and this surveyor reviewed a document titled "GMNH Discharge Instructions," located in Resident #64's paper chart, a progress note titled "Discharge Summary," located in Resident #64's electronic health record, and the facility

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F 661	Continued From page 47 "Discharge Summary and Plan" policy. Review of the Discharge Instructions form for Resident #64, dated as reviewed on 12/31/2023, shows that most of the required elements of the discharge summary and the post-discharge plan listed above are not included. S/He stated that the discharging resident does not receive a separate discharge summary and post-discharge plan. The RFSC explained that the Discharge Instructions form is what a resident receives on discharge, in addition to a medication list; they do not give the resident a copy of the progress note. S/He indicated that s/he had not seen the discharge summary and discharge plan policy before and was not aware that the discharge summary and discharge plan required so many components. S/He confirmed that the Discharge Instructions form Resident #64 received did not include all the required elements as stated in the facility policy. S/He explained that the Discharge Instructions form is what they use for all residents discharging and confirmed that the form does not contain the required elements as stated in the facility policy.	F 661		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility	F 684		

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F 684	Continued From page 48 failed to ensure that 1 of 23 residents sampled (Resident #29) did not recieve a medication that is listed in their medical record as a known drug allergy. Per record review Resident #29 has Tramadol listed as an allergy. A physicians order dated 3/23/2024 reflects Tramadol 25 mg give 1 tablet by mouth every 8 hours as needed for pain related to low back pain. Review of Resident #29's Medication Administration Record (MAR) reveals that on 3/23/24 Resident #29 receaved a dose of Tramadol 25mg for pain rated as 5 on a 10 pain scale. Per interview on 3/28/24 at 4:15 PM the Director of Nursing (DON) confirmed that Resident #29 had an order for and was administered Tramadol with a listed known allergy.	F 684	It is the policy of the facility to ensure that residents do not receive a medication that is listed in their medical record as a known drug allergy. Resident # 29 had tramadol prescribed by primary care physician. Resident # 29 has been deemed not to have a allergy to tramadol by the physician, allergy has since been discontinued on EHR by resident #29 physician. Documentation is noted in residents EHR record. No residents were adversely affected by this alleged deficient practice. All residents who are identified with a allergy have a potential to be affected by this alleged deficiency. To ensure this alleged deficient practice does not occur, review with nursing staff will be completed and documented on the importance of notifying physicians of drug allergies and reporting alerts to the physician with any newly prescribed orders.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F 690	A QAPI review will be completed under the supervision of the DON/ADON and/or designee to monitor implemented practices. Audits to be completed weekly for 30 days, then monthly for 90 days then quarterly on going. Audits to be submitted to QAPI team for review. **Completion Date: 5/11/2024** Tag F 684 POC accepted on 5/20/24 by S. Stem/P. Cota	

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F 690	Continued From page 49 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Per observation, interview, and record review, the facility failed to ensure that residents with urinary catheters received appropriate treatment and services to prevent urinary tract infections for one of four sampled residents (Resident #14). Findings include: 1. Per Record review on 3/26/24 reveals resident # 14 has a diagnosis of Flaccid Neuropathic Bladder (this is when the bladder does not contract to empty and therefore requires a catheter to empty the bladder). Resident #14 has orders for an indeweling foley catheter (an indwelling foley catheter is a tube that is maintained in the bladder to constantly drain urine). It is connected to a collection bag that requires frequent emptying. Per further review of the resident diagnosis list s/he has diagnosis of Urinary Tract infections and Infection and	F 690	It is the policy of the facility to ensure that residents with urinary catheters received appropriate treatment and services to prevent urinary tract infections. No residents were adversely affected by this alleged deficient practice. Resident # 14 Foley Catheter bags are anti reflex to prevent back flow to the bladder should tubing be above residents bladder. Staff did wear gloves during procedure. All residents who have a urinary catheter have the potential to be affected by this alleged deficient practice. To ensure this alleged deficient practice does not occur, review with nursing staff will be completed and documented on catheter care and infection control practices. A QAPI review will be completed under the supervision of the DON/ADON and/or designee to monitor implemented practices. Audits to be completed weekly for 30 days, then monthly for 90 days then quarterly on going. Audits to be submitted to QAPI team for review. **Completion Date: 5/11/2024** **Tag F 690 POC accepted on 5/20/24 by S. Stem/P. Cota**	

