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

January 4, 2022

Mr. Travis Bergeron, Administrator
Maple Lane Nursing Home
60 Maple Lane
Barton, VT 05822-9494

Dear Mr. Bergeron:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **December 8, 2021**. Please post this document in a prominent place in your facility.

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

Sincerely,

Pamela M. Cota, RN
Licensing Chief

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475042 | A. BUILDING _____ B. WING _____ | 12/08/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MAPLE LANE NURSING HOME | 60 MAPLE LANE BARTON, VT 05822 |

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| E 000 | Initial Comments<br><br>The Division of Licensing and Protection conducted an onsite, unannounced survey of the facility's emergency preparedness program on 12/8/21. The following regulatory deficiency was identified: | E 000 | | |
| E 037 SS=C | EP Training Program<br>CFR(s): 483.73(d)(1)<br><br>§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), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1).<br><br>*[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:]<br>(1) Training program. The [facility] must do all of the following:<br>(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.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.<br><br>*[For Hospices at §418.113(d):] (1) Training. The | E 037 | E 037<br>1. No residents were negatively affected by the alleged deficient practice.<br>2. Residents residing in the facility have the potential to be affected by the alleged deficient practice.<br>3. Facility administration is aware of the requirement to provide training on policies and procedures related to emergency preparedness to staff upon hire and annually.<br>4. Facility administration will provide training to staff regarding policies and procedures related to emergency preparedness.<br>5. Tracking of appropriate training will be maintained by facility administration.<br>6. The Administrator or designee will report to the QAA committee x3 months the results of the tracking and the committee will determine future reporting needs.<br>7. Corrective action will be completed by 1/7/2022. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12/28/21

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 037 | Continued From page 1<br>hospice must do all of the following:<br>(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.<br>(ii) Demonstrate staff knowledge of emergency procedures.<br>(iii) Provide emergency preparedness training at least every 2 years.<br>(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.<br>(v) Maintain documentation of all emergency preparedness training.<br>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.<br><br>*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:<br>(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.<br>(ii) After initial training, provide emergency preparedness training every 2 years.<br>(iii) Demonstrate staff knowledge of emergency procedures.<br>(iv) Maintain documentation of all emergency preparedness training.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF | E 037 | **TAG E 037 POC Accepted on 01/03/22 by K. Ruffe/P. Cota** | |

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| E 037 | Continued From page 2<br>must conduct training on the updated policies and procedures.<br><br>*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:<br>(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.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(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.<br>(iv) Maintain documentation of all training.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.<br><br>*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:<br>(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.<br>(ii) Provide emergency preparedness training at least annually.<br>(iii) Maintain documentation of all emergency preparedness training.<br>(iv) Demonstrate staff knowledge of emergency procedures.<br><br>*[For CORFs at §485.68(d):](1) Training. The | E 037 | | |

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| E 037 | Continued From page 3<br>CORF must do all of the following:<br>(i) 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.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(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.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.<br><br>*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:<br>(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.<br>(ii) Provide emergency preparedness training at least every 2 years.<br>(iii) Maintain documentation of the training.<br>(iv) Demonstrate staff knowledge of emergency | E 037 | | |

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| E 037 | Continued From page 4<br>procedures.<br>(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.<br><br>*[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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to provide emergency preparedness policies and procedures training to all new and existing staff at least annually. Findings include:<br><br>Per review of the facility's emergency preparedness documentation, there was no evidence of annual training for all staff on all emergency preparedness policies and procedures beyond initial orientation training. There was evidence of annual fire safety training provided to all staff, but not of annual training in any other emergency preparedness policies and procedures.<br><br>Per interview on 12/8/21 at approximately 10:00 AM, the Administrator confirmed that no annual emergency preparedness training for topics beyond fire safety is provided to staff after initial orientation. | E 037 | | |

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| F 000 | INITIAL COMMENTS<br><br>The Division of Licensing and Protection conducted an onsite, unannounced recertification survey from 12/6/21 through 12/8/21. The following regulatory deficiencies were identified: | F 000 | | |
| F 655 SS=D | Baseline Care Plan<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission.<br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders.<br>(B) Physician orders.<br>(C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable.<br><br>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-<br>(i) Is developed within 48 hours of the resident's admission.<br>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). | F 655 | F 655<br>Please note there is a typographical error in the 2567 related to resident number. Deficit practice was cited for #31 and #54. Resident #31 is referred to in the 2567 as #21 in the statement of evidence.<br>1. Residents #31 and #54 now have comprehensive care plans written.<br>2. Residents admitted to the facility have the potential to be affected by the alleged deficient practice.<br>3. Education will be provided to the IDT members regarding the requirement for a baseline care plan to be completed within 48 hours of admission.<br>4. The Director of Nursing or designee will complete audits weekly to monitor effectiveness and compliance with the plan.<br>5. The results of the audits will be reported to the QAA committee x3 months at which time the committee will determine further frequency of the audits.<br>6. Corrective action will be completed by 1/7/2022. | |

