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

November 13, 2023

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

Dear Mr. Carlson:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **October 25, 2023.** 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

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	476019	A. BUILDING _____ B. WING _____	C 10/25/2023

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

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F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an onsite, unannounced investigation of two complaints (ACTS #22312 and #22303) on 10/11/23 and 10/18/23, with additional offsite record review that ensued through 10/25/23, to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were identified:	F 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 mainatin compliance.	11/28/23
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to protect the resident's right to be free from neglect for one applicable resident (Resident #1) by neglecting to provide services that are necessary to avoid physical harm and emotional distress related to refusing to allow Resident #1 to get out of bed, putting them at increased risk for medical complications related to immobility such as, urinary tract infection (UTI),	F 600	F600 Specific Corrective Action 1.Resident #1 was discharged on 09/25/23 2. An audit of residents transfer assessment, mobility CP, and Kardex was completed to validate that staff have the necessary information to safely transfer the resident upon admission and thereafter. An audit of resident continence status was completed to validate brief usage is appropriate based on the residents continence status.	

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

Market Operations Advisor/WHA 11/13/23

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 600	Continued From page 1 pneumonia, and constipation and cardiovascular complications (which could promote a bowel obstruction); and failing to answer call bells and provide care for Resident #1 so that they maintain dignity and quality of life. Findings include: Per interview on 10/19/23 at 4:01 PM, Resident #1's Representative indicated that Resident #1 was neglected to be provided care while at the facility. S/He stated that Resident #1 was not allowed to leave his/her bed until 9/25/23, the day s/he was transferred to the hospital, was forced to wear a brief even though s/he was not incontinent and had requested multiple times to use the toilet, was not attended to in a timely manner by staff, and was left soiled for extended periods of time. S/He stated that Resident #1 was using a commode during the hospital stay for bowel elimination and was told by providers at the hospital prior to admission to the facility that Resident #1 should not being wearing briefs if s/he is continent of bowels because it would increase the chance of him/her getting a UTI. When the Representative asked the facility staff why Resident #1 was wearing a brief, staff told them that Resident #1 was incontinent of their bowels and was not allowed to be transferred out of bed. The Representative explained that Resident #1 was not incontinent of bowels, that they were only wearing briefs on admission because of the long drive from the hospital to the facility, in which Resident #1 had soiled themselves. S/He reports that both s/he and Resident #1 had asked to use the toilet and get out of bed multiple times and was told by facility staff that staff were not allowed to get them out of bed because s/he was not cleared to get out of bed. When the Representative explained that Resident #1 had been evaluated by therapy on	F 600	F600 continued.. 3.The facility assesses patients upon admission and on an ongoing basis to determine the patient's ability to transfer and reposition and the need for safe resident handling equipment. This will be entered into the Plan of Care and Kardex to provide communication to care staff to immediately meet the safe transfer needs of each resident. Nursing staff will be re-educated to this process. The facility assesses residents for the need for continence management as part of the nursing assessment process to provide appropriate treatment and services for patients incontinent of bowel to restore continence to the extent possible 4. DON/Designee will complete audits of lift/transfer assessments to validate they are completed timely and intervention for transfer status is noted in the Plan of Care and the Kardex. These audits will be weekly x 3, biweekly x 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	

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F 600	Continued From page 2 9/21/23, staff said there was no one to talk to about that and continued to refuse to transfer her/him out of bed to use the toilet or sit in a chair. The representative explained that s/he visited the facility multiple times during Resident #1's stay for extended periods of time and observed Resident #1 in a brief the entire time. Resident #1 had expressed back pain from being in bed so long and sadness that s/he "might as well be at home because if I'm just going to be in bed all day, I can do that at home." Resident #1's Representative reported that staff did not attend to Resident #1's needs. S/he stated that Resident #1 was in the same johnny on 9/23/23 that s/he had worn in the hospital even though Resident #1 had his/her own clothes. S/he stated that s/he and other family members would have to go ask staff at the nursing station for help after not responding to call bells. S/He did not observe staff reposition Resident #1 while they were visiting. S/He stated that s/he repositioned Resident #1 in bed and found him/her laying on a knife. S/He stated that one day, Resident #1 was vomiting, and s/he went to get help from staff. Staff had told him/her that they would be there later. The vomit was dark, almost black. The Representative said that s/he had to help Resident #1 reposition themselves so that they would not choke on their vomit. S/He explained that Resident #1 was left to sit in dirty clothes and bed sheets covered in coffee and vomit for hours. Staff had reported that they were short staffed, and one LNA (Licensed Nurse Aide) had asked for help from Resident #1's family member to help him/her to a chair because s/he was going to collapse from being so busy. The Representative expressed great sadness that Resident #1 experienced this type of care during the last days of their life.	F 600	F600 continued.. DON/Designee will complete audits of resident continence assessments to validate those residents, who are continent, are not utilizing briefs unnecessarily. These audits will be weekly x 3, biweekly x 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 11/28/23 **Tag F 600 POC accepted on 11/13/23 by S. Stem/P. Cota**	

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Per record review, a transfer of care report signed by a physician from the sending hospital dated 9/21/23 reveals that Resident #1 was admitted to the hospital on 9/13/23 for atrial fibrillation (irregular, often rapid heart rate), NSTEMI (heart attack), and HFrEF (type of heart failure). On discharge from the hospital on 9/21/23 Resident #1 had an indwelling urinary catheter, was being discharged for acute rehabilitation, and their condition at discharge was described as "improved."