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F 690	Continued From page 50 Inflammatory Reaction due to Indwelling Urethral catheter. An observation occurred on 3/26/24 at 1:05 pm of a Licensed Nurse Aide (LNA) changing resident #14 foley bag (the bag used to drain the bladder while the resident is in bed) to a leg bag (a drainage bag that is strapped to the resident's leg while the resident is out of bed). The LNA failed to adhere to infection control standards, and the below facility policy/procedure, putting the resident at risk for infection. (See citation at F880). A review of the facility policy Urinary Leg Drainage Bags reveals under section Steps in the Procedure "2. Wash and dry your hands. Apply Clean gloves. #3 Clean the catheter/bag junction with alcohol wipe before disconnecting. #7 Carefully remove cover over connection tip on the leg bag. #8 Connect the catheter to the leg bag with out touching the terminal end of the catheter tubing. " Further review of facility policy Emptying a Urinary Collection Bag reveals under section General Guidelines "#8 Keep the collection bag below the level of the residents bladder." Per an interview with the Director of Nursing on 3/26/24 at 3:30 pm, s/he indicated that the above policies should be followed while providing urinary catheter care.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and	F 692		

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F 692	Continued From page 51 percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that residents maintain acceptable parameters of nutritional status as evidenced by lack of weight monitoring for one of four sampled residents (Resident #16) and a lack of follow up on a significant weight loss for one of four sampled residents (Resident #56). Findings include: 1. Per record review, Resident #16 has a diagnosis of Congestive Heart Failure (a condition in which the heart pumps blood less efficiently, which can lead to fluid overload in the body). Resident #16's record did not contain an order for regular weights. The last documented weight for resident #16 was from 12/20/23. Per order review, Resident #16 was ordered for weights to be obtained monthly until discontinued on 2/23/24. Per a nutritional services order note	F 692	It is the policy of the facility to ensure that residents maintain acceptable parameters of nutritional status. Resident # 16 frequently refuses to get out of bed to obtain weights. Resident will be offered weight monitoring monthly, documentation will be completed on weight status, if resident refuses and measures taken to try and obtain monthly weights while respecting residents choice to refuse. Resident # 16 care plan is updated for the right to refuse care. Resident #56 weight loss has been addressed by the physician and a plan of care is in place. All residents have the potential to be affected by this alleged deficient practice. To ensure this alleged deficient practice does not occur review with nursing staff will be completed and documented, the weights of all residents are reviewed during weekly weight meetings. A QAPI review will be completed under the supervision of the Dietitian, DON/ADON and/or designee to monitor resident weights. Audits to be completed weekly for 30 days, then monthly for 90 days then quarterly on going. Audits to be submitted to QAPI team for review. **Completion Date: 5/11/2024** Tag F 692 POC accepted on 5/20/24 by S. Stem/P. Cota	

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F 692	Continued From page 52	F 692		

from 2/23/24 at 6:58 PM, the note states, "provider has approved discontinuation of monthly weight monitoring due to resident refusal." There is no documentation from any provider regarding discontinuation of weights for Resident #16. Per the Treatment Administration Record, Resident #16 refused monthly weights regularly. The reason given for refusals is that Resident #16 does not want to get out of bed to have weights obtained. Per review of Resident #16's care plan, a care plan focus for nutrition has the interventions "obtain weights as ordered" and "notify registered dietitian, family, and physician of significant weight changes", both initiated on 6/29/23. Per the care plan, Resident #16 also has chewing difficulties requiring a motified textured diet. There is no evidence anywhere in the record of any efforts by the facility to assess Resident #16's weight refusals or explore ways to increase Resident #16's compliance with obtaining weights prior to discontinuation. Additionally, Resident #16 has a code status of full code and is not on comfort care.

Per interview on 3/26/24 at approximately 4:15 PM, the Dietitian confirmed that there was a conversation between them and Resident #16's provider regarding the discontinuation of weights, but that this cannot be verified through provider documentation in the record. The dietitian stated that Resident #16 does not like to get out of bed, which is the main barrier to obtaining weights. The dietitian confirmed that they are not aware of any assessments or interventions done to explore ways to increase Resident #16's compliance with having weights obtained prior to the discontinuation of weights. The dietitian stated that they are also limited in their interventions for

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F 692	Continued From page 53 supplementing the resident's diet in the event of weight loss, as the family has refused meal supplementation for Resident #16 in the past. 2. Per record review, Resident # 56 has been in the facility since 11/25/22. S/he has the following diagnoses: metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body) and Diabetes. Further record review indicates the following entries: an 18-lb. weight loss, which is 14.6 % of his/her weight in the last 180 days. 9/7/2023 - 122.7 Lbs 10/23/2023- 116.7 Lbs. 11/1/2023 - 113.6 Lbs. 1/2/2024 - 109.9 Lbs. 2/3/2024 - 104.5 Lbs. 3/10/2024 - 99.6 Lbs. 3/26/2024 - 99.6 Lbs. Further record review indicates an entry dated 3/26/24 in the medical record titled "Weight Change Warning." A weight of 104.5 Lbs. is entered, and states, "documented PO [by mouth] intake is often less than 50%. Continues to take Mighty Shake (a dietary supplement for maintaining weight and nutrition) sometimes." The entry is signed by the Registered Dietician (RD). A nursing note dated 2/6/24: "MD is aware of weight decline and in agreement with weights weekly." A review of Resident 56's care plan reveals no documentation of weight loss or interventions to monitor and prevent it. A policy titled "Weight Assessment and	F 692		

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Intervention" with an "adoption date" of 9/22 under #5 states: "The threshold for significant unplanned and undesired weight loss will be based on the following criteria: 6 months-10% weight loss is significant; greater than 10% is severe." The treatment team evaluates undesirable weight loss; care planning for weight loss or impaired nutrition is a multidisciplinary effort and includes the physician, nursing staff, dietitian, consultant pharmacist, and the resident; individualized care plans shall address, to the extent possible, the identified causes of weight loss, goals and benchmarks for improvement and time frames and parameter for monitoring and reassessment."

