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

September 13, 2021

Mr. Ross Farnsworth, Administrator
St Johnsbury Health & Rehab
1248 Hospital Drive
Saint Johnsbury, VT 05819-9248

Dear Mr. Farnsworth:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **August 11, 2021.** Please post this document in a prominent place in your facility.

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

Sincerely,

Pamela M. Cota, RN
Licensing Chief

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475019 | A. BUILDING _____ B. WING _____ | C 08/11/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ST JOHNSBURY HEALTH & REHAB | 1248 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819 |

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| E 000 | Initial Comments<br><br>A review of Emergency Preparedness requirements was conducted by the Division of Licensing and Protection on 8/11/21, during the recertification survey. The facility is in substantial compliance with the Emergency Preparedness requirements. | E 000 | F000<br>The filing of this plan of correction does not constitute an admission of the allegations set forth in the statements of deficiencies.<br>St. Johnsbury Health & Rehab has prepared and executed a plan of correction as evidence of the facilities' continued compliance with applicable federal and state laws. | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced on-site recertification survey was conducted in conjunction with a complaint investigation by the Division of Licensing and Protection on 8/9 -8/11/21 at St. Johnsbury Health and Rehabilitation Center. There were regulatory violations identified. | F 000 | | |
| F 550 SS=E | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the | F 550 | F550<br>Residents #55, 18, 47, 12, 32, 46, 62, 58, 2, 38 affected by this alleged deficient practice have been eating in their location of choice. Other residents could be affected by this alleged deficient practice.<br><br>A whole house audit was completed to ensure residents preferences were met regarding location for meals.<br><br>The Administrator or designee will conduct random audits weekly x 4 weeks, and monthly x 3 months to ensure residents were dining in their place of choice and hallways are free of clutter.<br><br>All licensed staff, dietary staff and the ancillary staff that help during meals have been re-educated on Residents Rights and ensuring residents are treated with respect and dignity, Policy OPS206.<br><br>The Administrator or designee will conduct random weekly x 4 weeks, and monthly x 3 months to ensure nursing procedures not administered during meal service.<br><br>Audit results will be reviewed at QAPI and recommendations will be made as needed.<br><br>Completion date: September 15, 2021<br><br>**TAG F 550 POC Approved 9/13/21 by T. Dougherty/P.Cota** | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ross Farnsworth | TITLE: Administrator | (X6) DATE: 9/3/2021

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

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| F 550 | Continued From page 1 | F 550 | | |

provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, and staff interviews the facility failed to ensure that 10 applicable residents (#55, 18, 47,12, 32, 46, 62, 58, 2, 38 ) were treated with respect and dignity in the manner in an environment that promotes maintenance or enhancement of his or her quality of life. Findings include:

Per observation on 08/09/21 at 12:04 PM, 9 residents (#55, 18, 47, 12, 32, 46, 62, 58, 2) on B2 Wing were lined up on one side of the hallway waiting for the noon meal. The Residents were set up with tray tables in front of or beside them. The hallway was cluttered, with a clean linen cart, blood pressure monitor, hydration cart, a medication cart, 2 unused wheelchairs, a Hoyer lift and 4 dining room chairs (being used by residents for meals). There were 2 Licensed

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| F 550 | Continued From page 2<br>Nursing Assistants (LNAs) working on the B2 hallway. The Meal Cart arrived on the unit at 12:05 PM. The final meal was served at 1:12 PM. Meals were served in a seemingly random order. The residents sitting in the hallway were not being served at the same time. Resident # 38 was observed wheeling his/herself out of her room 3 times asking for his/her tray. His/her roommate had already been served and had finished his/her meal. There were minimal interactions between residents and staff to residents during the noon meal service.<br><br>On 8/10/21 at 12:01 PM, A B2 Wing nurse was observed performing a finger stick on Resident # 58 during the noon meal service. The nurse was then observed administering insulin into Resident # 58"s abdomen while Resident #58 was eating his/her meal in the hallway in plain view of other residents. Resident #23 was observed eating in his/her room while the unit nurse and 2 LNAs did a dressing change on his/her roommate.<br><br>During interview with the Director of Nursing (DNS) 8/10/21 at 2:00 PM, the DNS agreed that performing a finger stick and administering insulin during the noon meal service was not her expectation and that the noon meals on both days did not afford the resident's dignity. | F 550 | | |
| F 583 SS=E | Personal Privacy/Confidentiality of Records<br>CFR(s): 483.10(h)(1)-(3)(i)(ii)<br><br>§483.10(h) Privacy and Confidentiality.<br>The resident has a right to personal privacy and confidentiality of his or her personal and medical records.<br><br>§483.10(h)(l) Personal privacy includes | F 583 | | |

