AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

March 13, 2023

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 survey conducted on **February 15, 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

Pamela M. Cota, RN
Licensing Chief

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

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 ______	02/15/2023

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

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E 000	Initial Comments An unannounced onsite survey of emergency preparedness was completed by the Division of Licensing and Protection on 2/15/2023. No regulatory violations were identified related to emergency preparedness.	E 000		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an onsite, unannounced re-certification survey and staff vaccination review from 2/13/2023 through 2/15/2023. The following regulatory deficiencies were identified:	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §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). §483.12 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)(2) Ensure that the resident is free	F 604	This page left blank	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lynn Smith
TITLE: Executive Director
(X6) DATE: 3.8.23

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 604	Continued From page 1 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. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review the facility failed to treat one of twenty nine sampled residents with respect and dignity related to the use of physical restraints, as evidenced by: Per the record review Resident # 15 is a 90-year-old person with diagnoses including dementia without behavior disturbance, hypertension, atrial fibrillation, and heart failure. Resident #15 has a BIMS score of 2 per the assessment of 12/19/22 (a BIMS score is determined following a brief interview of mental status. A score of 0-7 indicates severe cognitive impairment). On 2/13/23 at approximately 12:00 PM Resident #15 was observed in the assistive dining room (which also functions as a day room) seated in a Geri-chair with an approximately 6-inch wide yellow lap restraint secured with velcro in the lap area, the belt encircled the resident's trunk and back of the chair, it was also noted that the resident was seated on a chair alarm (a pressure sensitive alarm which sounds when the resident lifts from the seat). During this observation Resident #15 was noted picking up a dish containing a slice of cake and attempting to consume it.	F 604	F 604 All residents have the potential to be affected by the same deficient practice. Resident #15 – on 2/14/23 the Velcro belt was removed as the resident was unable to self-release when asked to do so. A Velcro belt will be used only for Residents who are able to self-release and have been evaluated by Therapy. Nursing will assess resident every shift to ensure that resident is able to self-release when asked to do so. If resident is found to not be able to self-release, the belt will be removed and re-evaluated by Therapy. Director of Nursing or designee will conduct ongoing audits to assure compliance will be reviewed in QA. To be completed by 3/15/23. **Tag F 604 POC accepted on 3/11/23 by H. Fox/P. Cota**	

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F 604	Continued From page 2 On 2/14/23 at 11:35 am observed Resident #15 in the assistive dining room sitting in a Geri chair with a yellow lap restraint wrapped only around the resident's torso. Interviewed an LNA who was present at the time to inquire what the "belt" was and how it worked. The LNA stated it was used to keep the resident from getting up from the chair and falling adding that the resident is kept in the dayroom so staff can "keep an eye on him". On 2/14/23 at 11:50 am met with Clinical Coordinator to view the resident with a lap belt to see if the resident could release it on request. When the resident was asked what the belt was, he/she was unable to focus on the belt, when asked to release the lap belt the resident pulled at the blanket on the side of the chair and pulled at his/her pants while verbalizing in a non-coherent manner. The clinical coordinator confirmed the resident was not able to release the belt. Resident #15's electronic medical record was reviewed, and a fall risk assessment dated 12/21/22 was noted to contain 19 risk factors including decreased safety awareness, decreased muscle coordination, and balance problems when standing. A review of the resident care plan revealed the following intervention for the nursing diagnosis potential for injuries/trauma/falls "Lap belt to be on when seated in a wheelchair, the patient is able to remove and fasten voluntarily and at will, use of posey vest when in a wheelchair to help decrease the risk of falls (nursing staff made aware). Nursing staff to make daily checks to confirm the voluntary release of belt and posey". Also noted in the care plan written in all capital letters was "DO NOT LEAVE IN ROOM PLEASE ENCOURAGE RESIDENT TO REMAIN IN	F 604	This page left blank	

