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 15, 2024

Ms. Teresa Isabelle, Administrator
Mountain View Center Genesis Healthcare
9 Haywood Avenue
Rutland, VT 05701-4832

Dear Ms. Isabelle:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **April 11, 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
Licensing Chief

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475012	A. BUILDING _____ B. WING _____	C 04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW CENTER GENESIS HEALTHCARE	9 HAYWOOD AVENUE RUTLAND, VT 05701

(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 4/11/2024 during a recertification survey. There were no regulatory violations as a result of this survey.	E 000	This plan of correction is written to follow state and federal guidelines. It is not an admission of noncompliance. However it is the facility commitment to demonstrate and maintain compliance.	
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and complaint investigations # 22922 and #22921 on 4/9/24- 4/11/24 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	F 000	Date of Compliance: 05/24/2024	
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that 2 of 36 sampled residents were treated with dignity and respect, in relation to staff to resident interaction (Resident #66) and not providing assistance with meals and nutrition while other residents seated at the same table were served and eating their meal (Resident #99). Findings include:	F 557	F557 Specific corrective action: 1. There were no negative impacts on residents #107 and #99.Care plans for residents #107 and #99 were updated. 2. An audit was conducted and no other residents were affected. 3. Staff education completed regarding dignity & respect. 4. Will conduct weekly audits x4 and then monthly x3 to ensure that Patients are treated with dignity/ respect during interactions between Staff & Patients as well as providing timely assistance to Patients during meals (aka Patients at the same table eat at the same time). Compliance and results to be reviewed at QAPI meeting for further review and recommendations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Teresa Cioccolelli | TITLE: Administrator | (X6) DATE: 5/13/24

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

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F 557	Continued From page 1	F 557	**Tag F 557 POC accepted on 5/15/24 by S. Freeman/P. Cota**	

1. Per record review, Resident # 66 has resided in the facility since 11/12/21 and has a diagnosis of Dementia.

Per observation on 4/10/24 at approximately 5:10 PM, Resident # 66 was overheard saying, "I can't do it." They were seen sitting alone at a table in the dining room. A Licensed Nursing Assistant (LNA) was standing nearby. The LNA was heard loudly saying, "Just try!" The resident repeated that s/he could not do it. The LNA grabbed the knife and fork and forcefully cut up the resident's food. Resident #66 then pointed to their drink and asked what it was. The LNA turned their back without acknowledging the drink and replied, "I don't know," and walked away from the resident. The resident was seen pushing away their food and resting their head on the table, clearly distressed by the interaction.

Per interview with the LNA on 4/10/24 at approximately 5:15 PM, the LNAstated that s/he was trying to get the resident to do more for themselves. This surveyor directed the LNA's attention to the resident, who was observed with his/her head in his/her hands. The LNA agreed that his/her approach toward Resident #66 was undignified and disrespectful.
Per interview with Resident #66 on 4/10/24 at aproximately 5:20 PM, S/he indicated "I'm just upset, I don't want to eat."

Per interview with the facility Administrator on 4/10/24 at approximately 5:30 PM, the administrator confirmed that the LNA had displayed undignified and disrespectful behavior toward Resident #66.

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2. Per record review Resident #99 was admitted to facility on 02/04/2024 with the following diagnoses: Alzheimer's dementia, stroke with aphasia (inability to express speech), and heart failure. Resident # 99 has a care plan dated 02/14/2024 that states "resident is at risk for malnutrition related to mechanical soft diet, need for assistance with meals." A nursing note written by the Unit Manager (UM) dated 4/10/2024 reflects that Resident # 99 has evidence of weight loss. The note states" Resident triggers for weight loss. Meal intake varies at 50-100% for meals with snacks offered."

During observation on 4/09/2024 at 4:30 PM in the Cherry Tree Country Kitchen area, Resident # 99 was sitting in his/her wheelchair at the table with two other residents that eat independently. Per record review all three Residents at the table have a diagnosis of Dementia. At 4:50 PM the start of meal service began.

At 4:55 pm the two other residents at the table received their dining trays. Resident # 99 was not offered a tray or a beverage. A licensed nursing assistant (LNA) left the resident's table and continued to pass other trays.

At 5:00 pm the resident to the left of Resident #99 picked up a canned pear off his/her plate and with bare hands handed it to Resident # 99. Resident # 99 took the pear and began to eat it, until it slipped from their fingers and dropped to the floor.

At 5:05 pm Resident # 99's tray arrived at the dining area. A LNA placed Resident # 99's plate with a cover over it in the middle of the table out of Resident # 99's reach. The LNA was observed

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walking away from the table and did not interact with Resident #99.

At 5:20 pm Resident # 99 sat forward, stretched across the table, and removed the cover from the food. Resident # 99 looked around the room, staff did not assist Resident #99 at this time or notice that Resident #99 removed the cover of the food.

At 5:25 pm Resident # 99 took his/her paper menu, folded it up, and began scooping the condensation out of the food cover and bringing it to her/his mouth. Resident # 99 repeated this action over and over as if eating. Staff did not approach Resident # 99 to help.

At 5:30 pm no staff had attempted to provide food or beverage to Resident # 99. There were two LNA's assisting two other residents with their meals at the back of the room with their backs turned away from the dining area for 45 minutes during observation.

At 5:40 pm the Dietary Manager entered the dining area. This surveyor alerted them that the resident has still not been assisted with their meal and requested temperatures be completed on Resident # 9's food prior to it being served as it had been sitting out for 40 minutes.

At 5:45 pm using their own thermometer the Dietary Manager and this surveyor checked the temperature of the food on Resident # 99 s plate and confirmed the temperature of the food on Resident # 99's plate was no longer palatable. The Dietary Manager confirmed based on the temperature of the meal for Resident # 99 it should not be served and removed the plate from in front of Resident # 99. At 5:55 pm the Kitchen

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F 557	Continued From page 4 Manager returned with a new plate of food for Resident # 99. At 6:00 PM a Licensed Practical Nurse (LPN) began to assist Resident # 99 with their meal, while the other residents left the dining room. The LPN on duty stated that Resident # 99 does require assistance with eating but can also eat on their own. The LPN confirmed Resident # 99 should have been offered their food while others were dining. The LPN stated that some residents require assistance in their room, and others in the dining room, making assisting all residents with their meals at the same time challenging.	F 557		
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, 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,	F 584	F584 Specific Corrective Action 1. There were no negative impacts on residents living on Unit D including residents 94 and 30. Care plans for residents #94 and #30 were reviewed. 2. An audit was conducted and no other residents were affected. 3. Staff education completed regarding Safe/Clean/Comfortable/ Homelike Environment. 4. Will conduct weekly audits x4 and then monthly x3 to ensure call bell alarms are not repeatedly going off for extended periods of time on Unit D. Compliance and results to be reviewed at QAPI meeting for further review and recommendations. **Tag F 584 POC accepted on 5/15/24 by S. Freeman/P. Cota**	

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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:
Based on observation and interview, the facility failed to provide a homelike environment for 1 of 4 units (Unit D) resulting in all residents on the unit being subjected to continuous loud alarms throughout the day. Findings include:

Per observation on Unit D during the recertification survey on 4/9/2024 through 4/11/2024, call bell alarms were repeatedly going off for extended periods of time. Unit D has approximately 50 residents. There is a large multipurpose room in the center of the unit which serves as a living area and dining area. There is a television located on the wall.