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| F 583 | Continued From page 3<br>accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.<br><br>§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.<br><br>§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.<br>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.<br>(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to ensure the privacy and confidentiality of patient medical information.<br><br>Findings include:<br><br>On 08/10/21 at 08:45 am during observation of a medication administration pass on unit A 1-14, nurse A was noted to leave her workspace at the medication cart while leaving behind an open | F 583 | F583<br>Multiple residents could be affected by this alleged deficient practice. The nurse involved was provided on the spot re-education as she is a new graduate LPN.<br><br>All licensed nurses were reeducated on Personal Privacy/Confidentiality of Records, Policy OPS 209.<br><br>The DNS or designee will conduct random audits weekly x 4 and monthly x 3 months to ensure privacy/confidentiality of resident medical records are maintained.<br><br>Audit results will be reviewed at QAPI and recommendations will be made as needed.<br><br>Completion date: September 15, 2021<br><br>**TAG F 583 POC Approved 9/13/21 by T. Dougherty/P.Cota** | |

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| F 583 | Continued From page 4<br>computer screen and easy access to multiple residents' medical information, as well as a paper list of all resident names and information in clear public view. This nurse confirmed that s/he breached the privacy of residents' personal medical records. | F 583 | | |
| F 584 SS=E | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>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.<br><br>The facility must provide-<br>§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.<br>(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.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); | F 584 | F584<br>Residents on B2 Wing were affected by this alleged deficient practice. Other residents could be affected by this alleged deficient practice.<br><br>A whole house audit was completed to ensure residents preferences were met regarding location for meals. The dining room was reopened for the next day to allow residents to enjoy meals in a more homelike environment.<br><br>The Administrator or designee will conduct random weekly x 4 weeks, and monthly x 3 months to ensure<br>1. Residents are eating in their place of preference for a homelike dining experience and<br>2. Nursing procedures not administered during meal service.<br><br>Audit results will be reviewed at QAPI and recommendations will be made as needed.<br><br>Completion date: September 15, 2021<br><br>**TAG F 584 POC Approved 9/13/21 by T. Dougherty/P.Cota** | |

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§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, the facility failed to ensure that residents have a homelike environment. Findings include:

Per observation on 8/9/2021 and 8/10/2021 on B2 Wing, the noon meal service did not provide a comfortable and homelike environment. Per observation on 8/9/21 at 12:00 PM, several residents were lined up on one side of the hallway with trays on each side or in front of each other in preparation of the noon meal to be delivered. These residents were facing the opposite wall containing minimal decorations. Spacing between residents did not allow for personal interaction due to spacing and placement of their chairs or wheelchairs in a line. There were minimal interactions observed among residents and or staff due to the linear set up of the noon meal services.

Per observations on 8/9/21 and 8/10/21, items in the hallway included; a clean linen cart, blood pressure monitor, hydration cart, a medication cart, 2 unused wheelchairs, a Hoyer lift and 4 dining room chairs (being used by residents for meals). Observation of multiple staff maneuvering in and out of hallway during noon