A facility admission nursing assessment dated 9/21/23 reveals that Resident #1 was admitted to the facility on 9/21/23 for therapy, teaching, and training, in addition to care management related to a stroke and cardiac conditions. Resident #1's health history included congestive heart failure, diabetes, cardiac disease, hypertension, and stroke. The assessment reveals that Resident #1 is incontinent of bowels and his/her current toileting method for bowel elimination is marked "not applicable," (other choices include bathroom, commode, or bedpan). S/He has a urinary catheter on admission. On review of rehab service, Resident #1 indicates that s/he believes that s/he is capable of increasing independence in at least some activities of daily living (ADLs). Resident #1's mental status is described as alert and oriented to person and place.

Per record review, physician orders include: "May participate in activity and general conditioning program as desired. Activity as tolerated," with a start date of 9/21/23.

An occupational therapy evaluation dated 9/21/23 reveals that Resident #1 is dependent for care for

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F 600	Continued From page 4	F 600		

transfers, requiring 100% assistance or 2 or more helpers to transfer. Long term therapy goals established were for Resident #1 to return to their prior level of functioning (independent) with some modifications for ADLs by 10/20/23. The potential for Resident #1 reaching these rehab goals is described as "fair rehab potential as evidenced by the ability to follow 1- step directions, able to make needs known, motivated to return to prior level of living and higher prior level of function."

Per interview on 10/18/23 at 12:55, the Occupational Therapist who assessed Resident #1 on 9/21/23 revealed that Resident #1 was in a brief and soiled from the transfer to the facility when s/he was assessed. S/he stated that Resident #1 required a lift to transfer out of bed and communicated that to the staff on Resident #1's unit.

Per interview on 10/19/23 at 9:13 AM, the Interim Therapy Director confirmed that Resident #1 was evaluated on 9/21/23 by Occupational Therapy and the assessment determined that s/he required total assistance for bed mobility and transfer. S/He explained that therapy services will alert nursing staff about the results and nursing will incorporate the results into a resident's plan of care. Nursing staff can also go by hospital notes or can assist a resident with bed mobility and transferring with maximum staff assistance until the therapy team can assess the resident. The Interim Therapy Director confirmed that Resident #1 was not seen by physical therapy until 9/25/23.

A Lift Transfer Evaluation dated 9/21/23 indicates that Resident #1 is unable to independently reposition themselves in bed and recommendations reveal that Resident #1

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F 600	Continued From page 5 requires at least 2 staff with repositioning device and suggests a total lift divided leg sling for transfer. Resident #1's care plan includes the following care plan focuses: "Resident exhibits or is at risk for cardiovascular symptoms or complications related to CVA [stoke], MI [heart attack], Cardiac arrhythmia [irregular heartbeat]," created on 9/21/23. Interventions include: "monitor weight as ordered," created on 9/21/23, and "Encourage activities as ordered and tolerated," created on 9/21/23. "Resident is at risk for falls: CVA, Impaired mobility," created on 09/21/2023. Interventions include "Ambulation assistance: (# staff) [left blank] with (Device) [left blank] Maximize physical activity to enhance general muscle tone, functioning of lower G.I. tract, and ability to mobilize to bathroom in response to urge to defecate," created on 09/21/2023. "Resident requires assistance with cares [related to] weakness," created on 9/23/23, "total lift divided leg for transfers with assist of 2," created on 9/23/23. Per interview on 10/18/23 at 2:37 PM, a Licensed Nurse Aide stated that Resident #1's family had asked for Resident #1 to get out of bed so they could sit in a chair and s/he told the family that s/he couldn't get Resident #1 out of bed because s/he was not cleared to do so. S/He explained that s/he was never told what type of assistance Resident #1 required and would need a wheelchair, which s/he did not have, for support since Resident #1 was not strong enough to support his/herself in an armless chair. S/He explained that Resident #1 required a brief due to	F 600		

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F 600	Continued From page 6	F 600		

being incontinent of their bowels and believed they were not allowed to be transferred out of bed to use the toilet because they had not been assessed by therapy yet.

Nursing Aide documentation from 9/21/23 through 9/25/23 reveals that Resident #1 was not bathed during their stay and did not refuse bathing and s/he was not transferred in or out of bed and did not refuse transfer from 9/21/23 through the evening shift on 9/25/23.

