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

August 18, 2021

Mr. Timothy Urich, Administrator
The Pines At Rutland Center For Nursing And Rehab
99 Allen Street
Rutland, VT 05701-4501

Dear Mr. Urich:

Enclosed is a copy of your acceptable plans of correction for the investigation survey conducted on **July 6, 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
	475018	A. BUILDING _____ B. WING _____	C 07/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PINES AT RUTLAND CENTER FOR NURSING AND REHABI	99 ALLEN STREET 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
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced onsite investigation of three facility reported incidents in conjunction with four complaints on 6/15 - 7/6/2021. There were regulatory violations identified as a result of these investigations.	F 000		
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: Per staff interview and record review the facility failed to ensure that staff treated one (1) of four (4) residents in the applicable sample (Resident #1) with respect and dignity. Findings include: Per record review Resident # 1 has diagnoses of vascular dementia with behavioral disturbance, disruptive mood dysregulation disorder, restlessness and agitation, and anxiety disorder. S/he is resistive to care and becomes combative toward staff. Per care plan s/he requires two assist for transfer and ambulation and is non-compliant with transfer and ambulation assistive needs. A progress note written by the Registered Nurse (RN) Supervisor dated 5/30/2021 states that s/he was informed that the resident was yelling out and continually	F 557	Corrective Action: The incident in question was reported at the time of the incident to the RN Supervisor on duty. The Supervisor immediately reported to the unit where the incident occurred and instructed the staff to assist the resident from the floor and place him in his chair. The resident was assessed and no injuries were noted. Immediately upon learning of the incident, the facility initiated an internal investigation and placed the LPN involved on suspension. At the conclusion of the investigation, the LPN was terminated from employment. A report was filed with the VT Division of Licensing & Protection and Adult Protective Services by The Pines at Rutland. Identify Others: All residents of the facility would be at risk for the same practice. Systemic Change: All staff will receive inservice education on Residents' Rights with a specific focus on dignity and respect. Resident interviews will be conducted to ensure that the core principles of resident rights, dignity and respect are adhered to by all staff. One interview per unit per week will be conducted on a rotating basis. These interviews will be completed for three months ensuring that all residents and patients have been interviewed at least once.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8/3/2021

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

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F 557	Continued From page 1 attempting self-ambulation despite interventions. The resident was eased to the floor by the LPN to prevent fall/injury. When the RN responded, the resident was assisted off the floor to the wheelchair and assessed for injury. Per interview with a Licensed Nursing Assistant (LNA) on 6/17/2021 at 1:39 PM during the evening hours of 5/28/2021, s/he observed Resident #1 laying on the floor in front of the elevator. The LNA stated that "[Resident #1] was upset. [S/he] was on [her/his] back yelling "help me, help me". When the LNA informed the LPN that the resident was on the floor the LPN replied "He is there for his safety." Per interview with the Director of Nursing on 6/15//2021 at approximately 9:45 AM, the LPN should not have used these interventions to ensure safety and s/he had been terminated based on dignity issues. Per interview with the LPN on 6/25/2021 at approximately 12:45 PM, s/he confirmed that on 5/27 and 5/28/2021 s/he did put Resident #1 on the floor and left her/him there. The LPN stated that " Many other people do this, it was just me who got in trouble for it".	F 557	Continued From page 1 Monitoring: The results of these interviews will be reviewed by the Administrator as well as the facility's Quality Assurance Committee. Any resident concerns/grievances identified will be addressed as appropriate to the situation. The need for continued interviews beyond the three months will be determined by the committee. Responsible Party: Administrator Completion Date: 9/6/2021 **TAG F 557 POC Accepted on 8/18/21 by S. Freeman/P.Cota**	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and	F 600	Corrective Action: The incident in question was reported at the time of the incident to the RN Supervisor on duty. The Supervisor immediately reported to the unit where the incident occurred and instructed the staff to assist the resident from the floor and place him in his chair. The resident was assessed and no injuries were noted. Immediately upon learning of the incident, the facility initiated an internal investigation and placed the LPN involved on suspension.	