Per observation 3/26/24 at approximately 9:10 AM resident #56 was observed sleeping, sitting up with an untouched tray containing breakfast. Per an interview with an LNA on 3/26/24 at aproximately 11AM, s/he had removed untouched tray and offered a mighty shake (supplement). S/he reported the resident consumed 50% of it.

An interview with the unit manager on 3/26/24 at approximately 4:46 PM was conducted, where s/he indicated the nursing staff keeps track of Resident # 56's carbohydrate count for Insulin administration. She states, "The Director of Nursing (DON) runs the weight loss team, we tell [him/her] if we notice a resident is losing weight."

Per interview with the DON on 3/27/24 at approximately 10:20 AM, s/he confirmed that the weight loss team consisted of the DON and the RD, and both are aware of the 14% weight loss. S/he confirmed Resident #56 had documented weight loss, a nutrition assessment had not been perfomed and the resident's care plan did not

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F 692	Continued From page 55 contain interventions for weight loss.	F 692	It is the policy of Green Mountain Nursing & Rehabilitation to provide care and treatment of a gastrostomy tube (g-tube; a tube inserted directly into the stomach that can deliver nutrition, hydration, and/or medications) consistent with professional standards	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide care and treatment of a gastrostomy tube (g-tube; a tube inserted directly into the stomach that can deliver nutrition, hydration, and/or medications) consistent with professional standards for 1 of 24 residents in the sample (Resident #1). Findings include: Per record review, a hospital Transition of Care	F 693	Resident #1 does have paper care plans initiated, G-Tube plan of care under Focus of new G-Tube noting diagnosis for placement reason, goals , interventions and tasks. Focus of potential fluid deficit r/t GT feeding, a 9/11/23 goal target date and ongoing updates evidenced by changes noted 8/19/23 for tube site tx for infection, 8/24/23 tube site tx change, 9/13/23, 3/12/24 change to receiving flushes and nectar thick liquids a SLP plan of care was initiated on 1/18/24 that outlines safety considerations. Located in the paper chart of the care plan section. All residents who have a G-Tube have the potential to be affected by this alleged deficient practice. Resident #1 Order to resume treatment obtained and implemented for resident #1 on 3/25/2024. All residents who have a G-Tube have the potential to be affected by this alleged deficient practice. To ensure this alleged deficient practice does not occur a review with nursing staff will be completed and documented on the treatment of a gastrostomy tube. A QAPI review will be completed under the supervision of the DON/ADON and/or designee to monitor G-Tube orders and Treatments. Audits to be completed weekly for 30 days, then monthly for 90 days then quarterly on going. Audits to be submitted to QAPI team for review. **Completion Date: 5/11/2024** **Tag F 693 POC accepted on 5/20/24 by S. Stem/P. Cota**	

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F 693	Continued From page 56 note dated 6/05/2023 reveals that Resident #1 returned to the facility on 6/5/2023 following a hospital stay that required the placement of a g-tube. Per review of Resident #1's medical record, Resident #1 did not have a care plan related to g-tube site care, physician orders to care for the site, documentation of g-tube site care, documentation of a g-tube site assessment, or documentation of how s/he tolerated site care for over 9 months (6/5/2023 through 3/25/2024). Per facility policy "Gastrostomy and Jejunostomy Site Care" last reviewed in September 2022, states "the purpose of this policy/procedure are to promote cleanliness and to protect the gastronomy of jejunostomy site from irritation, breakdown and infection". Per policy the following is required "physician order to care for the site, care plan will be reviewed and updated for any special needs of the resident. Documentation of the g-tube site will include, when care was performed, how the resident tolerated care of the site, and assessment of the area. Documentation of the care will be completed by the license nursing staff and include date, time, and signature." Per a 11/18/2023 nursing progress note, Resident #1 suffered complications related to the g-tube breaking during medication administration and was sent to the emergency room for g-tube repair. Per the hospital discharge summary dated 11/19/2023 Resident #1 returned to the facility on 11/19/23 with the repaired G-tube. There is no evidence that the facility contacted the provider to obtain orders related to the care and monitoring	F 693		

