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

October 13, 2022

Ms. Diane Sullivan, Administrator
The Pines At Rutland Center For Nursing And Rehabilitation
99 Allen Street
Rutland, VT 05701-4501

Dear Ms. Sullivan:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 31, 2022.** Please post this document in a prominent place in your facility.

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

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

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 08/31/2022

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

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E 000	Initial Comments A review of the facility's Emergency Preparedness Program was conducted in conjunction with the annual recertification survey on August 29 through August 31, 2022. There were no regulatory deficiencies as a result of the review.	E 000	This plan of correction is the facility's credible allegation of compliance. The filing of this plan does not constitute an admission that the deficiencies alleged did in fact exist. This plan is filed and executed as evidence of the facility's desire to comply with the provisions of federal and state law, and to continue to provide quality care and services.	
F 000	INITIAL COMMENTS An unanncounced onsite recertification survey, review of the staff Covid vaccination requirement and two complaint investigations were completed by the Division of Licensing and Protection on August 29,2022 through August 31, 2022. The following regulatory violations were identified:	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the	F 578	**F578** **Request/Refuse/Discontinue Treatment; Formulate Advance Directives** The facility ensures that accurate advance directive choices are indicated for it's residents. Resident #102, and Resident #15, both have accurately completed COLST forms at the front of their medical record and on their EMR.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator 9/23/22

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 578	Continued From page 1 resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure accurate advanced directive choices were indicated for 2 of 29 sampled residents (Residents #102& # 15). Findings include: 1. The facility keeps code status (whether or not to perform cardiopulmonary resuscitation: CPR) documentation in the front of the resident's paper record kept on each nursing unit. In resident #15's record the first page is a form with The Pines at Rutland Center for Nursing and Rehabilitation logo across the top. Beneath is CPR with two choices: I understand and I have made an informed	F 578	All previously executed advance directives, other than the most recent directive, have been removed and filed outside of the current medical record. All medical records of residents of the facility were audited by the Nursing Leaders in order to ensure that all residents' advance directive wishes were accurately reflected both in the front of their medical record and in the EMR. Licensed Nurses were provided with in-service education by the ADNS on the facility's policy on Advance Directives, the F578 Regulation, and the placement and filing of new or updated Advance Directives, as well as the updating of the EMR. The Director of Nursing, or her designee, will audit 20% of the medical records	

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F 578	Continued From page 2 choice to have CPR administered in the event of a respiratory and cardiac arrest. The second option states: I understand and have made an informed choice to not have CPR administered in the event of a respiratory and cardiac arrest. The form had a large check mark in front of the first option indicating CPR should be administered, dated 12/14/20 signed by the resident and witnessed by a RN. Behind this form is a COLST form (clinician orders life support and treatment) with DNR/Do not attempt resuscitation (allow natural death) dated 12/22/21 with verbal consent from the resident chosen and signed by the physician. On 8/29/22 the Director of Nursing confirmed the conflicting information and admitted nurses would likely default to the first form indicating CPR should be provided but the second form is more current and should be honored. 2. Per record review Resident #102 was admitted in 2019 with diagnoses that include diabetes mellitus, heart failure, atrial fibralation, chronic obstructive pulmonary disease. Review of the resident's advanced directives revealed conflicting documentation in the electronic health record (EHR) and the residents paper chart related to their desired code status. A COLST (clinician orders for life sustaining treatment) form located in the front of the resident's paper chart, completed and signed by the resident reflects wishes to have Cardiopulmonary Resuscitation (CPR) performed if s/he has no pulse and/or no respirations. The resident's code status documented in the EHR reflects that the resident's code status is Do Not Resuscitate (DNR).	F 578	and EMR on each nursing unit for accuracy. Audits will occur weekly x 4 weeks, then monthly x3 months, and quarterly x2, to ensure compliance. Audit results will be presented to the QAPI Committee and reviewed/monitored by the Administrator. Completion Date: 9/30/22 and ongoing Tag F 578 POC accepted on 10/13/2022 by S. Freeman/ P.Cota	

