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

January 7, 2022

Ms. Melissa Haupt, Administrator
Saint Albans Healthcare And Rehabilitation Center
596 Sheldon Road
Saint Albans, VT 05478-8011

Dear Ms. Haupt:

Enclosed is a copy of your acceptable plans of correction for the investigation conducted on **December 7, 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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING ______ B. WING ______	C 12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ALBANS HEALTHCARE AND REHABILITATION CENTER	596 SHELDON ROAD SAINT ALBANS, VT 05478

(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 An unannounced on-site investigation of three complaints and one facility reported incident was conducted by the Division of Licensing and Protection on 12/6 - 12/7/2021. There were regulatory violations identified as a result of this investigation.	F 000	The filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. The plan of correction is prepared and executed as evidence of the facility's continued compliance with applicable law.	
F 557 SS=E	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 observations, record review, and staff interview the facility failed to ensure that staff treated all residents with respect and dignity related to verbal interactions, personal possessions, and personal care. 1. Per record review Resident #1 is incontinent of bowel and bladder and requires extensive assist of one with toileting and bed mobility. An incontinence care plan focus goal initiated on 9/26/2018 states "Resident will have incontinence care needs met by staff to maintain dignity and comfort and prevent incontinence related complications." A progress note dated 9/8/2020 at 1:41 PM states "Reported today that an LNA (Licensed Nurse Assistant) overheard another LNA yelling at [Resident #1] on Friday evening	F 557		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 1/3/2022

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 about an episode of incontinence." Per review of statements obtained during a facility internal investigation, a statement provided by a staff member dated 9/8/2020 reflects that, on 9/4/2020 Resident #1 reported that LNA #2 had been rude to her/him and s/he was upset but didn't want to get anyone in trouble. On 9/8/2020 Resident #1 reported to the same staff member that LNA #2 refused to help her/him reposition stating "you can move your legs yourself." Per review of LNA #2's employee file, an Individual Performance Improvement Plan (IPIP) had been initiated on 8/7/2020 when a resident complained that LNA #2 speaks disrespectfully to residents. LNA #2 was provided with training related to respectful and professional behavior in the workplace. 2. On 12/6/2021 at approximately 4:30 PM, during a facility environmental walk through, there were 9 wheelchairs noted to be stationed in a common area at the end of West Wing. Some of the wheelchairs had resident's personal items left on the seats, such as cushions, shoes, and blankets. During an additional walk through with the facility Administrator on 12/6/2021 at approximately 5:30 PM the Administrator identified the wheelchairs as belonging to residents of the West Wing. When asked why they were not in their respective resident's room - the Chief Nursing Executive (CNE) stated that the rooms were not big enough to keep them there. 3. On 12/6/2021 at approximately 4:40 PM observation of room E 25 revealed two framed paintings that belong to a resident, propped against the wall on the floor under the window to the outside. On 12/6/2021 at approximately 5:40	F 557	Resident #1 no longer resides in the center. LNA #2 no longer works in the Center. All residents that reside in the center have the potential to be affected by this alleged deficient practice. All wheelchairs are now stored in the resident rooms. The pictures in E25 are now hung. All residents have been evaluated for Unwanted facial hair and foot hygiene. Those affected have been addressed. Weekly environmental rounds occur on Wednesdays. CED/EVS/Maintenance/ IPP attend. A cart will accompany the Team to correct issues while rounding. Nursing staff have been educated on Grooming and wheelchair storage. Audits will occur weekly times 4, monthly Times 2, or until substantial compliance is Achieved. Results will be reported to QAPI. CED/CNE/Maintenance responsible to Ensure compliance.	

Date of compliance: January 6, 2022

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F 557	Continued From page 2 PM When asked why the paintings were on the floor the Administrator stated that they should be hung up. However, on 12/7/2021 at 11:30 AM the paintings were again observed to be on the floor. 4. On 12/6/2021 at approximately 5:10 PM Resident #6 was observed to be laying in a low bed, her/his right foot had black discoloration on the bottom, and s/he had an extensive amount of facial hair that was approximately 2 inches long. On 1/6/2021 at approximately 5:45PM the Administrator stated that s/he may refuse to allow staff to shave her/him. The Administrator shared her observations with the CNE and described this resident as having a "full beard." The CNE explained that this resident often refuses personal care and grooming. Review of this resident's record did show some refusals, however there were many days during the previous 3 months where there is no documentation of the resident refusing care. On 12/7/21 at approximately 11:30 AM, an observation of this same resident revealed that she had been groomed and her foot was now clean with no discoloration noted.	F 557	**TAG F 557 POC Accepted by S. Freeman/J. Kendall on 1/05/22**	
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.	F 584	Resident #4 received her clothing All residents that reside in the Center have the potential to be Affected by this alleged deficient Practice Additional staff has been secured For housekeeping and laundry and Are working on the backlog	