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F 693	Continued From page 57 of the g-tube after return from the hospital on 11/19/23. Per interview on 3/27/2024 at 2:00 pm a Licensed Practical Nurse (LPN) confirmed that Resident #1 did not have physician orders for g-tube care prior to 3/26/2024.The LPN stated that if ordered, the documentation and evaluation of G-tube would be on the treatment administration record (TAR). Confirmation was made that an order should be in place at start of care of resident with g-tube. Orders to include evaluation and care for the g-tube site and area. LPN confirms procedure would be to contact provider and obtain orders for Resident # 1's care of G-tube. There is no evidence that the facility contacted provider to obtain orders prior to 03/26/2024.	F 693		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 757		

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F 757	Continued From page 58 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that monthly pharmacist drug regimen reviews, recommendations, and attending physician responses are completed and documented in the resident record for 1 of 5 sampled residents. Findings include: Per record review, a pharmacy recommendation dated 10/24/23 for Resident #6 states "Obtain lab work digoxin level every 6 months most recent per record 3/09/2023." Per review of Resident #6's medical record, there was no documented evidence in the record that the physician reviewed the 10/24/23 Pharmacy Recommendations for Resident # 6 taking medication Digoxin. Digoxin can become toxic, which will be evident in the blood. During an interview on 3/28/24 at 2:00 pm the Director of Nursing (DON) confirmed that there was no evidence that the physician reviewed or addressed the recommendations. The DON confirmed that the blood work was not done until 12/20/23 for Resident #6.	F 757	It is the policy of the facility to ensure that monthly pharmacist drug regimen reviews, recommendations, and attending physician responses are completed and documented in the resident record. Resident #6 pharmacy review relating to digoxin level was ordered by physician and completed on 12/20/2023. All residents who pharmacy submits drug regimen review have a potential to be affected by this alleged deficient practice. December of 2023 it was identified by DON that some pharmacy reviews may have been overlooked and the process at that time may not be working. To ensure this alleged deficient practice does not occur a review with nursing staff will be completed and documented, physicians are reminded of the process, the pharmacy recommendations are received by DON and/ or designee, reviewed with physicians. Recommendations will be addressed with appropriate plan of care physician deems necessary according to residents condition. Plan of care deemed by physician to be carried out by physician order. A QAPI review will be completed under the supervision of the DON/ADON and/or designee to monitor pharmacy recommendations. Audits to be completed weekly for 30 days, then monthly for 90 days then quarterly on going. Audits to be submitted to QAPI team for review. **Completion Date: 5/11/2024** **Tag F 757 POC accepted on 5/20/24 by S. Stem/P. Cota**	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include,	F 758		

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F 758	Continued From page 59 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--- §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	F 758	It is the policy of the facility ensure that residents who use psychotropic drugs receive gradual dose reductions. Resident #6 pharmacy review relating to GDR was reviewed on 12/15/2023. All residents who have a order for psychotropic drugs have a potential to be affected by this alleged deficient practice. In December of 2023 it was identified by DON that some pharmacy reviews may have been overlooked and the process at that time may not be working. To ensure this alleged deficient practice does not occur review with nursing staff will be completed and documented, physicians are reminded of the process, the pharmacy recommendations are received by DON and/or designee, reviewed with physicians. Recommendations will be addressed with appropriate plan of care physician deems necessary according to residents condition. Plan of care deemed by physician to be carried out by physician order. A QAPI review will be completed under the supervision of the DON/ADON and/or designee to monitor pharmacy recommendations. Audits to be completed weekly for 30 days, then monthly for 90 days then quarterly on going. Audits to be submitted to QAPI team for review. **Completion Date: 5/11/2024** **Tag F 758 POC accepted on 5/20/24 by S. Stem/P. Cota**	

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F 758	Continued From page 60 drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that residents who use psychotropic drugs receive gradual dose reductions (GDR), unless clinically contraindicated, for 1 of 5 sampled residents (Resident #6). Findings include: Per record review, Resident # 6 has a diagnosis of depression with the following Physician order. Citalopram 40 miligrams (mg) once a day to be given by mouth., written 04/04/2023.(Citalopram is a psychotropic medication used to treat depression). Per record review, on 10/24/23 pharmacist medication regimen review recommends a "GDR for Citalopram, from 40 mg to 30 mg." There is no evidence that a physician reviewed the pharmacist recommendation prior to 12/15/2023 or that a GDR was attempted or the physician provided clinical rational as to why a GDR was not attempted prior to 12/15/2023. Review of Resident #6's Medication Administration Record reveals that Resident #6 received Citalopram 40 mg daily from 10/24/23 through 12/15/2023. Per interview on 3/28/2024 at 2:00 pm, the Director of Nursing confirmed that a physician did not review the pharmacy recommendations made for Resident #6 on 10/24/2023 or attempt a GDR for Resident #6 until 12/15/2023.	F 758		