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F 578	Continued From page 3 On 8/30/22 at 9:19 AM the Assistant Director of Nursing confirmed that there was conflicting documentation in the resident's medical record related to their code status. S/he stated that if the nurse was unsure of the resident's code status s/he would refer to the hard chart. If there was no COLST in the chart it would be determined that the resident was a full code.	F 578	Tag F600 POC accepted on 10/13/2022 by S. Freeman/P.Cota **F600** **Freedom from Abuse, Neglect, and Exploitation** The facility ensures that all residents are free from abuse, neglect, and exploitation. Resident #318 is now deceased related to a terminal diagnosis of late stage Alzheimer's Disease and multiple comorbidities, and Resident #48 has no injury or recollection of the incident with the butter knife. All residents with aggressive behaviors were audited by Nursing Leadership and were found to be followed by the geripsych NP, or other mental health provider, have interventions addressing the aggressive behavior as well as antecedents, and do not dine in close proximity to others when using silverware. All residents may be at risk of being exposed to an impulsive	
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 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: Based on staff interview and record review, the facility failed to ensure 1 applicable resident (Resident # 48) remained free from abuse. Findings include: Resident # 48 was the victim of physical abuse by Resident # 318 on 4/23/22. Per review of Resident # 318's clinical record, on 4/23/22, Residents 48 and 318 were in the dining room	F 600		

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F 600	Continued From page 4 eating dinner at the same table. Resident # 318 became agitated and became aggressive. Resident # 318 grabbed a knife from the dinner tray and pulled the other Resident # 48 closer to him/her. Resident # 48 attempted multiple times to push him/herself away from Resident # 318 but this resident kept pulling him/her closer. Resident # 318 then swung the knife at Resident 48 and the knife went between the resident's side and arm. There were no injuries from this swing. Resident # 318 then punched Resident # 48 in the forehead twice with the knife still in hand. This incident was witnessed by the aide monitoring the dining room. Review of the clinical record showed Resident # 318 had a history of aggressive behaviors and had a care plan in place to address this issue. On 08/30/22 at 11:52 AM, the facility Administrator confirmed the incident as between Residents # 318 and 48 occurred as described above.	F 600	resident with severe dementia and behavioral disturbance such as aggression or other behavioral responses. Staff will receive re-education by the Staff Educator and ADNS on resident abuse prevention.-the policy and regulation F600. Staff audits of 20% of staff regarding the staff education material will occur x4 weeks, then 1x per month for 2 months, then quarterly if continued compliance. Results of staff audits will be reported to the QAPI Committee and reviewed and monitored by the Administrator. Completion Date: 9/30/22 and ongoing. **F609** **Reporting of Alleged Violations** **F656**	
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	F 609		

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F 609	Continued From page 5 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 staff interview and record review, the facility failed to 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. Findings include: Resident # 48 was the victim of physical abuse by Resident # 318 on 4/23/22. Per review of Resident # 318's clinical record, on 4/23/22,	F 609	The facility reports all incidents of abuse, neglect, exploitation or mistreatment including injuries of unknown source and misappropriation of resident property to both Adult Protective Services and the Survey Agency, in a timely manner. The Facility reported the alleged incident of abuse on 9/2/22 for Resident #48, and received notification that an investigation was not warranted at that time. The ADNS and Staff Educator completed **Reporting Requirements** training for Abuse, Neglect, or Exploitation of a Resident. Staff audits will be performed to ensure 100% compliance with the reporting regulation. 20% of staff will be audited x 4 weeks, then 1xper month for 3 months. Audits will be	