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F 584	Continued From page 3 (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to maintain a safe/clean/comfortable/homelike environment throughout the facility. 1.) On 12/7/21 at approximately 11:15 AM an interview with a Resident #4 revealed that she/he often does not receive their clothes back from the laundry for a week or more and the resident most	F 584	Workflow has been adjusted to Allow more time to process Personal laundry The cleaning rags and mop heads will be hung on a rack in a single layer to dry Weekly environmental rounds occur on Wednesdays. CED/EVS/Maintenance/ IPP attend. A cart will accompany the Team to correct issues while rounding. A work order will be created for those Things that require more time Education has been provided to EVS And laundry staff about maintaining A sanitary environment and ensuring a System is in place for maintaining a Sanitary environment as well as having An effective system to ensure linens are Handled, stored, processed, and Transported to prevent the growth of Pathogens and spread of infection as well As the Requirement that they change the gown For each use The hallway has been cleaned up. An audit form has been created to Track personal laundry hours to ensure The personals are processed in a timely Manner.	

Audits will occur weekly times 4, monthly

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F 584	Continued From page 4 often has to request a staff member to go down to the laundry to find her/his clothes. The resident stated that there have been times where they had none of their own clothes to wear so staff provided them with a "Johnnie". 2.) Review of the Resident Council Minutes for the months of October, November, and December of 2021 revealed ongoing complaints regarding "West rooms not being properly cleanded [sic], long waits for clothing". There were 19 grievances specific to missing clothing/laundry services, and 2 grievances specific to housekeeping. Observation of the facility revealed many small piles on the floors consisting of dirt, paper, bandaids, dust balls, etc. throughout the facility as well as spider webs hanging from the hallway ceiling. Resident rooms were noted to have dirty floors, holes in the walls, heat registers falling off the walls, door frames to be scuffed and the stain and varnish missing and exposing the bare wood. Wheelchairs and equipment were noted to be on both sides of the hallway with a group of 9 wheelchairs at the end of the West hall that were identified by the Administrator as belonging to residents on the West hall. The grouping of wheelchairs contained various personal items of residents such as shoes and blankets. A resident seating area was noted to the left of the grouping of wheelchairs and there was one reclining wheelchair with a foot cradle that was place in the seat of the chair. Interview with several staff on 12/6/21 at approximately 3 PM, one staff member stated "this has been an ongoing issue and nursing staff have had to sweep some of the residents rooms and hallways because at times its worse than what you see here" as she/he pointed to one of the piles on the West Wing	F 584	Times 2, or until substantial compliance is Achieved. Results will be reported to QAPI. EVS manager and CED responsible for compliance Date of compliance January 6, 2022 **TAG F 584 POC Accepted by S. Freeman/J. Kendall on 1/05/22**	

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F 584	Continued From page 5	F 584		

floor.

Interview on 12/6/21 at approximately 2 PM with the Director of Recreation revealed that these have been on going issues that the facility has been working on for a while. She/he stated they have gone down to the laundry to obtain clothing for residents at times as well as going around to residents with pieces of laundry that are not labeled with a residents name to attempt to locate the resident they belong to.

3.) Interview with the Director of Housekeeping and Laundry on 12/7/21 at approximately 10:50 AM regarding the complaint log, grievances, and numerous resident and staff interviews. She/he confirmed that she/he has worked in the role of Director of Housekeeping and Laundry since August 2021. She/he stated there are currently 7 full time staff, 4 are housekeeping, 1 full time laundry person, 1 full time person who does floors and heavy housekeeping, 1 position is split between laundry and housekeeping. Housekeepers work 7 AM - 3 PM and the laundry person works between 5 AM to 1:30 PM. On Saturday and Sundays there are 2 housekeepers working, and Monday - Friday 1 person who works in the laundry. The Director of Housekeeping and Laundry cover the weekends. She/he stated that at this time the housekeeping and laundry positions are full - there are no openings. When asked about the issues that were noted in the Resident Council Minutes and the grievances that were reviewed, she/he stated that they were short staffed for a period of time and corporate staff were coming to the facility each week to help back in October of 2021. A tour of the laundry area was requested. The Director agreed to provide a tour and stated, "it's

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F 584	Continued From page 6	F 584		

a bit of a mess at this point, I am working to get caught up but it's taking a while."