Per record review, A 9/25/23 progress note reveals that Resident #1 was transferred to the hospital on 9/25/23 due to chest pain. A 9/25/23 hospital provider note reveals that Resident #1 presents to the ER [Emergency Room] with abdominal pain, chest pain, nausea, and vomiting, describing the pain as severe and constant for days. Resident #1 is described as alert, awake and with normal cognition. A 9/26/23 hospital provider note indicates that assessment reveals that Resident #1 has the following acute (newly acquired) complications: small bowel obstruction, urinary tract infection, pneumonia, and renal failure. The family reported to the provider that Resident #1's vomit was feculent smelling at the facility. Notes further reveal that Resident #1 was discharged home on hospice on 9/26/23. A Vermont Certificate of Death reveals that Resident #1 passed away on 9/27/23 with the cause of death determined to be "Sepsis in the Setting of Pneumonia, Acute Urinary Tract Infection, and Spontaneous Small Bowel Obstruction."

Per interview on 10/19/2023 at 1:09 PM, the Market Clinical Lead stated that based on assessment, Resident #1 should have been able

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F 600	Continued From page 7 to transfer out of bed before 9/25/23 and confirmed there was no documentation that s/he was out of bed, offered to get out of bed, or refused getting out of bed. S/He stated that the use of a brief for Resident #1 was due to him/her being incontinent of their bowels on admission and confirmed that s/he should have been reassessed for incontinence following admission, which had not been done. S/He confirmed that wearing a brief increases the risk for bacterial growth, increasing their risk for a UTI.	F 600		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 3 of 3 sampled residents (Residents #2, #3, and #4) remained free of accidents as possible related to creating and implementing interventions to reduce hazards for Residents #3 and #4; providing appropriate and sufficient supervision to prevent an avoidable accident for Residents #2, #3, and #4; and providing assistive devices necessary to prevent an avoidable accident from occurring for Resident #2. Findings include: 1. The facility failed to provide Resident #2 with sufficient supervision and assistive devices to	F 689	F689 Specific Corrective Action 1-Resident # 2 was discharged on 09/14/23 Resident #3 and #4 has intervention in place to reduce hazards and the facility is providing appropriate and sufficient supervision to prevent an avoidable accident. 2-An audit of resident fall CP was completed to validate interventions are in place to reduce hazards and prevent further falls. The facility validated that staffing patterns in the building, based on census and acuity, are sufficient to provide appropriate supervision for those resident at risk for falls. An audit of residents who's assessments indicate the need for rails for bed mobility was completed and validated that the bed rails were on the bed as indicated.	

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F 689	Continued From page 8 prevent an avoidable fall from occurring. As a result, Resident #2 suffered a fall in which s/he was on the floor for an extended period, soiled and cold, and dislodged his/her G-tube (a feeding tube inserted through the abdomen and directly into the stomach). Resident #2 required a transfer to the ER (Emergency Room) and have an Naso Gastric tube (NG tube; a feeding tube inserted through the nose, down the throat, and into the stomach) inserted. Per record review, Resident #2 was admitted to the facility on 9/13/23 for rehab related to complications from a recent stroke. His/her admitting diagnoses include myasthenia gravis (a neurological order causing voluntary muscles to become weak), history of a stroke affecting the left side, dysphagia (swallowing difficulties) following stroke, and a gastrostomy tube (G-tube; a feeding tube inserted through the abdomen and directly into the stomach) placement. Per interview on 10/12/23 at 2:59 PM, Resident #2's Representative stated that Resident #2 was using a bedrail at home prior to admission to the facility to reposition themself in bed since s/he is very large and has muscle weakness. The Representative explained that this was discussed with the nurse at the facility on admission and it was determined that Resident #2 could receive a bedrail but s/he would not get it installed until the next day because maintenance had already left for the day. The Representative explained that s/he was very nervous to leave his/her spouse for the evening because s/he didn't have the bedrails and staff were not attentive to his/her needs as it took almost 2 hours for staff to respond to a call bell request earlier that evening. S/He revealed that Resident #2 fell out of bed that night while	F 689	3- Patients are assessed for risk of falling as part of the nursing assessment process. Interventions to reduce risk and minimize injury will be implemented as appropriate. Patients experiencing a fall will receive appropriate care and post-fall interventions will be implemented. Nursing staff will be re-educated to this process. The Bed Rail Evaluation will be completed upon admission, re-admission, quarterly, change in bed or mattress, and with a significant change in condition. If a bed rail is used, the Center must ensure timely installation, use, and maintenance of bed rails. Nursing and maintenance staff will be re-educated to this process. The facility will have sufficient nursing staff, including nurse aides in accordance with state and federal regulations, with the appropriate competencies and skills sets to provide nursing and related services to assure patient safety and attain or maintain the highest practicable physical,mental, and psychosocial well-being of each patient. Facility NHA and nursing leadership will be re-educated to this process.	