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F 609	Continued From page 6 Residents 48 and 318 were in the dining room eating dinner at the same table. Resident # 318 became agitated and became aggressive. Resident # 318 grabbed a knife from the dinner tray and pulled the other Resident # 48 closer to him/her. Resident # 48 attempted multiple times to push him/herself away from Resident # 318 but this resident kept pulling him/her closer. Resident # 318 then swung the knife at Resident 48 and the knife went between the resident's side and arm. There were no injuries from this swing. Resident # 318 then punched Resident # 48 in the forehead twice with the knife still in hand. This incident was witnessed by the aide monitoring the dining room. Review of the clinical record showed Resident # 318 had a history of aggressive behaviors and had a care plan in place to address this issue. On 08/30/22 at 11:52 AM, the facility Administrator confirmed the incident as between Residents # 318 and 48 occurred as described above. He/she stated that h/she was unaware of the need to report when both residents have dementia. The Administrator agreed that in this case, this incident should have been reported to Licensing and Protection and confirmed that it was not	F 609	reported to the QAPI Committee and reviewed and monitored by the Administrator. Completion Date: 9/30/22 and ongoing Tag F609 POC accepted on 10/13/2022 by S.Freeman/P.Cota	
F 656 SS=E	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	**F656** **Develop/Implement Comprehensive Care Plan** The facility develops and implements a comprehensive person centered care plan for each resident. Resident #19 had orders for bladder scanning discontinued, and the plan of care updated. Resident #46 has been evaluated by the SLP and	

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F 656	Continued From page 7 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 on observation, staff interview, and record review the facility failed to ensure that the resident's care plan was implemented per	F 656	his plan of care is now noted to be "set up" assistance for eating. All Resident Care Plans have been reviewed by the Nursing Leaders to ensure that resident's care plans accurately reflect the care and services that they require and receive. Staff received re-education on comprehensive care plans policy and regulation F656, by the ADNS and Nurse Educator. The DNS or designee will audit 20% of all resident care plans to ensure that the care plan accurately reflects the care the resident is receiving. Audits will continue for 4 weeks, then monthly for 3 months. All audits will be reported to the QAPI Committee and will be reviewed and monitored by the Administrator. Completion Date: 9/30/22 and ongoing	

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F 656	Continued From page 8 assessment and physician's orders for 2 of 42 residents included in the sample (Resident #19 and Resident #46). 1. Per record review Resident #19 has diagnoses that include obstructive and reflux uropathy (a condition that causes the flow of urine to be obstructed and urine to flow backward into the kidneys) and benign prostatic hyperplasia with lower urinary tract symptoms (a condition that can cause urinary retention, urinary tract infections, bladder and kidney damage, and bladder stones). A physician's order with a start date of 5/11/2022 states "Bladder Scan every shift for post void residual [PVR]; Straight Cath if PVR > [greater than] 350." Review of the resident's 5/1 - 5/31/2022 treatment administration record (TAR) reflects that the first bladder scan was not documented until 5/20/22 on the 11:00PM - 7:00AM shift, 9 days after the order was given. The August 2022 TAR reflects that between 8/1 and 8/10 only 13 out of the 30 scans ordered were documented as being completed. There were no scans documented after 8/10/2022. Various progress notes written between 6/16-8/20 indicate that the bladder scanner was broken or not available. A progress note written on 6/16/2022 states "Resident has had 3 incontinent changes r/t bladder. Bladder scan machine not working." A progress note written on 6/22/2022 states "unable to scan. machine not working." On 7/3/2022 "bladder scanner not available" On 8/20/2022 at 2:19 PM and 4:31PM a progress note states "scanner broken." Per interview on 8/30/2022 at approximately 3:15	F 656	Tag F656 POC accepted on 10/13/2022 by S. Freeman/P.Cota	

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F 656	Continued From page 9 PM with the Registered Nurse (RN) assigned to Resident #19 they have not been able to do the bladder scan because the bladder scanner has been broken for quite some time. When asked how staff would know if the resident was retaining urine the (RN) stated that the staff monitor how wet the incontinent products are when doing care. Per interview on 8/31/22 at 10:53 AM with the Director of Nursing and the Licensed Nursing Home Administrator once they were aware of the broken bladder scanner they obtained a new one. They were not aware that there were any issues with the new scanner. Nor were they aware that Resident # 19 was not having her/his bladder scanned per physician's order. 2. Per record review Resident #46 has diagnoses that include Dysphagia (difficulty swallowing) following cerebral infarction. A Physicians diet order reflects ground texture, thin liquids, Aspiration precautions. The resident's activities of daily living Care Plan interventions include "The resident requires setup by staff to eat. Supervision. A care plan focus initiated on 6/30/2019 and revised on 8/25/2022 states "has a diagnosis of dysphagia" with an intervention of "[Resident] to eat only with supervision." The Resident Kardex also reflects that the resident requires set up and supervisor for meals. Per observation on 8/29/2022 during the lunch meal Resident #46 was seen in bed with her/his lunch tray on an overbed table feeding her/himself. There was no staff supervising the resident while s/he ate the meal.	F 656		