On 12/7/21 at approximately 11:00 AM a tour of the laundry area was conducted. Upon entering the hallway in the basement that is utilized by the laundry, there were many racks of clothing on clothes hangers hung on the racks that were uncovered. There were piles of unfolded clothes, yellow gowns, and bags of clothing/material/blankets etc. on the floor and chairs and on the flat surfaces of furniture that were along the hallway. There was a red biohazard bag that contained what appeared to be new (folded) red biohazard bags and a wrinkled, rag with a black substance in various spots on the rags surface. Upon entering the laundry room, there were 2 commercial washing machines and 3 commercial driers. One drier had a paper sign on it that reminded staff to use this drier for "small baby loads". All 3 driers were full of clothes. A squared, wheeled laundry tub of white wet laundry was sitting in front of one of the driers - the Director of Housekeeping and Laundry stated that it was waiting to go in to a drier from being washed earlier in the day. In the center of the room was a long table that appeared to be used as a folding station and it had some stacks of white linens folded on this table. Across from this table on hall side wall was another long table that was piled from one end to the other with unfolded clothes, socks, underwear, blankets, and various other types of material/clothes/items. The Director of Housekeeping and Laundry stated that this table was for clothes that had not yet been folded and there was one section at the end of the table that was for items that were not labeled and no one knew who these items belonged to. Between

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F 584	Continued From page 7 these 2 folding stations was a white bar, approximately 3 feet long, that was suspended from the ceiling with a chain on each end. On this bar were layers of white towels, and cloths - the top layer was dry and the bottom layer that was in contact with the bar was wet. At one end of the center folding station were a couple of square Laundry bins - one contained mop heads, long duster heads, and housekeeping rags inside the bin and all along the outside rim of the bin. The other laundry bin contained white towels and cloths, inside the bin and all along the outside rim of the bin. The Director of Housekeeping and Laundry stated that mop heads were air dried - they could not be dried in the driers because chemicals were used on them to clean. She/he went on to explain that the other bin with white towels and cloths belonged to the kitchen and they also could not be dried in the drier because chemicals were used on them to clean so they were also air dried. Within the kitchen bin were 2 pillows - the Director of Housekeeping and Laundry stated they didn't belong in this bin and that they too were to be air dried. The surveyor reached into the bin and underneath the top layer of towels and cloths, pulled out a wet clothing protector. The Director of Housekeeping and Laundry confirmed that this item was still wet and she/he did not know how it got mixed in with the kitchen towels and cloths. On the far wall of the laundry room were two four level racks. Each rack contained folded clothes. The Director of Housekeeping and Laundry stated that some of the clothes on these racks were clothes that belonged to unknown residents. A privacy curtain was draped over one of the two	F 584		

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F 584	Continued From page 8 racks. The Director of Housekeeping and Laundry stated that she/he put the privacy curtain there to dry as she/he is not allowed to dry them in the dryer. In front of this rack (where the privacy curtain was drying) was a 2 foot long by 1 foot deep, and 1 foot high (approximately) pile of clothing that were covered in dust and dirt. The Director of Housekeeping and Laundry stated that this pile had been here since she/he started in her/his current position and did not know who these clothes belonged to. At the opposite end of the laundry area, closest to the exit door, on the floor, was a black trash bag that had been ripped open and revealed various pieces of clothing. Leaning against this bag of clothing was a 2-foot by 3-foot piece of foam insulation board. The Director of Housekeeping and Laundry stated that this bag had been there since she/he had started her/his current position and she/he did not know who these clothes belonged to. To the left of this bag of clothes was a counter with a sink and to the far left of the sink was a door to a room that had several large bins and piles of clothes, and white and yellow reusable gowns. The Director of Housekeeping and Laundry stated that there is a chute on the first floor and this is where staff put all the dirty clothes - the chute drops into this room where laundry staff come in and sort it to be washed. The Director of Housekeeping and Laundry was asked about the process for reusable white and yellow gowns that came from rooms of residents that on transmission based precautions. She/he stated that these come down in bags and laundry staff open the bags and sort them into bins to be washed and all gowns are washed the same way with a special cleaner. She/he explained that staff who go into this room are required to wear goggles, gloves, mask, and a reusable yellow gown. She/he pointed to the	F 584		

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F 584	Continued From page 9 door frame inside this room showing that these are the gowns currently being used by staff entering this room. The Director of Housekeeping and Laundry was asked how often staff change the gowns used in this room, she/he stated it is changed weekly.	F 584		
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 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	F 609	F 609 LNA #1 & 2 no longer work at The center. Resident #1 & 2 no longer resides At the center. All residents that reside in the Center have the potential to be Affected by this alleged deficient Practice Education has been provided to Staff from all departments About abuse reporting Audits of staff members Knowledge of abuse reporting Will occur weekly times 4, Monthly times 2, and until Substantial compliance is achieved. Results will be reported to QAPI CED/SS responsible for completion Date of completion January 6, 2022	