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F 600	Continued From page 2 any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Per staff interview and record review the facility failed to ensure that one (1) of four (4) residents in the applicable sample (Resident #1) was free from abuse. Findings include: 1. Per record review Resident # 1 has diagnoses of vascular dementia with behavioral disturbance, disruptive mood dysregulation disorder, restlessness and agitation, and anxiety disorder. S/he is resistive to care and becomes combative toward staff. Per care plan s/he requires two assist for transfer and ambulation and is non-compliant with transfer and ambulation assistive needs. Per interview with a Licensed Nursing Assistant (LNA) on 6/17/2021 at 1:39 PM during the evening hours of 5/28/2021, s/he observed Resident #1 laying on the floor in front of the elevator. When the LNA asked the LPN why the resident was on the floor the LPN stated that he was there "for safety". The LNA stated that "[Resident #1] was upset. [S/he] was on [her/his] back yelling "help me, help me". Per interview with the Director of Nursing on 6/15//2021 at approximately 9:45 AM, the LPN should not have used these interventions to ensure safety and the results of the facility	F 600	Continued From page2 At the conclusion of the investigation, the LPN was terminated from employment. A report was filed with the VT Division of Licensing & Protection and Adult Protective Services by The Pines at Rutland. Identify Others: All residents of the facility would be at risk for the same practice. Systemic Change: All staff will receive inservice education on Abuse Prevention. Resident interviews will be conducted to ensure that the core principles of abuse prevention are adhered to by all staff. One interview per unit per week will be conducted on a rotating basis. These interviews will be completed for three months to ensure that all residents and patients have been interviewed at least once. Monitoring: The results of these interviews will be reviewed by the facility's Administrator as well as the facility's Quality Assurance Committee. Any resident concerns or grievances identified will be investigated immediately and the appropriate action taken. The need for continued interviews beyond the three months will be determined by the committee. Responsible Party: Administrator Completion Date: 9/6/2021 **TAG F 600 POC Accepted on 8/18/21 by S. Freeman/P.Cota**	

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F 600	Continued From page 3 investigations it was determined that the incident was a dignity issue. Based on staff interview and record review the facility failed to ensure that one (1) of four (4) sampled Residents (Resident #1) was free from unnecessary physical restraints. Findings include: 2. Per interview with a Licensed Nursing Assistant (LNA) on 6/17/2021 at approximately 1:39 PM, s/he and another LNA were instructed by an LPN to take Resident #1 and get her/him ready for a shower. During the shower Resident #1 became resistive, was attempting to stand, and was yelling. The LPN instructed the LNA to go get a sheet. When the s/he returned with the sheet the LPN put it around the resident to prevent her/him from rising from the chair. During this time the resident was attempting to stand up from the shower chair, and was yelling at the staff members "No stop this". Per interview with the LPN on 6/25/2021 at 12:45 PM, Resident #1 was resisting the shower by attempting to stand and yelling out.. S/he stated that Resident #1 is often uncooperative with staff during care. The LPN confirmed that s/he tied a sheet to the arms of the chair to prevent him from falling or sliding out of it.	F 600		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for	F 604	Corrective Action: The incident in question was reported at the time of the incident to the RN Supervisor on duty. The Supervisor immediately reported to the unit where the incident occurred and instructed the staff to assist the resident from the floor and place him in his chair. The resident was assessed and no injuries were noted. Immediately upon learning of the incident, the facility initiated an internal investigation and	

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F 604	Continued From page 4 purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to ensure that one (1) of four (4) sampled Residents (Resident #1) was free from unnecessary physical restraints. Findings include: 1. During an interview with the Director of Nursing (DNS) on 6/15/2021 at approximately 10:00 AM, s/he confirmed that s/he had been made aware of an incident involving a Licensed Practical Nurse (LPN) using a sheet while giving Resident #1 a shower. S/he had concluded that the LPN had placed the sheet around the resident provide privacy for the resident.	F 604	placed the LPN involved on suspension. At the conclusion of the investigation, the LPN was terminated from employment. A report was filed with the VT Division of Licensing & Protection and Adult Protective Services by The Pines at Rutland. Identify Others: All residents of the facility would be at risk for the same practice. Systemic Change: All staff will receive inservice education on the use of physical restraints in long term care. Resident interviews will be conducted to ensure that the core principles of restraint use are adhered to by all staff. One interview per unit per week will be conducted on a rotating basis. These interviews will be completed for three months ensuring that all residents and patients have been interviewed at least once. Monitoring: The results of these interviews will be reviewed by the Administrator as well as the facility's Quality Assurance Committee. Any identified issue will be investigated and appropriate action taken as necessary. The need for continued interviews beyond the months will be determined by the committee. Responsible Party: Administrator Completion Date: 9/6/2021 **TAG F 604 POC Accepted on 8/18/21 by S. Freeman/P.Cota**	

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F 604	Continued From page 5	F 604		

Per interview with a Licensed Nursing Assistant (LNA) on 6/17/2021 at approximately 1:39 PM, s/he and another LNA were instructed by an LPN to take Resident #1 and get her/him ready for a shower. During the shower Resident #1 became resistive, was attempting to stand, and was yelling. The LPN instructed the LNA to go get a sheet. When the s/he returned with the sheet the LPN put it around the resident to prevent her/him from rising from the chair. During this time the resident was attempting to stand up from the shower chair, and was yelling at the staff members to stop.