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F 689	Continued From page 9 trying to reposition him/herself which caused his/her G-tube to rip out of his/her stomach and the need to be sent to the ER for reinsertion. The hospital was unable to reinsert the tube because the skin was damaged due to trauma from being ripped out and Resident #2 needed to get a NG tube inserted. This set back his/her progress related to swallowing therapy greatly, caused him/her pain, and created additional setbacks in therapy and pain related to requiring an additional surgery to reinsert the G-tube. Per a 9/13/23 physical therapy evaluation note, Resident #2's functional bed mobility assessment reveals that s/he requires supervision/stand by assistance for rolling left and right, and needs moderate assistance to go from lying to sitting and sitting to lying while in bed. Per record review a 9/13/23 bed rail evaluation reveals that Resident #2 is identified to have a balance deficit, weakness, and need for aid for independent pressure redistribution while in bed, contributing to the need to use a bed rail. A recommendation to use upper half side rails is determined and resident consent and physician order for bed rail use is obtained. Resident #2's care plan includes the following care plan focus: "Resident/Patient requires assistance/is dependent for mobility," created on 9/13/23 with the following goal "Resident will utilize upper half side rails bed rail(s) bilaterally for turning and repositioning, transferring from to bed." Per interview on 10/11/23 at 3:12 PM, the Licensed Practical Nurse (LPN) that completed Resident #2's bed rail evaluation on 9/14/23 stated that Resident #2 and his/her Representative had explained that s/he needs a bedrail to reposition themselves at bed at home and determined	F 689	F689 continued.... 4- DON/Designee will complete audits of bed rail assessments to validate those residents whose assessment indicates the need for side rails and have those side rails installed timely. These audits will be weekly x 3 weeks, then bi weekly x 4 weeks, then monthly x 3 months.. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. NHA/Designee will validate that the facility has sufficient nursing staff to meet the needs of the facility. These audits will be daily x 30 days, weekly x 4 weeks, then bi weekly x 2 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. DON/Designee will complete audits of resident fall CP to validate that interventions are in place to reduce hazards, this includes those residents who have experienced a fall have received appropriate care and post-fall interventions have been added to the plan of care. weekly x 3 weeks, then bi weekly x 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations.	

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F 689	Continued From page 10 through the assessment that bedrails were recommended. The LPN stated that s/he obtained a physician order for the use of the bedrail and put in a work order to have the bedrails installed but knew that it wouldn't happen that day because the maintenance staff had already left for the day. S/He stated that s/he knew Resident #2 needed bedrails and did not make any other staff or management aware that Resident #2 did not have them installed. A facility incident report dated 9/14/23 at 3:30 AM reveals that the nurse found Resident #2 on the floor beside his/her bed wrapped in sheets. It describes Resident #2 as being incontinent of his/her bowel and bladder and having his/her G-tube removed from his/her abdomen. Resident #2 was sent to the ER to reinsert the G-tube. Per interview on 10/18/23 at 7:00 PM, the Registered Nurse (RN) who found Resident #2 on the floor on 9/13/23 stated that there was only him/herself and one aide on the unit for the entire night shift when typically there are two aides for that shift and confirmed that staffing was short that night. Per interview on 10/18/23 at 11:00 AM, Resident #2 and their Representative explained that Resident #2 was trying to reposition themselves in bed without the aid of a bedrail, which they normally use at home to reposition themselves, when s/he fell out of bed. Resident #2 stated that the fall occurred sometime after midnight, and they were found by staff sometime around 4:00 AM. S/He explained that while s/he does not know the exact length of time that s/he was on the floor, it was very painful and cold. The fall caused his/her G-tube to rip out of his/her stomach and s/he had an injury to a large toe. S/He was sent to the ER for replacement of the	F 689	Date of Compliance 11/28/23 **Tag F 689 POC accepted on 11/13/23 by S. Stem/P. Cota**	

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G-tube. The ER providers informed him/her they were unable to reinsert the G-tube because the tissue was damaged and s/he had to get an NG tube. The insertion of the NG tube set back his/her speech therapy progress. Per review of a 9/14/23 hospital ER visit note, Resident #2 was unable to have the G-tube reinserted until the abdomen healed, requiring a NG tube to be inserted for continued feeding purposes.

A review of Licensed Nursing Assistant (LNA) documentation does not provide evidence that Resident #2 was cared for by LNA staff during his/her stay at the facility. All interventions that were identified as care tasks, including staff assistance with bed mobility and personal hygiene, for the shifts from 3:00PM on 9/13/23-7:00 AM on 9/14/23 were left blank.

Per interview on 10/19/2023 at 1:09 PM, the Market Clinical Lead stated that s/he cannot produce evidence that staff had checked on Resident #2 during the evening and confirmed that Resident #2 should have had a bedrail on his/her bed the night of 9/13/23.

2. The facility failed to provide Resident #4 with sufficient supervision and implement and revise interventions to prevent an avoidable fall from occurring. As a result, Resident #4 suffered 7 falls within 48 days in which outcomes for one of the falls included multiple areas of bruising and dislodgement of his/her catheter, requiring a transfer to the ER the following day.

Per record review Resident #4 has diagnoses that include dementia, seizure disorder, history of falls, history of stroke with left side weakness, and urinary retention requiring a foley catheter

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(indwelling urinary catheter). An 8/17/23 MDS assessment reveals that Resident #4 requires a one person physical assist for locomotion on and off the unit and a two person assist for transferring; and uses a walker and wheelchair as a mobility device.