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F 604	Continued From page 3 COMMON AREA FOR OBSERVATION DUE TO IMPULSIVITY WITH SELF RELEASING SAFETY REMINDER BELT". The record indicates the lap belt was initiated on 12/21/21, and it is noted that the resident has had 12 falls documented since the initiation of this intervention.	F 604		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to initiate and complete a thorough investigation of a possible abuse allegation in accordance with state law for 1 of 29 sampled residents (Resident #5). Findings include: Per record review Resident # 5 was admitted on 04/04/2017 with diagnoses to include Alzheimer's disease and Major Depressive Disorder.	F 610	F 610 All residents have the potential to be affected by this deficient practice. All staff will be re-educated on the facility's Abuse Prevention Reporting Requirements. All nursing staff will be re-educated on proper documentation and investigation of reported incidents/accidents. Director of Nursing or designee will conduct ongoing audits to assure compliance will be reviewed in QA. To be completed by 3/15/23 **Tag F 610 POC accepted on 3/11/23 by H. Fox/P. Cota**	

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F 610	Continued From page 4 Physician notes written between 6/9/22 - 12/26/22 reflect that the Resident has intermittent episodes of irritability and agitation. Review of the resident's care plan revealed a behavior care plan focus of "alteration in thought process due to dementia." Interventions include "report pain indicators", "acknowledge resident's perspective" and "maintain safety of resident and others." Nurse's progress notes going back to July of 2022 show this resident has mood fluctuations which have resulted in episodes of anger directed at staff as noted on 07/31/22, 12/16/22, and 02/08/23. A progress note dated 10/05/22 reads that, "Resident is in a bad mood, tried to take another resident's glasses and sweater ... I separated the two and s/he has now settled down. Will continue to make sure they don't get close to each other as it really upset the other resident." Another progress note dated 10/26/22 reads, "The LNA's told me that resident threw a cup of coffee at another resident, so we will keep them separated." During interview on 2/15/23 at 9:15 AM the Director of Nursing confirmed that throwing coffee at another resident could be considered abuse, or in the least, an incident the facility would investigate to determine abuse. The DNS also confirmed that there was no further documentation regarding the incident in the medical records and no assessments were completed specific to the other resident involved. An investigation was not initiated or completed because administration, had not been made aware of the incident by the facility staff member who documented the incident. Review of the facility policy titled "Abuse Prevention Policy and Procedure and Reporting	F 610	This page left blank	

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F 610	Continued From page 5 Requirements" last reviewed and revised on 10/22, Page 6 reads, "All episodes of witnessed or suspected abuse ...must be reported to the Supervisor or Administrator/designee immediately. During off hours and weekends, the nursing supervisor is to contact the Director of Nursing Services or designee as soon as the incident has been reported." The policy also reads that, "The Administrator/designee will investigate the incident in the following ways: a. By interviewing all persons who may have knowledge of the incident. b. By reviewing medical records or other written reports. c. Or by taking any other action(s) believed to be helpful in establishing the facts of the incident ..." On page 9 of the policy specific to Follow-Up it reads, "All employees must orally report any incidents of witnessed or suspected altercations between residents/vulnerable adults to the supervisor immediately. This oral report must be followed by a written report within six hours of the altercation. During the interview on 2/15/23 at 9:15 AM the DNS confirmed the above policy was not followed.	F 610	This page left blank	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		