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| F 655 | Continued From page 6<br>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:<br>(i) The initial goals of the resident.<br>(ii) A summary of the resident's medications and dietary instructions.<br>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.<br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based upon interview and record review, the facility failed to develop and initiate a Baseline Care Plan upon admission for 2 residents [Res. #31 & #54] of 26 sampled residents.<br>Findings include:<br><br>1.) An interview was conducted with the Director of Nursing [DON] on 12/08/21 at 9:36 AM. The DON reported that for each resident, a Baseline Care Plan is entered into the computer on admission regarding identified areas of concern and issues where the resident is considered at risk. The Baseline Care Plan is entered into the computer, then printed on paper and placed in the resident's paper chart at the Nurse's station.<br><br>Per record review, Res. #31 was admitted to the facility on 10/20/21 with diagnoses that include a pelvic fracture, dementia, hallucinations, Parkinsonism, muscle weakness, osteoarthritis, and difficulty in walking. Further record review reveals the day after admission, on 10/21/21, Res. #31 'fell in [h/her] room this am witnessed by roommate. Roommate stated [h/she] got up without [h/her] walker, got to the doorway and | F 655 | **TAG F 655 POC Accepted on 01/03/22 by K. Ruffe/P. Cota** | |

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| F 655 | Continued From page 7<br>slipped down. Resident lifted up off floor by Hoyer lift.'<br>Per record review and confirmed during interview with the DON on 12/08/21 at 9:36 AM, there was no Baseline Care Plan for Res. #21 entered electronically in the facility's computer records or printed and placed on the resident's paper chart. The DON stated that a Baseline Care Plan should have been done but was not.<br>2.) Per record review, there was no baseline care plan for Resident #54 located within Resident #54's chart. Resident #54's comprehensive care plan was also not initiated within 48 hours of admission to the facility.<br><br>Per interview on 12/8/21 at approximately 1:00 PM, the Director of Nursing confirmed that all residents should have a baseline care plan completed on admission. They also confirmed that they located Resident #54's baseline care plan half-completed without any documentation as to who contributed to the plan and when it was done, so it was not fully completed on admission. | F 655 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain | F 656 | F656<br>1. Resident #31 now has a comprehensive care plan in place to identify areas of concerns including fall risk.<br>2. Resident #26 is now receiving medication per the plan of care and physician orders.<br>3. Education will be provided to staff regarding the requirement to have a comprehensive care plan in place for areas of concern and requirements for implementing care plan interventions. | |

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| F 656 | Continued From page 8<br>or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(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).<br>(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.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(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.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based upon interview and record review, the facility failed to develop and implement a Care Plan for identified concerns for 2 residents [Res. #31 & #26] of 26 sampled residents.<br>Findings include:<br><br>1.) Per record review, Res. #31 was admitted to the facility on 10/20/21 with diagnoses that include a pelvic fracture, dementia, hallucinations, | F 656 | 4. An initial audit will be completed for other residents residing in the facility to ensure a comprehensive care plan that identifies areas of concern and appropriate interventions are in place.<br>5. Education will be provided to licensed nurses regarding the protocol to follow when medications are not available.<br>6. The Director of Nursing or designee will conduct weekly audits to monitor effectiveness and compliance with the plan.<br>7. The results of the audits will be reported to the QAA committee x3 months at which time the committee will determine further frequency of the audits.<br>8. Corrective action will be completed by 1/7/2022.<br><br>**TAG F 656 POC Accepted on 01/03/22 by K. Ruffe/P. Cota** | |

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| F 656 | Continued From page 9 | F 656 | | |

Parkinsonism, muscle weakness, osteoarthritis, and difficulty in walking. Further record review reveals the day after admission, on 10/21/21, Res. #31 'fell in [h/her] room this am witnessed by roommate. Roommate stated [h/she] got up without [h/her] walker, got to the doorway and slipped down. Resident lifted up off floor by Hoyer lift.' Res. #31's record documents the resident fell again 2 days later on 10/23/21. Progress notes record 'Resident had a witnessed fall today at 9:50 AM. Saw resident slip off the side of [h/her] bed landing on [h/her] right side and right buttock.' On, 11/25/21, Res. #31's medical record reveals '4:35 AM. Found Resident sitting on [h/her] buttocks on the floor beside [h/her] bed. [H/she] did have some redness on the right hip. [H/she] also stated that [h/she] slid out of bed as [h/she] was trying to go to the bathroom. Had one sock on.' Per record review and confirmed during interview with the DON on 12/08/21 at 9:36 AM, the DON stated a resident fall would be included in the resident's Care Plan, and confirmed that after 3 falls there was no Care Plan regarding falls and fall prevention in Res. #31's record.