Resident #4's care plan includes the following care plan focuses:
"Resident is at risk for falls: Impaired mobility, decreased safety awareness. history of fall," created on 8/12/23. Interventions include: "non skid strips on both sides of the bed," created on 8/14/23, and "provide checks throughout shift," created on 8/13/23.
"Resident requires assistance with cares [related to] left side weakness [status post] cva [stroke]," created on 8/13/23. Interventions include, "provide cueing for safety and sequencing to maximize current level of function," created on 8/13/23.
Per review of facility incident reports since 9/1/23, Resident #4 had falls on 9/1/23, 9/17/23, 9/18/23, 9/26/23, 9/30/23, 10/11/23, and 10/14/23. The incident reports reveal the following:
On 9/1/23, Resident #4 had an unwitnessed fall in his/her room from his/her bed.
On 9/17/23, Resident #4 had an unwitnessed fall.
On 9/18/23, Resident #4 had an unwitnessed fall in his/her room from his/her bed.
On 9/26/23, Resident #4 had an unwitnessed fall.
On 9/30/23, Resident #4 had an unwitnessed fall resulting in bruising to his/her left hand and left knee. Resident #4 was found with his/her foley catheter pulled out and would not let staff replace it. A 10/1/23 progress note states, "Resident agreed to replacement of foley following its inadvertent dislodgement last night during [his/her] fall. This writer re-inserted the foley and

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F 689	Continued From page 13 the catheter tube immediately filled with congealed blood and no urine was passed through. The foley was removed and an additional attempt was made with the same result. [On call provider] contacted and an order was provided to have resident transported to the ED [Emergency Department] for evaluation." On 10/11/23, Resident #4 had an unwitnessed fall. On 10/14/23, Resident #4 had a witnessed fall. Review of care plan revisions related to fall prevention for Resident #4 since 9/1/23 include the following: "Monitor for positioning in bed and reposition as needed," created on 9/4/23. "Provide checks to monitor for positioning," created on 9/18/23. This is a rephrase of prior interventions created on 8/13/23 and 9/4/23. "Redirect during self transfers, attempt repositioning in bed," created on 9/28/23. This is a rephrase of prior interventions created on 8/13/23, and 9/4/23. "Refer to pharmacy for [medication] review 10/13," created on 10/16/23. Per a 10/11/23 progress note, a medication review was performed on 10/11/23 for Resident #4. "Continue to encourage not to self transfer. monitor for sitting on edge of bed and reposition/redirect as needed," created on 10/16/23. This is a rephrase of prior interventions created on 8/13/23 and 9/4/23. While new care plan interventions were created after Resident #4's fall on 9/1/23 and 10/11/23, interventions were either not created or previous ineffective interventions were rephrased after the falls on 9/17/23, 9/18/23, 9/26/23, 9/30/23, and 10/14/23.	F 689		

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F 689	Continued From page 14 Per observation on 10/18/23 at 10:36 AM, Resident #4 is in bed. Resident #4's bed is pushed against the wall . Nonskid strips are located underneath the bed and in the middle of the room as if they were placed to be on both sides of the bed if the bed were in the middle of the room. Per interview on 10/18/23 at 1:56 PM, the Nurse Manager confirmed that the skid strips were not effective for where the bed is place. Per interview on 10/18/23 at 1:59 PM, the Interim Director of Nursing stated that Resident #4's bed has been against the wall for about a month. Per interview on 10/18/23 at 12:20 PM, a Licensed Practical Nurse stated that the facility started one hour checks for location with Resident #4 about a week earlier. S/He explained that the staff started to keep track of the hourly checks on a piece of paper but it is not documented in Resident #4's record and is unsure if this is part of his/her plan. Per interview on 10/19/2023 at 1:09 PM, the Market Clinical Lead confirmed that Resident #4's care plan was not revised with new interventions to reduce the likelihood of another fall after all falls referenced above. S/He indicated that during a meeting held a week earlier, the interdisciplinary team recognized the need for more supervision for Resident #4 and created the intervention to complete one hour checks and confirmed that this was not entered into Resident #4's care plan or being documented in the record and it should be . 3. The facility failed to provide Resident #3 with sufficient supervision and implement and revise	F 689		

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interventions to prevent an avoidable fall from occurring. As a result, Resident #3 suffered 6 falls within 48 days in which outcomes for two of the falls included multiple areas of bruising and a skin tear.

Per record review, Resident #3 has diagnoses that include dementia, Parkinson's disease, depression, orthostatic hypotension, and a history/risk of falls. S/He was assessed on 8/17/23 to have a BIMS of 8 (brief interview for mental status; a cognitive assessment score indicating moderately impaired cognition). An 8/17/23 Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) assessment reveals that Resident #3 requires 1 person physical assistance for walking. A care plan intervention created on 6/2/2023 states that Resident #3 requires supervision with the use of roller walker for ambulation. A 5/4/23 elopement evaluation states that "resident is a known wander and fall risk." Resident #3 has an active physician order, since 4/7/23, for a "Wander Guard/Wander Elopement Device due to poor safety awareness," and a 10/7/23 nursing note states, "Wandering occurs daily or almost daily," for Resident #3.