Observations were made during lunch and dinner on 4/9/2024, breakfast, lunch, and dinner on 4/10/204, and lunch and dinner on 4/11/2024. There was an average of 8 to 10 residents eating

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in the common area during the above meals. Call bell alarms went off for at least 10 minutes and up to 40 minutes straight for all of the meals observed. Once stopped, the call bell alarms usually started back up again a few minutes later. The alarm bell sounds was at a loud volume the entire time; as loud as the surveyors speaking voice.

Per observations on 4/9/2024 the call bell alarms were going off on Unit D at 10:50 AM through 11:20 AM straight with only a couple 30 second pauses. 8 residents were sitting in the common area during this time.

Per interview on 4/9/2024 at approximately 4:30 PM, Resident #94 stated that the call bell alarms were bothersome.

Per observation and interview on 4/10/2024 at 8:30 AM, Resident #30 was sitting in the common area at a table eating breakfast watching TV. S/He stated that s/he hated the call bells and that they were very loud. The call bell alarms were louder than the TV volume.

Per interview on 4/10/24 at 4:45 PM, a Licensed Nurse Aide (LNA) explained that the call bells go off non-stop, all day long, every day.

Per interview on 4/11/24 at 10:49 AM, LNA #2 stated that the call bell alarms are going off all the time and a Licensed Practical Nurse agreed.

Per interview on 4/11/2024 at approximately 5:45 PM, the Administrator confirmed that the alarms were very loud for an area that is frequently used by residents.

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F 609 SS=D	Continued From page 7 Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record, the facility failed to ensure that an alleged incident of a resident-to-resident altercation, which resulted in potential verbal abuse, was reported to the State Survey Agency for 1 of 36 of the applicable sample (Resident#66) Findings Include:	F 609 F 609	F609 Specific Corrective Action 1. There were no negative impacts on resident #66. Care plan for resident #66 was updated. 2. An audit was conducted and no other residents were affected. 3. Staff education completed regarding reporting of alleged violations. 4. Will conduct weekly audits x4 and then monthly x3 to ensure that alleged violations are reported timely. Compliance and results to be reviewed at QAPI meeting for further review and recommendations. **Tag F 609 POC accepted on 5/15/24 by S. Freeman/P. Cota**	

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Per record review, a nursing progress note reveals an entry dated March 31, 2024, "This writer observed patient demonstrating verbal and aggressive behavior towards roommate due to frustration of time spent in the bathroom and patients inability to use facilities sooner causing incontinence. Patient attempted to throw self out of bed while screaming [I'm gonna beat [him/her!]! and other obscenities were yelled. This writer assisted RN with boosting patient back into bed to prevent fall/injury. Roommate exited bathroom and began instigating patient in bed, this writer then intervened between both patients while this patient was attempting to throw him/herself towards the roommate. LNA came into room to provide further assistance, roommate was redirected to his/her side of the room with curtain drawn to prevent escalation of situation. Patient assisted to bathroom with care provided and is now sitting in WC watching TV in room with intermittent supervision from RN".

Per review of the facility policy with a title of Abuse Prohibition, #6, "Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately, regardless of shift worked. 6.1 "The notified supervisor will report the suspected abuse immediately to the Administrator or designee and other officials in accordance with state law."

Per interview on 4/10/24 at approximately 5:15 PM with the Administrator, s/he revealed that the incident between the two residents was not reported to him/her and not reported to the State

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F 609 SS=E	Continued From page 9 Agency. 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 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	F 609 F 656	F656 Specific Corrective Action 1. There were no negative impacts on residents #72, #3 & #83. Care plans for residents #72, #3 & #83 were updated. 2. . An audit was conducted and no other residents were affected. 3. Staff education completed regarding the development of patient specific comprehensive care plans. 4. Will conduct weekly audits x4 and then monthly x3 to ensure that all residents have care plans to address their nutritional risk, shaving preferences (if not daily) and passive range of motion needs. Compliance and results to be reviewed at QAPI meeting for further review and recommendations. **Tag F 656 POC accepted on 5/15/24 by S. Freeman/P. Cota**	

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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.
§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 review the facility failed to develop a person-centered comprehensive care plan for 3 of 36 residents sampled (Resident #72, #3, and #83). Findings include:

1. Per observation and interview on 4/10/24 at 10:05 AM, Resident #72 stated that s/he has lost a lot of weight being at the facility. While s/he is speaking, it appears as though s/he has no top teeth and most of the bottom teeth that remain are extremely decayed and most of his/her bottom teeth are so loose that they are moving around in his/her mouth.

Per record review, Resident #72 weighed 175.2 pounds on 7/2/22. The next weight entered into his/her medical record is 139.0 pounds, taken on 2/28/2024. Resident #72's 1/26/24 Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) reveals s/he is at risk of malnutrition. While a 1/26/24 Nutritional Assessment completed by the Dietician reveals that there were no nutritional concerns identified, the assessment was completed based on the 7/2/2022 weight. There are no nutritional assessments completed following Resident #72's

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2/28/2024 weight of 139.0, a 36 pound difference from the weight used for the previous month's nutritional assessment. Resident #72's care plan does not include goals, measurable objectives, interventions, and timeframes for how staff will meet the resident's needs for nutrition.

Per interview on 4/11/2024 at 5:01 PM, the Director of Nursing confirmed that Resident #72's care plan did not adequately address nutrition or risk for weight loss.

2. Per interview on 4/09/24 at 5:18 PM, Resident #3 explained that s/he has not had his/her face shaved in three weeks and his/her preference is to be shaved twice a week. S/He explained that having his/her face shaved is really important to him/her and because s/he cannot use his/her hands to shave his/her face, s/he has to depend on staff entirely to complete this task.

Per record review, Resident #3's care plan states "Patient is at risk for decreased ability to perform ADL's [activities of daily living] in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting, related to: MS [multiple sclerosis] and Limited mobility, weakness," revised on 8/25/2023 with an intervention to "Provide 2 assist with ADLs," revised on 5/05/2023. There are no interventions in Resident #3's care plan that describe his/her preference to be shaved twice a week.

Per interview on 4/10/24 at 4:45 PM, a Licensed Nurse Aide explained that there is not a system to alert staff about when to shave a resident and indicated that s/he is not sure where s/he would find Resident #3's preferences documented.

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Per interview on 4/11/2024 at 9:21 AM, the acting Unit Manager explained that Resident #3's shaving preferences should be on his/her care plan.

3. Per observation and interview on 4/9/2024 at 1:36 PM, Resident #83 explained that s/he has contractures in his/her hand because s/he has Parkinson's (a disorder of the central nervous system that affects movement). S/He explained that she likes to have staff help him/her open his/her hands at least three times a day so s/he can exercise her hands in order to maintain the function s/he has left in her hands. While s/he was talking, s/he demonstrated for this surveyor how s/he couldn't open his/her hands and wanted to. S/He stated that it is very important to remain as independent as possible.

