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

January 7, 2022

Ms. Lynnette Smith, Administrator
The Manor, Inc
577 Washington Highway
Morrisville, VT 05661-8972

Dear Ms. Smith:

Enclosed is a copy of your acceptable plans of correction for the recertification survey and complaint investigation conducted on **December 15, 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
	475057	A. BUILDING _____ B. WING _____	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MANOR, INC	577 WASHINGTON HIGHWAY MORRISVILLE, VT 05661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced on-site off-hours recertification survey was conducted in conjunction with 2 complaint investigations by the Division of Licensing and Protection at The Manor nursing home on 12/13- 12/15/21. There were no regulatory violations identified regarding the complaint allegations. There were regulatory violations identified regarding the recertification survey.	F 000	This page left blank	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 1.4.22

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

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F 656	Continued From page 1 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to ensure Care Plan interventions were implemented for 3 residents [Res. #35, #41, & #5] of 20 sampled residents. Findings include: 1.) Per review of Res. #35's Care Plan, the resident is identified as at risk for infection due to a left calf wound and a recent left great toe amputation, and at risk for skin breakdown due to vascular complications, post-surgical complications, and poor wound healing and perfusion. Care Plan interventions include "wound care per order" and "administer medications/treatment as ordered". Per record review, Physician Orders for Res. #35 for September 2021 read "Skin Treatment: Cleanse open area on left shin and calf with soap and water, rinse, pat dry, apply skin prep to periwound skin, cover with non-adhesive optifoam and wrap with kerlix [dressing] daily."	F 656	F 656 All RNS and LPNS are receiving education on the importance of following care plan interventions and on The Manor's policies and procedures, which include completing treatments as ordered, and signing off on completed treatments. All residents have the potential to be affected by the same deficient practice.	

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F 656	Continued From page 2 Additional Skin Treatment orders include "Cleanse area on left second toe and dehiscence [splitting or bursting open of a wound] site on great toe with warm soapy water, rinse, pat dry. Cut a piece of puracol dressing to fit into dehiscence site, cover with gauze and affix with paper tape. Apply small amount of purogel to optifoam dressing and apply to wound bed on Left second toe, affix with paper tape daily." Review of Treatment Administration Records [TARs] for Res. #35 reveal for September 2021 blank spaces on the TAR where the nurse would initial after treatments were completed on 9/1, 9/3, 9/8, 9/9, 9/12, &. 9/13. The TAR for October 2021 contains blanks under skin treatment on 10/2, 10/4, and 10/6. The November 2021 TAR includes blank spaces on 11/3 and 11/17. An interview was conducted with the Director of Nursing [DON] on 12/15/21 at 10:45 AM. The DON confirmed that the Skin Treatments ordered by the Physician "are signed off by the nurse who does it" to confirm and assure that the treatments were done as ordered. The DON confirmed that Nurses Notes did not contain any documentation regarding if the treatments were completed or if not, why they were not. The DON reported notes regarding skin treatments could be contained elsewhere in the resident's chart but could not confirm exactly where. The DON stated if the treatments were in fact done, they "should be checked off" on the Treatment Administration Records [TARs] for Res. #35 but were not. The DON confirmed that interventions of "wound care per order" and "administer medications/treatment as ordered" were not implemented per the resident's Care Plan.	F 656	To ensure that the same deficient practice does not recur, random audits will be performed weekly by Nursing Director and/ or designee. Any areas of concerns that require further education will be addressed immediately to ensure full compliance from all RNs and LPNs. Completed audits will be reviewed at quarterly QAPI meetings. To be completed by 1/15/2022	

