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

May 20, 2019

Mr. Dane Rank, Administrator
Thompson House Nursing Home
80 Maple Street
Brattleboro, VT 05301

Dear Mr. Rank:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 10, 2019**. 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
	475050	A. BUILDING _____ B. WING _____	04/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THOMPSON HOUSE NURSING HOME	80 MAPLE STREET BRATTLEBORO, VT 05301

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E 000	Initial Comments An unannounced on-site Emergency Preparedness review was conducted on 4/10/2019, in conjunction with the annual re-certification survey by the Division of Licensing an Protection. The following regulatory deficiency was identified as a result of the review:	E 000		
E 006 SS=D	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide	E 006	Risk assessments were completed for snowstorms and missing residents. Emergency policies for these two risk assessments were reviewed. Snowstorm policy was found to be in the facility emergency procedure manual under "incliment weather." It will be separated into its own "snowstorm" policy. The missing residents policy was copied from the Nursing Policy Manual to the Emergency Policy Manual. Emergency Policies will be reviewed yearly by the Administrator or designee to ensure that these policies stay in the manual. The Emergency Manual will be presented yearly to the QAPI committee in meetings to ensure continued compliance. E006 POC accepted 5/16/19 SFreemanRN/PMC	05/10/19 05/04/19 05/10/19 and ongoing 05/10/19 and ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/19/19

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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E 006	Continued From page 1 care. This REQUIREMENT is not met as evidenced by: Based on record review the facility failed to assure that the risk assessment included an all-hazards approach, including snow storms, frequent in the area, and missing residents, as required for Long Term care facilities per regulation. Findings include: Per record review the Risk Hazard Assessment tool used by the facility has a, preprinted, list of hazard risks. The facility is located in an area that experiences frequent significant snow storms throughout the winter season. Snowstorms are not listed, in the hazard risk assessment, as a risk hazard for this facility. It is required by Long Term Care (LTC) emergency preparedness regulations that LTC facilities include missing residents as a risk. There is no risk hazard, for missing residents, included in the facility risk hazard list. The facility Administrator acknowledged in a telephone interview on 4/11/19 that these risk hazards, as above, were not identified in the Emergency Preparedness Plan.	E 006		
F 000	INITIAL COMMENTS An unannounced on-site re-certification survey was conducted by the Division of Licensing and Protection between 4/8 - 10/2019. There were regulatory findings.	F 000		
F 605 SS=D	Right to be Free from Chemical 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:	F 605	Located notification of the responsible party for resident #240 for admisitration of IM Haldol in PointClickCare Progress notes dated 01/19/19. Usure why surveyor never asked to see this.	04/25/19

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F 605	Continued From page 2 §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 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 staff interview and record review the facility failed to ensure that 1 of 16 residents, Resident #240, was free from chemical restraints for agitated/aggressive behaviors. Findings include: Per review of the nursing progress notes from 1/19/19, at 7:00 PM the resident spit out his/her scheduled medications. At 7:20 PM, the resident	F 605	Located in resident #240's Point-ClickCare progress note the non-pharmacalogical interventions of one on one and change of location from hallway to her room prior to obtaining MD order and administration. Unsure why surveyor never asked to see this. Reviewed charts for all residents currently receiving PRN psychoactive medication to ensure non-pharmacological interventions were tried prior to administration. A mandatory inservice was conducted on Resident Rights and specifically the right for resident refusal of medications. This inservice included the use of non-pharmacological interventions. Quarterly audits will be comlpeted by DNS or designee on all residents receiving PRN psychoactive medications. Audits will contain documentation of the presence of non-pharmacological interventions prior to administration of medication. Also notification of responsible party prior to medication administrtion will be checked. Results will be reported in QAPI meetings quarterly to ensure continued compliance. F605 POC accepted as encircled 5/16/19 SFramanRN/PMC	04/25/19 05/10/19 05/10/19 05/09/19 and ongoing

