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

March 6, 2024

Mr. Scott Mow, Administrator
Springfield Health & Rehab
105 Chester Rd
Springfield, VT 05156-2106

Dear Mr. Mow:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **January 10, 2024.** Please post this document in a prominent place in your facility.

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

Sincerely,

PamelaMCotaRN
Pamela M. Cota, RN
Licensing Chief

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGFIELD HEALTH & REHAB	105 CHESTER RD SPRINGFIELD, VT 05156

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E 000	Initial Comments The Division of Licensing and Protection conducted an onsite, unannounced investigation of the facility's compliance with Emergency Preparedness regulations on 1/10/2024 as part of an annual recertification survey. There were no regulatory findings.	E 000	This plan of correction was written to follow state and federal guidelines. It is not an admission of noncompliance. However, it is the facility's commitment to demonstrate and maintain compliance.	
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and complaint investigation, including reports #22540, #22611, and #22619, from 1/8/2024 through 1/10/2024 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to treat the resident with respect and dignity and failed to provide an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 of 5 (Resident # 334).	F 557	F557 Specific Corrective Action 1. Social Services met with resident #334 to ensure their needs are being met with dignity and respect. 2. An audit, by way of resident interviews, was completed to ensure all residents are treated with dignity and respect, including timely response to call bells and being provided the level of assistance requested 3. NHA and/or designee educated all staff on Resident Rights policy and procedure.	

2.

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

NHA | 2-8-24

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

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F 557	Continued From page 1 Findings include: Per record review, Resident #334 was admitted to the facility on 12/29/23 with the following diagnoses: spinal stenosis, rheumatoid arthritis, morbid obesity, and end-stage renal disease. An activities of daily living (ADL) care plan initiated on 12/29/23 reflects that the resident requires assistance/is dependent for ADL care related to limited mobility. Her/his Brief Interview for Mental Status (BIMS) score is 15, suggesting that s/he is cognitively intact. Per interview on 1/9/2024 at 8:30 AM, Resident # 334 indicated s/he had back pain and painful joints due to their arthritis, making it challenging to move around and care for her/him self. S/he feels limited in mobility and thinks that the Licensed Nursing Assistants (LNA) don't understand and tell her/him , "You are not disabled; you should help yourself and not make us do all the work." S/he states that s/he was not feeling well during an evening shift and asked for assistance. The LNA was gone for a long time, s/he vomited and had to clean themself up. An LNA told them, "s/he was on the light too much." Per interview with the Unit Manager (UM) on 1/10/24 @ 4:20 PM, s/he states that resident #334 goes to dialysis and returns during the dinner hour, often feeling nauseated and requiring immediate attention. S/he did not have immediate recall of this specific incident but could easily see how this might happen, s/he also states Resident #334 is new to the facility, and the staff may not be familiar with her/his habits. An interview with the Market Operations Advisor on 1/10/23 at approximately 4:40 PM, where s/he	F 557	F557 continued.. 4. NHA and/or designee to randomly audit weekly x4 weeks then monthly x3 months to ensure residents are treated with dignity and respect. The results of this monitoring will be reviewed in QAPI with any corrective actions indicated. Date of Compliance 2/22/2024 **Tag F 557 POC accepted on 2/5/24 by K. Ruffe/P. Cota**	

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F 557	Continued From page 2 confirmed Resident #334 was not treated with dignity and respect.	F 557		
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 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.	F 578	F578 Specific Corrective Action 1. Resident #9's advanced directive and care plan has been updated to reflect their choice 2. An audit was completed to ensure all advanced directives are current to the residents' choice. 3. NHA and/or designee to educate Social Services on the Advance Directive Policy and Procedure. 4. NHA and/or designee to randomly audit advanced directives weekly x4 then monthly x3 to ensure accuracy. The results of this monitoring will be reviewed in QAPI with any corrective actions indicated. Date of Compliance 2/22/24 **Tag F 578 POC accepted on 2/5/24 by K. Ruffe/P. Cota**	

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F 578	Continued From page 3	F 578		

(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 interview and record review the facility failed to ensure that a Resident's choice regarding life sustaining treatment was updated on their COLST (clinician's order or orders for treatment or limitation of treatment such as intubation (insertion of a tube through a person's mouth or nose, then down into their trachea to open the airway and allow passage of air), mechanical ventilation (a machine that takes over the work of breathing when a person is unable to breath on their own), transfer to hospital, antibiotics, artificially administered nutrition, or other medical intervention) for one of 23 residents (resident #9).