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| F 584 | Continued From page 6<br>meal service included; B2 Wing nurse administering medications during the noon meal service, laundry staff delivering laundry to residents rooms, and housekeeping was observed entering and exiting residents rooms cleaning. On 8/9/21, a Licensed Nurse Aide (LNA) was observed carrying clear trash bags with soiled briefs and used wound care dressings, through the hallway during the noon time meal. During interview with the Director of Nursing (DNS) on 8/11/21 at 1:40 PM, the DNS agreed that the hallway meal time seating arrangement was not very homelike for the residents on B2 Wing. | F 584 | | |
| F 604 SS=D | Right to be Free from Physical Restraints<br>CFR(s): 483.10(e)(1), 483.12(a)(2)<br><br>§483.10(e) Respect and Dignity.<br>The resident has a right to be treated with respect and dignity, including:<br><br>§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).<br><br>§483.12<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must- | F 604 | F604<br>Resident 45 could have been affected by this alleged deficient practice.<br>Other wheel chair bound residents could be affected by this alleged deficient practice.<br><br>A whole house audit was completed on 8/11/21 inspecting all wheelchairs in Center both in use and any spare wheelchairs that could be put in use to ensure no device was attached to the chair that could be used as a restraint.<br><br>All licensed staff, therapy staff and maintenance staff we re-educated on the Restraint Policy NSG233 as the center is committed to remaining restraint free.<br><br>The Administrator or designee will audit all new/donated wheelchairs weekly x 4 , and then monthly x 3 months to ensure wheelchairs have no device attached to the chair that could be used as a restraint.<br><br>Audits will be reviewed at QAPI and recommendations will be made as needed.<br>Completion date: September 15, 2021<br><br>Type text here | |

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| F 604 | Continued From page 7<br>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure that residents are free from physical restraints that are not required to treat a resident's medical symptoms for one of 20 residents (Resident 45). Findings include:<br><br>1. Per observation on 8/9/21 at 10:18 AM, Resident 45 was sitting in a specialized, personal wheelchair in the hallway outside of their room. Resident 45 was observed to have a fastened lap belt over their lap with their left hand wedged underneath the belt. The left hand had contractures (chronic rigidity of the joints resulting in a tight fist). At 10:22 AM, an LNA (licensed nursing assistant) approached the resident and unfastened the lap belt before walking away. The LNA was overheard saying "I just noticed it" to their coworker.<br><br>Record review shows that there is no evidence of any assessment for a lap restraint or lap positioning device, no order for a lap restraint or lap positioning device, or any other mention of a lap restraint or lap positioning device in the EHR. Resident 45 does not use bed rails to aid in repositioning or care. | F 604 | **TAG F 604 POC Approved 9/13/21 by T. Dougherty/P.Cota** | |

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Review of Resident 45's record shows diagnoses of Hemiplegia and Hemiparesis (paralysis of one side of the body) following Cerebral Infarction (stroke) Affecting Left Non-Dominant Side, Sequelae of Cerebral Infarction, and Weakness. Review of Resident 45's Functional Abilities Assessment from 7/2/21 at 9:53 AM shows that Resident 45 is completely dependent or requires maximal assistance for all activities of daily living except eating. Eating requires supervision. Resident 45's Minimum Data Set assessment information from 7/2/21 also shows that Resident 45 is completely dependent or requires maximal assistance for all activities of daily living except eating. Review of Resident 45's care plan shows an intervention that reads "requires one staff participation to eat. Requires set up assistance and may require physical assist at times" under the care plan focus for "ADL self-care performance deficit related to history of CVA (stroke), impaired physical mobility". This intervention was initiated on 03/22/2021 and revised on 04/21/2021.

Per interview on 8/9/21 at 2:00 PM, the LNA who unfastened the lap belt stated that during Resident 45's morning care, they noticed that there was a lap belt on the wheelchair and fastened it. The LNA stated that residents who are care planned for a lap belt need to have it fastened when in their wheelchairs, so they "just assumed" that it needed to be fastened. They confirmed that they did not check the Resident's record before doing so. The LNA stated that they came back to unfasten the belt once they were informed by their manager that Resident 45 was not care planned for the lap belt. The LNA stated they did not know why or how it was put onto the wheelchair originally.