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F 657	Continued From page 6 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to review and/or revise care plans regarding fall prevention for 2 residents (#17 0) of 29 sampled residents. Findings include: 1. Per record Review, Resident #17 was admitted to the facility on 8/8/22 and has diagnoses that include acute respiratory failure, mild acute heart failure, and history of falls. Since his/her admission, S/he has sustained falls on 8/13/22, 8/15/22, 8/18/22, 8/23/22, 8/25/22, 8/30/22, 9/5/22, 9/17/22, 11/16/22, 1/26/23, and 2/7/23. Review of Resident #17's care plan does not reveal any interventions to prevent falls on after S/he suffered from falls on 8/18/22, 9/5/22, 9/17/22, 11/16/22, and 1/26/22.	F 657	F 657 All residents have the potential to be affected by this deficient practice. Resident #17 & 48 – care plans for these two residents have been updated with fall prevention interventions. Director of Nursing or designee will review 24-hour report daily and care plan(s) will be revised with fall prevention interventions as falls are identified. Falls Committee will meet bi-weekly to ensure that fall care plans have been effective. Director of Nursing or designee will conduct ongoing audits to assure compliance will be reviewed in QA. To be completed by 3/15/23. **Tag F 657 POC accepted on 3/11/23 by H. Fox/P. Cota**	

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F 657	Continued From page 7 Per interview on 2/15/23 at 1:13 PM, the DON stated that it is hard for staff to know what are new care interventions and where to enter interventions the way it is set up in the electronic medical system. S/He confirmed that Resident #17 did not have new interventions added to his/her care plan for each fall since his/her admission. 2. Per record Review, Resident #48 was admitted to the facility on 5/19/22 and has diagnoses that include dementia with behavioral disturbances, neurogenic bladder [loss of bladder control], and anemia. Since his/her admission, S/he has sustained falls on 7/25/22, 8/31/22, 9/18/22, 11/23/22, 1/3/23, 1/8/23, and 1/11/23. Review of Resident #48's care plan does not reveal any interventions to prevent falls on after S/he suffered from falls on 7/27/22, 9/18/22, 1/3/23, 1/8/23, and 1/11/23. Per interview on 2/15/23 at 1:13 PM, the DON confirmed that Resident #48 did not have new interventions added to his/her care plan for each fall since his/her admission.	F 657	This page left blank	
F 689 SS=E	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	F 689		

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F 689	Continued From page 8 by: Based upon interview and record review, the facility failed to ensure 5 residents [#15, #21, #51, #17, & #48] of 29 sampled residents remained free of accident hazards as possible regarding adequate supervision, implementing interventions to reduce hazards and risks, and assessing interventions for effectiveness: Findings include: Review of the facility's "Resident Falls and Incident Reporting" policy includes "It is The Manor Policy to promote an environment that minimizes the occurrence of falls and other incidents that place residents at increased risk for injury ... minimizing injury through the use of ... post incident monitoring and post incident analysis are an integral part of The Manor's approach to resident safety". Under the policy's "Prevention" section is "All staff are responsible for identifying and addressing conditions that may place residents at increased risk of falling ... care plans will be updated based on identified needs." 1.) Per record review Resident #15 is a 90-old person with diagnosis including dementia without behavior disturbance, hypertension, atrial fibrillation, and heart failure. Record review reveals Resident #15 has sustained numerous falls including, 2 falls on both 2/14/22 and 2/15/22, 1 fall on 4/13/22, 4/19/22, 6/1/22, 8/1/22 and 11/26/22. A review of Resident #15's care plan revealed that the most recent care plan update was completed on 11/26/22. Following the update to the care plan Resident #15 suffered 3 more falls (12/26/22, 12/29/22, and 2/8/23). The fall on 2/8/23 resulted in documented injuries including a skin tear, avulsion (a traumatic injury in which one or more pieces of tissue are torn	F 689	F 689 All residents have the potential to be affected by this deficient practice. Residents 15, 21, 51, 17, & 48 – care plans for these five residents have been updated with fall prevention interventions. Director of Nursing or designee will review 24-hour report daily and care plan(s) will be revised with fall prevention interventions as falls are identified. Falls Committee will meet bi-weekly to ensure that fall care plan interventions have been effective. Director of Nursing or designee will conduct ongoing audits to assure compliance will be reviewed in QA. To be completed by 3/15/23. **Tag F 689 POC accepted on 3/11/23 by H. Fox/P. Cota**	

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F 689	Continued From page 9	F 689		

and detached from the body), and a hematoma (collection of blood beneath the skin) to the right forearm. On 2/14/23 the DON confirmed the care plan had not been revised since 11/26/22.