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F 656	Continued From page 3 2.) Per review of Res. #41's medical record, the resident's Care Plan lists interventions that include "administer medications as ordered". Per review of the medical record for Res. #41, there are Physician Orders for daily administration of the following medications: Tramadol for pain Furosemide for edema Gabapentin for pain Xarelto for deep vein thrombosis Carvedilol for high blood pressure Famotidine for Gastroesophageal Reflux Disease Melatonin for insomnia Colace for constipation prevention Levothyroxine for Hypothyroidism Simvastatin for Cholesterol Per review of Medication Administration Records [MARs] for Res. #41 On 8/1/21, for Gabapentin the MAR is blank and nurses' notes record the "Med Unavailable" On 8/26/21 through 8/29/21, for Famotidine the MAR is blank and nurses' notes record the "Med. Unavailable". On 9/22/21, for Carvedilol, Xarelto, and Famotidine, the MAR is blank and there is no nurses note explaining why they were not given as ordered. On 9/26/21, for Melatonin and Colace the MAR is blank and there is no nurses note explaining why they were not given as ordered. On 9/27/21, for Simvastatin and Gabapentin the MAR is blank and there is no nurses note explaining why they were not given as ordered. On 10/13/21, for Levothyroxine and Furosemide, the MAR is blank and there is no nurses note explaining why they were not given as ordered.	F 656	For Resident # 41 All RN's and LPNs will be re-educated on The Manor's policies and procedures on holding medications, reordering medications, and how to document when medications are unavailable. All residents have the potential to be affected by this deficient practice. To ensure that the same deficient practice does not recur, random audits will be performed weekly by Nursing Director and/or designee. Any areas of concerns that require further education will be addressed immediately to ensure full compliance from all RNs and LPNs.	

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F 656	Continued From page 4 On 10/28/21, for Levothyroxine and Furosemide, again the MAR is blank and there is no nurses note explaining why they were not given as ordered. On 11/12/21, for Furosemide the MAR is blank and there is a note reporting the 'Med. Unavailable'. On 11/23/21, for Tramadol the MAR is blank and there is a note reporting the 'Med. Unavailable.' 3.) Per review of Res. #5's medical record, the resident's Care Plan lists interventions that include "administer medications as ordered". Per review of the medical record for Res. #5, there are Physician Orders for daily administration of the medication Melatonin, for a diagnosis of insomnia. Per review of Medication Administration Records [MARs] for Res. #5: On 7/21/21, for the Melatonin, the MAR is blank and there is a note reporting the 'Med. Unavailable'. On 7/22, 8/27, 9/22, 10/7, and 12/10/21 the MAR is blank and there is no nurses note explaining why it was not given as ordered. An interview was conducted with the Director of Nursing [DON] on 12/15/21 at 10:45 AM. The DON stated that medications on the MAR should be marked as missed or refused, and not left blank. The DON confirmed that for Res. #41 and Res. #5, when the medication[s] were unavailable, there was no documentation that the pharmacy was contacted regarding a replacement, the 'Back up Medication Kit' checked to see if the medication was available, or the medication taken from another resident's supply and the Nursing	F 656	Completed audits will be reviewed at quarterly QAPI meetings. To be completed by1/15/2022 Resident #5 All RN's and LPNs have been re-educated on The Manor's policies and procedures on holding medications, reordering medications, and how to properly document when medications are unavailable. All residents have the potential to be affected by this deficient practice. To ensure that the same deficient practice does not recur, random audits will be performed weekly by Nursing Director and/or designee. Any areas of concerns that require further education will be addressed immediately to ensure full compliance from all RNs and LPNs.	

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F 656	Continued From page 5 Supervisor notified. The DON also confirmed that when a medication was missed, the physician was not notified, and the reason the medication missed was not documented in the resident's medical record or on the resident's MAR. The DON confirmed that Care Plan interventions for Res. #42 & #5 of "administer medications as ordered" were not implemented per the Care Plan.	F 656	Completed audits will be reviewed at quarterly QAPI meetings. To be completed by 1/15/2022 **TAG F 656 POC Accepted on 1/07/22 by T. Dougherty/ P.Cota**	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that 4 of 20 residents (Residents #61, #35, #41 & #5) received treatment and care in accordance with professional standards of practice. Findings include: 1.) Resident # 61 was administered Morphine without a proper physicians order regarding parameters for administration. There is a physician order dated 9/25/21 for Morphine 5 or 10 mg by po (by mouth) every 2 hours as needed for dyspnea, pain discomfort. Per review of the Medication Administration Record (MAR) the Morphine was administered 4 times on 9/25/21.	F 684	F 684 Resident #61 expired on 9/26/21 All RNs and LPNs will be reeducated on transcribing orders, co-signing, and clarifying orders, per The Manor's policies and procedures. All residents have the potential to be affected by this deficient practice. To ensure that the same deficient practice does not recur, random audits will be performed weekly by Nursing Director and/or designee. Any areas of concerns that require further education will be addressed immediately to ensure full compliance from all RNs and LPNs.	