Per record review, a 12/7/2023 nursing note reveals that Resident #83 has "Left upper extremity contracture. Right upper extremity contracture. Left lower extremity contracture. Right lower extremity contracture. Upper extremity impairments on both sides. Lower extremity impairments on both sides." Resident #83's care plan reveals that "Patient is at risk for decreased ability to perform ADLs related to activity intolerance, weakness, limited mobility, Parkinson's disease, long term care need," revised on 7/5/2023, with the goal to "improve current level of function in ADLs by next review as evidenced by improved ADL scores," revised on 3/1/2024, and an intervention that s/he "eats independently after set up," created on 5/4/2023. There are no interventions that address Resident #83's contractures or the care that s/he as expressed as being important to her (such as assistance with range of motion exercises in her

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hands).

F 658 SS=D Services Provided Meet Professional Standards
CFR(s): 483.21(b)(3)(i)

§483.21(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on resident interview and record review, the facility failed to ensure that services provided meet professional standards as evidenced by failing to follow physicians' orders for 1 of 36 sampled residents (Resident #15). Findings include:

Per record review, Resident #15 has diagnoses that include anxiety disorder and major depressive disorder. Resident #15's care plan states "Resident/patient exhibits or is at risk for distressed/fluctuating mood symptoms related to: History of Sadness/depression and Anxiety," created on 9/1/2020. Resident #15 has physician orders for the following antianxiety medications: "Hydroxyzine HCl Oral Tablet 25 MG (Hydroxyzine HCl) Give 25 mg by mouth as needed [PRN] for anxiety for 14 Days Administer 1 capsule PO TID PRN for anxiety\ X 14 days\ -Start Date- 03/04/2024 and Hydroxyzine HCl Tablet 25 MG (Hydroxyzine HCl) Give 1 tablet by mouth every 12 hours as needed for anxiety for 30 Days -Start Date- 03/21/2024" In addition to the above medications there is a physician order for "Non-Pharmacological Intervention(s) used before PRN anti-depressant, antianxiety, anti-psychotic or sedative/hypnotic medication

F 658 F658 Specific Corrective Actions

1. There was no negative impacts on resident #15. Care plan for resident #15 was reviewed.
2. An audit was conducted and no other residents were affected.
3. Staff education completed regarding Services Provided Meet Professional Standards.
4. Will conduct weekly audits x4 and then monthly x3 to ensure that residents receiving as needed psychotropic medications have a non-pharmacological intervention attempted and documented prior to the administration of a prn medication. Compliance and results to be reviewed at QAPI meeting for further review and recommendations.

Tag F 658 POC accepted on 5/15/24 by S. Freeman/P. Cota

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F 658	Continued From page 14 Document by number:1 Reposition for comfort 2 massage 3 involve in activity/alt. activity to divert 4 provide quiet setting with reduced stimuli as needed 5 relaxation technique 6 music 7 remove from area 8 direction/distraction 9 toilet 10 ambulate 11 provide food/drink 12 educated 13 one:one 14 other -add to PN the description -Start Date- 03/04/2024." Per review of Resident #15's Medication Administration Record (MAR) Resident #15 was administered PRN Hydroxyzine on 3/4/24 through 3/11/14, 3/13/24, 3/17/24, 3/22/24 through 3/25/24, 3/27/24 through 3/29/24, 4/1/24, 4/5/24, 4/6/24, 4/8/24, and 4/10/24 for anxiety. The MAR shows documentation that a non-pharmacological intervention was used before PRN antianxiety medication only 5 of the 22 times the medication was administered (3/5/24, 3/13/24, 3/22/24, 3/23/24, 4/1/24). Per interview on 4/11/24 at approximately 5:45 PM the Director of Nursing stated a non-pharmacological intervention should be attempted and documented prior to administering PRN medications and confirmed that this did not happen every time a PRN was administered for Resident #15. Ref: Lippincott Manual of Nursing Practice (9th Edition) Wolters, Kluwer Health/Lippincott, Williams, & Wilkens.	F 658		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		

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F 677	Continued From page 15 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure that residents who are unable to carry out activities of daily living receive the necessary services to maintain good hygiene as evidenced by excessively long fingernails, long thick toe nails, not providing showers, shaving, and range of motion exercises, for 4 of 36 sampled residents (Resident #102, #40, #83, and #3). Findings include: 1. Per observation on 4/9/24 at 2:17 PM Resident #102 was noted to have long fingernails with chipped nail polish and brown substance under their nails. Resident #102 was sitting in their wheelchair in their room with their hand up to her/his eye rubbing it. Resident #102 also was noted to have approximately 1/4 inch stubble on their chin. Per record review Resident #102's care plan reflects that staff should provide extensive assist for dressing and personal hygiene. On 4/11/2024 at 4:00 PM during an interview with the Unit Manager (UM) Resident #102's fingernails were again observed long with chipped nail polish and brown substance under the nails. The UM confirmed that Resident #102's nails were long and dirty and that it is the expectation that nursing staff would trim and clean finger nails when needed. The UM confirmed that the resident's nails were long and dirty. Resident #102 also was noted to have facial hair growth on their chin. The UM also confirmed that staff are expected to shave residents when they have hair growth on their face.	F 677	F677 Specific Corrective Action 1. There were no negative impacts on residents #103, #3, #83 & #40. Care plans for residents #103, #3, #83 & #40 were reviewed. 2. An audit was conducted and no other residents were affected. 3. Staff education completed regarding the performance of ADL care for dependent residents reflects good grooming. 4. Will conduct weekly audits x4 and then monthly x3 to ensure that residents' fingernails, facial hair and toenails show good hygiene. Compliance and results to be reviewed at QAPI meeting for further review and recommendations. **Tag F 677 POC accepted on 5/15/24 by S. Freeman/P. Cota**	

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2. Per interview on 4/09/24 at 5:18 PM, Resident #3 explained that s/he has not had his/her face shaved in three weeks and his/her preference is to be shaved twice a week. S/He explained that having his/her face shaved is really important to him/her and because s/he cannot use his/her hands to shave his/her face, s/he has to depend on staff entirely to complete this task. S/He stated that staff report to him/her that they are too busy to shave him/her because they are short staffed.

Per record review, Resident #3's care plan states "Patient is at risk for decreased ability to perform ADL's [activities of daily living] in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, and toileting, related to: MS [multiple sclerosis] and Limited mobility, weakness," revised on 8/25/2023 with an intervention to "Provide 2 assist with ADLs," revised on 5/05/2023. There are no interventions in Resident #3's care plan that describe his/her preference to be shaved twice a week.

Per interview on 4/10/24 at 4:45 PM, a Licensed Nurse Aide (LNA) explained that Resident #3 likes to be shaved frequently but staff have a hard time getting to it because they are so busy. This LNA explained that s/he had been shaving Resident #3's face the previous month and was unable to complete the task due to the workload. S/He had informed the oncoming evening shift to shave the other half of Resident #3's face but they never did. It had to be done the next day and Resident #3 was very upset.

Per interview on 4/11/2024 at 9:21 AM, the acting Unit Manager explained that Resident #3's shaving preferences should be on his/her care plan.

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3. Per observation and interview on 4/9/2024 at 1:36 PM, Resident #83 explained that s/he needs her toenails cut but no one is doing them. His/her toenails are very long, appearing to be at least a half inch past the end of his/her toes.

Per record review Resident #83's care plan reveals that "Patient is at risk for decreased ability to perform ADLs related to activity intolerance, weakness, limited mobility, Parkinson's disease [a disorder of the central nervous system that affects movement], long term care need," revised on 7/5/2023, with the goal to "improve current level of function in ADLs by next review as evidenced by improved ADL scores," revised on 3/1/2024. While there are no interventions related to hygiene, or nail cutting in Resident #83's care plan, a 3/4/2024 Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) reveals that s/he is dependent on staff for all personal hygiene.