2.) Per record review, Res. #21 was admitted to the facility with diagnoses that include depression, functional quadriplegia, psychoactive substance use, and wandering.

The resident's Care Plan identified the resident as having "Potential for Trauma- falls, due to Impaired balance, decreased mobility, unsteady gait, and use of devices for walking."
Shortly after Res. #21's admission, several interventions are added to the Care Plan to decrease the risk of falls, dated 3/2/22.

Review of the facility's "Resident Falls and Incident Reporting" policy includes "It is The Manor Policy to promote an environment that minimizes the occurrence of falls and other incidents that place residents at increased risk for injury ... minimizing injury through the use of ... post incident monitoring and post incident analysis are an integral part of The Manor's approach to resident safety". Under the policy's "Prevention" section is "All staff are responsible for identifying and addressing conditions that may place residents at increased risk of falling ... care plans will be updated based on identified needs."

A review of Nurses Notes for Res. #21 reveal:

On 11/8/22 at 8:46 PM "resident fell onto [his/her] left side in hallway while ambulating with walker in hallway".
On 11/13/22 at 12:30 AM "Licensed Nurses Aid

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F 689

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[LNA] was walking in hallway and when passed by resident's room, found resident lying on floor by bed".
On 11/14/22 at 8:40 AM "resident found on floor with walker in front of [him/her] ... per previous staff notes resident has been exhibiting similar behavior past few days."
On 11/17/22 at 3:16 AM "LNA hears resident hollering "help". Resident noted kneeling on the floor next to her bed with vomit on self and bed."

Review of Res. #21's Care Plan after the fall on 11/8/22 reveals interventions repeated from the Care Plan dated 3/2/22, with no new interventions added to prevent future falls. When Res. #21 falls again 5 days later on 11/13/22, there is no mention of the fall in the resident's Care Plan and no changes or new interventions added. Per Nurses Notes, Res. #21 falls again the next day, 11/14/22, and the Care Plan again repeats interventions from 3/22/22 that have not prevented the resident from falling on 11/8/22, 11/13/22, and 11/14/22. No new interventions were added to the Care Plan. On 11/17/22, 3 days after the last fall, Res. #21 falls again. The resident's Care Plan on 11/21/22 notes the fall and lists "continue with plan of care": no new interventions are added.

An interview was conducted with the facility's Director of Nursing [DON] on 02/15/23 at 8:36 AM. The DON confirmed that despite the 4 documented falls listed above, the facility did not add any new interventions to Res. #21's Care Plan to prevent future falls.

3.) Per record review, Res. #51 was admitted to the facility with diagnoses that include a displaced fracture of the right lower leg, stroke, and

F 689

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F 689	Continued From page 11	F 689	This page left blank	

dementia.
The resident's Care Plan identified the resident as having "Potential for Trauma- falls, due to "gait/balance, history of falls, dementia/cognitive impairment, and age related physical decline."
A review of Nurses Notes for Res. #51 reveal:

On 1/6/23 at 4:02 PM "Activity assistant updated nurse that resident was on the floor. Staff went to room and observed recliner in upright position, resident on floor in front of recliner, on back with blanket and pillow on ground with resident".
On 1/15/23 at 12:30 PM "LNA found resident on floor and notified nursing."

Review of Res. #51's Care Plan reveals no mention of either fall. Further review reveals no new interventions added to Res. #51's Care Plan after the fall on 1/6/23. When the resident falls again on 1/15/23, again no new interventions are added to the Care Plan.

An interview was conducted with the facility's Director of Nursing [DON] on 02/15/23 at 8:36 AM. The DON confirmed that the facility did not add any new interventions to Res. #51's Care Plan to prevent future falls after either fall on 1/6/23 or 1/15/23.