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F 684	Continued From page 6 On 12/14/21 at 01:56 PM, The Director Of Nurses (DON) stated there should be parameters for administration of the Morphine and confirms the Morphine was administered 4 times without parameters 2.) Per record review, Physician Orders for Res. #35 for September 2021 read "Skin Treatment: Cleanse open area on left shin and calf with soap and water, rinse, pat dry, apply skin prep to periwound skin, cover with non-adhesive optifoam and wrap with kerlix [dressing] daily." Additional Skin Treatment orders include "Cleanse area on left second toe and dehiscence [splitting or bursting open of a wound] site on great toe with warm soapy water, rinse, pat dry. Cut a piece of puracol dressing to fit into dehiscence site, cover with gauze and affix with paper tape. Apply small amount of purogel to optifoam dressing and apply to wound bed on Left second toe, affix with paper tape daily." Review of Treatment Administration Records [TARs] for Res. #35 reveal for September 2021 blank spaces on the TAR where the nurse would initial after treatments were completed on 9/1, 9/3, 9/8, 9/9, 9/12, &. 9/13. The TAR for October 2021 contains blanks under skin treatment on 10/2, 10/4, and 10/6. The November 2021 TAR includes blank spaces on 11/3 and 11/17. An interview was conducted with the Director of Nursing [DON] on 12/15/21 at 10:45 AM. The DON confirmed that the Skin Treatments ordered by the Physician "are signed off by the nurse who does it" to confirm and assure that the treatments were done as ordered. Per review of the facility's Dressings, Dry/Clean Policy, under Documentation, "the following	F 684	Completed audits will be reviewed at quarterly QAPI. To be completed by 1/15/2022 For resident #35 All RNS and LPNS employed at The Manor will receive education on the importance of following treatment orders and on The Manor's policies and procedures, which include completing treatments as ordered, signing off on completed treatments, and documentation of treatments. All residents have the potential to be affected by this deficient practice. To ensure that the same deficient practice does not recur, random audits will be performed weekly by Nursing Director and/or designee. Any areas of concerns that require further education will be addressed immediately to ensure full compliance from all RNs and LPNs.	

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F 684	Continued From page 7 information should be recorded in the resident's medical record, treatment sheet, or designated wound form: -The date and time the dressing was changed. -The name and title (or initials) of the individual of changing the dressing. -The signature and title (or initials) of the person recording the data. -Report other information in accordance with facility policy and professional standards of practice." The DON confirmed that Nurses Notes did not contain any documentation regarding if the treatments were completed or if not, why they were not. The DON reported notes regarding skin treatments could be contained elsewhere in the resident's chart but could not confirm exactly where. The DON stated if the treatments were in fact done, they "should be checked off" on the Treatment Administration Records [TARs] for Res. #35 but were not. 3.) Per review of the medical record for Res. #41, there are Physician Orders for daily administration of the following medications: Tramadol for pain Furosemide for edema Gabapentin for pain Xarelto for deep vein thrombosis Carvedilol for high blood pressure Famotidine for Gastroesophageal Reflux Disease Melatonin for insomnia Colace for constipation prevention Levothyroxine for Hypothyroidism Simvastatin for Cholesterol Per review of Medication Administration Records [MARs] for Res. #41	F 684	Completed audits will be reviewed at quarterly QAPI meetings. To be completed by 1/15/2022 For Resident #41 All RN's and LPNs will be re-educated on The Manor's policies and procedures on holding medications, reordering medications, and how to document when medications are unavailable.	

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F 684	Continued From page 8 On 8/1/21, for Gabapentin the MAR is blank and nurses' notes record the "Med Unavailable" On 8/26/21 through 8/29/21, for Famotidine the MAR is blank and nurses' notes record the "Med. Unavailable". On 9/22/21, for Carvedilol, Xarelto, and Famotidine, the MAR is blank and there is no nurses note explaining why they were not given as ordered. On 9/26/21, for Melatonin and Colace the MAR is blank and there is no nurses note explaining why they were not given as ordered. On 9/27/21, for Simvastatin and Gabapentin the MAR is blank and there is no nurses note explaining why they were not given as ordered. On 10/13/21, for Levothyroxine and Furosemide, the MAR is blank and there is no nurses note explaining why they were not given as ordered. On 10/28/21, for Levothyroxine and Furosemide, again the MAR is blank and there is no nurses note explaining why they were not given as ordered. On 11/12/21, for Furosemide the MAR is blank and there is a note reporting the 'Med. Unavailable'. On 11/23/21, for Tramadol the MAR is blank and there is a note reporting the 'Med. Unavailable.' 4.) Per review of the medical record for Res. #5, there are Physician Orders for daily administration of the medication Melatonin, for a diagnosis of insomnia. Per review of Medication Administration Records [MARs] for Res. #5: On 7/21/21, for the Melatonin, the MAR is blank and there is a note reporting the 'Med. Unavailable'. On 7/22, 8/27, 9/22, 10/7, and 12/10/21 the MAR is blank and there is no nurses note explaining	F 684	All residents have the potential to be affected by this deficient practice. To ensure that the same deficient practice does not recur, random audits will be performed weekly by Nursing Director and/ or designee. Any areas of concerns that require further education will be addressed immediately to ensure full compliance from all RNs and LPNs. Completed audits will be reviewed at quarterly QAPI meetings. To be completed by 1/15/2022 For Resident #5 All RN's and LPNs will be re-educated on The Manor's policies and procedures on holding medications, reordering medications, and how to document when medications are unavailable.	