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F 605	Continued From page 3	F 605		

became weepy and required one to one attention. At 8:15 PM, the resident was assisted to his/her room by a Licensed Nursing Assistant (LNA) and began to scream. At that time, a Licensed Practical Nurse (LPN) had attempted to administer an as needed medication (Clonazepam-medication used to treat anxiety and agitation) to the resident and s/he spit the medication out. At 8:45 PM, the LPN called the on-call physician and received an order for Haldol 0.5 mg (milligrams) IM now. At 9:10 PM, the LPN had administered the medication to Resident #240 in his/her right arm. On 1/24/19, at 11:15 PM the resident was agitated and combative. S/he kicked a LNA and a RN. On 1/25/19 at 12:15 AM, The RN called the physician and received an order for Haldol to be given IM at that time. The nursing progress notes from 12/28, 12/29, 12/30, 1/1, 1/2, 1/7, 1/8, 1/9, 1/10, 1/11, 1/13, and 1/14 reflect resident #240 received scheduled and PRN Clonazepam for behaviors with no evidence of non-pharmacological interventions. There was also no evidence in the record that Resident #240 consented to receiving the medications IM and/or that his/her healthcare representative was notified that the medication was given in this manner.

Per interview on 4/10/19 at 10:55 AM with a LPN, s/he stated that on the evening of 1/19/19, Resident #240 was screaming no matter what the staff did. There was just no consoling the resident. S/he was disrupting other residents on the unit. The resident spit out his/her scheduled medications; and due to the resident's agitation the LPN attempted to administer a prn dose of Clonazepam. The resident spit the prn medication out as well. S/he obtained a prn order from the physician for a dose of Haldol IM. S/he

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F 605	Continued From page 4 stated that a LNA was gently holding the resident's arm while s/he was administering the injection in case the resident became out of control. During an interview on 4/10/19 at 11:23 AM with a RN, s/he confirmed that the resident had behavior problems and became combative at times requiring staff to give him/her PRN (as needed) medication. S/he stated that s/he "could not really recall this particular incident" (on 1/25/19). S/he stated that the resident had refused his/her scheduled medications on 1/25/19; however, allowed the injection of Haldol with encouragement from the LNA.	F 605		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the	F 623	Social Services Designee spoke with all affected residents to ensure their continued understanding of our bed hold policy when they are discharged Type text here The transfer/discharge notice and bed hold authorization forms were revised. The procedure was modified in order for the nursing department to give this notice to the resident who is being transferred at the time of the transfer or before. In the event that the resident is unconscious at the time of transfer, notice of the bed hold and transfer will be given to the resident, and the responsible party will be informed. All transfers/discharges for the past 3 months were reviewed. Any omissions in notification were noted and discussion with affected resident was conducted to ensure under-	05/09/19 05/09/19 05/09/19

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F 623	Continued From page 5 resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and	F 623	standing of policy and standard of notification. Quarterly audits of transferred/discharged residents will be completed by Administrator or designee to check that bed-hold notification and/or notification of transfer was given. Results of these audits will be presented in QAPI meetings quarterly to ensure continued compliance. F623 POC accepted 5/16/19 SFreamanRN/PMC	05/09/19 and ongoing 05/09/19 and ongoing

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F 623	Continued From page 6	F 623		

telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to notify the resident and/or resident's representative in writing of a transfer/discharge for two (2) of three (3) residents in the applicable sample, (Resident #6 and #7). The findings include the following:

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F 623	Continued From page 7	F 623		

1. Per record review, Resident #7 was transferred to the Emergency Room for evaluation after a fall on 9/2/18 at approximately 7:30 AM. The resident returned to the facility 9/3/19 at 12:50 PM. Per review of the medical record for Resident #7, there is no evidence that a transfer/discharge notice was sent in writing to the resident and/or the resident's representative.

The Social Service Designee confirmed on 4/10/19 at approximately 10 AM, that the transfer/discharge written notice was never provided at time of transfer/discharge or as soon as possible to the resident and/or representative. Confirmation was also made that the facility did not follow their policy 3.14 (d) notice before transfer or discharge.

Per review of the facility document, identified as Discharge/Transfer Notice, evidences that the contents of the facility notice does not contain all required elements per Federal CMS (Centers for Medicare Services) requirements listed in this regulation. Since the notice was not provided the information was not available to the resident and/or representative.