Per record review Resident #9 has a COLST that was signed on 12/13/2022 that reflects that Resident #9 would want a trial course in intubation and ventilation treatment if s/he were in respiratory distress. On 10/27/24 Resident #9 requested a change to their COLST to remove their previous choice to trial intubation and ventilation. A care plan meeting note written on 10/27/2023 that lists attendees as Resident #9, the Ombudsman, Wound Care Nurse, Director of Nursing, Business Office Manager, Activities Director, Social Services Director (SSD) and, Nurse Practitioner states "COLST reviewed. Will need to be updated as [Resident #9] no longer wants intubation. Ombudsman states [s/he] will come back to update VT (Vermont) advanced

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F 578	Continued From page 4 directives." Per record review a care plan focus initiated on 6/12/23 and revised on 9/21/23 states Resident #9 has an established advanced directive/living will and is a DNR (Do Not Resuscitate), and Resident #9 or healthcare decision maker shall participate in decisions regarding medical care and treatment through next review. Code Status: DNR. Allow opportunities for expression of feelings and ask questions. Inform resident/patient and/or healthcare decision maker of any change in status or care needs. During an interview with the Social Services Director (SSD) on 1/10/24 at 10:32 AM when asked about the notes reflecting that Resident #9 had requested changes to her/his advanced directives. The SSD stated that s/he had discussed this with Resident #9 and informed her/him that s/he could reach out to the Ombudsman for assistance or if she went back to the hospital they could make changes there but the SSD was unable to do it here. During interview on 1/10/24 at 11:22 AM the Clinical Market Lead confirmed that it was the expectation that the SSD assist residents with their Advanced Directives and to ensure that residents' COLSTs were updated to reflect their choices with life sustaining treatment.	F 578		
F 584 SS=D	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	F 584	F584 Specific Corrective Action 1. Resident #40’s room is comfortable and homelike. The facility has ensured that the resident can receive care and services safely and that the physical layout of the resident’s room maximizes the resident's independence and does not pose a safety risk. The resident’s care plan has been updated	

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F 584	Continued From page 5 supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, 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 upon observation, interview, and record review, the facility failed to provide a comfortable	F 584	F584 continued.. 2. An audit of resident rooms was completed to ensure they were comfortable and homelike per their choice. 3. NHA and/or designee to educate IDT staff on a comfortable and homelike environment. 4. NHA and/or designee to randomly audit resident rooms weekly x4 weeks then monthly x3 months in a comfortable and homelike environment. The results of this monitoring will be reviewed in QAPI with any corrective actions indicated. Date of Compliance 2/22/2024 **Tag F 584 POC accepted on 2/5/24 by K. Ruffe/P. Cota**	

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F 584	Continued From page 6	F 584		

and homelike environment for 1 resident [Res.#40] of 32 sampled residents.
Findings include:

Review of Res.#40's Care Plan reveals the resident is assessed as "exhibits or has the potential to
exhibit physical behaviors such as hitting and banging the wall, rearranging furniture, related to: Cognitive Loss/Dementia with psychotic features and primary open-angle glaucoma, bilateral, severe stage" [damage to the Optic nerve that leads to vision loss]. Care Plan interventions for this include "Have minimal decorations in resident's room due to resident behavior/glaucoma" along with "Facility will secure dresser to the wall" [marked as "Resolved" on 1/2/24].

Per observation of Res.#40's room on 1/8/24, the room contained a single bed, a chair, and a nightstand located across the room from the bed with 4 books stored on a shelf below the nightstand drawer. There was no dresser in the room. The walls in the room were bare, with no artwork, posters, personal items, or activity calendar. There was no TV, radio, or CD player visible. There was no phone in the room. The room contained no mirror, and no personal items present except for a baby doll on the resident's bed, which contained a fitted sheet, no cover sheet, a single pillow, and a blanket.