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F 684	Continued From page 9 why it was not given as ordered. Review of the facility's 'Transcription of Order Policy' reads "If medication/treatment will not be available at the ordered time, nurse must contact the prescriber and obtain order to "start when med arrives" or obtain specific start date and document such in order and in E-MAR [electronic MAR]" An interview was conducted with the Director of Nursing [DON] on 12/15/21 at 10:45 AM. The DON stated that if a medication is unavailable, the pharmacy should be contacted regarding a replacement, a 'Back up Medication Kit' should be checked to see if the medication was available there or take the medication from another resident's supply and notify the Nursing Supervisor. The DON also stated that if a medication is missed, the physician should be notified, and the reason the medication missed documented in the resident's medical record. The DON stated that medications on the MAR should be marked as missed or refused, and not left blank. The DON confirmed that for Res. #41 and Res. #5, when the medication[s] were unavailable, there was no documentation that the pharmacy was contacted regarding a replacement, the 'Back up Medication Kit' checked to see if the medication was available, or the medication taken from another resident's supply and the Nursing Supervisor notified. The DON also confirmed that when a medication was missed, the physician was not notified, and the reason the medication missed was not documented in the resident's medical record or on the resident's MAR.	F 684	All residents have the potential to be affected by this deficient practice. To ensure that the same deficient practice does not recur, random audits will be performed weekly by Nursing Director and/or designee. Any areas of concerns that require further education will be addressed immediately to ensure full compliance from all RNs and LPNs. Completed audits will be reviewed at quarterly QAPI meetings. To be completed by 1/15/2021 **TAG F 684 POC Accepted on 1/07/22 by T. Dougherty/P.Cota**	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning	F 695		

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F 695	Continued From page 10 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure a resident receiving respiratory care was provided care consistent with professional standards of practice for 1 resident in a standard survey sample of 20 residents. (Resident ID #57) Resident #57 Observation on 12/14/21 at 11:19 AM revealed an oxygen concentrator outside of Resident #57's room. An oxygen tube was connected to the concentrator which was connected to nasal cannula tubing that was being worn by resident #57. The oxygen concentrator was set at 4 LPM (liters per minute) of oxygen delivery to this resident. Review of Resident #57's medical record revealed an order for oxygen that read, "RESPIRATORY TREATMENT: Apply O2 Therapy (cont/daily) May taper oxygen saturation as needed to maintain oxygen saturation of 93% via Nasal cannula daily continuous NOC (night) AM PM first date: 03/02/2021". This order does not contain a parameter for oxygen.	F 695	F 695 For Resident # 57 The order has been clarified and changed to include parameters for oxygen. Resident preference is to keep concentrator outside of room. All RNs and LPNs will be re-educated on transcribing orders, co-signing, and clarifying orders, per The Manor's policies and procedures. All residents have the potential to be affected by this deficient practice To ensure that the same deficient practice does not recur, random audits will be performed weekly by Nursing Director and/or designee. Any areas of concerns that require further education will be addressed immediately to ensure full compliance from all RNs and LPNs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475057	A. BUILDING _____ B. WING _____	C 12/15/2021