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F 656	Continued From page 10 Per interview with two Licensed Nurse Assistants (LNAs) on 8/30/2022 at approximately 2:30 PM Resident #46 does not require supervision while he eats. On 8/31/2022 at 8:55 AM Resident #46 was observed being set up with her/his meal then left to eat her/his breakfast meal in bed with no staff supervision. Per interview at this time with the LNA who had delivered the meal, s/he is familiar with Resident #46 care needs. The LNA stated that the resident is "a set up" and they "check in on [her/him] for meals." If they needed to know resident specific care needs, they would go to the Kardex or Care Plan. The LNA also stated that the resident does not have any swallowing issues that s/he is aware of. Per interview with the Assistant Director of Nursing (ADNS) on 8/31/22 at 9:04 AM there is a book at the nurse's station with Rehab updates that indicates the amount of supervision a resident requires for eating. The forms are named Swallowing Precautions with a section titled supervision and listed are "None, Distant supervision (2-4 visual checks during meal), close supervision, 1:1 feeding." The appropriate option would be checked off. The ADNS confirmed that there was no form in the book for Resident #46. Per ADNS the staff should also refer to the Kardex and Care Plan for supervision needed. On 8/31/2022 at 11:30 AM during an interview with the Speech Language Pathologist (SLP) and the Director of Rehab Services, the SLP stated that the resident had not been evaluated by	F 656		

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F 656	Continued From page 11 Speech Therapy in over a year. No concerns related to the resident's swallowing had been directed to her/him since. S/he confirmed that the resident had been care planned for supervision while eating due to swallowing concerns related to Dysphagia.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657	Tag F657 POC Accepted on 10/13/2022 by S.Freeman/P.Cota	

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F 657	Continued From page 12 by: Based on staff interview and record review the facility failed to review and revise the comprehensive care plan for one of 29 sampled residents (Resident #70). Findings include: Per record review, Resident #70, admitted to the facility on 7/22/2020, has active diagnoses including non-Alzheimer's dementia, primary generalized arthritis, muscle weakness, and depression. Resident #70's Minimum Data Set (MDS), a standardized assessment tool for long term care residents, dated 7/27/2022, indicates that his/her activities of daily living (ADLs) self-performance and support needed for dressing is "total dependence with one person physical assist," for personal hygiene is "extensive assist with one person physical assist," and for bathing is "total dependence with one person physical assist." Resident #70's care plan, last reviewed on 8/17/22, identifies the resident as having an ADL self-care performance deficit, needing extensive assistance by staff for dressing, limited assistance by 1 staff for personal hygiene/oral care, and extensive assistance by 1 staff for bed baths. Per interview on 8/31/22 at approximately 11:00 AM, a Licensed Nurse Aid (LNA) stated that Resident #70 has declined in his/her ADL self-performance and needs more care than what is identified in their care plan. The LNA stated that "[s/he] needs more than limited assistance for ADL like hygiene and oral care because s/he is at least an extensive assist." Per interview on 08/31/22 at 11:27 AM, the Unit Manager stated that Resident #70 is mostly	F 657	**F657** **Care Plan Timing and Revision** The facility reviews and revises the comprehensive care plans of all residents. Resident #70 ADL care plan was reviewed and now accurately reflects the resident's need for "extensive" one for oral care. All residents care plans were reviewed for accuracy by the Clinical Leaders of the facility. The ADNS and Staff Educator provided re-education on the policy for revising resident care plans and F657 to nursing staff and other members of the interdisciplinary team. The Director of Nursing or her design will audit 20% of care plans for 4 weeks for compliance, and then monthly for 3 months, and quarterly twice. Audit findings will be reported to the QAPI Committee	