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F 609	Continued From page 10 by: Based on staff interviews and record review, the facility failed to ensure an allegation of employee to resident abuse was reported to the Division of Licensing and Protection within the required time frame, for 2 of 3 residents in the applicable sample (Resident #1 & Resident #2). Findings include: Per review of statements obtained during a facility internal investigation, on 9/4/2020 a Licensed Nurse Assistant (LNA) #1 over heard another LNA (LNA #2) "complaining and getting mad at [Resident #1]. [LNA #2] then yelled at [Resident #1] because [s/he] had no reason to be a full bed of urine and BM (bowel movement) because [her/his] brief had been changed 15 minutes prior. [LNA #2] then walked out of [Resident #1's] room and told me (LNA #1) that [s/he] just had to yell at [Resident #1] for [being incontinent] in bed." LNA #1 states that s/he told LNA #1 that they are there to help them, and not yell at [her/him] and make [her/him] feel bad. According to LNA #1's statement, s/he and LNA #2 then assisted Resident #2 to bed. LNA #2 began shoving Resident #2 around and using foul language to describe Resident #2's incontinence and telling "[her/him] that [s/he] needs to not shit." LNA #1 reported that s/he told LNA #2 that s/he needed to calm down and watch what [s/he] was saying. [S/he] said that [Resident #2] couldn't even hear." Per review of another staff member's statement dated 9/8/2020, on 9/4/2020 Resident #1 reported that LNA #1 had been rude to her/him and s/he was upset but didn't want to get anyone in trouble. On 9/8/2020 Resident #1 reported to the same staff member that LNA #1 refused to help her/him reposition stating "you can move	F 609	**TAG F 609 POC Accepted by S. Freeman/J. Kendall on 1/05/22**	

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F 609	Continued From page 11 your legs yourself. Per review of LNA #2's employee file, an Individual Performance Improvement Plan (IPIP) had been initiated on 8/7/2020 when a resident complained that LNA #2 speaks disrespectfully to residents. LNA #2 was provided with training related to respectful and professional behavior in the workplace. Facility administration did complete a report to the Division of Licensing and Protection on 9/8/2020 when they became aware of the alleged incident: however, the allegation was made on 9/4/2020. Failure of the staff to report the incident to administration on 9/4/2020, resulted in LNA #2 having continued access to residents, exposing them to possible further abuse and mistreatment. Per interview on 12/7/2021 at 4:40 PM with the Center Executive Nurse (CNE), once administration became aware of the allegation, LNA #2 was put on administrative leave pending investigation and a report was submitted to the Division of Licensing and Protection. The CNE confirmed that the report was not submitted timely due to the delay in staff reporting to administration.	F 609		
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:	F 658		

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F 658	Continued From page 12 Based on record review and staff interview, the facility failed to ensure that a resident received treatment and services, consistent with professional standards of practice, by failing to ensure thorough monitoring of the size and status of an unidentified wound for 1 of 3 residents in the applicable sample (Resident #3). Findings include: Per record review, Resident #3 was admitted to the facility on 2/11/2021 with diagnoses that include dementia, type 2 diabetes, and a diabetic ulcer of the right foot. An admission skin check completed on 2/11/2021 at 5:38 PM identifies a 4cm x 2cm bruise on her/his left hand, a 3.5cm x 4cm pink area on her/his right butt, a 3.5 x 3.5 pink area on left butt, a 1.5cm x 1.5cm necrotic area on her/his right lateral foot by 5th metatarsal, a 4cm x 5cm scab on left lateral leg and a 1.2cm x 1cm scab on left medial shin. Wound Evaluation reports completed weekly revealed photos and measurements of Resident #3's right foot diabetic ulcer. The photos were taken from various angels each week exposing different aspects of the foot. A photo of the wound dated 4/28/2021 showed a dorsal view of Resident #3's right foot with all 5 toes visible and intact. The weekly photos from 4/29 through 8/2/2021 did not include the dorsal view and the toes were not visible. Photos taken on 8/3, 8/17, and 8/31/2021 show a scabbed over wound on the dorsal aspect of the 2nd toe. Based on the previous views captured in the photos it is uncertain when the wound began. Per resident care plan s/he required assistance with all activities of daily living including bathing, grooming, toileting, and bed mobility. A care plan	F 658	Resident #3 no longer resides at the Center. All residents with wounds have the Potential to be affected by this alleged Deficient practice. Audits have occurred for all residents With wounds Education has been provided to nurses Regarding wound documentation and Care planning of wounds Audits of wounds will occur during skin Rounds to ensure all areas have been Addressed, documented, and care planned weekly times 4, Monthly times 2, and until substantial Compliance is achieved. Results will be Reported to QAPI. CNE/CWOCN responsible for completion Date of completion: January 6, 2022	