4. Review of wound documentation for residents pressure ulcer on her/his right great toe that required amputation revealed wound pictures that showed toe nails that were thick and long - each wound assessment picture showed additional growth and thickening of the residents nails. Interview on this date at approximately 2:30 PM with Licensed Practical Nurse (LPN) stated that there is currently no access to podiatry services and residents need to be sent out for these service.

Per record review revealed pictures of a wound on the residents right great toe. In a picture taken from the inner side of the residents right foot, dated December 6, 2023 at 07:23 of this wound, showed the resident is noted to have long and

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thick toenails. A picture taken from the inner side of the residents right foot, of the same wound dated December 14, 2023 at 13:20 revealed the residents nails were longer than in the picture on 12/6/23. A picture taken from the inner side of the residents right foot, of the same wound dated Decemeber 23, 2024 at 13:32 revealed the residents nails were longer than in the picture on 12/14/23. A picture taken from the inner side of the residents right foot, of the same wound dated January 2, 2024 at 12:16, revealed the residents nails were longer than in the picture on 12/23/24. A picture taken at a different angle, looking down at the tips of the residents toes, revealed the same wound dated January 3, 2024 at 10:41, showed the residents nails were noted to be long and thick with a thick placque/debris under their right great toenail. A picture taken on January 11, 2024 at 09:48, from a similar angle to the picture on 1/3/24 revealed long and thick toenails. A picture taken on January 17, 2024 at 08:57 taken from the bottom of the residents right foot, looking at the underside of the toenails, revealed long and thick toenails with the toenail of the great toe extending beyond the end of the residents toe.

Interview on 4/11/24 at approximately 4 PM with a unit LPN, who confirmed that the residents toenails were quite long however the facility did not have a podiatrist at the time. When asked what the process was for residents receiving podiatry care, s/he stated that a call is made to the residents doctor for an order and then once the order is received a call is made to a local podiatrist and an appointment is made. S/he stated that there is no log book kept for residents needing podiatry. This was confirmed by an RN who was also present during this interview. The resident has since passed away.

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F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)	F 679	F 679 Specific corrective action	

§483.24(c) Activities.
§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure that the activities program meets the needs of each resident for 5 of 9 Sampled Residents (Residents #91, #19, #15, #95, and #72). Findings include:

1. Per interview on 4/9/24 at approximately 6:00 PM, Resident #91's daughter stated that since admission on 3/21/24, Resident #91 has spent their days sitting in their room with no activities or stimulation other than the television. At home, Resident #91 would color, listen to music, do puzzles or cards, as well as get stimulation from their visiting aides. At the facility, they don't give Resident #91 anything to do. No one in the facility has asked her about what activities Resident #91 likes.

Per record review, Resident #91 has diagnoses of Parkinson's Disease and Dementia. Their Admission MDS (Minimum Data Set Assessment) from 3/24/24 lists their BIMS (brief interview of mental status) score as 4, indicating serious impairment of cognitive abilities. Their MDS

- There were no negative impacts on residents: #91, #19, #15, #95, and #72. Care plans were updated for residents #91, #19, #15, #95, and #72.
- An audit was conducted on residents to ensure activities participation, and correct non-participation.
- Education was completed with staff about the importance of resident engagement and involvement with Activties. Education was completed with all Activties staff to show proper participation/ independent participation logs.
- Audits will be conducted by the administrator to ensure that participation logs are acurate and complete. Audits will be done weekly x4 and monthly x3. Results will be brought to QAPI for further review and recommendations.

Tag F 679 POC accepted on 5/15/24 by S. Freeman/P. Cota

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activities assessment lists having family involved in discussions about care and doing their favorite activities as "somewhat important". Resident #91's care plan for activities, created on 3/28/24, lists the following interventions:
- It is important for me to have family or a close friend involved in discussions about my care.
- I like to listen to music, look out the window, lay down/rest, watch TV/movies by myself in my room.
- It is important for me to engage in my favorite activities.

Per review of the facility's activities participation logs for Residents, no log could be found for Resident #91.

Per observations on 4/9/24 at 2:00 PM, 6:00 PM, and on 4/10/24 at 10:00 AM, 2:00 PM, 5:00 PM, and 6:00 PM, Resident #91 was observed to be sitting in a recliner looking out the window or watching TV with an empty tray table in front of them and no activities or engaging materials in the room. There were also no signs of any visitation by facility staff for the purposes of engagement during these observations.

Per observation/interview on 4/11/24 at approximately 9:00 AM, Resident #91 was observed with a packet that contained a list of the day's group activities, a selection of news articles, and a crossword puzzle. This surveyor asked Resident #91 if they were interested in any of the group activities today. Resident #91 said "no". This surveyor then asked if Resident #91 would like to do more activities in their room. Resident #91 nodded and said "yes". This Surveyor asked if Resident #91 would like to do the crossword puzzle. Resident #91 nodded and looked around

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for a writing utensil. There were no writing utensils in the room.

Per interview on 4/11/24 at approximately 9:10 AM, an activities assistant confirmed that every resident in the building gets a packet each morning with a list of the day's group activities as well as news articles and a puzzle. When asked how residents who choose to/must stay in their rooms are engaged in the activities program, the activities assistant stated that one-on-one visits are done for some residents, but they aren't sure how these residents are determined to need one-on-one visits or how frequently they are expected to happen. The activities assistant stated that every new Resident gets assessed by an activities staff member on admission for their activities interests but that Resident representatives are not regularly included in this assessment, even if the resident has cognitive deficits.

Per interview on 4/11/24 at approximately 9:30 AM, the Activities Director stated that they don't attend initial care plan meetings with residents and/or representatives. Newly admitted Residents will have an initial activities assessment done with them to determine their preferences for activities. Resident representatives are only consulted on this assessment if the resident is unable to answer questions, and the Resident's mental status is not taken into account. The Activities Director stated that some Residents receive regular one-on-one visits, but there is no formal process for determining which Residents should receive these or how frequently. One-on-one visits are also not regularly documented as having been conducted on activities logs for Residents. The Activities Director confirmed that

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Resident #91 does not wish to attend group activities and does not receive one-to-one visits or activities support from the activities program.

On 4/11/24 at 11:00 AM and 12:00 AM, Resident #19 was again observed to be sitting in a recliner looking out the window or watching TV with an empty tray table in front of them and no activities or engaging materials in the room.

2. Interview on 4/9/24 at approximately 2:45 PM, Resident #19 stated s/he is not able to leave their room, or sit in a wheelchair because they are not able to support their own weight due poor upper body strength. Resident #19 was asked what activities they are able to participate in, they replied they are not able to leave their room, so they are not able to participate in group activities. This surveyor asked what activities are provided to the resident in their room and s/he stated there is nothing provided to them in their room. When asked if they were happy doing independent activities or if they would like to have additional activities provided to them in their room, they stated they would enjoy some facility activities instead of having to entertain themselves all the time.