2.) Per record review, Res. #26 was admitted to the facility on 6/16/20 with diagnoses that include Parkinson's Disease, depression, and chronic pain. Physician notes dated 9/27/21 record "patient has had 'burning' of his bilateral Lower extremities for some time, but did not want to take anything but Tylenol for his pain-today: '...I can't take it, I dread night time, I can't sleep- it is awful...' [S/He] is having issues with sleeping because of this-discussed Gabapentin [used to relieve nerve pain] will help with sleep, and neuropathy [damaged or malfunctioning of nerves that causes weakness, numbness and pain in hands and feet]-will start at low dose and titrate

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| F 656 | Continued From page 10<br>as needed, patient in agreement. Plan of care: Neuropathy-Gabapentin 100mg by mouth at bedtime. Will revisit in 1 week."<br><br>Nursing notes the same day, 9/27/21, record 'NEW ORDER: Advance Practice Registered Nurse rounds today; start Gabapentin 100mg for neuropathy. [Res. #26] aware and in agreement.' A review of Res. #26's Medication Administration Record [MAR] for September 2021 reveals the resident did not receive the ordered Gabapentin on Sep. 27, 28, 29, or 30. Per record review and confirmed during interview with the DON on 12/08/21 at 9:36 AM, if the medication was not available from the pharmacy, the medication was on-site and available in the facility's Emergency Medications Kit. Per record review and confirmed by the DON, Res. #26's Care Plan includes interventions that read "meds/labs/treatments per MD orders". The DON confirmed the pain medication for Res. #26 was not given for 4 days, per MD orders and the Care Plan intervention for 'meds/labs/treatments per MD orders' was not implemented. | F 656 | | |
| F 657 SS=E | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the | F 657 | F657<br>1. Resident's #11, #37, and #10 have had the care plans reviewed and updated to reflect current needs and appropriate interventions.<br>2. Residents residing in the facility have the potential to be affected by the alleged deficient practice.<br>3. Education will be provided to the IDT members regarding the requirement to ensure care plans are updated to reflect current needs and appropriate interventions. | |

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| MAPLE LANE NURSING HOME | 60 MAPLE LANE BARTON, VT 05822 |

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| F 657 | Continued From page 11<br>resident.<br>(D) A member of food and nutrition services staff.<br>(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.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and record review, the facility failed to revise the plan of care for 3 of 26 applicable residents in the sample (residents 11, 37 & 10).<br>Findings include:<br><br>1. Resident # 11's care plan was not revised to reflect current needs related to nutrition. The care plan for risk of inadequate or excess nutrition intake/poor nutrition status due to chronic illness included the following interventions:<br><br>-Provide preferred food/fluids;<br>-Monitor I/O's (intakes and outputs) and weights;<br>-Monitor for signs of dehydration;<br>-Honor food preferences.<br><br>On 12/7/21 at 1:57 PM, the facility Clinical Consultant on confirmed that Resident # 11 is not currently on I/Os and that the care plan had not been revised to reflect this. | F 657 | 4. An initial audit will be completed for other residents residing in the facility to ensure the care plan addresses appropriate concerns and interventions.<br>5. The Director of Nursing or designee will conduct audits weekly to monitor the effectiveness and compliance of the plan.<br>6. The results of the audits will be reported to the QAA committee x3 months at which time the committee will determine further frequency of the audits.<br>7. Corrective action will be completed by 1/7/2022.<br><br>**TAG F 657 POC Accepted on 01/03/22 by K. Ruffe/P. Cota** | |

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| F 657 | Continued From page 12 | F 657 | | |

2.) An interview was conducted with the Director of Nursing [DON] on 12/08/21 at 9:36 AM. The DON reported that for each resident, a Baseline Care Plan is entered into the computer on admission regarding identified areas of concern and issues where the resident is considered at risk. The Baseline Care Plan is entered into the computer, then printed on paper and placed in the resident's paper chart at the Nurse's station. Later, a more extensive electronic Care Plan is entered into the computer, and the areas of concern from the Baseline Care Plan are carried over into the new, electronic Care Plan. The DON stated that a resident's Care Plan should be updated/revised with new interventions after each fall. Review of the facility's 'Falls and Fall Risk, Managing' policy includes "if falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant."