4.) Per record Review, Resident #17 was admitted to the facility on 8/8/22 and has diagnoses that include acute respiratory failure, mild acute heart failure, and history of falls. Since his/her admission, S/he has sustained falls on 8/13/22, 8/15/22, 8/18/22, 8/23/22, 8/25/22, 8/30/22, 9/5/22, 9/17/22, 11/16/22, 1/26/23, and 2/7/23. Review of Resident #17's care plan does not reveal any interventions to prevent falls on

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F 689	Continued From page 12 after S/he suffered from falls on 8/18/22, 9/5/22, 9/17/22, 11/16/22, and 1/26/22. Per interview on 2/15/23 at 1:13 PM, the DON stated that Resident #17 did not have new interventions added to his/her care plan for each fall since his/her admission. 5.) Per record Review, Resident #48 was admitted to the facility on 5/19/22 and has diagnoses that include dementia with behavioral disturbances, neurogenic bladder [loss of bladder control], and anemia. Since his/her admission, S/he has sustained falls on 7/25/22, 8/31/22, 9/18/22, 11/23/22, 1/3/23, 1/8/23, and 1/11/23. Review of Resident #48's care plan does not reveal any interventions to prevent falls on after S/he suffered from falls on 7/27/22, 9/18/22, 1/3/23, 1/8/23, and 1/11/23. Per interview on 2/15/23 at 1:13 PM, the DON confirmed that Resident #48 did not have new interventions added to his/her care plan for each fall since his/her admission.	F 689	This page left blank	
F 758 SS=E F329	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		

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

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F 758	Continued From page 13 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure PRN (as needed) orders	F 758	This page left blank	

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F 758	Continued From page 14 for psychotropic drugs are limited to 14 days for 3 of 29 sampled residents (Residents #11, #33, and #34) and that a GDR (gradual dose reduction) was attempted for 2 of 29 sampled residents (Resident #20 and #50). Findings include: 1. Review of Resident #11's medical record reveals a physician order dated 1/13/23 for Clonazepam (anti-anxiety; psychotropic) 0.25 milligrams (mg) every 8 hours as needed for anxiety/air hunger with no end date. Review of Resident #11's medication administration record (MAR) reveals they are currently receiving approximately one as needed dose per day. A Pharmacist recommendation from 2/3/23 states "Per the November 2017 Medicare MEGA Rule regulations, if PRN psychotropic medications are to be continued, they need a specific duration & rationale for continuing use. Resident has the following order: Clonazepam 0.25 mg po q8hrs prn [by mouth every 8 hours as needed] anxiety/air hunger. Resident has requests ~one dose per day ... Please document rationale for continuing this order." 2. Review of Resident #33's medical record reveals a physician order dated 1/9/23 for Lorazepam (anti-anxiety; psychotropic) 0.5 mg every 8 hours as needed for anxiety with no end date. Review of Resident #33's MAR reveals they received the as needed dose once in January 2023. A Pharmacist recommendation from 2/3/23 states "Per the November 2017 Medicare MEGA Rule regulations, if PRN psychotropic medications are to be continued, they need a specific duration & rationale for continuing use. Resident has the	F 758	F 758 All residents have the potential to be affected by this deficient practice. Residents #11, 33 & 34 – the physician(s) have been faxed requesting documented rationale for continuing the psychotropic medications, if they wish to continue them. All nurses will be re-educated when a physician orders a PRN psychotropic medication that there must be a 14 day limit, or documented rationale for psychotropic medication to be continued. Psychotropic medications will be reviewed bi-weekly to ensure that 14-day limit is maintained. Residents #20 & 50 - the physician(s) have been faxed requesting GDR as recommended by the pharmacy consultant, or documented	

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F 758	Continued From page 15	F 758		

following order: Lorazepam 0.5 mg po q8hrs prn [by mouth every 8 hours as needed] anxiety. Resident has used one dose since this order was started 1/9/23 ... Please document rationale for continuing this order."