Review of Resident #19's activity logs for February, March, and April 2024 reveal the following:
In February 2024, Resident #19's participation in activities included independent "Computer/Tablet/Technology Use" for 29 of 29 days, and independent "Current Events/News/Mail" for 13 of 29 days; in March 2024, Resident #19's participation in activities included independent "Current Events/News/Mail" for 16 of 31 days; and in April 2024, Resident

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#19's participation in activities included independent "Current Events/News/Mail" for 5 of 10 days.

Review of Resident #19's current care plan revealed s/he is care planned for activities of [pronoun omitted] preference - it is documented that [pronoun omitted] enjoys doing activities in [pronoun omitted] room like listening to music, using [pronoun omitted] cell phone, watching the news etc.

3. Per interview on 4/09/24 at 11:56 AM, Resident #95 explained that the only thing s/he does is watch TV and play bingo. S/He likes bingo but wished there were other activities to participate in. On 4/11/2024 at 5:44 PM, Resident #95 explained that s/he would like to participate in more activities but they do not have much for him/her to participate in and no one does any kind of activities, like 1 on 1 visits, in his/her room. S/He explained that s/he does not go out for walks or go outside and s/he would like to. S/He said s/he is very "bored."

Per record review, Resident #95's care plan states "While in the facility, [Resident #95] states that it is important that [s/he] has the opportunity to engage in daily routines that are meaningful relative to [his/her] preferences," created on 12/15/2022, with interventions that include "[Resident #95] will plan and choose to engage in preferred activities ...I like to participate in social activities with groups of people ...It is important for me to engage in my favorite activities ...It is important for me to go outside when the weather is good and enjoy sitting/relaxing and talking/visiting," all created on 12/15/2022. Resident #95 does not have any activity interventions in their care plan created or revised

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after 12/15/2022.

Review of Resident #95's activity logs for February, March, and April 2024 reveal the following:
In February 2024, other than bingo and watching TV, Resident #95's participation in activities included salon/painting nails 5 times, 2 social visits, and receiving the newsletter; in March 2024, other than bingo and watching TV, Resident #95's participation in activities included salon/painting nails 4 times and 2 social visits; and in April 2024, other than bingo and watching TV, Resident #95's participation in activities included 5 social visits and receiving the newsletter. Of note, the activity log for April 2024 was reviewed on 4/11/2024 and the activity log was filled out through the end of the month for TV and social visits.

4. Per interview on 4/10/24 at 10:05 AM, Resident #72 indicated that there is nothing to do for activities that interests him/her in the facility. S/He said, "all they have is bingo or toss the ball, but there is nothing to do and they used to have more." S/He said s/he would like to sit outside for a little bit or go for a walk but doubt that will happen since they are short staffed.

Per record review, Resident #72's care plan states "it is important that [s/he] has the opportunity to engage in daily routines that are meaningful relative to [his/her] preferences," revised on 10/13/2020, with interventions to "Encourage and facilitate [Resident #72's] activity preferences ...It is important for me to go outside when the weather is good and enjoy sitting, talking/visiting, walking." A recreation assessment dated 1/26/2024 states "Recreation will

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encourage more participation in group activities as they have decreased since the pandemic."

Review of Resident #72's activity logs reveals that s/he does not have a log for February or March 2024 and April 2024's log reveals that the only participation Resident #72 had in activities was receiving the newsletter. There is no record of additional group, individual, or independent engagement for this period. There is no evidence on the log that Resident #72 refused to participate in activities.

5. Per interview on 4/09/24 at 12:31 PM, Resident #15 explained that s/he likes bingo, but there is not too much other than that. On 4/11/2024 at 5:20 PM, s/he explained that s/he would like to do more activities in his/her room. S/He explained that s/he would also like to go outside but can't because "there is no one to bring [him/her] since they are so short staffed."

Per record review, Resident #15's care plan states, "While in the facility, [Resident #15] states that it is important that [s/he] has the opportunity to engage in daily routines that are meaningful relative to [his/her] preferences, " revised on 5/24/2021, with interventions that include "It is important for me to engage in my favorite activities ...It is important for me to go outside when the weather is good and enjoy sitting/relaxing," revised on 5/24/2021.

Review of Resident #15's activity logs for February, March, and April 2024 reveal that the only participation in activities was receiving the newsletter. There is no record of additional group, individual, or independent engagement for this period.

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F 684 SS=D	Quality of Care CFR(s): 483.25	F 684	F684 Specific Corrective Action	

§ 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 observation, record review, interview, and policy review, the facility failed to provide safe and effective skin and wound care for 2 of 36 sampled residents (Resident #125 and #94) by failing to regularly and accurately perform and document weekly skin checks and non-pressure ulcer wound evaluations consistent with professional standards of practice and facility policy. Findings include:

Facility policy titled "NSG236 Skin Integrity and Wound Management," last revised on 2/1/2023, states that a licensed nurse will perform weekly skin inspections and complete wound evaluations weekly and with unanticipated decline.

1. Per interview and observation on 4/09/24 at 3:14 PM, Resident #94 is in bed and their wheelchair has a white towel on its seat that has a 2 inch spot of bright red blood. When asked about the blood, Resident #94 said they had a wound on their bottom that hurts a lot, so much that it is hard for him/her to stay in his/her wheelchair sometimes. S/He stated that because the wound causes him/her so much pain, s/he is not able to attend activities like s/he would like to.

1. There were no negative impacts on residents #94 & #125. Care plans for residents #94 & #125 were updated.
2. An audit was conducted and no other residents were affected.
3. Staff education completed regarding quality of care for skin and wounds.
4. Will conduct weekly audits x4 and then monthly x3 to ensure that residents have weekly skin checks and each open area also has a weekly Skin & Wound Evaluation. Compliance and results to be reviewed at QAPI meeting for further review and recommendations.

Tag F 684 POC accepted on 5/15/24 by S. Freeman/P. Cota

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This surveyor asked a Licensed Nursing Assistant (LNA) to position Resident #94 so their bottom could be observed. The LNA stated that the wound had been there for a while. Resident #94 had bilateral redness on both thighs that measured approximately 3 by 1 inches on each thigh. Resident #94's right thigh had open damage that measured approximately 2 by 1.5 centimeters and was bleeding.

Per record review, Resident #94 has diagnoses that include morbid obesity, type 2 diabetes, and mixed urinary incontinence. Resident #94's care plan states, "Resident at risk for skin breakdown related to recently healed PU, weakness, limited mobility, incontinence, tendency to "scratch and pick at skin", and excessive moisture with skin folds. Actual skin breakdown: Chronic bilateral posterior thighs (MASD [moisture-associated skin damage])," revised on 3/1/2024. Resident #94 has a physician order for "Desitin External Cream 13 % (Zinc Oxide (Topical)) Apply to Posterior thighs topically two times a day for MASD," with a start date of 5/27/2023.

Per record review Resident #94's last documented skin assessment was on 2/22/2024. There are no weekly skin assessments after this date. According to the facility's policy and professional standards, there should have been a minimum of 6 weekly skin assessments during this time. There are no initial or weekly wound assessments during this time for the MASD present on Resident #94's thigh.

Per interview on 4/11/24 at 10:52 AM, a Licensed Practical Nurse stated that Resident #94's wound had gotten worse since s/he had last seen in a couple weeks ago. S/He stated that wound

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assessments should be done weekly and confirmed that Resident #94's did not have a wound assessment that reflected Resident #94's wound.
Per interview on 4/11/2024 at 11:50 AM, the Director of Nursing confirmed that skin checks should be completed weekly and wounds should be assessed weekly per facility policy. S/He confirmed that the facility was not completing weekly wound assessment for Resident #94's MASD.