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F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews and record review, the facility failed to consistently store food in accordance with professional standards for food service safety. Findings include. On 3/25/24 at 11:05 am an initial tour of the facility kitchen was conducted; the Dietary Manager and Registered Dietitian (RD) were present during this tour. During an observation of a refrigerator/freezer in the kitchen, the following was observed: 1. A package of donuts with no date and no label. 2. A package of English muffins, with no date and no label.	F 812		

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F 812	Continued From page 62 3. A container with what appeared to be mixed iced tea with no date with no date and no label on the container. 4. What appeared to be 4 baked cake layers, frozen with no dates, and no labels. 5. A bag plastic bag with what appeared to be hash browns that had no label and no date. 6. A plastic bag of what appeared to be pepperoni with no date and no label. 7. A plain plastic bag with no label and no date that appeared to be fish. 8. A steel pan covered with tin foil that had a tear in the tin exposing the food in the container, the foil was labeled beef teriyaki no date was noted. 9. 10 individual serving-size containers with a white substance in them that the Kitchen manager stated was Mayonnaise there were no dates or labels on these containers. 10. A small container of what appeared to be pickles with no date or label. 11. In a different freezer unit, there was a metal pan covered with alumni foil labeled "kielbasa cabbage" There was a break in the foil that exposed the food, and another metal pan was underneath, with the foil that was covering the food in that pan pushed down, exposing the food to the bottom of the top pan. 12. In a dry food storage area there was a large bag labeled "dry pancake mix" that had no date on it as to when it was opened. When asked about the missing open date, the dietary manager wrote today's date on it, and s/he was asked if the bag was in fact opened today s/he stated "I don't know when it was opened". The top of the opened bag was folded down but was not secured shut.	F 812		

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F 812	Continued From page 63 13. In another dry storage area there were 2 racks of what appeared to be muffins covered with plastic wrap, both with no label or dates. On 3/28/24, a review of refrigerator temperatures revealed the following: 1. In August 2023, the milk cooler was recorded at 50 degrees (F) on 8/1, 8/2, 8/3, 8/4, 8/5 and 8/6. 2. During November 2023 the Milk cooler has recorded temperatures between 60 degrees (F) and 80 degrees (F) from November 5th through to November 21st On 03/28/24 at 12:26 PM interview with the kitchen manager reveals that during the episodes in August and November when the milk cooler was out of the acceptable temperature range, the milk was removed and stored in "the cave refrigerator". S/he further explained that this is a refrigerator that is kept unplugged and empty in the basement, however, the dietary manager revealed that when the milk was put in this refrigerator the temperature of the refrigerator was not taken at any time while the milk was being stored there in August or November. An interview on 3/28/24 with the Maintenance Supervisor reveals that s/he does recall both of the times the milk cooler was down, s/he reveals that the milk was taken out of the milk cooler and brought to the refrigerator in the basement the cooler was taken out of service and was fixed by a vendor.	F 812	It is the policy of the facility to consistently store food in accordance with professional standards for food service safety. All foods have been dated and labeled. Back up refrigerator is no longer in use as milk cooler is fixed. No residents were adversely affected by this alleged deficient practice. All residents have the potential to be affected by this alleged deficient practice. To ensure this alleged deficient practice does not occur review with staff will be completed and documented of the policy and procedure for food storage and labeling. Staff will put temp log on back up refrigerator when in use should it need to be utilized again. Reminders posted on refrigerators. A QAPI review will be completed under the supervision of the Dietitian and Dietary Supervisor. Audits to be completed 2 x weekly for 30 days, then weekly on going. Audit review submitted to QAPI team on a monthly basis for 6 months, then Quarterly. **Completion Date: 5/11/2024** Tag F 812 POC accepted on 5/20/24 by S. Stem/P. Cota	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		

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F 842	Continued From page 64 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842	It is the policy of the facility to ensure that records are complete,accurately documented, readily accessible, and systematically organized related to physician. The facility has a hybrid medical record system, it is the practice of the facility to utilize PCC for EHR, physician notes, x rays and labs are documented in UVMMC Epic software. As reasonably practicable facility staff will print and scan documents in PCC this was implemented in or about Jan/Dec 2023, previous process was to file physician progress notes, x rays, and labs in paper chart. The facility has been working on a consolidation and processes of EHR since implementation of PCC 4/1/2023. Resident #63 physician visit notes and x-ray results are documented in UVMMC, facility staff could have accessed them for survey team upon request. There is a physician note dated 1/12/2024 relating to death that is imported from our on call after hours physicians from Third Eye Health. Resident #56 was seen by physician, dated 9/11, 9/12, 9/13, 9/21, 10/20.10/21, 10/26, 11/7, 11/9, 11/15, 11/20, 11/24, 11/29, 12/2, 12/27,12/29/23,1/3, 1/11, 1/19, 2/21, 2/27, and 3/5/24 notes are scanned into the misc tab of PCC.	