3. Review of Resident #34's medical record reveals physician orders for Lorazepam 0.5 mg every 2 hours as needed for anxiety with no end date starting 11/16/22, and Prochlorperazine 10 mg every 6 hours as needed for nausea with no end date starting 1/13/23. Review of Resident #34's MAR reveals they are currently receiving approximately 1-5 as needed doses of Lorazepam per day.

A Pharmacist recommendation from 2/3/23 states "This portion of my consult is repeated from December, as it has not yet been addressed. Per the November 2017 Medicare MEGA Rule regulations, if PRN psychotropic medications are to be continued, they need a specific duration & rationale for continuing use. It appears that the following order had a change in directions 11/19/11, but no duration given: Lorazepam 0.5 mg po q2hrs prn [by mouth every 2 hours as needed] anxiety. Resident does use anywhere from 2-5 doses per day ... Please document rationale for continuing this order," and "Resident has the following order: Prochlorperazine 10 mg po q6hrs prn [by mouth every 6 hours as needed] nausea. Though this med is used for nausea, it is classified as an antipsychotic & is therefore subjected to the MEGA rule & PRN orders can only be used for 14 days."

4.Review of Resident #20's clinical record reveals a physician order dated 7/27/22 for Fluoxetine (an antidepressant and psychotropic) 40 mg daily.

Provider's Plan of Correction (F 758):

rationale for psychotropic medication to be continued.

All GDR pharmacy consultation reports that are currently faxed to physicians will be tracked for return response.

Director of Nursing or designee will conduct ongoing audits to assure compliance will be reviewed in QA.

To be completed by 3/15/23.

Tag F 758 POC accepted on 3/11/23 by H. Fox/P. Cota

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F 758	Continued From page 16 Review of Resident #20's MAR reveals they are currently receiving this medication as ordered. A Pharmacist recommendation from 1/5/2023 states "Per survey guidelines, it is time for me to ask for a Gradual Dose Reduction (GDR) of Resident's antidepressant. They currently receive: Fluoxetine 40 [by mouth daily]. Consider a dose reduction to Fluoxetine 30 mg [by mouth daily]. During their most recent MDS mood interview, they did not have any complaints. In your October note, you mentioned reassessing in the winter if dose could be decreased or discontinued. If a GDR is not indicated, please document a RISK/BENEFIT note or an official 'no GDR' note, so we can be complaint for Survey." 5. Review of Resident #50's medical record reveals physician orders dated 5/25/22 for Aripiprazole [Abilify; antipsychotic] 30 mg daily in the morning, Citalopram [antidepressant; psychotropic] 10 mg daily in the morning, Quetiapine [Seroquel; antipsychotic] 100mg daily in the morning and 600 mg daily in the evening. Review of Resident #50's MAR reveals they are currently receiving these medications as ordered. A Pharmacist recommendation from 11/4/2022 states "Per Survey Guidelines, each psychotropic Medication requires periodic attempts at GDRs (Gradual Dose Reductions). Resident currently receives: Abilify 30 mg po qd [by mouth once daily], Citalopram 10 mg po qd [by mouth once daily], Seroquel 100 mg po qam [by mouth every morning] + 600 mg po hs [by mouth every evening]. I am aware that Resident has long standing schizophrenia. If you wish to continue their current regimen, please document a RISK/BENEFIT note or why a GDR would be	F 758	This page left blank	

