VERMONT

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

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

November 22, 2024

Mr. Bradford Ellis, Administrator
Vernon Green Nursing Home
61 Greenway Drive
Vernon, VT 05354-9474

Dear Mr. Ellis:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **October 30, 2024.** 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, BS
Assistant Division Director
State Survey Agency Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475008	A. BUILDING _____ B. WING _____	C 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERNON GREEN NURSING HOME	61 GREENWAY DRIVE VERNON, VT 05354

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E 000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 10/28/2024 exit date 10/30/2024. There were no regulatory violations identified.	E 000		
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and investigation of one facility reported incident and two complaints (#23180, #22826 and #23237) from 10/28/2024 through 10/30/2024 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following deficiencies were identified:	F 000	Allegation of Substantial Compliance: Vernon Green Nursing Home, Herein after "facility", has and continues to be in substantial compliance with 42 CFR Part 483 subpart and State of Vermont Licensing and Operations Rules for Nursing Homes. Vernon Green Nursing Home has or will have substantially corrected the alleged deficiencies and achieved substantial compliance by the date specified herein. This Plan of Correction constitutes Vernon Green Nursing Home's allegation of substantial compliance such that the alleged deficiencies cited have been or will be substantially corrected on or before December 15, 2024. The statements made on this plan of correction are not an admission to and do not constitute agreement with the alleged deficiencies herein. To continue to remain in substantial compliance with the state and federal regulations, Vernon Green Nursing Home has taken or will take the actions set forth in this plan of correction.	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based upon interview and record review, the facility failed to ensure one resident [Res. #35] of	F 600	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M.Bradford Ellis | TITLE: Executive Director | (X6) DATE: 11.21.24

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

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F 600	Continued From page 1	F 600		

21 sampled residents remained free from physical abuse. Findings include:

Per record review of Progress Notes for Res. #35 dated 7/22/24 "Other resident was in [h/her] room when [Res.#35] tried to enter the room. [Res.#35] asked the person to leave [h/her] room and they got agitated and would not let [h/her] in [h/her] own room. They took [Res.35's] glasses off and threw them across the room, poured a soda on [h/her] head and then was moving [h/her] wheelchair from side to side until [s/he] ultimately fell out of the wheelchair. [Res.#35] did call for help and staff arrived as soon as heard [h/her]". Per review of the facility's investigation of the incident, the investigation concluded "the allegation was verified by evidence collected during the investigation" and "was witnessed by staff".

Per review of corrective actions taken by the facility after the incident, the residents were immediately separated after the incident and assessed for injuries. Close supervision was provided. Care plans for both residents were updated. Family, physician, and authorities were notified, the incident was reported to the State Agency and investigated in the appropriate time frame. The perpetrator was psychologically evaluated and medications were adjusted. Res. #35 was moved off the perpetrator's unit, and Social Services and Behavioral Health Services were involved in care and treatment for both residents post incident. Review of Res.#35's medical record reveals no negative physical or psychological outcomes from the incident.
The facility conducted a Behavior Analysis Report regarding the perpetrator's behaviors before and after the incident. Behaviors that were monitored

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F 600	Continued From page 2 included grabbing others, hitting others, pushing others, cursing at others, screaming at others, threatening others, and rejection of care. The facility monitored the number of behaviors, when they occurred, the intervention[s] provided, and whether the interventions were effective. Per review of the Behavior Analysis Report, interventions implemented to halt the behavior during the incident on 7/21/24 and new interventions implemented to prevent future incidents were documented and noted effective. Per interview with staff Licensed Practical Nurse [LPN] on 10/30/24 at 8:34 AM, the LPN confirmed the perpetrator's past behaviors and improvement post incident. The facility completed corrective actions after identifying this deficient practice, prior to the survey entrance; therefore, this deficiency is considered past noncompliance.	F 600		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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	F 656	The facility has and will continue to comply with CFR(s): 483.21(b)(1)(3), Develop and Implement of a Comprehensive Care Plan **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Resident #25 expired on 11/16/24 Resident #30 Occupational Therapy involved to address seating and positioning needs	11/20/24