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F 658	Continued From page 13 focus identifies "at risk for skin breakdown related to limited mobility and has actual skin breakdown. Diabetic Ulcer Location right lateral foot. MASD (moisture associated skin damage): buttocks." However, it does not address the wound on Resident #3's 2nd toe nor is there evidence that the care required for the wound was ever included in the care plan. There is no documentation in the clinical record that reflects that there had ever been a wound on the dorsal 2nd toe. There is also no evidence in the record that supports that the wound was identified, treated, or monitored. During interview on 12/7/2021 at approximately 4:45 PM with the CNE s/he stated that the Physician Assistant (PA) may have documented the wound in another place, and s/he would look for documentation. When the CNE returned s/he stated that the wound on the toe "had healed", and the PA "had not wanted to treat it as it was doing so well and improving." The CNE confirmed that there was no evidence of documentation related to the development, assessment, treatment, or monitoring of the wound on the 2nd toe. Ref: Ignatavicius, D. D., Workman, M. L., & Rebar, C. R. (2017). Medical-surgical nursing: Critical thinking for interprofessional collaborative care. (9th ed.). Elsevier pg. 460	F 658	**TAG F 658 POC Accepted by S. Freeman/J. Kendall on 1/05/22**	
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 14 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to carry out the activities of daily living and provide residents with necessary services to maintain good nutrition, grooming, and personal care for 4 of 12 residents in the sample (Residents #4, #5, #6, and #7). 1.) On 12/6/21 at approximately 5:10 PM, observation of the East wing revealed a female Resident #6 in room E17 who was in a low bed, the bottom of the residents right foot had black discoloration, and she had an extensive amount of facial hair that was approximately 2 inches long. Interview on 12/6/21 at approximately 5:45 PM with the Administrator regarding the above noted observations. The Administrator accompanied the surveyors to the East wing where the Administrator confirmed the above findings, and shared this with the DON/CNE stating, the resident "has a full beard". The DON/CNE explained that this resident often refuses personal care and grooming. Review on 12/6/21 of the residents medical record revealed many days and evenings where the resident had no behaviors or refusals of care. 2.) On 12/7/21 at approximately 4 PM an interview with Resident #4 revealed that she/he states they often goes to bed hungry. She/he explained that on 12/6/21 she/he was in the dining room waiting for dinner to be served along with other residents and she/he had a plate set	F 677	Resident # 6 received foot care and Grooming All residents have the potential to Be affected by this alleged deficient Practice New management has been secured For the kitchen All residents meal preferences will Be redone and updated in meal Tracker PAR lists will be set up by the District manager to ensure Adequate supply of food and snacks Menu substitutions will be recorded And approved by the dietician A meal cart sign off has been Implemented to ensure timeliness Dietary and nursing staff have Been educated on preferences, Cart sign off, meal timeliness, substitution process, and Importance of a balanced diet	

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F 677	Continued From page 15 down in front of her/him with a grilled cheese sandwich on it and nothing else. She/he went on to say that the grilled cheese sandwich was made with a hot dog roll - no bread. She/he asked the server about this and was told the "kitchen is all out of bread". She/he was offered nothing more than this sandwich and a drink for supper. A second resident, Resident #5 complained about receiving a grilled cheese sandwich on a hot dog roll and no other foods were offered or provided. On 12/7/21 at 2:15 PM an interview with the Director of Food Service revealed that she/he had made 4 grilled cheese sandwiches on hot dog rolls the day before (12/6/21) as she/he had ordered enough bread for breakfasts throughout the week but staff used the bread for other needs leaving the kitchen short on bread. The Director of Food Service provided a list of the 4 residents that had received the grilled cheese sandwich, however failed to mention the 2 residents that stated this this is what they received for their meal on 12/6/21. She/he stated that the only residents who received a grilled cheese sandwich were those who refused the regular meal and requested a grilled cheese sandwich. The Director of Food Service was asked by this surveyor if a grilled cheese sandwich on a hot dog roll with no other food offered or provided would be considered a nutrition and balanced meal, and included enough protein - she/he stated "no, it is not a balanced meal and does not contain enough protein". She/he explained that when a resident asks for a sandwich they are served a sandwich and nothing else unless they request more. On 12/7/21 at 2:45 PM a re-interview with Resident #4 and Resident #5 revealed that	F 677	Audits of grooming and Dietary process will occur Weekly times 4, monthly times 2 and until substantial Compliance is achieved Dietary manager and CED Responsible for compliance Date of compliance: January 6, 2022 **TAG F 677 POC Accepted by S. Freeman/J. Kendall on 1/05/22**	