Per interview with the LPN on 6/25/2021 at 12:45 PM, Resident #1 was resisting the shower by attempting to stand and yelling out. The LPN confirmed that s/he tied a sheet to the arms of the chair to prevent him from falling or sliding out of it.

2. Per record review Resident # 1 has requires two assist for transfer and ambulation and is non-compliant with transfer and ambulation assistive needs. On 5/27 and 5/28/2021 the resident was continually attempting self-ambulation despite interventions. The resident was eased to the floor by the LPN to prevent fall/injury.

On 6/15/2021 at approximately 2:30 PM during an interview with an LNA, s/he stated that on the evening of 5/28/2021 s/he observed Resident #1 on the floor in front of the elevator. When the LNA asked the LPN if the resident had fallen, the LPN stated "No, I put her/him there so s/he wouldn't get hurt". The LNA stated that the resident "was trying to pull her/himself up from the floor, and

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F 604	Continued From page 6 yelling "help me". During an interview with the LPN on 6/25/2021 at 12:45 PM s/he confirmed that she put the resident on the floor to prevent her/him from falling and that the resident is unable to get himself up from the floor. The LPN stated that with Resident #1 "there is nothing else you can do. There is not enough staff to do one on one and you have to leave her/him to go do the medication pass".	F 604		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(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	F 609	Corrective Action: The incident in question was reported to the VT Division of Licensing & Protection therefore, there is no further corrective action necessary at this time. Identify Others: All residents of the facility would be at risk for the same practice. Systemic Change: The facility will incorporate the review of all Incident and Accident reports into the facility's Daily Clinical Review meeting for the purpose of timely identification of incidents that require report to the regulatory body. Additionally, the IDT will review the 24-Hour Progress Report in the EMR for the same purpose. Any incident that meets the criteria for reporting will be investigated and reported to the regulatory body within the appropriate timeframe. Monitoring: A log of all Incident & Accident Reports will be maintained for 3 months to ensure compliance. The log will be reviewed monthly by the facility's Quality Assurance Committee. Responsible Party: Administrator Completion Date: 9/6/2021 **TAG F 609 POC Accepted on 8/18/21 by S. Freeman/P.Cota**	

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F 609	Continued From page 7	F 609		

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 upon interview and record review, the facility failed to ensure that three of three sampled alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported in the required timeframe, and that the results of investigations into the incident were reported in accordance with State law, including to the State Survey Agency. Findings include:

1. Per review of medical records for Res.#2, an Incident Note dated 4/11/2021 at 2:45 PM reveals

"Resident and another resident [#3] were heard yelling at each other. Aid went to investigate and found this resident [#2] in the bathroom, repeatedly opening the door, hitting another resident in the arm and side. When verbal request to stop did not have effect, aid interjected his/her foot in the door to stop this resident. The residents were separated. Later in the day, the other resident told this nurse that this incident was the second and that the first occurred earlier in the morning in the bathroom when this resident pushed the other resident and he/she fell and hit his/her head. The other resident complained that his/her right elbow hurt. Nothing visible noted. He/She showed this nurse where he/she hit their head. That resident has a quarter-sized lump where he/she indicated. Nursing supervisor notified. Supervisor speaking with ADON [Assistant Director of Nursing] and DON [Director

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F 609	Continued From page 8	F 609		

of Nursing] to determine what should be done." Per review of records of the State Survey Agency, and per interview with the facility's Administrator [ADM] on 6/15/21 at 4:45 PM, the facility did not report the alleged abuse allegations that occurred on 4/11/2021 until 9 days later, on 4/20/2021. When asked to confirm that the report was not submitted in the required time frame, the ADM stated "It is what it is."

2. Per record review, Resident #1 is care planned as an assist of two staff members for ambulation however, s/he does attempt to stand and ambulate independently. On the evenings of 5/27 and 5/28/2021 Resident #1 was attempting to stand from a wheelchair and ambulate unassisted. A Licensed Practical Nurse (LPN) removed Resident #1 from the wheelchair, placed her/him on the floor, and left her/him there while the LPN continued with her/his duties.