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F 656	Continued From page 3 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 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to implement care planned interventions for 2 of 29 Residents in the sample (Resident # 30) related to positioning, and (Resident #25) related to pressure ulcer prevention, pain control, and nutritional risks. Findings include: 1. Per recd review Resident #25 has advanced dementia. S/he developed an in house acquired	F 656	**How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** • An audit was completed of care plans to ensure that appropriate interventions are in place for offloading heels and repositioning. • An audit was completed of dietitian recommendations to ensure that recommendations were addressed by the physician and implemented as ordered. • Observation of seating at mealtime completed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** • Education provided to nursing staff regarding care plan intervention implementation, positioning and addressing dietitian recommendations. • Observation of seating at mealtime and repositioning will be completed on B-Wing 3x a week x 1 month, 2x a week x 1 month then 1x a week x 1 month. • Care plans will be audited for all new admissions to ensure that appropriate interventions are in place for offloading heels and repositioning x 3 months. • Dietitian recommendations will be audited weekly x 3 months to ensure they are addressed by the physician. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** • Results of the audits will be discussed at monthly QAPI meetings for further recommendations. • The Director of Nursing and/or designee will oversee compliance of the plan of correction.	12/15/24 12/15/24 12/15/24

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stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an open/ruptured serum-filled blister) pressure ulcer on her/his left heel and has experienced a significant weight loss of 11.84% over 3 months.

A Nurses Progress note dated 9/10/2024 12:12 PM reads "a fluid-filled blister was noted at outer edge of left heel found this AM during therapy session; resident c/o discomfort when blister was pushed on; the skin over the blister is dry/calloused; the right heel is slight pink..."

A Care Plan Problem with a start date of 2/19/2022 stated that Resident #25 has the potential for skin breakdown related to incontinence and decreased mobility, as well as a decline in ability to participate in ADL (Activities of Daily Living) care. A listed approach to care with a start date of 10/17/2024 reads "Provide me with pressure relief boots on in r/c [reclining chair]." Another approach with a start date of 2/19/2022 is "Assist me with frequent position changes."

Per observation on 10/28/2024 at 3:00 PM Resident #25 was observed lying in a reclining chair. There were no pressure relief boots on her/his feet.

During an interview on 10/28/24 at approximately 4:15 PM a Licensed Nurse Assistant (LNA) who is familiar with Resident #25 confirmed that the Resident should have pressure relief boots on when up in the reclining chair, and that s/he did not have them on. The LNA retrieved the boots from the Resident's room and applied them to the Resident's feet.

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During observations on 10/29/2024 at 12:40 PM Resident #25 was seen asleep in a reclining chair leaning to the right with a pillow on the arm of the chair under the right side of her/his head. There were no pressure relief boots on her/his feet. This Surveyor observed the Resident lying in the recliner from 12:40 PM - 4:10 PM without being assisted with repositioning. At 4:10 PM s/he was still lying in a recliner leaning to the right with her/his head on a pillow on the arm of the chair. S/he had not been repositioned and there were no pressure relief boots on her feet per care plan.

Per interview with a LNA on 10/29/2024 at 4:20 PM Residents are usually toileted and repositioned about every two hours. The LNA confirmed that Resident #25 did not have pressure relief boots on her/his feet and that s/he should. The LNA retrieved the boots and applied them to Resident #25's feet.

Further review of Resident 25's record revealed a Dieticians Progress Note dated 9/11/2024 that states "Recommend increase in supplement to TID [three times per day] to provide 750 cal/27 gm pro., and Centrum silver QD [every day] to support wound healing and deter weight loss. See care plan."

A Care Plan Problem for Nutritional Status last edited on 10/23/24 states "I have a [history] of weight loss along with behavioral changes, and I am at risk for additional weight loss. I have increased pro/cal/vit [protein/calories/vitamin] needs for wound healing (Stage] II area 9/10/24). I can no longer feed myself due to decline in cognition." Care Plan interventions last edited on 9/11/24 state "Provide me with my nutritional

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supplement as ordered. Increase to TID recommended 9/11/24 to support wound healing. Provide vitamins as ordered to support wound healing-centrum silver recommended."