An interview was conducted with the facility's Marketing Clinical Advisor on 1/9/24. The Marketing Clinical Advisor confirmed that the resident's room does not contain a TV, radio, or CD player which are listed as preferred activities on the resident's Care Plan. The Marketing

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F 584	Continued From page 7 Clinical Advisor also confirmed that the walls in the room were bare, with no artwork, posters, or activity calendar. There was no phone in the room, and the room contained no mirror, no shelves and no personal items. The Marketing Clinical Advisor reported that the resident had previously pulled on items in the room but confirmed there were no progress notes in the resident's record documenting that behavior. The Marketing Clinical Advisor also confirmed though the resident's Care Plan listed a dresser secured to the wall, there was no dresser present in the room. The Marketing Clinical Advisor confirmed Res.#40's room was not "comfortable or homelike".	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656	F656 Specific Corrective Action 1. Resident #6's care plan has been updated with communication needs. 2. An audit of hearing impaired residents was completed to ensure a care plan was in place with communication needs. 3. NHA and/or designee to educate the IDT team on Communication: Special Needs Policy and Procedure. 4. Social Service and/or designee to randomly audit weekly x4 and then monthly x3 for communication needs of hearing impaired residents. The results of this monitoring will be reviewed in QAPI with any corrective actions indicated.	

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F 656	Continued From page 8 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review the facility failed to develop a comprehensive care plan related to the communication needs of one hearing impaired resident (Resident #6) in the sample. Findings include: During interview with Resident #6 on 1/9/24 at 10:10 AM s/he stated loudly "I can't hear you." When asked if s/he had hearing aids, Resident #6 stated "I don't read lips." Resident #6 smiled, shrugged her/his shoulders, and shook her/his	F 656	Date of Compliance 2/22/24 **Tag F 656 POC accepted on 2/5/24 by K. Ruffe/P. Cota**	

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F 656	Continued From page 9 head. Per record review Resident #6 was admitted to the facility with a significant hearing impairment. Activities care plan initiated by the Director of Recreation on 10/16/23 states "would benefit from accommodation for hearing loss by using communication board, placement near speaker/leader, use of amplifiers/headphones and written instructions/gestures. On 1/10/24 the care plan was updated to reflect impaired communication as evidenced by impaired hearing. Intervention included "Ensure that resident has [his/her] hearing aids in ears during day time hours, as [s/he] allows. Speak in normal tone voice clearly and slowly. Reduce external noise when communicating with patient (i.e. Turn off TV or radio) and Speak facing the patient." However, the care plan did not address communication needs related to hearing loss or interventions related to the use of a hearing aide since admission until 1/10/24. Per interview with the Social Service Director (SSD) on 1/10/24 at 10:45 AM Resident #6 does utilize hearing aides and a white board for communication when s/he is having trouble hearing staff. The SSD confirmed that Resident #6's care plan had not addressed communication needs or interventions related to hearing loss.	F 656		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of	F 679	F679 Specific Corrective Action 1. The Activities Director and/or designee met with resident #40 and updated their activity care plan per their choice	

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F 679	Continued From page 10 activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based upon observation, interview, and record review, the facility failed to provide appropriate activities per the resident's plan of care for 1 resident [Res. #40] of 32 sampled residents. Findings include: Per review of Res.#40's medical record, the resident was admitted to the facility with diagnoses that include Glaucoma [damage to the Optic nerve that leads to vision loss] and Adjustment Disorder with Depressed Mood. Per observation, the resident resides in a room by themselves with a single bed and no roommate. Review of Res.#40's Care Plan reveals the resident is assessed as "While in the facility, [Res.#40] states that it is important that [they] have the opportunity to engage in daily routines that are meaningful relative to [their] preferences", with the Care Plan Goal that the resident "should attend/participate in activities of choice 3 times weekly". Care Plan interventions include "I enjoy listening to music and prefer country, 60's, 70's, 80's on the radio, CD player, and live entertainment", "I keep up with the news by discussions with another person, group discussions and listening to the radio", "I enjoy watching/listening TV", "Invite and assist [Res.#40], as needed, to activities of interest" [the Care Plan Goal notes the resident "enjoys Bingo"], and "Provide	F 679	F679 continued... 2. An audit was completed to ensure residents' activity care plan reflects their choice. 3. NHA and/or designee to educate the Activity's Department on Care Plan policy and procedure 4. Activity's Director and/or designee to randomly audit activity care plans weekly x4 weeks then monthly x3 months for resident activity choice. The results of this monitoring will be reviewed in QAPI with any corrective actions indicated. Date of Compliance 2/22/24 **Tag F 679 POC accepted on 2/5/24 by K. Ruffe/P. Cota**	