2. Per record review, Resident #125 has diagnoses that include venous insufficiency, type 2 diabetes, and need for assistance with personal care. Resident #125's care plan states, "Resident at risk for skin breakdown related to weakness, limited mobility, vascular disease," initiated on 1/27/2024 with the following intervention "Weekly skin check by license nurse," created on 7/15/2023. A 3/22/2024 skin assessment reveals that Resident #125 does not have any wounds.

Per record review, a 4/1/2024 nursing note states "dressing done to coccyx. On 4/1/2024 Resident #125's record does not have a care plan for a coccyx wound, a wound evaluation, a change of condition notifying a provider of a wound on Resident #125's coccyx, or any physician orders to treat a wound to the coccyx.

On 4/2/2024, Resident #15's care plan is updated to reflect skin breakdown. The following physician order was started on 4/5/2024, "Wound Treatment (coccyx slit): Cleanse with Remedy cleansing lotion. Pat dry. Apply a thin layer of Remedy Zinc Oxide Protectant Paste combined with anti-fungal powder to the affected area. Do not scrub. Use Remedy cleansing lotion with a

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F 684	Continued From page 29 wipe to gently cleanse only the soiled layer. Every day shift for MASD." A skin check dated 4/5/2024 does not accurately reflect Resident #125's skin status as it stated that there are no skin injuries or wounds identified. As of 4/10/2024, there are no wound assessments of the wound on Resident #125's coccyx. Per interview on 4/11/2024 at 11:50 AM, the Director of Nursing confirmed that there was no initial or weekly wound assessment for Resident #125's coccyx wound.	F 684		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides.	F 725	F725 Specific Corrective Action 1. There were no negative impacts on residents #95, #83, #94, #15, #3, #107, & #99. Care plans for residents #95, #83, #94, #15, #3, #107, & #99 were reviewed 2. An audit was conducted and no other residents were affected. 3. Staff education completed to review how the facility must operate with the sufficient amount of Staff. 4. Will conduct weekly audits x 4 and then monthly x3 to ensure that the facility provides services by sufficient numbers of each of the types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans. Compliance and results to be reviewed at QAPI meeting for further review and recommendations.	

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F 725	Continued From page 30 §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation and resident and staff interview, the facility failed to ensure there are a sufficient number of skilled licensed nurses, nurse aides, and other nursing personnel to provide care and respond to each resident's basic needs and individual needs impacting 2 of 4 units (Units Dogwood and Cherry Tree). Findings include: 1. Per interview on 4/09/24 at 11:52 AM, Resident #95 expressed frustration that there are not enough staff in the facility and sometimes the staff are miserable because of how few staff are on. S/He explained that she had to wait for 45 minutes for staff to help him/her get off of the toilet recently. S/He explained that s/he would like to get up and walk everyday but there are not enough staff to help him/her do that and s/he ends up just sitting 13 hours straight in his/her wheelchair. Per observation and interview on 4/9/2024 at 1:36 PM, Resident #83 explained that s/he needs her toenails cut but no one is doing them. His/her toenails are very long, appearing to be at least a half inch past the end of his/her toes. Resident #83 explained that s/he has contractures in his/her hand because s/he has Parkinsons. S/He explained that she likes to have staff help him/her open his/her hands at least three times a day so s/he can exercise her hands in order to maintain the function s/he has left in her hands. While s/he was talking, s/he demonstrated for this surveyor	F 725	**Tag F 725 POC accepted on 5/15/24 by S. Freeman/P. Cota**	

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how s/he couldn't open his/her hands and wanted to. S/He stated that it is very important to remain as independent as possible. S/He stated that s/he is not getting these things done because there are not enough staff and the ones that are on are too busy.

Per interview on 4/09/24 at 3:14 PM, Resident #94 stated that there are many times when there are not enough staff to help. S/He explained that sometimes s/he needs a bed pan and sometimes s/he is incontinent before s/he gets help. S/He explained there is about a 50/50 chance that staff will get to him/her on time to help him/her before s/he has an accident.
Per interview on 4/09/24 at 4:16 PM, Resident #15 stated that the facility is short staffed. S/He said it is hard for her to get help doing things, like having someone put lotion on him/her or cut his/her nails.

Per interview on 4/09/24 at 5:18 PM, Resident #3 explained that s/he has not had his/her face shaved in three weeks and his/her preference is to be shaved twice a week. S/He explained that having his/her face shaved is really important to him/her and because s/he cannot use his/her hands to shave his/her face, s/he has to depend on staff entirely to complete this task. S/He stated that staff report to him/her that they are too busy to shave him/her because they are short staffed.

Per observation and interview on 4/10/24 at 8:32 AM, Resident #107 was sitting in the dining room. S/He explained that s/he has to sit and wait in the dining room for a very long time after s/he finishes eating, sometimes for an hour, before staff are able to bring him/her back to his/her room, every day. S/He said s/he cannot bring

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herself back to his/her room on his/her own and does not want to be in the dining area. S/He reports that staff tell her they are too busy to take him/her back all the time.

2. Per interview on 4/11/24 at 10:49 AM, LNA #2 stated that aides cannot get all their patient care done when there are only 3 or 4 aides working on the unit. S/He explained that there are many times on weekends when there are only 3 aides working on the unit.

Per interview on 4/10/24 at 4:45 PM, a Licensed Nurse Aide explained that it is hard to get resident care done if there are less than 5 aides on the unit and extremely hard if there are less than 4 aides on the unit. She explained that staff "run around like chickens with their heads cut off a lot of the time because there is so much work to do." S/He explained that call bells are going off non-stop throughout her shift all the time.

3. Per record review Resident # 99 has the following care plan dated 02/14/2024 that states "resident is at risk for malnutrition related to mechanical soft diet, need for assistance with meals."

During observation on 4/09/2024 at 4:30 PM in the Cherry Tree Country Kitchen area, Resident # 99 was sitting in his/her wheelchair at the table with two other residents that eat independently. Per record review all three Residents at the table have a diagnosis of Dementia. At 4:50 PM the start of meal service began. At 4:55 pm the two other residents at the table received their dining trays. Resident # 99 was not offered a tray or a beverage. A licensed nursing assistant (LNA) left the resident ' s table and continued to pass other

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F 725	Continued From page 33 trays. At 5:00 pm the resident to the left of Resident #99 picked up a canned pear off his/her plate and with bare hands handed it to Resident # 99. Resident # 99 took the pear and began to eat it, until it slipped from their fingers and dropped to the floor. Staff who were present in the dining room did not notice the interaction or the dropped pear. At 5:05 pm Resident # 99's tray arrived at the dining area. A LNA placed Resident # 99's plate with a cover over it in the middle of the table out of Resident # 99 ' s reach. The LNA was observed walking away from the table and did not interact with Resident #99. At 5:55 PM, 50 minutes after Resident #99's meal had been placed on the table, after being made aware of the situation, the Kitchen Manager provided a new plate of food for Resident # 99. At 6:00 PM a Licensed Practical Nurse (LPN) began to assist Resident # 99 with their meal, while the other residents left the dining room. The LPN on duty stated that Resident # 99 does require assistance with eating but can also eat on their own. The LPN confirmed Resident # 99 should have been offered their food while others were dining. The LPN stated that some residents who eat in their room require assistance with eating, and others in the dining room, making assisting all residents with their meals at the same time challenging. See F-557	F 725		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		

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§483.45(c) Drug Regimen Review.
§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.