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F 677	Continued From page 16 she/he had in fact not refused the main meal and was under the assumption that the grilled cheese sandwich was the main meal, as nothing else was offered. 3.) On 12/7/21 at approximately 3:45 PM - 4:10 PM, interview's with Residents #4, #5, and #7 revealed that meals are always late being served. Four residents stated that supper is scheduled to arrive in the dining at 5 PM and more often than not, it does not arrive until 5:45 PM at the earliest. On 12/7/21 at 1:00 PM observations were made of the meal delivery system and it was noted that the lunch meal did not arrive on the West wing until 1:00 PM. On 12/7/21 at 4:15 PM an interview with the Director of Food Service regarding resident complaints about the time in which meals are served and that they are most often well past the scheduled meal time. She/he explained that if the breakfast meal is late being prepared, plated, and served then every meal after that, for that day, is also late in being served. She/he explained that she/he is new to the position and has been down staff which has affected the meal delivery system. The Director of Food Service confirmed that the lunch meal on 12/7/21 was served after 1:00 PM and further stated that the dinner meal will also be late.	F 677		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:	F 687		

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F 687	Continued From page 17 (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to ensure that 1 of 4 residents in the applicable sample (Resident #3) received appropriate preventative foot care in accordance with professional standards of practice. Findings include: Per record review Resident #3 had a diagnosis of diabetes myelitis and was receiving wound care for a diabetic ulcer on her/his right lateral foot. A care plan focus for at risk and actual skin breakdown intervention initiated on 3/9/2021 states Diabetic foot checks every evening, report any open areas or redden areas to the MD." An intervention implemented on 9/6/2021 states "Apply Eucerin lotion to dry skin as ordered." A physicians order dated 9/1/2021 states "Eucerin Lotion (Emollient) Apply to Bilateral Legs topically every day and evening shift for dry skin." A physician order dated 2/27/2021 states "Diabetic Foot Care/Check Daily Observation of feet, toes, ankles, soles noting any alteration in skin integrity, color, temperature, and cleanliness. Inspect shoes for proper fit and excessive wear, check Pedal Pulses every evening shift for Diabetes... CODE: 1= no alteration noted CODE: 2= New alteration noted	F 687	Resident # 3 no longer resides in the Center. All residents Have the potential to be affected by this Alleged deficient practice. All residents residing in the center have Had their feet checked for wounds and Long nails. Nursing staff have been educated on the Process for foot care and wound Documentation. Audits will occur weekly times 4, monthly Times 2 and until substantial compliance Is achieved. CNE/CWOCN responsible for compliance Date of compliance: January 6, 2022 **TAG F 687 POC Accepted by S. Freeman/J. Kendall on 1/05/22**	

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F 687	Continued From page 18 CODE: 3= Previously noted alteration Pedal Pulse (PP): P=Palpable NP=non-Palpable" Wound Evaluation reports completed weekly revealed photos and measurements of Resident #3's right foot diabetic ulcer. The photos of the wound were taken from various angels each week exposing different aspects of the foot. Photos dated 3/10, 4/14, 4/28, 8/3, 8/17, 8/31, 9/16, and 10/5/2021 showed that her/his right foot and lower leg were extremely dry with thick flaking and peeling skin. Resident #3's toenails were also noted to be very long (extending over the tip of the toe), untrimmed, and jagged. Review of Resident #3's October 2021 medication administration record (MAR) revealed that on October 6th ,7th, 8th, 11th, and 12th the nurses on duty coded 3, indicating a previously noted alteration. On October 1st, 2nd, 3rd, 9th, and 10th nurses coded 1 indicating that there was no alteration noted. However, the Wound Evaluation photo of the resident's right foot dated 10/5/2021 shows dry, thick, and flaking skin, long, untrimmed, and jagged toenails, and a diabetic ulcer. During interview on 12/7/2021 at approximately 4:45 PM with the CNE s/he confirmed that Resident #3's skin was very dry and that her/his toenails were long. S/he stated that Resident #3's spouse "took care of [her/his] feet. S/he took care of [the resident] for years at home and that is what s/he wanted to do, so we let her/him."	F 687		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4)	F 814		