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F 695	Continued From page 11 Interview on 12/14/21 at approximately 3 PM with the DON (Director of Nursing), who confirmed that the current order was not complete and needs to list a range that includes the max LPM that can be administered to Resident #57.	F 695	Completed audits will be reviewed at quarterly QAPI meetings. **TAG F 695 POC Accepted on 1/07/22 by T. Dougherty/P.Cota**	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on Observation and interview, it was determined that the facility failed to ensure food was stored in accordance with professional standards for food service safety for 2 of 2 kitchettes. 1.) Observation on 12/13/21 at 11:04 AM of the Elmore Unit kitchenette revealed a refrigerator with a note on the front that stated the refrigerator	F 812	To be completed by 1/15/2022 F 812 All employees will be educated on not placing ice packs in the Elmore/Spruce Kitchenettes. This freezer is for resident food only. A separate freezer has been purchased for ice packs to be stored in the therapy gym. All residents have the potential to be affected by this deficient practice. To ensure that the same deficient practice does not recur, random audits will be performed weekly by Nursing Director, Hospitality Director and/or designee. Any areas of concerns that require further education will be addressed immediately to ensure full compliance.	

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F 812	Continued From page 12 was not working. The freezer was working and contained individual ice creams and 3 ice packs. Interview on 12/13/21 at approximately 11:30 AM with the Elmore Unit's Unit Manager who confirmed that the refrigerator was not working, however the freezer was working and was being used for resident foods. The Unit Manager confirmed that the freezer contained 3 ice packs and she/he explained that these ice packs are used for residents when they have pain, swelling or various other issues. Observation on 12/15/21 at approximately 10:30 AM revealed that a the broken refrigerator had been removed from the Elmore Unit and a new refrigerator was in place. The freezer contained individual ice creams and 3 ice packs. Interview on 12/15/21 at approximately 10:45 AM with the facility's Rehabilitation Director, who confirmed that the Rehabilitation Department does not have their own refrigerator to store ice packs for residents medical needs so they are stored in the kitchenette refrigerators as the refrigerators are only used by the residents. Rehabilitation Director confirmed that the ice packs that are being kept in the kitchenette refrigerators/freezer are for the use of patients in therapy or recovering from surgical procedures. 2.) Observation on 12/15/21 at 11:04 AM of the Spruce Unit kitchenette revealed a refrigerator/freezer combination. The freezer contained individual ice creams and 4 ice packs. Interview on 12/15/21 at 11:45 AM with an LNA/MNA [Licensed Nursing Aide/Medication Nursing Aide] who confirmed the presence of the	F 812	Completed audits will be reviewed at quarterly QAPI meetings. To be completed by 1/15/2022 **TAG F 812 POC Accepted on 1/07/22 by T. Dougherty/P.Cota**	

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F 812	Continued From page 13 4 ice packs and that they are used for residents body aches and pains.	F 812		
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Per staff interview and record review, the facility failed to provide a sanitary environment for residents as evidenced by the facility's unsanitary laundry procedures. Findings include: 1. During a tour of the facility's laundry area on 12/14/21 at approximately 12:30 PM, a linen department employee stated that loads of isolation gowns and environmental services cleaning rags are loaded into the washing machines with cycles started prior to the linen department employees leaving for the day. The loads of wet laundry are then left overnight until the employees return the following morning to place them in the dryer for drying. The employee confirmed that this happens on a regular basis. Per interview on 12/14/21 at approximately 3:00 PM, the Administrator confirmed that employees of the linen department only work day shifts and that there is no evening or night shift coverage in the department for additional processing of laundry. Per interview on 12/15/21 at approximately 9:00 AM, the facility's practice of leaving wet facility laundry in washing machines overnight was	F 921	F 921 All employees in the linen department have been educated on not leaving wet laundry in the washing machines overnight. All residents have the potential to be affected by this deficient practice. To ensure that the same deficient practice does not recur, random audits will be performed weekly by the Hospitality Director and/or designee. If deficient practice persists then further education will be addressed immediately to ensure full compliance from the linen department.	

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F 921	Continued From page 14 discussed with the Director of Nursing. The Director of Nursing did not provide any evidence to the contrary. Leaving wet linens for long periods of time (or overnight) in washing machines without any ventilation creates the risk for the growth of mold and other microorganisms which may not all be killed by the dryer cycle. Since the reprocessed linens are used for every resident throughout the facility, this practice has the potential to impact all residents.	F 921	Completed audits will be reviewed at quarterly QAPI meetings. To be completed by 1/15/2022 **TAG F 921 POC Accepted on 1/07/22 by T. Dougherty/P.Cota**	