Per observation on 10/11/23 at 11:07 AM. Resident #3 was observed from the hallway in his/her bed with his/her legs entirely exposed. On approach, a large bruise was visible on his/her left leg between his/her knee and ankle. When asked how s/he got the bruise, Resident #3 said that s/he had fallen. S/He appeared weak and asked if s/he could have a drink. There were no drinks on his/her bedside table. When asked how s/he normally asks for a drink, s/he gestured to

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the call bell cable which was wrapped around the bedrail tightly. S/he was unable to reach it; if s/he could reach it, pulling on the cable wouldn't activate the system as it was wrapped too tightly.

Per record review, Resident #3's care plan includes the following care plan focus: "Resident is at risk for falls/has actual fall [history] of repeat falls, Parkinson's Disease, Muscle weakness, history of orthostatic hypotension. Recommended to have limited assist, however due to confusion she ambulated by herself," created on 9/23/22. Interventions created before 9/1/23 include: "Implement the following safety precautions: proper footwear," created on 12/1/22, "ensure call light is within reach," created 9/23/22, and "Therapy/Rehab-PT/OT screen," created on 4/23/23. A 5/4/23 elopement evaluation states that "resident is a known wander and fall risk."

Per review of facility incident reports since 9/1/23, Resident #3 had falls on 9/1/23, 9/2/23, 9/14/23, 9/24/23, 10/7/23, and 10/14/23. The incident reports reveal the following:
On 9/1/23, Resident #3 had an unwitnessed fall in his/her room.
On 9/2/23 Resident #3 had an unwitnessed fall. Resident #3 had wandered into another resident's room and fell, hitting his/her head on furniture. As a result, Resident #3 had a skin tear to his/her lower left leg and large bruises on his/her left shoulder and elbow.
On 9/14/23, Resident #3 had an unwitnessed fall in his/her room.
On 9/24/23, Resident #3 had a witnessed fall. Staff found Resident #3 ambulating in the hall without his/her walker and s/he lost his/her balance.
On 10/7/23, Resident #3 had an unwitnessed fall

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in his/her room. A 10/10/23 progress note reveals bruising to Resident 3's leg.
On 10/14/23, Resident #3 had an unwitnessed fall in his/her room.

Review of care plan revisions related to fall prevention for Resident #3 since 9/1/23 include the following:
"Encourage resident to keep her nonskid socks on [her/his] feet," created on 9/1/23. This is a rephrase of a prior intervention created on 12/1/22.
"Continue to encourage to wear non skid footwear," created on 9/4/23. This is a rephrase of prior interventions created on created on 12/1/22 and 9/1/23.
"Therapy referral," created on 9/28/23. This is a rephrase of a prior intervention created on 4/23/23, In addition, a 9/5/23 progress note indicated that Resident #3 was recently referred to therapy.

Although care plan interventions were created after Resident #3's fall on 9/1/23, 9/2/23, and 9/24/23, they were rewordings of prior interventions. No additional interventions were created after Resident #3's falls on 9/14/23, 10/7/23, and 10/14/23 falls. There are no care plan interventions addressing the wandering that occurred during the 9/2/23 fall as described above, until 10/12/23.

Per interview on 10/18/23 at 12:33 PM, an LNA, when asked about interventions to prevent falls for Resident #3, indicated that there are not enough staff to provide Resident #3 with routine supervision. S/He explained that sometimes s/he might be the only LNA on the floor and in those times s/he is unable to complete care for all the

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F 689	Continued From page 18 residents on her/his assignment. Per observation on 10/18/23 at 3:30 PM, Resident #3 was sitting on his/her walker in his/her room, struggling to close his/her top dresser, which is located against the wall across the foot of her/his bed. S/He states that s/he is thirsty. There are six full cups of drinks on the bedside table which is located near the top of his/her bed. When asked if s/he realized there were drinks on the bedside table, s/he said that s/he could not reach them and asked for help getting into the bed. When asked if s/he could pull the call bell for help, s/he revealed that s/he did not know where it was. The call bell was clipped to the head of the bed, out of his/her reach. This was the second observation of Resident #3 unable to reach the call bell. Per interview on 10/19/2023 at 1:09 PM, the Market Clinical Lead confirmed that Resident #3's care plan was not revised with new interventions to reduce the likelihood of another fall after each fall referenced above .	F 689		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must	F 690	F690 Specific Corrective Action 1-Resident #1 was discharged on 09/25/23 2- An audit of residents with indwelling catheters was completed to validate the residents have an order for an indwelling catheter, orders to empty the catheter drainage bag, and order for catheter care BID and PRN.	