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(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 679	Continued From page 11	F 679		

[Res.#40] one-to-one visits 1-2 times per week, individualized to [their] interests and needs".
Per observation of Res.#40's room on 1/8/24, there was no TV, radio, or CD player visible. There was no phone in the room. There were no personal items present except for a baby doll on the resident's bed.
Pe observation on 01/9/24 at 2:36 PM, Activities staff were conducting Bingo in the dining room on Res.#40's unit. Doors to the dining room were closed to residents in the unit's hallway. Per observation, during this time Res.#40 was sitting alone on the side of the bed in their room, their used meal tray from the lunch served greater than an hour and a half prior sitting on a bedside table.
Review of Res.#40's One-to-One Activity log- which lists the frequency of One-to-One Activities as "1 to 2 times weekly" reveals no activities documented for January 2024.
For the entirety of 2023, the One-to-One Activity Log lists 11 times total the resident was offered one to one activity.
The 11 times the resident was engaged in activities listed "walked around" [two times], "guided back to her room" [two times], "walked and talked" [two times], "assisted with dinner/walked", "socialized" [two times], "socialized/went for a walk" and "Brief Interview for Mental Status [an assessment used in nursing homes and other long-term care facilities to monitor cognition]- and talked"- listed as an activity.
There are no One to One Activities listed for 7 of 12 months of 2023 [January through May, October, November].
Per review of Res.#40's Quarterly Recreation Evaluation, dated 11/17/23, the resident's "Care Plan goal was achieved ...[Res.#40] does well in

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F 679	Continued From page 12 most areas of activities. [Their] lack of vision and cognitive state limits what [they] can do sometimes and makes it difficult to fully participate ...we will continue to provide 1:1 visits once a week". Per interview with the facility's Activities Assistant and the Marketing Clinical Advisor on 1/9/24, both staff members confirmed that the resident's room does not contain a TV, radio, or CD player which are listed as preferred activities, and that documentation illustrated that Res.#40 did not receive One-to-one activities per the Care Plan, including none documented for 7 of 12 months in 2023, and none documented for 2024 up to the date of the survey.	F 679		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a	F 732	F732 Specific Corrective Action 1.The nursing staffing information is now posted in a prominent place readily accessible to residents and visitors. 2. All residents have the potential to be affected by this deficient practice. 3. NHA and/or designee to educate the IDT team on Posting Staffing policy and procedure. 4. Scheduler and/or designee will audit staff posting data daily x2 weeks then 3 times per week x2 weeks then 3 times bi-weekly x2 weeks then randomly monthly x3 months. The results of this monitoring will be reviewed in QAPI with any corrective actions indicated. Date of Compliance 2/22/24	

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F 732	Continued From page 13 daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based upon observation and interview, the facility failed to post nurse staffing data on a daily basis in a prominent place readily accessible to residents and visitors as required by federal regulation. Findings include: Per observation on Monday, 1/8/24 at 10:24 AM, nurse staffing data dated Friday, 1/5/24 was posted in the facility lobby where all staff, residents, and visitors enter the building. Per interview with the facility's Marketing Operations Advisor, the Advisor confirmed the nurse staff posting observed on 1/8/24 was out of date and did not accurately reflect the facility staffing.	F 732	**Tag F 732 POC accepted on 2/5/24 by K. Ruffe/P. Cota**	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review.	F 756	F756 Specific Corrective Action	

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F 756	Continued From page 14 §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the	F 756	F756 continued.. 1. Resident #5's pharmacy recommendations have been reviewed and documented by the physician for the resident's current plan of care. 2. All residents have the potential to be affected by this deficient practice. 3. DON and/or designee to educate nursing leadership staff on the policy and procedure for monthly pharmacy reports. 4. DON and/or designee to audit monthly pharmacy reports weekly x4 weekly then monthly x3 months. The results of this monitoring will be reviewed in QAPI with any corrective actions indicated. Date of Compliance 2/22/24 **Tag F 756 POC accepted on 2/5/24 by K. Ruffe/P. Cota**	