Per record review, Res. #37 was admitted to the facility on 10/29/21. Per record review, Res. #37's Baseline Care Plan, dated the day of admission on 10/29/21, is checked off for 'Safety', related to a 'history of falls.' Further review of the resident's current Care Plan reveals the Baseline concern regarding safety was not carried over into the current Care Plan, despite the resident identified as having a 'history of falls'. Per review of Nursing Notes dated 11/18/21, '[Res. #37] had a witnessed fall at 4:15 PM. [h/she] fell to [h/her] bottom and right side and leaned up against a box on the floor.' Per record review and confirmed during interview with the DON on 12/08/21 at 9:36 AM, there were no interventions added to the Baseline or current Care Plan for Res. #37 regarding preventing future falls and

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| F 657 | Continued From page 13<br>possible injury after the fall on 11/18/21.<br><br>3.) Per record review, Res. #10 was admitted to the facility with diagnoses that include morbid obesity, dementia, Alzheimer's disease, and abnormalities of gait and mobility. Res. #10's Care Plan identified the resident as 'At Risk for Falls related to impaired mobility, requiring assistive device (walker) and 1 limited assistance for mobility.' The Care Plan is dated as being initiated in 2017, and the most recent intervention to prevent falls dated 10/4/21. On 10/4/21, the Care Plan notes 'Reviewed: [Res. #10] has had 7 falls in the last review period. All falls have been in the last 2 months. [Res. #10] is able to ring for assistance as she will ring for drinks and/or food however rarely rings for assistance for transfers... Attempted U-bar and currently has and is using a half rail. The intervention added on 10/4/21 is listed as 'Half-rail on left side of bed to assist resident to seated position on the edge of the bed and in and out of bed.'<br><br>An interview was conducted with the Director of Nursing [DON] on 12/08/21 at 9:36 AM. The DON stated the resident had falls on 11/8/21 and 11/10/21 [11/10/21 was not documented in any Nurses Notes] and both falls were reviewed. The DON confirmed no new interventions were placed. The DON stated that Res. #10 had the hand rail in place as a fall prevention [initiated on 10/4/21]. Record review since 10/4/21 reveals that, including the documented fall on 11/8/21, Staff 'Have found [Res. #10] many times now half on the bed and leaning into the grab bar. She will argue with you that she will not fall off the bed because the bar in holding her on to the bed. After long discussion am able to get her to use the bar and push onto the bed'. Progress notes | F 657 | | |

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| F 657 | Continued From page 14<br>also include 'She needs constant reminder today to not lay on the edge of the bed that she could easily slip and fall. Resident would state "I know, leave me alone".' The day before her fall on 11/8/21, Nursing notes record 'On change of shift rounds, found resident laying into her U-bar. Resident instructed on need to move away from the edge of bed.' 2 days after the fall, on 11/10/21, Nursing notes again record how the hand-rail/grab bar is not working as an intervention. Staff report 'Again I have found her laying in bed, hanging her belly over the edge of the bed. Discussed she needed to use the U-Bar to push herself over in the bed. She just ignores the conversation but will try to and can push herself back.'<br><br>On 12/8/21, at 6:00 AM, Nursing Notes record 'LNA came to get Nursing. Upon arriving to [Res. #10's] side of room, resident was on her knees on the floor and her face was against the 1st 2 bars of her assist rail on her bed and chin and right side of neck against the 1st rail. Resident gripping the bar. Resident yelling "help me" and very fearful, "don't let me fall I'm going to fall." Resident reassured we were not going to let her fall. but she needed to let go so we could get her up. Once resident let go of rail, staff able to get her positioned on her butt then Hoyered [a mechanical lift] back onto the bed.' Per interview with the DON on 12/8/21 at 9:36 AM, the DON confirmed Res. #10 had suffered a fall that morning, the fall committee had reviewed falls on 11/8/21 and 11/10/21, and there had been no new interventions to prevent further falls since 10/4/21. | F 657 | | |
| F 689 SS=E | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) | F 689 | F689 | |