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F 690	Continued From page 19 ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that 1 of 3 sampled residents (Resident # 1) with a urinary catheter receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. Findings include: Per record review, Resident #1 was admitted to the facility on 9/21/23 following a hospital stay for cardiac complications. Resident #1's health history included congestive heart failure, diabetes, cardiac disease, hypertension, and stroke. A hospital discharge note dated 9/21/23	F 690	F690 continued... 3- Patients who have urinary catheters upon admission or subsequently receive one will be assessed for removal of the catheter as soon as possible unless the patient's clinical condition demonstrates that catheterization is necessary. For those residents requiring an indwelling catheter, at a minimum there should be an order for an indwelling catheter, orders to empty the catheter drainage bag, and order for catheter care BID and PRN. Licensed staff will be re-educated to this process. 4-DON/Designee will complete audits of residents with indwelling catheters to validate the residents have an order for an indwelling catheter, orders to empty the catheter drainage bag, and order for catheter care BID and PRN. These audits will be daily x 30 days, weekly x 3 weeks, biweekly x 4 weeks, then monthly x 3 months. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of Compliance 11/28/23	

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F 690	Continued From page 20 reveals that Resident #1 had an indwelling urinary catheter. Facility policy titled NGS209 Catheter: Urinary-Justification for Use, last reviewed 8/7/23 states: "Patients who have urinary catheters upon admission or subsequently receive one will be assessed for removal of the catheter as soon as possible unless the patient's clinical condition demonstrates that catheterization is necessary." "If patient's situation meets any of the indwelling catheter criteria, obtain physician order, include in care plan, and follow Catheter: Indwelling Urinary-Care of procedure." Facility Procedure titled Catheter: Indwelling Urinary-Care of indicates that catheter care should be performed and documented twice a day and as needed, and the catheter drainage bag should be emptied when it becomes ½ to 2/3 full. Per record review, Resident #1's medication and treatment administration records and physician orders reveal that Resident #1 did not have an order for an indwelling catheter, orders to empty the catheter drainage bag, or orders for catheter care every day and night shift until approximately 8:30 PM on 9/23/23. The treatment record reveals that Resident #1's catheter drainage bag was only emptied six times during their stay and catheter care was only performed 4 times during their stay. There is no evidence that nursing staff or a physician assessed Resident #1 for removal of the catheter during their stay. Per interview on 10/19/23 at 4:01 PM, Resident #1's Representative stated that Resident #1 was using a commode during the hospital stay for bowel elimination and was told by hospital	F 690	**Tag F 690 POC accepted on 11/13/23 by S. Stem/P. Cota**	

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F 690	Continued From page 21 providers that Resident #1 should not being wearing briefs if s/he is continent of bowels because it would increase the chance of him/her getting a UTI (urinary tract infection). When the Representative asked staff why Resident #1 was wearing a brief, staff told them that Resident #1 was incontinent of their bowels and was not allowed to be transferred out of bed. The Representative explained that Resident #1 was not incontinent of bowels, that they were only wearing briefs on admission because of the long drive from the hospital to the facility, in which Resident #1 had soiled themselves. S/He reports that both s/he and Resident #1 had asked to use the toilet and get out of bed multiple times and was told by facility staff that staff were not allowed to get them out of bed because they were not cleared to get him/her out of bed. The Representative explained that s/he visited the facility multiple times during Resident #1's stay, for extended periods of time, and observed him/her in a brief the entire time. Per interview on 10/18/23 at 2:37 PM, a Licensed Nurse Aide indicated that Resident #1 was wearing a brief because they were incontinent of their bowels and believed they were not allowed to be transferred out of bed to use the toilet because they had not been assessed by therapy yet. Per interview on 10/18/23 at 3:05 PM, the Nurse Manager stated that residents that are not incontinent should not be put in briefs and confirmed that incontinence should not be determined just by the status of the resident on admission, but also based on report from the sending facility, resident, or resident representative.	F 690		

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	475019	A. BUILDING _____ B. WING _____	C 10/25/2023

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F 690	Continued From page 22 Per record review, Resident #1 was transferred to the hospital on 9/25/23. A 9/25/23 hospital provider note reveals that Resident #1 presents to the ER (emergency room) with abdominal pain, chest pain, nausea, and vomiting, describing the pain as severe and constant for days. A 9/26/23 hospital provider note indicates that assessment reveals that Resident #1 has the following acute complications: small bowel obstruction, urinary tract infection (UTI), pneumonia, and renal failure. Notes further reveal that Resident #1 was discharged home on hospice on 9/26/23. A Vermont Certificate of Death reveals that Resident #1 passed away on 9/27/23 with the cause of death determined to be "Sepsis in the Setting of Pneumonia, Acute Urinary Tract Infection, and Spontaneous Small Bowel Obstruction." Per interview on 10/19/2023 at 1:09 PM, the Market Clinical Lead stated that the use of a brief for Resident #1 was due to him/her being incontinent of their bowels on admission and confirmed that s/he should have been reassessed for incontinence following admission, which had not been done. S/He confirmed that wearing a brief increases the risk for bacterial growth, increasing their risk for a UTI. S/He stated that the admitting nurse should have put in orders for Resident #1's catheter and catheter care. S/He confirmed that this was not done and there was no evidence that catheter care was performed before 9/23/23. S/He confirmed that a catheter care plan was not created until 9/25/23 and it should have been created within 48 of his/her admission.	F 690		
F 725 SS=F	Sufficient Nursing Staff	F 725		