A Dietician Progress Notes dated 10/28/2024 reveals that Resident #25 had "not started centrum tab or had any increase in her/his dietary supplement; this [was] recommended by dietician to support wound healing; sent fax to Doctor [name omitted] r/t [related to] this;."

Review of Resident #25's October 2024 Medication Administration Record (MAR) revealed that the increase in dietary supplement and the administration of the Centrum Silver did not start until 10/29/2024.

During an interview on 10/30/2024 at 3:33 PM the Director of Nursing confirmed that the the recommendations made by the dietician on 9/11/2024 had not been implemented until 10/29/2024.

2. Per observation on 10/28/2024, at 05:19 PM Resident #30 was sitting at the dining table in a reclining chair. S/he was leaned over the left side of the chair with his/her face at eye level with the edge of the table. Resident #30 was not repositioned from his/her side prior to being given his/her meal. At 5:30 PM on 10/28/2024 the License Nursing Assistant (LNA) brought resident's tray to the table and without repositioning Resident #30, s/he handed the resident a half a sandwich. Resident #30

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F 656	Continued From page 7 remained in the leaned over to the left side of the chair and was not repositioned prior to his/her meal. Resident #30 remained on his/her left side at eye level with the table while s/he attempted to eat the sandwich. Per record review Resident #30 was admitted to the facility with a diagnosis of Vascular Dementia, dysphasia and reflux disease. His/her care plan included " ...due to my medical diagnosis of dysphasia, I am an aspiration risk ... Approach starting 3/14/2023 "I need to be seated upright in the chair at 90 degrees for all intake ... I need to be seated upright for 45-60 minutes after every meal to decrease my chance of reflux." Per further record review Speech, Language and Pathology note dated 6/8/2024 in section titled "Impact on burden of care / daily living without interventions implemented, [Resident #30] is at risk for aspiration and general discomfort during intake due to severity of [his/her] cough [and] clearing [his/her] airway ..." Per interview on 10/28/2024 at 5:45 PM with the LNA staff confirmed that Resident #30 should have been repositioned and sat up prior to meal, and that s/he requires observation and assistance with all meals.	F 656		
F 657 SS=D	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--	F 657	The facility has and will continue to comply with CFR(s): 483.21(b)(2)(i)-(iii), Care Plan Timing and Revision. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Resident #9 Care plan updated to reflect current status for assistance with meals and ADL's Resident #15 Care plan updated to reflect current fall risk interventions.	11/20/24

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F 657	Continued From page 8 (A) The attending physician. (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 on observations, staff interviews and record reviews, the facility failed to revise the comprehensive care plan for two of twenty nine Residents in the sample (Resident #9 and Resident #15) as the Residents' plans of care changed related to Activities of Daily Living (ADLs) and Nutritional Status for Resident #9, and a fall with major injury at the facility for Resident #15. Findings include: 1. Per Observation on 10/28/24 and 10/29/2024, Staff were seen assisting Resident #9 with eating a meal. This surveyor observed the need for total assistance. Per record review, Resident #9's current Care Plan Problem category "Nutritional Status" states	F 657	**How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** • Audit completed of care plans to ensure interventions are current for assistance with meals and ADL's. • Audit completed of care plans to ensure interventions are current for fall risk interventions. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** • Education provided to staff responsible for care plan revision regarding revising the care plan as necessary when the residents plans of care change related to ADLs and Nutritional Status. • Audits will be completed for all MDS Significant Change MDS Assessments to ensure revisions are appropriate related to ADLs and Nutritional Status. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** • Results of the audits will be discussed at monthly QAPI meetings for further recommendations. • The Director of Nursing and/or designee will oversee compliance of the plan of correction. **Tag F 657 POC accepted on 11/21/24 by K. Humphrey/P. Cota**	12/15/24 12/15/24 12/15/24