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| F 604 | Continued From page 9<br><br>Per interview on 8/9/21 at approximately 2:05 PM, the LPN responsible for Resident 45's care confirmed that there was a lap belt on the wheelchair but could not identify the reason for it. They reviewed the resident's chart and confirmed that there was no order for the belt or any other mention of the lap belt in the record.<br>Per interview on 8/9/21 at 2:30 PM, the Unit Nurse Manager confirmed that they were aware of the lap belt on Resident 45's chair and confirmed that there is no mention of it in the record. The Unit Nurse Manager stated they do not know why there is a lap belt on the wheelchair.<br><br>Per two observations on 8/10/21 at 10:00 AM and 4:00 PM, the lap belt was still affixed to Resident 45's wheelchair. Resident 45 was not in the wheelchair either time. Visual inspection of the lap belt showed that it was not a permanent fixture on the chair.<br><br>Per interview on 8/11/21 at 11:45 AM, the Director of Nursing (DON) confirmed that it is unlikely that Resident 45 would be able to unfasten the lap belt by themselves, given their condition, and that a lap belt is not indicated for Resident 45's condition. The DON also confirmed that they were unaware of why or how the lap belt was placed on Resident 45's wheelchair. | F 604 | | |
| F 725 SS=E | Sufficient Nursing Staff<br>CFR(s): 483.35(a)(1)(2)<br><br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure | F 725 | | |

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| F 725 | Continued From page 10<br>resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interviews, the facility failed to ensure there was sufficient qualified nursing staff available at all times, particularly on the B2 unit during meal service, to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental and psychosocial well-being.<br><br>Findings Include:<br><br>Per observation of the noon meal on 08/09/21, there was insufficient nursing staff to meet resident dining needs. Observations of the noon | F 725 | F725<br>Residents 55, 18, 47, 12, 32, 46, 62, 58 continue to reside on B2 Wing were affected by this alleged deficient practice. Other residents could be affected by this alleged deficient practice.<br><br>A whole house audit was completed to ensure residents preferences were met regarding location for meals.<br><br>All licensed nursing staff have been re-educated on the revised dining process and effective use of staff during meals.<br><br>The Administrator or designee will conduct random audits of meals being served in dining room with nursing staff supervision completed weekly x 4 weeks, and monthly x 3 months.<br><br>Audits will be reviewed at QAPI and recommendations will be made as needed.<br><br>Completion date: September 15, 2021<br><br>**TAG F 725 POC Approved 9/13/21 by T. Dougherty/P.Cota** | |

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meal on B2 Wing occurred between 12:00 PM - 1:12 PM. Nine residents (#55, 18, 47,12, 32, 46, 62, 58, 2) were brought into the hallway for the noon meal. The food cart to B2 Wing arrived at 12:05 PM. The last meal on B2 Wing was served at 1:12 PM. Resident # 38 was observed during this time frame to be wheeling his/herself out of his/her room 3 times asking for his/her tray. His/her roommate had already been served and had finished his/her meal at the time of the observations. Resident # 23 was observed eating in his/her room while the B2 Wing unit nurse and 2 LNAs were doing a dressing change on his/her roommate. The 2 LNAs were observed toileting another resident during the noon meal service, interrupting the passing of trays.

A unit LNA stated in a 08/09/21, 02:30 PM interview that B2 is his/her normal assigned unit and that 2 LNAs is the normal assignment for the B2 Unit. The LNA stated hat there are 8 residents requiring 2 person assist on the unit. The LNA also stated that h/she has asked the Director of Nursing Services (DNS) several times for a third LNA on the unit with no success. The LNA stated that they often have to interrupt passing meal trays to provide resident care. The LNA also states that other staff are rarely available to will assist with meal service.

A second B2 unit LNA stated that residents have been eating in the B2 Wing hallway for approximately one and a half months. The LNA stated some residents do not want to come out into hallway to eat, and therefore will stay in their rooms. H/she stated that there are 3 residents that need to be fed and have to wait to be fed in their rooms. Stated the residents had started to go to the dining room a few months ago, but then