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| F 689 | Continued From page 15<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure that the resident environment remains as free of accident hazards as is possible. Findings include:<br><br>1. Per observation on 12/6/21 at 2:49 PM, water temperatures in 3 resident bathrooms were read as follows :<br><br>Room 22 - 132 degrees Fahrenheit (F);<br>Room 27 - 135 F;<br>Room 26 - 146 F.<br>These temperatures were taken with a calibrated analog thermometer. All 3 rooms had ambulatory residents with varying levels of cognitive impairment.<br><br>On 12/06/21 at 03:02 PM the following water temperatures were taken with the same analog thermometer and a calibrated digital thermometer belonging to two surveyors. The surveyors were accompanied by a facility maintenance staff member.<br><br>Room 22 was below 120 F as required by regulation;<br>Room 26 - 135 F;<br>Room 27 138.7 F. | F 689 | 1. No residents were negatively affected by the alleged deficient practice.<br>2. Residents residing in the facility have the potential to be affected by the alleged deficient practice.<br>3. The Maintenance Director obtained a new thermometer and adjusted the water temperatures.<br>4. The Maintenance Director immediately began random checks of water temperatures throughout the building.<br>5. Facility administration and maintenance staff are aware of the regulatory requirements related to water temperature.<br>6. The Maintenance Director or designee will continue to do random audits 3x weekly to evaluate water temperatures throughout the building and appropriate adjustments to the water temperature will be made as needed.<br>7. The results of the audits will be reported to the QAA committee x3 months at which time the committee will determine further frequency of the audits.<br>8. Corrective action has been completed since 12/8/2021.<br><br>**TAG F 689 POC Accepted on 01/03/22 by K. Ruffe/P. Cota** | |

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| F 689 | Continued From page 16<br><br>These temperatures were confirmed at the time of the 3:02 PM observation by the facility maintenance staff member. The maintenance staff member was in agreement with and confirmed the surveyor's temperature readings, stated that his/her thermometer was not working properly and that h/she was not sure if it was the correct thermometer. | F 689 | | |
| F 697 SS=D | Pain Management<br>CFR(s): 483.25(k)<br><br>§483.25(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based upon interview and record review, the facility failed to ensure pain medication was administered per physician order for 1 resident [Res. #26] out of 26 sampled residents.<br>Findings include:<br><br>Per record review, Res. #26 was admitted to the facility on 6/16/20 with diagnoses that include Parkinson's Disease, depression, and chronic pain.<br>Physician notes dated 9/27/21 record "patient has had 'burning" of his bilateral Lower extremities for some time, but did not want to take anything but Tylenol for his pain- today: "I am ready, I can't take it, I dread night time, I can't sleep- it is awful" ...He is having issues with sleeping because of this-discussed Gabapentin [used to relieve nerve pain] will help with sleep, and neuropathy | F 697 | F697<br>1. Resident #26 is now receiving medication to assist with pain management per the physician orders.<br>2. Residents requiring pain management have the potential to be affected by the alleged deficient practice.<br>3. Education will be provided to licensed nurses regarding the protocol for when medications are not available.<br>4. The Director of Nursing or designee will monitor the effectiveness and compliance with the plan by completing weekly audits.<br>5. The results of the audits will be reported to the QAA committee x3 months at which time the committee will determine further frequency of the audits.<br>Corrective action will be completed by 1/7/2022.<br><br>**TAG F 697 POC Accepted on 01/03/22 by K. Ruffe/P. Cota** | |

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| F 697 | Continued From page 17<br>[damaged or malfunctioning of nerves that causes weakness, numbness and pain in hands and feet]-will start at low dose and titrate as needed, patient in agreement. Plan of care: Neuropathy-Gabapentin 100mg by mouth at bedtime. Will revisit in 1 week."<br>Nursing notes the same day, 9/27/21, record 'NEW ORDER: Advance Practice Registered Nurse rounds today; start Gabapentin 100mg for neuropathy. [Res. #26] aware and in agreement.'<br>A review of Res. #26's Medication Administration Record [MAR] for September 2021 reveals the resident did not receive the ordered Gabapentin on Sep. 27, 28, 29, or 30.<br>Nursing Notes dated 10/1/21 reveal "Resident ambulated out to the Nurses station with [h/her] walker asking about the Gabapentin order. Was told that it hadn't come in tonight, and they would be working on it tomorrow. Hopefully it would be here tomorrow night."<br>Per review of the facility's Pharmacy Medication Administration policy, under 'Documentation' reads "Medications which are not given will be noted on the MAR. The reason for not giving the medication will be documented and communicated to the physician."<br>Per record review and confirmed during interview with the DON on 12/08/21 at 9:36 AM, for 3 days there was no documentation why the pain medication was not given to Res. #26, and at no time was the physician notified that the medication orders were not carried out as written.<br>Per the DON, if a medication is not available, the pharmacy should be notified, along with the Nursing Supervisor and the DON. The DON confirmed this did not happen. Additionally, the DON confirmed the medication was on-site and available in the facility's Emergency Medications Kit, but "new people were training" and were not | F 697 | | |

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| F 697 | Continued From page 18<br>aware of this. | F 697 | | |