Per interview on 6/16/2021 at approximately 1:45PM, with a Licensed Nursing Assistant (LNA) s/he stated that on the evening of 5/28/2021 Residnet #1 was laying on the floor yelling out "Help me, help me". The LNA asked the LPN why resident #1 was on the floor and was told that s/he was there for her/his safety. The LNA left the unit and reported to the house RN Supervisor that the resident was on the floor.

Per interview on 6/17/2021 at 1:39PM with an LNA on duty the evening of 5/28/2021, s/he told the LPN that Residnet #1 was on the floor and the LPN responded "[s/he] is there for [her/his] safety." The LNA stated that "[Residnet #1] was upset. [S/he] was on [her/his] back yelling "help me , help me".

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F 609	Continued From page 9 Per review of the facility report submitted to the licensing agency on 6/1/2021, the incident involving the LPN leaving Resident #1 on the floor occured on 5/28/2021. However, it did not include information regarding the incident from 5/27/2021, nor was a seperate report of the 5/27/2021 incident made to the licensing agency. Per interview with the Administrator on 6/21/2021 at approximatey 1:45PM, s/he confirmed that the incident that occured on 5/27/2021 was not included in the 6/1/2021 report to the licensing agency. 3. Per interview with an LPN on 6/25/2021 12:45PM while attempting to provide a shower to Resident #1, s/he was attempting to stand from the shower chair. The LPN confirmed that s/he tied a sheet to the chair, across the resident's abdomen to prevent him from sliding out of the chair. During an interview with the Administrator on 6/21/2021 at approximately 1:45 PM s/he stated that the incident had been investigated and was determind to be a dignity concern rather than abuse. S/he confirmed that the allegation had not been reported to the licensing agency.	F 609		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656	Corrective Action: The care plan of the affected resident has been reviewed and revised to indicate extensive assist of two staff for dressing and bed mobility. Identify Others: All residents within the facility must have a comprehensive plan of care and therefore could be a risk for this same practice. Systemic Change: (1) All nursing staff will receive inservice education on the importance of reviewing each resident's careplan prior to rendering care. (2) All residents within the facility will have their ADL care plans reviewed to	

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THE PINES AT RUTLAND CENTER FOR NURSING AND REHABI	99 ALLEN STREET 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
F 656	Continued From page 10 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to implement Care Plan interventions regarding the extensive assistance of 2 staff members required to safely render care	F 656	Continued from page 10 ensure that the careplan appropriately addresses their level of assistance needed with ADL's. An audit of each corresponding Kardex will be conducted as well to ensure consistency between the CCP and the Kardex. Monitoring: Care audits of Licensed Nurses Aides will be conduct to ensure compliance with the ADL care plan. 3 audits per shift per week will be conducted for a period of three months. The results of the audits will be reviewed by the facility's Quality Assurance Committee and the need for further auditing beyond the three months will be determined by the committee. Responsible Party: Director of Nursing Completion Date: 9/6/2021 **TAG F 656 POC Accepted on 8/18/21 by S. Freeman/P.Cota**	

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and treatment to 1 resident [Res.#4] of 4 sampled residents.
Findings include:
Per review of the facility's investigation into an incident that occurred on 6/4/21 at 2:30 PM involving Res.#4:
"Description of event: While administering care to [Res.#4] (in his bed). [Res.#4] rolled over to his/her right side and fell from his/her bed to the floor. [Staff 'A'] reports that he/she attempted to prevent [Res.#4] from falling. However, he/she was unsuccessful as he/she stated that [Res.#1] was too heavy and he/she could not stop [Res.#4's] momentum. [Res.#4] struck his/her head when falling to the floor and sustained laceration on his/her forehead above his/her left eye."
The facility interviewed Staff 'A' and recorded "According to [Staff 'A'], he/she was providing care to [Res.#4] and was in the process of getting [Res.#4] dressed."
An interview was conducted with Staff 'A' on 6/15/21 at 2:08 PM. Staff 'A' stated that he/she was working by his/herself, that he/she walked onto the resident unit and was handed an assignment and had "never met any of the residents" and this was his/her "first time working with [Res.#4]". Staff 'A' continued that he/she "didn't' think I needed help to get [Res.#4] dressed" and stated that if he/she had any questions, he/she would ask a nurse or "show me the Kardex or the care plan ...When in doubt, go to the care plan."
Per interviews with Staff 'A', the facility's Administrator, and the Director of Nursing, and per review of Res.#4's medical chart and the facility's investigation into the incident on 6/4/2021, Staff 'A' was working alone with Res.#4 with no assistance.