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"I have a history of weight loss. I continue to be at risk for weight loss and altered fluid status due to my variable meal intake at times, related to my cognitive/ mood state, as well as possible medication side effects". This Problem category has an Approach dated 12/04/2023 that states "I am dependent on you to assist me with my meal to help me have sufficient intake. I will occasionally feed myself a drink". There is another Approach, dated 04/29/2021 that states "Set my meal up for me to encourage my independent eating"

Resident #9's current Care Plan Problem category "ADLs Functional Status/ Rehabilitation Potential" states "I have a self care deficit secondary to my physical limitations, as well as a decline in my functional strength and endurance with poor activity tolerance". This Problem category has an Approach dated 09/26/2022 that states "Cue me for mouth and hair care and assist me as needed and as I will allow". There is another Approach that states "Provide setup for my ADL care at my bedside or in my bathroom, which ever I may prefer. Encourage and cue me as needed to wash what I can and provide me with assistance as needed".

Per interview on 10/30/2024, at 3:37 pm with Licensed Nursing Assistant (LNA) "Resident #9 will open his/her mouth to be fed and to allow us to brush his/her teeth", but otherwise is dependent on staff for all ADLs.

Per interview 10/30/24, at 3:45 pm, MDS Coordinator confirmed that the current Care Plan is incorrect/ contradictory and has not been revised.

2. Per the facility's "Falls Risk Assessment and

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F 657	Continued From page 10 Care Planning" policy, "5. Assessment data shall be used to identify underlying medical conditions that may increase the risk of injury from falls ... 6. The staff, with the support of the Attending Physician and therapy department, will evaluate functional and psychological factors that may increase fall risk, including ambulation, mobility, gait, balance, excessive motor activity, Activities of Daily Living (ADL) capabilities, activity tolerance, continence, and cognition...The care plan will be reviewed and revised by the charge nurse or designee after each fall and additional nursing staff will be notified through shift reports and communication logs." Per record review, on 9/28/24 at approximately 7:54 PM Resident #15 had an unwitnessed fall in his/her room. Resident #15 was transported to the hospital by EMS [Emergency Medical Services]. Per record review of physician documentation, Resident #15 was admitted to the hospital for "Left Hip fracture with small extraperitoneal pelvic hemorrhage (a left broken hip with some internal bleeding)." S/he had surgery to fix his/her broken hip. Per record review of Resident #15's care plan states "I am at risk for falling R/T my decreased activity tolerance, as well as my decreased safety awareness." This was last edited on 9/5/24. There are no new revisions in this section of the care plan after Resident #15's fall and hospitalization. Per interview with the DON [Director of Nursing] on 10/30/24 at 10:06 AM it was confirmed that Resident #15's care plan was not revised after his/her fall with major injury.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards	F 658	The facility has and will continue to comply with CFR(s): 483.21(b)(3)(i), Services Provided Meet Professional standards.	

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F 658	Continued From page 11 CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to meet professional standards related to a Licenced Nursing Assistant (LNA) acting outside his/her scope of practice by administrating medications to one resident in the sample (Resident # 205). Findings include Per observation at approimately 2:00 PM on 10/28/2024 the LNA was observed administrating medications to Resident #205 while at the nurse's station. Per Interview with a Licensed Nurse on 10/28/2024 at approximately 2:05 PM s/he stated that s/he or the other Nurse were unable to administer the medication to the Resident. S/He stated that they delegated the task to the LNA because s/he had a good rapport with Resident #205. Per Interview with the LNA on 10/28/2024 at 3:40 PM s/he confirmed that s/he gave Resident #205 his/her medications crushed in ice cream. The LNA stated that this was not the first time s/he has been delegated by nurses to give medications. The LNA stated that s/he has not been trained by the facility to give medications. According to the Vermont State Board of Nursing and the LNA scope of practice "An LNA may not	F 658	**What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Resident 205 received the appropriate medication and the administration of the medication had been observed by the nurse. No adverse effects were identified. Education was provided to the Licensed Nurse and the LNA regarding LNA Scope of Practice and Delegation of duties. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents that have the potential to be affected. Medication audits will be performed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** • Medication Administration Competencies completed for Licensed Nurses responsible for medication administration. • Education provided to Licensed Nurses and LNA's regarding LNA Scope of Practice and Delegation of duties. • Medication Administration audits will be performed 3x a week x 1 month, 2x a week x 1 month then 1x a week x 1 month. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** • Results of the audits will be discussed at monthly QAPI meetings for further recommendations • The Director of Nursing and/or designee will oversee compliance of the plan of correction.	10/30/24 12/15/24 12/15/24 12/15/24