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F 842	Continued From page 65 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that records are complete, accurately documented, readily accessible, and systematically organized related to physician notes for 2 of 23 sampled residents (Residents #63, # 56), laboratory results for 1 of 23 sampled residents (Resident #63), medication reviews for 1 of 5 sampled residents (Resident #35), and care plan revision notes for 3 of 23 sampled residents (Residents #35, #52, and #39). Findings include:	F 842	Resident #52's care plan was reviewed and updated by IDT team on January 18th 2024 due to significant change in residents condition not February 2024. Evidenced by updated care plan with January 18th date. Resident #39,care plan had been reviewed and revised by the IDT. Evidenced by Social Service care plan reviewed note and dates of update on the written care plan, Resident #35 care plan meeting was completed on January 24th 2024 not February 2024 with IDT due to a significant change, Evidenced by paper chart documentation of signature sheet, updated care plan. Resident # 35 pharmacy medication regimen review recommendations were reprinted and provided to surveyor. To ensure this alleged deficient practice does not occur physician notes and pharmacy recommendations will be monitored for completion and scanned into PCC for easier accessibility. Review with nursing staff will be completed and documented. Care plan sign sheets will be kept in the residents medical record with written care plan until full EHR care plan transition occurs. A QAPI review will be completed under the supervision of the DON/ADON to monitor pharmacy recommendations, Resident Family Service coordinator to monitor care plan signature sheets . Audits to be completed weekly for 30 days, then monthly for 90 days then quarterly on going. Audits to be submitted to QAPI team for review. **Completion Date: 5/11/2024** Tag F 842 POC accepted on 5/20/24 by S. Stem/P. Cota	

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	475040	A. BUILDING _____ B. WING _____	03/28/2024

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GREEN MOUNTAIN NURSING AND REHABILITATION	475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446

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F 842	Continued From page 66 1. Per review of 1/11/2024 nursing progress notes, Resident #63 was showing respiratory symptoms on 1/11/2024 and staff notified the physician. Resident #63 was seen by a physician that day and confirmed him/her to be positive for RSV and ordered a chest x-ray to be complete. A 1/12/2024 nursing progress note reveals that Resident #63 passed away the following day. A review of both Resident #63's electronic medical record and the paper chart does not contain the 1/11/2024 physician visit note or the 1/12/2024 x-ray results. On 3/27/2024 at 11 AM, the Administrator confirmed that the 1/11/2024 physician note and the 1/12/2024 x-ray results were not in Resident #63's medical record. 2. Per record review, Resident #56 has resided at the facility since 11/25/22. A review of the electronic medical record (EMR) and Resident #56's paper chart indicated no evidence of provider visits after September 5, 2023. Per an interview with the Unit Manager on 3/26/24 at approximately 2:20 PM, s/he indicated the facility had been in the process of transferring the paper charts to an electronic health record (EMR) since April 2023. S/he indicated that when there was time, s/he would access Resident #56's provider notes from the provider's EMR and place them in the paper chart; s/he did not know how the facility was managing the transfer of resident information from the paper chart to the EMR. 3. Per record review, 25 documents containing provider information, dated 9/11, 9/12, 9/13, 9/21, 10/20.10/21, 10/26, 11/7, 11/9, 11/15, 11/20,	F 842		

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F 842	Continued From page 67 11/24, 11/29, 12/2, 12/27,12/29/23,1/3, 1/11, 1/19, 2/21, 2/27, and 3/5/24 were missing from both the paper chart and the EMR. Per interview on 3/26/24 at approximately 3 PM, a Licensed Practical Nurse (LPN) functioning as the evening charge nurse reported s/he did not have access to Prism, preventing access to Resident records. Per interview on 3/27/24 at approximately 1:00 PM, the Unit Manager confirmed that the facility was not maintaining medical records in a systemically organized manner that was readily accessible. 3. Per record review Resident #35's monthly Consultant Pharmacist's Medication Regimen Review recommendations for September and October of 2023 were not available in the medical record. During an interview on 3/27/24 at approximately 3:00 PM the Director of Nursing (DON) confirmed that the September and October 2023 Consultant Pharmacist's Medication Regimen Review recommendations were not available in the medical record. The DON printed the recommendations during this interview and provided them to this surveyor. 4. Per record review Resident #52 last had a care plan meeting documented on 11/1/23. A Resident Care Plan / Review - Sign Sheet dated 11/1/2023 reflects that members of the Interdisciplinary team (IDT) met to review Resident #52's care plan on 11/1/23. There was no documented evidence in the record that Resident #52's care plan had been reviewed and revised by the IDT in February 2024 as required.	F 842		