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F 758	Continued From page 17 contraindicated at this time." Per interview on 2/15/23 at 1:13 PM, the Director of Nursing (DON) stated that the facility had lost a provider and there are new providers. S/He confirmed that PRN psychotropic medications need an end date and there were no end dates for the PRN psychotropic medications prescribed to Residents #11, #33, and #34, and a GDR had not been attempted or documented for Residents #20 and #50. On 2/15/23 at 2:35 PM, the DON confirmed that a physician did not include the required rational for not attempting a GDR in Resident #20's and #50's medical record.	F 758	F 841 All residents have the potential to be affected by this deficient practice. The facility has contracted with a physician to fill the Medical Director role, effective 3/1/2023, with annual renewal. To be corrected by 3/15/23.	
F 841 SS=F	Responsibilities of Medical Director CFR(s): 483.70(h)(1)(2) §483.70(h) Medical director. §483.70(h)(1) The facility must designate a physician to serve as medical director. §483.70(h)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and review of documentation, the facility failed to designate a physician to serve as medical director and who coordinates medical care and implements facility policies. Findings include: On 02/15/23 review of the facility's documentation of Quality Assurance Performance and Improvement (QAPI) meeting agenda and staff attendee signature sheets, reveal the presence of	F 841	**Tag F 841 POC accepted on 3/11/23 by H. Fox/P. Cota**	

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F 841	Continued From page 18 a medical director's participation at meetings for the following dates: April 2022, July 2022, and October 2022 on a quarterly bases, however there is no proof of attendance at a meeting held on January 17, 2022. The next quarterly meeting is due to be held in April 2023. Interview on 02/15/23 at 1:30pm with the Administrator, Director of Quality, and the Director of Nursing reveals that the facility does not currently have a Medical Director. (cross tag F 868)	F 841	This page left blank	
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement	F 868		

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F 868	Continued From page 19 projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and review of documentation, the facility failed to maintain the position of a Medical Director as part of the Quality Assurance Performance and Improvement (QAPI) committee. Findings include: On 02/15/23 review of the facility's documentation of Quality Assurance Performance and Improvement (QAPI) meeting agenda and staff attendee signature sheets, reveal the presence of a medical director's participation at meetings for the following dates: April 2022, July 2022, and October 2022 on a quarterly bases, however there is no proof of attendance at a meeting held on January 17, 2022. The next quarterly meeting is due to be held in April 2023. Interview on 02/15/23 at 1:30pm with the Administrator, Director of Quality, and the Director of Nursing reveals that the the facility does not currently have a medical director. (cross tag F841)	F 868	F 868 Medical Director position was vacant from January 1, 2023, through February 28, 2023. **Tag F 868 POC accepted on 3/11/23 by H. Fox/P. Cota**	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880	F 880 All residents have the potential to be affected by this deficient practice. The facility has implemented a Legionella Surveillance Policy. To be corrected by 3/15/23. **Tag F 880 POC accepted on 3/11/23 by H. Fox/P. Cota**	

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F 880	Continued From page 20 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880	This page left blank	

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F 880	Continued From page 21 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview it was determined that the facility failed to ensure a system to prevent and identify causes of infection by failing to develop and implement measures to prevent the growth of Legionella in the facility's water system. Findings include: Per the Mayo Clinic: 'Legionnaires' disease is a serious type of pneumonia you get when Legionella bacteria infect your lungs. Symptoms include high fever, cough, diarrhea, and confusion. You can get Legionnaires' disease from water or cooling systems in large buildings,	F 880	This page left blank	

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F 880	Continued From page 22 like hospitals or hotels. Legionnaires' disease can be life-threatening. (https://www.mayoclinic.org/diseases-conditions/legionnaires-disease/symptoms-causes) On 2/15/23 at 10:09 AM an interview was conducted with the Director of Nurses (DON), who is also one of the two Certified Infection Preventionist (CIP) in the facility, revealed that S/he is unaware of Centers for Disease Control (CDC) and Center for Medicare and Medicaid Services (CMS) required that the facility have Legionella prevention measures in place and referred to the Maintenance Director and/or the Administrator. On 02/15/23 at 1:30 PM an interview with the Facility Administrator revealed that S/he was unaware of the CDC and CMS requirements related to prevention of Legionella in the facilities water system. The Administrator confirmed that the facility does not have measures in place to prevent the growth of Legionella in the facility water system.	F 880	This page is blank	