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| F 725 | Continued From page 12<br>it stopped and is unsure why.<br><br>On 08/10/21 at 08:50 AM a 3rd B2 unit LNA stated that the unit is supposed to have 3 LNA's but "there are many times when there are only two of us on". The LNA added "it is easier for us to keep eyes on the residents in the hall when they are eating, it's just easier for us". | F 725 | | |
| F 759 SS=E | Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)<br><br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and record review, the facility failed to ensure that its medication error rates are not 5 percent or greater as evidenced by two medication administration omissions and one administration of an incorrect dose of medication for one resident (Resident 25). Findings include:<br><br>1. Medication pass was observed for 4 residents (36, 44, 25, and 45) on 8/10/21 starting at approximately 8:00 AM. The LPN administering the medications was instructed to hand the containers of medication (either in bottles or bubble packs) to this surveyor following the placement of the medication dose into the medication cup. The LPN was also instructed to verbally confirm how many individual pills were being placed into the medication cup for each type of medication being administered. This surveyor documented each individual medication | F 759 | F759<br>Residents 25, 36, 44, and 45 were affected by this alleged deficient practice. Other residents could be affected by this alleged deficient practice.<br><br>Education was provided to licensed nursing staff on medication administration policy NSG 305. All licensed nursing staff completed medication administration competency.<br><br>Director of Nursing or designee will conduct random audits of medication administration passes weekly x 4, and then monthly x3 to ensure medication error rates are not 5 percent or greater.<br><br>Audits will be reviewed at QAPI and recommendations will be made as needed.<br><br>Completion date: September 15, 2021<br><br>**TAG F 759 POC Approved 9/13/21 by T. Dougherty/P.Cota** | |

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administered, including the number of pills and the amount of medicine in each individual pill, and observed the administration process from start to finish (which included the placing of pills in the cup, the documenting of each medication as "administered", and the actual administration of each medication into the resident's body as appropriate). The LPN's medication administration practice involved placing all pills for each different type of medication in the medication cup, followed by documenting each medication as "administered" in the electronic medication administration record. The LPN was observed to place multiple different medications into the cup at one time without referencing the medication administration record (MAR) between medications. There were a total of 35 separate medications observed to be administered (also called "opportunities" for medication administration).

Resident 25 was observed and documented to have been given 13 different types of medications. The medications administered included two 500 milligram (mg) tablets of acetaminophen, one 325 mg tablet of iron, one 400 mg tablet of magnesium oxide, one tablet of acidophilus, one 5mg tablet of donezapil, one 1 mg tablet of folic acid, one 800mg tablet of metaxalone, one 25 mg tablet of metoprolol, one 50 mg tablet of sertraline, one 0.4mg tablet of tamsulosin, one tablet of vitamin B complex, and two 500 microgram (mcg) tablet of vitamin B12. In addition, one pill of prednisone (a medication used to treat inflammation) was administered. Each pill contained 5 mg of prednisone, making 5 mg the total dose of prednisone administered to resident 25.

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Per review of Resident 25's MAR and physician orders following the observation of medication administration, prednisone was ordered as follows: "predniSONE Tablet 5 MG Give 3.5 tablet by mouth one time a day for chronic hip pain [3.5 tablets = 17.5 mg] give with/after food -Start Date- 07/18/2021 0800). The LPN documented the administration of the ordered dose of prednisone despite the observation/documentation of only 5 mg being administered. There were also two additional medications scheduled on the MAR for 8:00 AM with a physician's order that were omitted from the observed medication administration for resident 25. These included the following orders: "Multivitamin Tablet [Multiple Vitamin] Give 1 tablet by mouth one time a day for supplement -Start Date- 06/08/2021 0800" and "Pantoprazole Sodium Tablet Delayed Release 40 MG Give 1 tablet by mouth one time a day for GERD -Start Date- 06/08/2021 0800". The LPN documented the administration of both of these medications despite the observation/documentation of neither of these medications being administered.

Per interview on 8/10/21 at approximately 4:00 PM, this surveyor brought the observed errors to the attention of the LPN for discussion. The LPN stated that they believed they had administered the medications correctly. This surveyor requested to see the containers for the 3 medications.

This surveyor confirmed that the bottle of multivitamins had not been observed/documented to be removed from the medication storage cart at all during medication preparation.

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There was no bubble pack for the pantoprazole sodium tablets for Resident 25 in the medication storage cart, either in the drawer of medications currently being administered or in the drawer of back-up bubble packs. The LPN stated that they may have given the last dose of the pantoprazole in a bubble pack and then thrown away the empty pack. This surveyor did not observe any empty bubble packs handed them, nor any bubble packs being disposed of or set aside on the medication cart during medication administration. There were also no empty bubble packs of pantoprazole for Resident 25 in the section of the cart designated for Resident 25. The LPN confirmed that they could not remember if they had observed or disposed of an empty bubble pack specifically for Resident 25's pantoprazole.