1. There was no negative impact on resident #47. Care plans for resident #47 was reviewed.
2. An audit was conducted and no other residents were affected.
3. Staff education completed on the monthly Drug Regimen Reviews.
4. Will conduct weekly audits x4 and then monthly x3 to ensure the implementation of the monthly Drug Regimen Review recommendations accepted by the Provider. Compliance and results to be reviewed at QAPI meeting for further review and recommendations

Tag F 756 POC accepted on 5/15/24 by S. Freeman/P. Cota

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This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to follow Pharmacy Recommendations related to monitoring of heartrate prior to administration of digoxin (a medication to slow the heartrate) for 1 Resident out of 6 sampled (Resident # 47). Findings include:

Per record review Resident #47 admitted to the facility on 11/10/2021 with diagnosis of cerebral vascular accident (CVA) with left sided weakness and atrial fibrillation fast (irregular heartbeat). Resident # 47 has the following medication order prescribed on 10/26/23 "Digoxin 125 mcg one time a day by mouth for atrial fibrillation (atrial fibulation is an abnormal heart rhythm). "Digoxin helps the heart beat more efficiently in adults and pediatric patients and decreases the heart rate at rest during abnormal rhythms in adults" (FDA, 2011).

Per Pharmacy Review and Recommendations on 3/5/2024 states "Medication requires monitoring due to risk of cardiac arrythmias (irregular heartbeat). Prior to administration check an apical pulse, if less than 60 beats per minute hold digoxin and contact provider." Pharmacy review was signed by the provider on 03/21/2024.

Record review revealed no evidence of instructions to check pulse (heart rate) for Resident # 47 prior to administration of digoxin.. According to National Library of Medicine, (2024), digoxin may be contraindicated in individuals experiencing bradycardia. (heart rate less then 60 beats per minute).

Per interview on 4/11/2024 at approximately 4:00

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F 756	Continued From page 36 PM Unit Manager confirmed that medication parameters to check pulse and hold medication would need to be written on the actual order to be seen by nurse. During interview the Unit Manger confirmed that there was no evidence of parameters on the digoxin order, or evidence that the pulse was checked prior to administration. The Unit Manager confirmed that there should be an order and a pulse should be documented on the medication administration record. Reference: David MNV, Shetty M. Digoxin. [Updated 2023 Jan 19]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK556025/	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a	F 758	F758 Specific Corrective Action 1. There was no negative impacts on residents #15, #10 & #98. Care plans for residents #15, #10 & #98 were reviewed. 2. An audit was conducted and no other residents were affected. 3. Staff education completed regarding residents being free from unnecessary psychotropic meds/prn use. 4. Will conduct weekly audits x4 and then monthly x3 to ensure residents receiving psychotropic medications are having adverse behaviors monitored and medications used to treat behaviors will be monitored for the harm of adverse consequences. Compliance and results to be reviewed at QAPI meeting for further review and recommendations.	

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specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure that residents who use psychotropic drugs are accurately monitored for behaviors and/or side effects for 3 of 6 sampled residents (Residents #15, #10, and #98).
Findings include:

1. Per record review, Resident #15 has

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diagnoses that include anxiety disorder and major depressive disorder. Resident #15's care plan states, "Resident is at risk for complications related to the use of psychotropic drugs-Sertraline- major depressive disorder. Hydroxyzine- anxiety," revised on 10/23/2023. Resident #15 has physician orders for the following psychotropic medications: "Hydroxyzine HCl Tablet 25 MG (Hydroxyzine HCl) Give 1 tablet by mouth every 12 hours as needed for anxiety for 30 Days -Start Date- 03/21/2024 and Sertraline HCl Oral Tablet 50 MG (Sertraline HCl) Give 1 tablet by mouth one time a day for depression -Start Date- 02/21/2024."

Per review of Resident #15's Medication Administration Record (MAR) Resident #15 was administered Hydroxyzine on 3/22/24, 3/23/24, 3/24/24, 3/25/24, 3/27/24, 3/28/24, 3/29/24, 4/1/24, 4/5/24, 4/6/24, 4/8/24, 4/10/24 for anxiety. There is no documentation on Resident #15's MAR, Treatment Administration Record (TAR), or in Resident #15's POC (point of care; electronic documentation system for Licensed Nursing Assistants) that Resident #15 was experiencing any behaviors and there were no orders or tasks to monitor behaviors. Resident #15's care plan did not include interventions to monitor behaviors.

2. Per record review, Resident #10 has diagnoses that include schizophrenia, bipolar disorder, major depressive disorder, and anxiety. Resident #10's care plan states, "Resident is at risk for complications related to the use of psychotropic drugs Medication: risperidone-schizophrenia paxil-depression," revised on 1/20/2024 with an intervention to "Complete behavior monitoring flow sheet," created on 11/5/2019. Resident #10 has

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physician orders for the following psychotropic medications: "Paroxetine HCl Oral Tablet 10 MG (Paroxetine HCl) [Paxil] Give 0.5 tablet by mouth at bedtime for depression given with 20mg tab to equal 25mg at Bedtime -Start Date- 01/18/2024; Paroxetine HCl Oral Tablet 20 MG (Paroxetine HCl) [Paxil] Give 20 mg by mouth at bedtime for depression -Start Date- 01/19/2024; and risperidone Oral Tablet 1 MG (Risperidone) Give 1 mg by mouth in the morning for antipsychotic -Start Date- 01/19/2024."

There is no documentation on Resident #10s MAR, TAR or in Resident #10's POC that Resident #10 was experiencing any behaviors and there were no orders or tasks to monitor behaviors.

Per interview on 4/11/24 at approximately 5:45 PM the Director of Nursing stated that behaviors should be monitored 3 times a day for residents taking psychotropic medications and confirmed that Resident #15 and #10 did not have behavior monitoring.

3. Per record review Resident # 98 was admitted to the facility on 10/09/2023 with diagnoses that include dementia with behavioral disturbances, agitation, restlessness, and hyperactive behaviors. Resident # 98 has the following orders written by advance nurse practitioner, prescription last updated on 4/01/2024: Seroquel 50 mg by mouth. Directions give 50 mg of Seroquel two times a day by mouth for delusions, psychosis, and agitation, and 25 mg as needed. Hold for Lethargy (excessive tiredness) and Trazadone 25 mg by mouth three times a day for agitation and 25 mg every 8 hours as needed, hold for lethargy.

Resident # 98 has been receiving psychotropic

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medications since 10/09/2023 without an order to monitor behavior or adverse reaction to medication. Review of medication administration record for March and April 2024 shows that Resident # 98 received all scheduled doses of psychotropic medications without monitoring for behaviors or adverse effects.

Resident # 98's care plan initiated on 10/09/2023 "Resident is at risk for complications related to the use of psychotropic drugs Medication: Trazadone- agitation, restlessness Seroquel- agitation/psychotropic medications. Monitor for changes in mental status and functional level and report to MD (Physician). Monitor for continued need of medication as related to behavior and mood."