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The facility was requested to supply electronic access to residents' Care Plans- the same access available to the facility's staff.
Per review of the information in Res. #4's Care plan, identical to the information supplied to staff to ensure universal care to the resident by all disciplines in the facility:
Res. #4 is identified as having "an ADL [Activities of Daily Living] self-care performance deficit." The Care Plan documents this was initiated on 4/19/2019. The Admission date on the care plan is documented as 4/19/2019, and the last Care Plan Review completed on 3/31/21. After identifying the resident as having an ADL [Activities of Daily Living] self-care performance deficit on the date of admission, 4/19/2019, the Care Plan lists the following interventions:
"Dressing: The resident requires extensive assistance by 2 staff to dress."
Date initiated 4/19/2019.
"Bed Mobility: The resident requires extensive assistance by 2 staff to turn and reposition in bed".
Date initiated 4/19/2019.

An interview was conducted with the facility's Administrator [ADM] on 6/15/21 at 4:45 PM. The ADM referred to the facility's investigation of the incident and stated that Res.#4's Care Plan did not list the resident requiring "extensive assistance by 2 staff to dress" prior to the incident, and that the Care Plan was revised to include this after the resident returned from the hospital on 6/8/2021. The ADM was asked and confirmed that the surveyor's electronic access to residents' Care Plans was the same access available to the facility's staff. With the ADM

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present, Res.#4's Care Plan was reviewed. Per review of Res.#4's Care Plan, and confirmed by the ADM:
Res. #4 is identified as having "an ADL [Activities of Daily Living] self-care performance deficit." The Care Plan documents this was initiated on 4/19/2019.
The Care Plan lists the following interventions:
"Dressing: The resident requires extensive assistance by 2 staff to dress."
"Date initiated 4/19/2019.
Revision on 6/8/2021. Cancelled date 6/8/2021."
The interventions then list a 'revision', dated 6/9/21, as
"Dressing: The resident requires extensive assistance by 2 staff to dress" [identical to the previous intervention dated 4/19/2019]
Further review of interventions under Res. #4's ADL self-care performance deficit care area reveals
"Bed Mobility: The resident requires extensive assistance by 2 staff to turn and reposition in bed".
"Date initiated 4/19/2019. Revision on 6/8/2021. Cancelled date 6/8/2021."
The interventions then list a 'revision', dated 6/9/21, as
"Bed Mobility: The resident requires extensive assistance by 2 staff to turn and reposition in bed". "Bathing/Showering: The resident requires extensive assistance by 2 staff with bathing/showering." "Date initiated 4/19/2019. Revision on 6/8/2021. Cancelled date 6/8/2021."
The interventions then list a 'revision', dated 6/9/21, as "Bathing/Showering: The resident requires extensive assistance by 2 staff with bathing/showering."
The ADM confirmed that the Care Plan, an interdisciplinary resource for staff to ensure

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universal care to the resident by all disciplines in the facility, listed Res.#4 requires extensive assistance by 2 staff to dress, and this intervention was in place when the resident was attended by a single staff member and subsequently fell and sustained an injury.

Further record review was conducted of Res.#4's Minimum Data Sheet- Resident Assessment and Care Screening. Per review of the Annual assessment dated 12/15/2020, and again on the Quarterly Assessment dated 3/13/2021, under Section G: Functional Status, Activities of Daily Living Assistance, for Dressing, Res. #4 is assessed as requiring "2+ persons physical assist" along with transfers, bed mobility, and personal hygiene.
Per interview with the facility's Administrator [ADM] on 6/15/21 at 4:45 PM, the ADM stated that the coding for the Minimum Data Sheet "is frequently wrong". Further review of the Minimum Data Sheet [MDS] reveals the signatures of the persons completing Res.#4's assessment include the MDS coordinator and Registered Nurse, the facility's Dietician, Activities Director, and Social Worker.

Per interview with the Director of Nursing [DON] and the Assistant Director of Nursing [ADON] on 6/15/21 at 4:36 PM, The DON and the ADON produced a Kardex dated 4/8/21 that did not include instructions that Res. #4 required the assistance of 2 staff members during ADL care. The DON confirmed that the Care Plan interventions that were in place during the time of the incident included "extensive assistance by 2 staff" and stated that the Kardex and Care Plan interventions should be identical but were not. The DON had no explanation as to why Kardex

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F 656	Continued From page 15 and Care Plan interventions were not the same, or how staff would know which interventions to follow.	F 656		