2. Per record review, Resident #6 was transferred to the Emergency Department (ED) on 11/17/18, after a fall. There was no evidence in the medical record that a written transfer/discharge notice was given to the resident and/or resident's representative upon the transfer to the ED. Per interview on 4/10/19 at 9:41 AM with the Social Worker, s/he confirmed that a written transfer/discharge notice was not given to the resident and/or resident's representative upon the transfer to the ED.

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F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to notify the resident and/or resident's representative of a bed hold in writing for 1 of 3 applicable residents (Resident #6). Findings include: Per record review, Resident #6 was transferred to	F 625	Social Services Designee spoke with affected residents to confirm their prior understanding that we were, and will, hold their room when they are transferred to the hospital. The transfer/discharge notice and bed hold authorization forms were revised. The procedure was modified in order for the nursing department to give this notice to the resident who is being transferred at the time of the transfer or before. In the event that the resident is unconscious at the time of transfer, notice of the bed hold and transfer will be given to the resident, and the responsible party will be informed. All transfer and discharges for the past 3 months were reviewed for presence of bed-hold authorization letters. Any affected residents were informed of our intention at the time, and in the future, to hold their bed at the time of transfer unless they notify us of their intent to do otherwise. A quarterly review of all transferred and discharged residents will be completed by the Administrator or designee to ensure that bed-hold forms were given at time of transfer. Results of these reviews will be presented in QAPI meetings to ensure continued compliance.	05/09/19 05/19/19 and ongoing 05/09/19 05/09/19 and ongoing Type text here 05/09/19 and ongoing

F625 POC accepted 5/16/19 SFreemanRN/PMC

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F 625	Continued From page 9 the Emergency Department (ED) on 11/17/18, after a fall. There was no evidence in the medical record that a bed hold notice was given to the resident and/or resident's representative in writing upon the transfer to the ED. Per interview on 4/10/19 at 9:41 AM with the Social Worker, s/he confirmed that a bed hold notice was not given to the resident and/or resident's representative in writing upon the transfer.	F 625		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to	F 756	Audit of all charts for Pharmacist review was completed. No other residents were affected. Monthly review of pharmacist report by DNS or designee for notification to all providers to whom Pharmacist has provided notification. DNS or designee will allow up to 72 - hours for physician response, then will call physician to receive verbal instructions. Quarterly review of all Pharmacist recommendations to providers will be completed by DNS or designee. Results of monthly reviews will be presented quarterly in QAPI meetings to ensure continued compliance. F756 POC accepted 5/16/19 sFreemanRN/PMC	04/11/19 05/05/19 and ongoing 05/09/19 and ongoing 05/09/19 and ongoing

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F 756	Continued From page 10 be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility pharmacist failed to report drug irregularities to the attending physician, medical director, and/or director of nursing for 1 of 5 applicable residents in the sample (Resident #17). Findings include: Per record review a physician's order dated 2/5/19, read, "Lorazepam (medication for anxiety) tab 0.5 mg (milligrams) 1 tablet by mouth every 6 hours as needed for anxiety". The pharmacist reviewed Resident #6's medications on 2/26/19 and noted that the Lorazepam was ordered prn (as needed); however, did not denote that the order was past the required renewal period of 14 days per regulation. S/he also reviewed the resident's medications on 3/27/19, and did not report any irregularities. Per interview on 4/10/19 at approximately 2:00 PM with the Director of Nursing (DNS), s/he confirmed the above information.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that	F 758	Monthly reviews of all medications by a licensed Pharmacist will be completed with a review of recommendations by the Medical Director, DNS, and Administrator.	05/05/19 and ongoing

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	475050	A. BUILDING _____ B. WING _____	04/10/2019

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F 758	Continued From page 11 affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.	F 758	Results of these reviews will be presented in quarterly QAPI meetings to ensure continued compliance. Palliative Care policy was updated to include "duration" of medications for these patients to note duration of the order with a start and end date as determined by the physician and in consideration of the patient's specific needs. Review of 3 months of Pharmacy recommendations was completed to identify any other recommendations that were not addressed. F758 POC accepted 5/16/19 SFreamand/pmc	07/30/19 05/10/19 05/09/19