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F 814	Continued From page 19 §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on direct observation and staff interview the facility failed to ensure that food waste was properly disposed of. Findings include: During observation of the kitchen on 12/7/2021 at 12:11PM there were two tables used for food prep between the entry way and the kitchen appliances. The tables were noted to have 4 open bins of food that included scrambled eggs and toast There was a plate on the table that had bread and another that had a large stick of butter. There was also a large can open and emptied of its contents. On the floor under one of the tables was a dirty bowl. All the food present was open without a lid. During interview on 12/7/2021 at approximately 12:30PM the Administrator confirmed that the food left out on the prep table was left over from breakfast. S/he stated that it was compost and had not been taken care of yet. During interview on 12/7/2021 at 2:15PM the Food Service Director confirmed that the leftover food had been left out on the prep table after breakfast until after lunch. S/he stated that s/he had cooked breakfast and went right into cooking lunch. S/he also confirmed that this food was compost and would not be used for other meals.	F 814	All residents that reside in the center Have the potential to be affected by This alleged deficient practice. The kitchen has been deep cleaned Dietary staff have been educated on The proper procedure for compost and Kitchen cleanliness Audits of kitchen cleanliness will Occur weekly times 4, monthly times 2 and until substantial compliance is Achieved. Results will be reported to QAPI Dietary manager/CED responsible for Compliance Date of compliance: January 6, 2022 **TAG F 814 POC Accepted by S. Freeman/J. Kendall on 1/05/22**	

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F 880	Continued From page 20	F 880		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880	All residents that reside in the Center have the potential to be Affected by this alleged deficient Practice Additional staff has been secured For housekeeping and laundry Workflow has been adjusted to Allow more time to process Personal laundry Personal laundry stored in the hall Will be covered The cleaning rags and mop heads will be hung on a rack in a single layer to dry Weekly environmental rounds occur on Wednesdays. CED/EVS/Maintenance/ IPP attend. A cart will accompany the Team to correct issues while rounding. Education has been provided to EVS And laundry staff about the drying of Rags and mop heads as well as the Importance of room cleaning and covering carts Audits of room cleaning and rag drying will occur weekly times 4, monthly Times 2, or until substantial compliance is	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 21 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to maintain a safe, sanitary, and comfortable environment to prevent the development and transmission of communicable diseases and infections throughout the facility. 1.) Review of the Resident Council Minutes for the months of October, November, and	F 880	Achieved. Results will be reported to QAPI. EVS and CED manager responsible for compliance Date of compliance January 6, 2022 **TAG F 880 POC Accepted by S. Freeman/J. Kendall on 1/05/22**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475021	A. BUILDING ______ B. WING ______	C 12/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 22	F 880		

December of 2021 revealed ongoing complaints regarding "West rooms not being properly cleanded [sic], long waits for clothing". There were 19 grievances specific to missing clothing/laundry services, and 2 grievances specific to housekeeping. Observation of the facility revealed many small piles on the floors consisting of dirt, paper, bandaids, dust balls, etc. throughout the facility as well as spider webs hanging from the hallway ceiling. Interview with several staff on 12/6/21 at approximately 3 PM, one staff member stated "this has been an ongoing issue and nursing staff have had to sweep some of the residents rooms and hallways because at times its worse than what you see here" as she/he pointed to one of the piles on the West Wing floor.

Interview on 12/6/21 at approximately 2 PM with the Director of Recreation revealed that these have been on going issues that the facility has been working on for a while. She/he confirmed that during Resident Council residents have complained about the cleanliness of the facility and this has been an ongoing issue.

2.) Interview with the Director of Housekeeping and Laundry on 12/7/21 at approximately 10:50 AM regarding the complaint log, grievances, and numerous resident and staff interviews. She/he confirmed that she/he has worked in the role of Director of Housekeeping and Laundry since August 2021. A tour of the laundry area was requested. The Director agreed to provide a tour and stated, "it's a bit of a mess at this point, I am working to get caught up but it's taking a while."

On 12/7/21 at approximately 11:00 AM a tour of the laundry area was conducted. Upon entering

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F 880	Continued From page 23 the hallway in the basement that is utilized by the laundry, there were many racks of clothing on clothes hangers hung on the racks that were uncovered. There were piles of unfolded clothes, yellow gowns, and bags of clothing/material/blankets etc. on the floor and chairs and on the flat surfaces of furniture that were along the hallway. There was a red biohazard bag that contained what appeared to be new (folded) red biohazard bags and a wrinkled, rag with a black substance in various spots on the rags surface. In the center of the room was a long table that appeared to be used as a folding station and it had some stacks of white linens folded on this table. Across from this table on hall side wall was another long table that was piled from one end to the other with unfolded clothes, socks, underwear, blankets, and various other types of material/clothes/items. The Director of Housekeeping and Laundry stated that this table was for clothes that had not yet been folded and there was one section at the end of the table that was for items that were not labeled and no one knew who these items belonged to. Between these 2 folding stations was a white bar, approximately 3 feet long, that was suspended from the ceiling with a chain on each end. On this bar were layers of white towels, and cloths - the top layer was dry and the bottom layer that was in contact with the bar was wet, this was confirmed by the Director of Housekeeping and Laundry. Interview with the Director of Housekeeping and Laundry revealed that it takes several days for these kitchen cloths and towels to dry and is a place where bacteria, pathogens, and mold could develop, grow, and be spread throughout the facility. At one end of the center folding station were a	F 880		