The bubble pack of prednisone for Resident 25 only contained whole 5 mg pills. In order to properly administer 3.5 pills of prednisone as ordered by the physician, one of the whole 5mg pills would have needed to be split in half with a device for splitting pills. This surveyor did not observe the splitting of any pills for any resident during administration. The LPN stated "I did not split a pill. That was my error."

35 opportunities for medication administration were observed by this surveyor with one incorrect dose. The two medication administration omissions count as two additional opportunities for medication administration. Another surveyor observed 13 opportunities for medication administration without any errors. The total number of opportunities for medication administration total 50 with three errors, making the facility error rate 6%.

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| F 761 SS=D | Continued From page 16<br>Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, patient medications were not labeled with open or use by dates as a precautionary measure in accordance with accepted professional standards for one resident (Resident # 4).<br><br>Findings include the following:<br><br>On 08/10/21 at 08:45 am during inspection of a | F 761<br>F 761 | F761<br>Resident #4 was affected by this alleged deficient practice. Other residents receiving insulin could be affected by this alleged deficient practice.<br><br>A whole house audit was completed on 8/12/21 to ensure insulin pens were dated upon opening and labeled with appropriate expiration dates.<br><br>Education was provided to all licensed nursing staff on policy NSG304.<br><br>Director of Nursing or designee will complete audits of medication carts to ensure insulin medication are dated when opened and are labeled with appropriate expiration dates weekly x4, then monthly x 3.<br><br>Audits will be reviewed at QAPI and recommendations will be made as needed.<br><br>Completion date: September 15, 2021<br><br>**TAG F 761 POC Approved 9/13/21 by T. Dougherty/P.Cota** | |

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| F 761 | Continued From page 17<br>medication cart on unit A 1-14, there were no open dates on two insulin pens for Resident # 4. The resident is prescribed to use a Basalgar Kwik pen which must be used within 28 days. A Victoza Pen-Injector is also prescribed which must be used within 30 days. Nurse A confirmed that there were no open or use by dates indicated and s/he was not aware that there should be. | F 761 | | |
| F 802 SS=E | Sufficient Dietary Support Personnel<br>CFR(s): 483.60(a)(3)(b)<br><br>§483.60(a) Staffing<br>The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.60(a)(3) Support staff.<br>The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.<br><br>§483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii).<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interviews, the facility failed to ensure that there was sufficient dietary staff to safely and effectively allow for dignified dining experiences for residents.<br><br>Findings include: | F 802 | F802<br>Dining Room service resumed on 8/11/21.<br><br>A whole house audit was completed to ensure residents preferences were met regarding location for meals.<br><br>The Administrator or designee will conduct random audits weekly x 4 weeks, and monthly x 3 months to ensure residents were dining in their place of choice<br><br>Audit will be the calendar checked off daily that dining room service occurred for at least two meals a day, seven days a week. If the dining room service has to be cancelled the Administrator/DNS is to be notified prior to.<br><br>Audits will be reviewed at QAPI and recommendations will be made as needed.<br><br>Completion date: September 15, 2021<br><br>**TAG F 802 POC Approved 9/13/21 by T. Dougherty/P.Cota** | |

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| F 802 | Continued From page 18<br><br>During surveyors' observations during the lunch hour on 08/09/21, it was noted that all dining rooms were closed to residents. Many residents were eating in their rooms while others were eating in the halls outside their doorways.<br><br>Per interview on 08/10/21 at 7:30am, the kitchen manager stated they are "working hand in hand with the administrator and his team to get more Licensed Nursing Assistants (LNA) because we have not had the proper help to have residents in the dining room. It's been challenging with hiring. We are actively hiring in the dietary department, not due to call outs but due to staff leaving for other jobs." Per the dietary corporate manager, two staff are not available due to medical needs and sickness.<br><br>Review of the facilities dining experience checklist completed in May 2021 indicates under the Comments Section Plan: To reopen dining room services June 2021. The purpose of this checklist is to ensure systems are in place to provide for an enjoyable, dignified, and sanitary dining experience. It is now August 12, 2021 and the dining room was not in use.<br><br>Refer also to F550, F584 and F725. | F 802 | | |