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F 756	Continued From page 15 facility failed to ensure that irregularities noted during monthly pharmacist medication regimen reviews are documented in a written report for one of 5 sampled Residents (Resident #5). The facility also failed to ensure that the attending physician reviewing the report documents a rationale for not changing the medication according to the pharmacist's recommendations for one of 5 sampled Residents (Resident #5). Findings include: 1. Per record review, Resident #5's medication regimen was reviewed by the pharmacist on 2/1/2023. The Pharmacist Medication Regimen Review note states "Comment/recommendations noted - see report". Per review of pharmacist recommendation reports for Resident #5, no report for February of 2023 could be located. 2. Per record review, the pharmacist recommended an increase in Resident #5's Basal Insulin order on 12/1/2023 through the pharmacist recommendation report. The attending physician marked "disagree" on the report and signed it. Per review of the record, no documented rationale could be found as to why the physician disagreed with this recommendation from the pharmacist. Per interview on 1/10/24 at approximately 2:23 PM, the Market Clinical Lead confirmed that they could not locate a pharmacist recommendation report for February of 2023, nor a physician rationale for the report in December of 2023.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758	F758 Specific Corrective Actions	

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F 758	Continued From page 16 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and	F 758	F758 continued.. 1. Resident #5 psychotropic medications were reviewed by the physician and the plan of care was documented in the resident's medical record. 2. DON and/or designee completed an audit of January's pharmacy report to ensure all recommendations were acted upon with supporting documentation. 3. DON and/or designee to educate nursing leadership staff on Unnecessary Medication policy and procedure. 4. DON and/or designee to audit monthly pharmacy report monthly x3 months to ensure pharmacy recommendations on GDRs are acted up with supporting documentation from the physician. The results of this monitoring will be reviewed in QAPI with any corrective actions indicated. Date of Compliance 2/22/24 **Tag F 758 POC accepted on 2/5/24 by K. Ruffe/P. Cota**	

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indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and record review, the facility failed to ensure that residents who use psychotropic drugs receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue the drugs for one of 5 sampled residents (Resident #5). Findings include:

Per record review, Resident #5 receives the following psychotropic medications:
- Clonazepam (an antianxiety medication) 1mg three times a day
- Trazodone (an antidepressant) 50mg before bed
- Duloxetine (an antidepressant) 120mg once a day
- Latuda (an antipsychotic) 60 mg in the morning and 20mg at bedtime
- Divalproex Sodium (an anticonvulsant used to treat mood disorders) 25 mg once a day

Resident #5 has been on all of these psychotropic medications for over a year. The doses of these medications have either remained the same or have increased over the last year. There is no evidence in Resident #5's record to indicate that the physician has attempted a gradual dose reduction for any of these medications. There is also no documentation from the physician explaining why a gradual dose

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F 758	Continued From page 18 reduction of any of these psychotropic medications would be contraindicated for Resident #5. Per interview on 1/10/24 at approximately 2:30 PM, the Market Clinical Lead confirmed that there is no evidence that gradual dose reductions had been attempted for Resident #5's psychotropic medications.	F 758	F842 Specific Corrective Action 1. The State was provided resident #32's podiatry records showing they received care in June and September. The State was provided a copy of the Infection Preventionists Certificate on 1/17/24. 2. All residents have the potential to be affected by this deficient practice. 3. DON and/or designee to educate Infection Preventionist on maintaining a copy of their certification at the center. DON and/or designee to educate Medical Records on maintaining resident records policy and procedure. 4. Medical Records and/or designee to randomly audit resident records for completeness weekly x4 weeks then monthly x3 months. Medical Records and/or designee to to audit Infection Preventionist's certification weekly x4 weeks then monthly x4 months. The results of this monitoring will be reviewed in QAPI with any corrective actions indicated. Date of Compliance 2/22/24	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;	F 842		

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F 842	Continued From page 19 (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:	F 842	**Tag F 842 POC accepted on 2/5/24 by K. Ruffe/P. Cota**	

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Based on staff interview and record review, the facility failed to ensure that required documentation and medical records are readily accessible. Findings include:

1. Per observation on 1/8/24 at approximately 2:15 PM, Resident #32's toenails were very long, extending approximately 1/3-1/2 inch out from the top of their toes. One of Resident #32's middle toes had grown down and around the top of the toe. Resident #32 stated that this toe was painful.

Per record review, a podiatry request for nail care had been ordered in May of 2023, to be addressed during the Podiatrist's scheduled June 2023 visit to the facility. There are no records to confirm that Resident #32 had been seen that June or at any point after June up until the present.