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F 842	Continued From page 68 Per record review Resident #39 last had a care plan meeting documented on 11/8/23. A Resident Care Plan / Review - Sign Sheet dated 11/8/2023 reflects that members of the Interdisciplinary team (IDT) met to review Resident #39's care plan on 11/8/23. There was no documented evidence in the record that Resident #39's care plan had been reviewed and revised by the IDT in February 2024 as required. Per record review Resident #35 last had a care plan meeting documented on 11/8/23. A Resident Care Plan / Review - Sign Sheet dated 11/8/2023 reflects that members of the Interdisciplinary team (IDT) met to review Resident #35's care plan on 11/8/23. There was no documented evidence in the record that Resident #35's care plan had been reviewed and revised by the IDT in February 2024 as required. During an interview on 3/28/24 at 4:15 PM the Director of Nursing (DON) confirmed that the last Resident Care Plan Sign Sheets in the record were documented in November of 2023 and that there was no documented evidence in the record that a care plan meeting where the IDT met to review and revise the care plans for Residents #52, #39, and #35 happened in February of 2024 as required.	F 842		
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	F 880		

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F 880	Continued From page 69 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, 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	F 880	It is the policy of the facility for staff to maintain proper procedures and techniques to ensure infection prevention was maintained during catheter care. Resident #14 catheter bag has an anti back flow system to ensure urine does not re enter the bladder. Resident #14 leg bag has a cap on the spout applied, connection ends are being cleaned when performing catheter changes, barrier is utilized on the floor when staff are performing catheter changes. Resident #14 is offered hand hygiene when assisting in his/her changing of catheter bags. All residents who have a foley catheter have the potential to be affected by this alleged deficient practice. To ensure catheter care and infection prevention during catheter care is followed a review with nursing staff will be completed and documented, competencies reviewed relating to catheter care and infection prevention procedures during catheter care. A QAPI review will be completed under the supervision of the DON/ADON and/or designee to review catheter care and infection prevention during catheter care. Audits to be completed weekly for 30 days, then monthly for 90 days then quarterly on going. Audits to be submitted to QAPI team for review. **Completion Date: 5/11/2024** **Tag F 880 POC accepted on 5/20/24 by S. Stem/P. Cota**	

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F 880	Continued From page 70 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure that staff maintained proper procedures and techniques to ensure infection prevention was maintained during catheter care for 1 of 27 residents sampled. (Resident #14) Record review reveals Resident #14 has a diagnosis of Flaccid Neuropathic Bladder (this is when the bladder does not contract to empty and therefore requires a catheter to empty the bladder). Resident #14 has orders for a foley catheter (a foley catheter is a tube that is maintained in the bladder to constantly drain urine). It is connected to a collection bag that requires frequent emptying. An observation on 3/26/24 at 1:05 pm of a	F 880		

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F 880	Continued From page 71 Licensed Nurse Aide (LNA) changing resident #14's foley bag [the bag used to drain the bladder while the resident is in bed] to a leg bag [a drainage bag that is strapped to the resident's leg while the resident is out of bed] revealed the following. 1. Before the start of the procedure there were noted to be two leg bags in the bathroom hanging on a rail, the bags were exposed with no cover, neither bag was labeled or dated and both bags had residual urine in them. They both had no cap on the spout that empties the bags or on the connector that connects the bag to the catheter. 2. Resident #14 was assisted to roll to his/her side while in bed, before the foley bag was emptied. The foley bag that had urine in it was lifted up over the resident and the bag was placed on the opposite side of the bed. This was done a second time when the resident was rolled back to the other side. [Lifting the foley bag above the bladder can cause the urine that is in the tube to backflow into the bladder putting the resident at risk for infection] 3. The LNA placed a container on the floor next to where the foley bag was hanging. The LNA did not place a barrier between the floor and the container, and s/he continued to disconnect the valve to release the urine into the container, Urine was noted to spray onto the floor in multiple places, this was not noted by the LNA, and was not cleaned up. 4. When the LNA was ready to disconnect the connection from the foley bag and the catheter, Resident #14 took hold of the tubing at the connection site and pulled the tubes apart. S/he then bent the end of the catheter over in his/her hand and held the catheter there. The resident had not sanitized his/her hands and was not wearing a glove.	F 880		

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F 880	Continued From page 72 5. The LNA then asked the resident for the end of the catheter so he/she could connect it to the leg bag. The LNA did not clean the end of either tube with alcohol before connecting the two tubes. The resident was not offered hand sanitizer after releasing the catheter tube. Per an interview with the LNA on 3/26/24 at 2:15 pm s/he confirmed that there should have been a barrier on the floor and that s/he did not notice the urine that sprayed on the floor. S/he confirmed that s/he should have cleaned the catheter off with alcohol when s/he reconnected the bag but stated that there was no alcohol handy to do that. S/he confirmed that the foley bag should be kept at bladder level and not lifted higher. When asked about the resident separating the tubing and holding the catheter end folded over in his hand s/he stated there was not anything she could do about that but confirmed having the resident sanitize his/her hands and or put gloves on would be a good idea. A review of the faciliy policy Urinary Leg Drainage Bags reveals under section Steps in the Proceedure "2. Wash and dry your hands. Apply Clean gloves. #3 Clean the catheter/bag junction with alcohol wipe before disconnecting. #7 Carefully remove cover over connection tip on the leg bag. #8 Connect the catheter to the leg bad with outh touching the terminal end of the catheter tubing. " Further review of facility policy Emptying a Urinary Collection Bag reveals under section General Guidlines "#8 Keep the collection bag below the level of the residents bladder." Per an interview with the Director of Nursing on 3/26/24 at 3:30 pm, s/he indicated that the	F 880		