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F 880	Continued From page 24 couple of square Laundry bins - one contained mop heads, long duster heads, and housekeeping rags inside the bin and all along the outside rim of the bin. The other laundry bin contained white towels and cloths, inside the bin and all along the outside rim of the bin. The Director of Housekeeping and Laundry stated that mop heads were air dried - they could not be dried in the driers because chemicals were used on them to clean. She/he went on to explain that the other bin with white towels and cloths belonged to the kitchen and they also could not be dried in the drier because chemicals were used on them to clean so they were also air dried. Within the kitchen bin were 2 pillows - the Director of Housekeeping and Laundry stated they didn't belong in this bin and that they too were to be air dried. The surveyor reached into the bin and underneath the top layer of towels and cloths, pulled out a wet clothing protector. The Director of Housekeeping and Laundry confirmed that this item was still wet and she/he did not know how it got mixed in with the kitchen towels and cloths. As a result of the above findings, there were many areas where pathogens and mold could be developing, growing, and being spread throughout this facility.	F 880		

IC204 Linen Handling

MANUAL TITLE:	Infection Control Policies and Procedures
POLICY TITLE:	IC204 Linen Handling
APPLICATION:	Genesis HealthCare Affiliated Skilled Nursing Centers
EFFECTIVE DATE:	09/01/04
REVIEW DATE:	11/15/21
REVISION DATE:	11/15/20

POLICY

All linen will be handled, stored, transported, and processed to contain and minimize exposure to waste products. All soiled linen will be handled the same, using Standard Precautions. Soiled linen from isolation rooms does not require special handling. All employees who collect, transport, sort, or wash soiled/contaminated linens will be trained and supervised in proper technique.

PURPOSE

To provide effective containment and reduce potential for cross-contamination from soiled linen.

PROCESS

1. Maintain clean linen in a closed storage area.
   - 1.1 Keep clean linen covered.
   - 1.2 Keep clean storage area separate from soiled storage area.
2. Transport clean linen in covered carts or bags.
3. Cleanse hands before handling clean linen; do not allow linen to touch clothing.
4. If mattress is soiled, clean with disinfectant and allow to dry before applying clean linens.
5. Take only amount of linen needed for bed change into resident's room. Do not leave extra clean linen in the resident's room.
6. Minimize linen handling. Do not shake linen.
7. Handle all soiled linen the same.
   - 7.1 Handle as little as possible. Do not hold contaminated linen and laundry bags close to the body or squeeze when transporting.
   - 7.2 Use minimum agitation.
   - 7.3 Use Standard Precautions:
     - 7.3.1 Wear gloves,
     - 7.3.2 Wear gown/apron if linen is visibly soiled and may come in contact with clothes.
   - 7.4 Soiled linen should be bagged or directly placed in covered container at the location where removing linen. Water soluble bags are not necessary.
     - 7.4.1 If solid body waste on linen, remove and empty into toilet. Do not rinse or sort linen in resident care areas.
     - 7.4.2 Double bagging of linen is only recommended if the outside of the bag is visibly contaminated or is observed to be wet through the outside of the bag.
   - 7.5 Remove gloves and wash hands after handling soiled linen and before transporting bagged linen.
8. Maintain appropriate, adequate system for containing soiled linen.
   - 8.1 Provide clean, disinfected, covered linen containers.
   - 8.2 Maintain regular collection and distribution of containers.
   - 8.3 Do not allow containers to become overfilled.
   - 8.4 Do not place any loose linen in the laundry and/or chute. All linen must be bagged.
9. Maintain soiled linen processing area separate from clean linen storage area in the laundry.
10. Use Standard Precautions and personal protective equipment (PPE) as indicated in the laundry.
    - 10.1 Wear gloves when handling and sorting soiled linen.
    - 10.2 Wear gown or apron and mask when sorting visibly soiled linen.
    - 10.3 Remove PPE and wash hands after handling soiled linen and before leaving laundry.
11. Wash and promptly dry clean linen.
12. Reprocess any linen dropped on the floor after washing or drying.
13. Cleanse hands after handling soiled linen and before handling clean linen.

Refer to:

- *Standard Precautions policy*
- *Safety and Health Policies and Procedures:*
  - *Personal Protective Equipment: Assessment Of policy*
  - *Personal Protective Equipment policy*
  - *Hazardous Drugs: Handling, Exposure, Spills, and Disposals policy*

POC Accepted by S. Freeman/J. Kendall on 1/05/22