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F 657	Continued From page 13 totally dependent for ADLs and the care plan should be updated to reflect that for the areas of dressing, personal hygiene, and bathing. Per interview on 8/31/22 at 2:23 PM, the Director of Nursing confirmed that the care plan should have been updated one way or another to reflect the changes that were made in the MDS in July 2022.	F 657	and reviewed and monitored by the Administrator. Completion Date: September 30, 2022 and ongoing.	
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review, the facility failed to ensure that pain management was provided for 1 of 29 applicable residents in the sample (Resident # 217). Findings include: Per record review, staff failed to ensure adequate pain control and administer pain medications per physician orders for Resident # 217. Per observation on 08/29/22 at 4:00 PM, Resident # 217 appeared to be irritable, rigid and grimacing. Resident #217 stated that s/he has waited hours after requesting pain medications, especially on the night shift. The resident stated that s/he is in pain unless s/he holds completely still at the time of the interview. In reviewing the	F 697	**F697** **Pain Management** The facility ensures that pain management is provided to residents who require such services, consistent with professional standards of practice and physician orders.Resident #217 has been discharged from the facility. All other residents were re-assessed for pain. No other residents were experiencing uncontrolled pain. The EMAR for all residents was reviewed and pain levels were accurately documented on all residents. The narcotic record accurately reflects the administration and reconciliation of	

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F 697	Continued From page 14 medication administration record (MAR) the resident's pain level was recorded as 7/10 (pain scale of 1-10, with 10 being the worst pain experienced) for the 7:00 am-3:00 PM shift on 08/29/22. Resident #217's care plan states medications are to be given per orders, and staff are to anticipate resident need for pain relief and immediately respond to any complaint of pain. Review of physician orders include the following scheduled pain medications: #1) hydrocodone/acetaminophen 10-325 milligrams (mg), give 1 tablet by mouth every 8 hours for pain. Start Date 08/26/2022. Scheduled medication times are 6:00 am, 2:00 PM, and 10:00 PM. #2) Acetaminophen Tablet 325 MG, give 2 tablets by mouth every 6 hours for pain, NTE (not to exceed) 3 grams in a 24-hour period. Start Date 08/26/2022. There is no record of administration on 08/28/22 at 6:00 am documented on the MAR. The hydrocodone/acetaminophen was not signed out on the MAR for 08/28/22 at 6:00 am and review of the narcotic sign out book showed that the medication for that date and time is recorded as "wasted" with no documented reason and no other administration of this medication documented for that time. The time recorded in the narcotic book for evening shift medication administration on 08/27/22 and 08/28/22 is 8:00 PM, which is 2 hours prior to the 10:00 PM prescribed medication time. Review of the MAR indicates that the 6:00 am dose of medication on 08/29/22 was administered but no record of administration from the narcotic book is documented.	F 697	controlled substance medications for all residents. All unused controlled substance medications were disposed of per facility policy. The ADNS and Staff Educator provided re-education to all licensed nurses on the facility's policy on pain medication and medication administration, including documentation, waste, and disposal and F697. The Director of Nursing, or designee, will perform weekly audits of 20% of residents, to ensure 100% compliance with policy and regulation. Audits will occur weekly x4 weeks, monthly x 3 months, and then quarterly x2. Audit findings will be reported to QAPI Committee and will be reviewed and monitored by the Administrator. Completion Date: 9/30/22 and ongoing	