Per interview on 1/10/24 at approximately 12:00 PM, the Market Clinical Lead confirmed that no records could be located to indicate that Resident #32's toenails had been cut in June of 2023 or any point thereafter, though they believed that evaluations did take place. They confirmed that the records were not currently accessible in the facility and that they would have to wait until the Podiatry clinic was open to access the records.

On 1/11/24 at 5:00 PM, the facility provided the podiatry records showing that Resident #32 received foot care and assessments from the Podiatrist in June of 2023 and September of 2023.

2. Per entrance conference on 1/8/24 at approximately 10:30 AM, the survey team requested a copy of the Infection Preventionist's

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F 842	Continued From page 21 specialized training certification. Per interview on 1/10/24 at approximately 4:30 PM, the Market Clinical Lead confirmed that the Infection Preventionist's certification documentation could not be located in the facility and they would have to get this documentation from the Center for Disease Control and Prevention. On 1/17/24 at approximately 2:30 PM, the facility provided a copy of the Infection Preventionist's training certification.	F 842		
F 882 SS=C	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that the individual who has	F 882	F882 Specific Corrective Action 1. The State was provided a copy of the Infection Preventionists Certificate on 1/17/24 2. All residents have the potential to be affected by this deficient practice. 3. DON and/or designee to educate Infection Preventionist on policy and procedure of Infection Control Program. 4. DON and/or designee to to ensure the Infection Preventionist is overseeing all aspects of the Infection Control and Prevention Program weekly x4 weeks then monthly x3 months. The results of this monitoring will be reviewed in QAPI with any corrective actions indicated. Date of Compliance 2/22/24	

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F 882	Continued From page 22 completed the specialized training in infection prevention and control oversees the facility's infection prevention and control program. Findings include: Per interview on 1/8/24 at approximately 10:30 AM, the DON (Director of Nursing) stated that the former IP (Infection Preventionist) was Nurse 1, who has since transitioned to work full time as the facility's wound nurse. While Nurse 1 is still kept up to date on the goings-on of the IPCP (infection prevention and control program), they are no longer overseeing the IPCP. The DON stated that they are taking primary accountability of ensuring all delegated IPCP tasks are being completed, along with the Administrator. The DON confirmed that they have not completed their specialized infection prevention and control training at this time. Per interview on 1/10/24 at approximately 4:30 PM, the Market Clinical Lead confirmed that while Nurse 1 has completed the specialized infection prevention and control training and was previously the facility's IP, they no longer oversee the IPCP. They also confirmed that the DON is currently overseeing the IPCP and will complete their specialized training shortly, but that they have not done so yet.	F 882	**Tag F 882 POC accepted on 2/5/24 by K. Ruffe/P. Cota**	
F 887 SS=C	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the	F 887	F887 Specific Corrective Action 1. The center will maintain documentation on the following: -The staff has been provided with education regarding the benefits and potential risks associated with Covid-19 vaccine. -The staff has been offered the Covid-19 vaccine or information on obtaining the Covid-19 vaccination. -The Covid-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).	

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(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 887	Continued From page 23 immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that	F 887	2. All residents have the potential to be affected by this deficient practice. 3. DON and/or designee to educate the Infection Preventionist on maintaining documentation related to staff Covid-19 vaccination. 4. DON and/or designee to audit staff Covid-19 vaccination documentation weekly x4 weeks then monthly x3 months. The results of this monitoring will be reviewed in QAPI with any corrective actions indicated. Date of Compliance 2/22/24 **Tag F 887 POC accepted on 2/5/24 by K. Ruffe/P. Cota**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475025	A. BUILDING _____ B. WING _____	C 01/10/2024

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F 887	Continued From page 24	F 887		

includes at a minimum, the following:
(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;
(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and
(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).
This REQUIREMENT is not met as evidenced by:
Based upon interview and record review, the facility failed to maintain documentation related to staff COVID-19 vaccination that includes at a minimum, the following:
(A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine;
(B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and
(C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN).
Findings include:
During the facility's Recertification Survey conducted 1/8 - 1/10/24, the facility was asked to provide documentation related to staff COVID-19 vaccination as required by Long Term Care federal regulations. Per interview with the facility's Marketing Operations Advisor on 1/9/24 at 5:13 PM, the facility did not have any of the required documentation.