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F 880	Continued From page 73 expectation would be for staff to follow facility policy and confirmed that the unused catheter leg bags would be rinsed, the ends would be capped, and the bags should be labeled, dated, and should have a clean bag covering them when they are taken off. The DON also confirmed that the LNA should use a barrier between the container and the floor when emptying the bag. S/he confirmed that the connector should be cleansed with an alcohol sponge prior to connection and that the resident should have hand hygiene and a glove to assist with his/her catheter care.	F 880		
F 940 SS=F	Training Requirements CFR(s): 483.95 §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to- This REQUIREMENT is not met as evidenced by: Based on interview, employee record review, facility assessment, facility policy, and facility onboarding training, the facility failed to implement and maintain an effective training program for all new and existing staff related to QAPI (quality assurance and performance improvement), communication, and emergency preparedness, for 10 of 10 sampled direct care staff, and failed to implement and maintain an effective training program for all new contracted	F 940		

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F 940	Continued From page 74 staff for 3 of 3 direct care staff sampled. Findings include: Per facility policy titled "In-Service Training, All Staff," last revised 8/2022 states. "All staff must participate in initial orientation and annual in-service training. . . For the purpose of this policy, "staff" means all new and existing personnel, individuals providing services under contractual agreement, and volunteers. . . Required training topics include the following: a. effective communication. . . d. elements and goals of the facility QAPI program. . . Training requirements are met prior to staff providing services to residents, annually, and as necessary based on the facility assessment. . . Completed training is documented by the staff development coordinator, or his or her designee and includes: the date and time of training. The topic of the training, the method used for training; a summary of the competency assessment; and the hours of training completed." Review of the facility's Facility Assessment dated 2024, included in section "staff training/education and competencies," training such as emergency preparedness training should be completed upon new employee orientation and annually. There is an extensive list of all the required training the facility has determined necessary for staff to complete in order to provide competent support and care for the resident population. Per review direct care staff education files, 10 of the 10 sampled staff did not have education related to communication, QAPI, or Emergency Preparedness in their files. 3 of the 10 staff	F 940	It is the policy of the facility to develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. All residents have the potential to be affected by this alleged deficiency. Ongoing training is provided to staff to include but not limited to QAPI, Emergency Preparedness and communication. To ensure new staff are trained in accordance with facility policy, new hires will be given education packets on their first assigned shift. Staff will receive ongoing education and training throughout employment on a scheduled basis to make every attempt for staff to complete required education. HR director will monitor staff attendance, correction of test staff submit will be completed by the department in which the training was initiated from. A QAPI review will be completed under the supervision of the Administrator, DON/ADON, HR Director and Maintenance Supervisor and/ or designee to review training programs. Audits to be completed weekly for 30 days, then monthly for 90 days then quarterly on going. Audits to be submitted to QAPI team for review. **Completion Date May 10th 2024** **Tag F 940 POC accepted on 5/20/24 by S. Stem/P. Cota**	

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F 940	Continued From page 75	F 940		

sampled were hired within the past year. These 3 staff did not have evidence of onboarding education in their files [Licensed Nursing Assistant #1 (LNA), LNA #2, and Registered Nurse #1 (RN)].

Per interview on 3/28/24 at 3:15 PM, the Staff Educator, whom is also the Director of Nursing, explained that onboarding education consists of the new staff member reading handouts that are included in their new hire packets. Staff are to read the materials, take a quiz on the materials, and return the quiz to Human Resources, who keeps track of training. S/He indicated that there is no communication training. S/He explains that s/he is not responsible for emergency preparedness and QAPI training and is unsure when these trainings are completed and how they are tracked. The Educator confirmed that contracted staff are supposed to do the education as well.

Per interview on 3/28/2024 at 4:20 PM, the Human Resource Specialist explained that new employees are given new hire folders that contain handouts, that serve as the required trainings, and follow up quizzes to these handouts. S/He explained that s/he keeps records of the quizzes but is unsure that the quizzes are reviewed for correction. S/He explained that contracted staff do not return quizzes. S/He indicated that there is no system in place to follow up with employees that have not returned the onboarding quizzes and employees can work their assignments without having evidence of training completed. The Human Resource Specialist confirmed that s/he did not have evidence that LNA #1, LNA #2, or RN#1 had completed any onboarding education and confirmed that they worked

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F 940	Continued From page 76 assignments without having this education completed. Per review of an employee onboarding packet, there is no evidence of communication training, QAPI training, or emergency preparedness training in the packet.	F 940		