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F 697	Continued From page 15 On 08/30/22 the Director of Nursing stated that if a medication is held, refused, or changed, this should be documented in the progress notes or MAR notes (if applicable) with a corresponding provider order, and should be coded accurately on the MAR. After record review, no order for time change of medication was found in nurses notes. No reason for wasting the medication at 6:00 am on 08/28/22 was found in progress notes. No documentation of reason narcotic was not signed out of the narcotic book on 08/29/22 was found. Coding was not done on the MAR for 08/28/22 at 6:00 am and 10:00 PM, the sign out boxes were left blank. On 08/31/22 at 1:30 PM, the Director of Nursing (DON) confirmed the medications were not administered per physician orders. Inadequate pain management for resident #217 occurred as a result of these errors.	F 697	Tag F697 POC Accepted on 10/13/2022 by S.Freeman/P.Cota **F812** **Food Procurement, Store/Prepare/Serve-Sanitary** On 9/1/22, all equipment and kitchen surfaces were thoroughly cleaned, as well as ensuring that all food in the walk in fridge was within its expiration date. A cleaning schedule was provided to the IFSD by the Administrator and Registered Dietician. All staff were in-serviced by the RD and IFSD regarding the Deficiency F812, and the cleaning schedule. Staff received a copy of both. Weekly audits by the RD, or designee, of the completed cleaning schedule and rounds of the kitchen equipment, surfaces, and refrigerator inspection for spoiled or out dated food were initiated and will continue weekly for 4 weeks, then	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		

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F 812	Continued From page 16 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure foods were stored and/or prepared under sanitary conditions. Findings include: The following observations were made during the initial tour of of the kitchen with the Interim Food Services Director (IFSD) on 8/29/22 at 9:56 AM: 1. The meat slicer was observed sitting under a prep table. Much of the slicer was coated in a sticky white film. The IFSD stated that staff did use the slicer. 2. The vent hood over the main stove was soiled with grease and dust. The IFSD stated that the hood is cleaned every 180 days and is due in September 2022. 3. The steam table is heavily soiled with stuck on dripped food, grease and dust. 4. A microwave on a kitchen shelf is heavily soiled with spilled foodstuffs. When the surveyor opened the microwave door, several small flying insects flew out. 5. A clear container located in the walk-in refrigerator contained moldy green peppers. The above observations were confirmed by the IFSD at the time of observations. The IFSD stated that h/she is unaware of a written kitchen cleaning schedule and staff cleaned " when they noticed something".	F 812	2x monthly for 3 months, and monthly ongoing. Audit results will be presented monthly at the QAPI committee meetings, and will be reviewed and monitored by the Administrator. Completion Date: 9/30/22 and ongoing Tag F812 POC Accepted on 10/13/2022 by S.Freeman/P.Cota	
F 883	Influenza and Pneumococcal Immunizations	F 883		

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F 883 SS=E	Continued From page 17 CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal	F 883	**F883 Influenza and Pneumococcal Immunizations** The facility ensures that all residents are offered, and receive influenza and pneumococcal immunizations unless refused or contraindicated. Residents #16, 48, 70, and 92 consented and immediately received the pneumococcal vaccine as per each resident's wishes. All residents EMRs were audited to confirm their pneumococcal status, and all new admissions are offered the vaccine on the day of admission to the facility. Licensed Nurses were provided education on the Vaccination Policy and F883, by the ADNS and Staff Educator. The Director of Nursing, or designee, will perform audits on 20 % of all new admissions weekly x 4	

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F 883	Continued From page 18 immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that each resident receives optimal protection against the pneumococcal infection by not vaccinating eligible residents with the pneumococcal vaccine(s) for four of seven sampled residents (Residents #16, #48, #70, and #92). Findings include: Per record review, Resident #16, admitted 5/30/2017, Resident #48, admitted 8/11/2014, Resident #70 admitted 7/22/2020, and Resident #92, admitted 7/15/2019, did not have documentation that all recommended pneumococcal vaccinations were administered, refused, or medically contraindicated. Facility policy "Clinical Services; Subject: Pneumococcal Vaccination," last reviewed on 2/25/22, states on page 1 that "The facility will	F 883	weeks, 1 x monthly for 3 months, and 1 x quarterly for 6 months to ensure compliance. Audit findings will be reported to the QAPI Committee and will be reviewed and monitored by the Administrator. Completions Date: 9/30 and ongoing Tag F883 POC Accepted on 10/13/2022 by S.Freeman/P.Cota	