Per observations of Resident # 98 on 04/09, 04/10, and 04/11/2024, on the unit in the Cherry Tree Country Kitchen area, Resident # 98 was sleeping in their wheelchair on several occasions. Resident #98 was observed frequently sleeping though meals each day at different mealtimes.

Review of the medication administration record for March and April 2024 there is no documented evidence that Resident #98 was evaluated for adverse effects prior to medication administration. There is no evidence that psychotropic medications were held related to sleepiness.

Facility Policy "Psychotropic Medication Use", last revised, 10/24/2022 states "All medications used to treat behaviors must have a clinical indication and be used in the lowest possible does to achieve the desired therapeutic effect. All medications used to treat behaviors should be

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F 758	Continued From page 41 monitored for efficacy, risks, benefits, and harm or adverse consequences." Policy also states medications used to treat behaviors will be monitored for harm of adverse consequences." Per interview 4/11/2024 at approximately 3:00 pm the License Practical Nurse (LPN) Unit Manager (UM), confirmed that Resident #98 has had an increase in sleepiness thought to be due to a recent pneumonia. However there is no evidence of monitoring for adverse effects or increased behaviors related to the psychotropic medications. The Unit Manager confirmed that the expectation would be to have an order to monitor and document in the medical record any adverse effects or behaviors. The Unit Manager also confirmed that Resident # 98 received all scheduled doses of Seroquel and Trazadone for the months of March and April 2024.	F 758		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to serve food that is palatable and at an appetizing temperature to 3 of 36 sampled residents (Resident # 99, #11 and #12) Findings include:	F 804	F804 Specific Corrective Action 1. There was no negative impacts on residents #99, #11, #12 & 17. Care plans for residents #99, #11, #12 & 17 were reviewed. 2. An audit was conducted and no other residents were affected. 3. Staff education completed regarding nutritive value/appear, palatable/ prefer temperature. 4. Will conduct weekly audits x4 and then monthly x3 to ensure residents are served their meals promptly and at the same time as the other residents at the table. Compliance and results to be reviewed at QAPI meeting for further review and recommendations.	

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1. Per record review Resident #99 was admitted to facility on 02/04/2024 with the following diagnosis: Alzheimer ' s dementia, stroke with aphasia (inability to express speech), and heart failure. Resident # 99 has the following care plan dated 02/14/2024 that states "resident is at risk for malnutrition related to mechanical soft diet, need for assistance with meals." A nursing note written by the Unit Manager (UM) dated 4/10/2024 reflects that Resident # 99 has evidence of weight loss note states" Resident triggers for weight loss. Meal intake varies at 50-100% for meals with snacks offered."

During observation on 4/09/2024 at 4:30 PM until 6:00 pm in the Cherry Tree Country Kitchen area, Resident # 99 was sitting in his/her wheelchair at the table with two other residents. At 4:50 PM the start of meal service began.At 4:55 pm the two other residents at the table received their dining trays. Resident # 99 was not offered a tray or a beverage. A licensed nursing assistant (LNA) left the resident's table and continued to pass other trays.

At 5:40 pm the Dietary Manager entered the dining area. This surveyor alerted them that the resident has still not been assisted with their meal and that meal was sitting on the table, uncovered for several mintues. Requested temperatures be completed on Resident # 99 ' s food prior to it being served as it had been sitting out for 40 minutes.

At 5:45 pm using their own thermometer the Dietary Manager and this surveyor checked the temperature of the food on Resident # 99's plate and confirmed the temperature of the food on

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Resident # 99's plate was no longer palatable. The Dietary Manager confirmed based on the temperature of the meal for Resident # 99 it should not be served and removed the plate from in front of Resident # 99. At 5:55 pm the Kitchen Manager returned with a new plate of food for Resident # 99.

2. Observation on 4/9/24 at 5:45 PM of the Beech Tree BLVD (Boulevard) dining room revealed resident's #11, #12 and # 17 sitting at a table together. Resident #17 was eating their dinner while Resident #11 and Resident #12 watched Resident #17 eat. It was noted that at 6:00 PM Resident #11 and Resident #12 had still not received their meals. The RN/Unit Manager was observing the staff passing trays in the dining room, and had observed two surveyors discussing this particular observation. The RN/Unit Manager went over and spoke to an LNA who had been passing trays in the dining room. This LNA gathered a tray from the food cart and brought it to the table for Resident #12. This LNA immediately returned to the food cart and gathered a second tray which they brought to the table for Resident #11.

Interview on 4/9/24 at 6:10 PM with an LNA who was preparing drinks for the food trays and who was present at the time of these observations, stated that the food carts had arrived late and staff were trying to get the meals out. They stated that the food carts usually arrive between 5:15 PM and 5:30 PM. This LNA was asked about the dining process and if it is typical for a table of 3 residents to not all have their meals at the same time. S/he stated that they (staff) "try to serve restaurant/dining style where everyone gets

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F 804	Continued From page 44 served together, however, with the food carts arriving late, staff were trying to get all the trays out and this was missed."	F 804		
F 812 SS=E	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 interview the facility failed to ensure that refrigerated food temperatures were maintained at a safe level (Below 41 degrees) in the unit refrigerator in the Cherry Tree Country Kitchen. Findings include: Per observation on 4/9/2024 at 5:26 PM the refrigerator in the Cherry Tree "Country Kitchen" that is use to store resident drinks and snacks such as juices, milk, sandwiches, and deserts was noted to be open approximately 2 inches.	F 812	F812 Specific Corrective Action 1.There were no negative impacts on residents on Cherry Tree Lane. 2. An audit of all refrigerator temps was completed to ensure proper food storage for the whole house. 3. Education was completed with dietary staff and floor staff about the importance of proper storage and food safety. Education also covered who should be notified when food is not at the proper temps, or a refrigerator isn't working. 4. The Administrator will conduct audits to ensure proper fridge temps and food storage weekly x3 and monthly x4. Audits will be brought to QAPI for review and further recommendations. **Tag F 812 POC accepted on 5/15/24 by S. Freeman/P. Cota**	

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F 812	Continued From page 45	F 812		

This surveyor looked inside the refrigerator to determine if something was protruding into the doorway preventing it from closing. When pushed shut, the door would bounce back open between 1-2 inches. There were no items preventing the door from closing. Review of the temperature monitoring log on the refrigerator listed temps of 41 degrees between 4/1/24 - 4/9/24. However, the temperature at 5:26 PM was noted to be 56 degrees.

Per interview with a Licensed Nursing Assistant (LNA) on 4/9/2024 at 5:27 PM s/he stated that the refrigerator had been broken for "sometime now" and was not sure if anyone knew about it. When asked if the refrigerator was at the proper temp the LNA said that it was the kitchen's job to do that. The LNA stated that they did not work on Cherry Tree that often so s/he was not sure exactly how long it was broken.

Per interview with the Dietary Manager (DM) on 4/09/24 at 5:30 PM s/he confirmed that the fridge was broken and that the temp inside was 58 degrees. The DM stated that all of the food and drinks in the refrigerator would be thrown out and the refrigerator would not be used.

Per interview with the administrator on 4/9/2024 at approximately 6:00 PM this particular refrigerator has had trouble with the seal and it has been replaced several times. S/he was not aware that there was still an issue. The administrator confirmed that a new refrigerator was being purchased to replace the broken one on Cherry Tree.