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F 725	Continued From page 23 CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure 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). §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: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §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. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that the facility has sufficient nursing staff to provide nursing services to maintain the highest practicable well-being. The lack of sufficient direct care staff has the potential to affect all residents residing in the home. Findings include:	F 725	F725 Specific Corrective Action 1.The facility currently has staffing patterns in place, based on census and acuity, that are sufficient to assure patient safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each patient. 2. All residents have the potential to be affected 3- The facility ensures they have sufficient nursing staff, including nurse aides in accordance with state and federal regulations, with the appropriate competencies and skills sets to provide nursing and related services to assure patient safety and attain or maintain the highest practicable physical,mental, and psychosocial well-being of each patient. Facility NHA and nursing leadership will be re-educated to this process. 4.NHA/Designee will validate that the facility has sufficient nursing staff to meet the needs of the facility. These audits will be daily x 30 days, weekly x 4 weeks, then bi weekly x 2 months.	

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F 725	Continued From page 24 1. Per record review, Resident #1 was admitted to the facility on 9/21/23 for therapy and care management related to a stroke and cardiac conditions. Resident #1 was transferred to the hospital on 9/25/23 and passed away on 9/27/23. Per Resident #1's care plan created on 9/23/23, s/he requires extensive assistance from staff for transferring, bed mobility, dressing, toileting, hygiene, and bathing. Per interview on 10/19/23 at 4:01 PM, Resident #1's Representative indicated that Resident #1 was neglected care while at the facility because staff did not attend to Resident #1's needs. The representative explained that s/he visited the facility multiple times during Resident #1's stay for extended periods of time S/he stated that Resident #1 was in the same johnny on 9/23/23 that s/he had worn in the hospital even though Resident #1 had his/her own clothes. S/he stated that s/he and other family members would have to go ask staff at the nursing station for help after not responding to call bells. S/He did not observe staff reposition Resident #1 while they were visiting. S/He stated that s/he repositioned Resident #1 in bed and found him/her laying on a knife. S/He stated that one day, Resident #1 was vomiting, and s/he went to get help from staff. Staff had told him/her that they would be there later. The vomit was dark, almost black. The Representative said that s/he had to help Resident #1 reposition themselves so that they would not choke on their vomit. S/He explained that Resident #1 was left to sit in dirty clothes and bed sheets covered in coffee and vomit for hours. Staff had reported that they were short staffed, and one LNA (Licensed Nurse Aide) had asked for help from Resident #1's family member to help him/her to a chair because s/he was going to	F 725	F725 continued.. Results of these audits will be brought to the monthly QAPI Committee for further review and recommendations. Date of compliance 11/28/23 Tag F 725 POC accepted on 11/13/23 by S. Stem/P. Cota	

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F 725	Continued From page 25	F 725		

collapse from being so busy. The Representative expressed great sadness that Resident #1 experienced this type of care during the last days of their life.

2. Per record review, Resident #2 was admitted to the facility on 9/13/23 for rehab related to complications from a recent stroke. Per a 9/24/23 facility incident report, Resident #2 suffered a fall on the morning of 9/14/23. A review of Licensed Nursing Assistant (LNA) documentation does not provide evidence that Resident #2 was cared for by LNA staff during his/her stay at the facility. All interventions that were identified as care tasks, including staff assistance with bed mobility and personal hygiene, for the shifts from 3:00PM on 9/13/23- 7:00 AM on 9/14/23 were left blank.

Per interview on 10/12/23 at 2:59 PM, Resident #2's Representative indicated that on Resident #2's night of admission, Resident #2 had to wait almost two hours before someone answered his/her call bell. The Representative stated that s/he had approached the nursing station during this time to get help and multiple call bells were going off.

Per interview on 10/18/23 at 7:00 PM, the Registered Nurse (RN) who found Resident #2 on the floor on 9/13/23 stated that there was only him/herself and one aide on the unit for the entire night shift when typically there are two aides for that shift and confirmed that staffing was short that night.

3. Review of facility incident reports from 9/1/23 through 10/18/23 for Residents #3 and #4 reveal that Resident #3 had 5 unwitnessed falls and Resident #4 had 6 unwitnessed falls during this

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F 725	Continued From page 26 time frame. See F689 for more information. Per interview on 10/18/23 at 12:33 PM, an LNA stated that s/he might be the only LNA on the floor and in those times s/he is unable to complete care for all the residents on her/his assignment. S/He indicated that there are a lot of residents on the unit that require a two person assist for activities of daily living care and there are not always staff to assist in caring for these residents. S/He indicated that Resident #3 requires more supervision than staff are able to provide. 4. Per interview on 10/19/23 at 1:09 PM, the Market Clinical Lead stated that there are frequently open shifts and call outs for direct care staff. S/He indicated that licensed nurses and nurse management often fill in for licensed nursing assistants. A review of direct care staff schedules for sampled dates for September and October of 2023 reveal multiple call outs and unscheduled shifts for licensed nursing assistants. The facility was unable to produce accurate direct care schedules that reflected which staff worked, in what role, and on which unit, for all the shifts sampled.	F 725		