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§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 interview and record review the facility failed to to ensure that resident's drug regimens were free from unnecessary psychotropic drug use for 2 of 5 applicable residents in the sample (Resident #6 and #240). Findings include:

1. Per record review a physician's order dated 2/5/19, read, "Lorazepam (medication for anxiety) tab 0.5 mg (milligrams) 1 tablet by mouth every 6 hours as needed for anxiety". There was no evidence in the medical record that the physician documented the rationale for the use of the PRN Lorazepam beyond the 14 day period as per regulation. Per interview on 4/10/19 at 12:45 PM with the DNS, s/he confirmed that the physician did not document the rationale and/or duration of use for the PRN Lorazepam in the medical record.
2. Per review of the nursing progress notes from January 2019, Resident #240 had received Haldol (antipsychotic medication) IM (intramuscularly) on two separate occasions: 1/19/19 and 1/25/19. On 1/19/19, at 7:00 PM the resident spit out his/her scheduled medications. At 7:20 PM, the resident became weepy and required one to one attention. At 8:15 PM, the resident was assisted to his/her room by a Licensed Nursing Assistant (LNA) and began to scream. At that time, a Licensed Practical Nurse (LPN) attempted to administer an as needed medication (Clonazepam-medication used to

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treat anxiety and agitation) to the resident and s/he spit the medication out. At 8:45 PM, the LPN called the on-call physician and received an order for Haldol 0.5 mg (milligrams) IM now. At 9:10 PM, the LPN had administered the medication to Resident #240 in his/her right arm. On 1/24/19, at 11:15 PM the resident was agitated and combative. S/he kicked a LNA and a RN. On 1/25/19 at 12:15 AM, The RN called the physician and received an order for Haldol to be given IM to the resident at that time. The nursing progress notes from 12/28, 12/29, 12/30, 1/1, 1/2, 1/7, 1/8, 1/9, 1/10, 1/11, 1/13, and 1/14 reflect resident #240 received scheduled and PRN Clonazepam for behaviors with no evidence of non-pharmacological interventions. There was also no evidence in the record that Resident #240 consented to receiving the medication IM and/or that his/her healthcare representative was notified that the medication was given in this manner.

Per interview on 4/10/19 at 10:55 AM with a LPN, s/he stated that on the evening of 1/19/19, Resident #240 was screaming no matter what the staff did. There was just no consoling the resident. S/he was disrupting other residents on the unit. The resident spit out his/her scheduled medications; and due to the resident's agitation the LPN attempted to administer a PRN dose of Clonazepam. The resident spit the PRN medication out as well. S/he obtained a PRN order from the physician for a dose of Haldol IM. S/he stated that a LNA was gently holding the resident's arm while s/he was administering the injection in case the resident became out of control. During an interview on 4/10/19 at 11:23 AM with a RN, s/he confirmed that the resident had behavior problems and became combative at times requiring staff to give him/her PRN (as

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F 758	Continued From page 14 needed) medication. S/he stated that s/he "could not really recall this particular incident" (on 1/25/19). S/he stated that the resident had refused his/her scheduled medications on 1/25/19; however, allowed the injection of Haldol with encouragement from the LNA.	F 758		
F 838 SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and	F 838	The facility assessment tool was further updated to include all applicable information. The information will be presented in a more cogent fashion so that anyone viewing the assessment can ascertain the individualized nature of the assessment. Quarterly presentation of the facility assessment will be conducted in quarterly QAPI Meetings. F838 POC accepted 5/16/19 SFreemanRN/PMC	05/08/19 05/08/19 and ongoing 07/30/19 and ongoing

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(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to document the Facility Assessment which contained all the required information. Findings include:

In a review of the facility assessment it is found that the Facility Assessment consisted of documentation on a Facility Assessment Tool but

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F 838	Continued From page 16 did not contain all the required information and was not individualized but was instead on the Facility Assessment Tool template. The template was provided to facilities, by the Center for Medicare & Medicaid Services (CMS), to assist in writing the Facility Assessment. The document contains facility information and the instructions provided by CMS on how to document a facility assessment. The above was confirmed by the facility Administrator on 4/10/19 at 2:20 PM.	F 838		