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F 658	Continued From page 12 perform activities which exceed the scope of practice defined by their level of licensure. This means that the LNA may not perform, even if directed to do so, an activity not appropriate to their level of licensure or otherwise prohibited by law. Examples of activities not within the LNA scope of practice include: nursing assessments, nursing judgments, and development of the plan of care." Durnig interview on 10/30/2024 at approximately 4:00 PM the Director of Nursing confirmed that administrating medications to residents is not in a LNA's scope of practice, and that the LNA should not do so.	F 658	**Tag F 658 POC accepted on 11/21/24 by K. Humphrey/P. Cota**	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interviews and record review the facility failed to provide adequate supervision to maintain safety for one (1) resident (Resident #15) out 2 sampled residents. Findings include: Per record review Resident #15 was admitted to the facility on 8/5/22 with diagnoses of Atrial Fibrillation (an irregular heartbeat), depression, hypertension (high blood pressure), and dementia. Resident #15's care plan states "I am	F 689	The facility has and will continue to comply with CFR(s): 483.25(d)(1)(2), Residents are Free of Accident Hazards. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Resident #15 care plan updated to include implementation of individualized, resident-centered interventions. **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** Audit completed to ensure residents at risk of falls have appropriate individualized, resident-centered interventions are in place.	11/18/24 12/15/24

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F 689	Continued From page 13 at risk for falling R/T [related to] my decreased activity tolerance, as well as my decreased safety awareness." This was last edited on 9/5/24. Per record review, on 9/28/24 at approximately 7:54 PM Resident #15 had an unwitnessed fall in his/her room. Resident #15 was transported to the hospital by EMS [Emergency Medical Services]. Per record review of physician documentation, Resident #15 was admitted to the hospital for "Left Hip fracture with small extraperitoneal pelvic hemorrhage (a left broken hip with some internal bleeding)." S/he had surgery to fix his/her broken hip. Per the facility's "Falls Risk Assessment and Care Planning" policy, "5. Assessment data shall be used to identify underlying medical conditions that may increase the risk of injury from falls ... 6. The staff, with the support of the Attending Physician and therapy department, will evaluate functional and psychological factors that may increase fall risk, including ambulation, mobility, gait, balance, excessive motor activity, Activities of Daily Living (ADL) capabilities, activity tolerance, continence, and cognition. 7. The staff will seek to identify environmental factors that may contribute to falling, such as lighting and room layout." Per record review of the facility's internal report, there is no documentation of an evaluation and analysis of hazards and risks in Resident #15's environment that could have caused the unwitnessed fall. There is no implementation of individualized, resident-centered interventions to reduce Resident #15's risks for falls related to possible hazards in the environment.	F 689	**What measures will be put into place or what systemic changes you will make to endure that the deficient practice does not recur;** • Education provided to Licensed Nurses regarding implementation of appropriate individualized, resident-centered interventions related to fall risk. • Audits will be conducted of residents with falls to ensure individualized, resident-centered interventions are in place. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** • Results of the audits will be discussed at monthly QAPI meetings for further recommendations. • The Director of Nursing and/or designee will oversee compliance of the plan of correction. **Tag F 689 POC accepted on 11/21/24 by K. Humphrey/P. Cota**	12/15/24 12/15/24

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F 692 F 692 SS=D	Continued From page 14 Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that recommendations made by the Registered Dietician were implemented to support wound healing and deter weight loss for 1 of 29 Residents in the sample (Resident #25). Per record review Resident #25 had experienced a significant weight loss of 11.48% over 3 months, and had a stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an open/ruptured serum-filled blister) facility acquired pressure ulcer. A	F 692	The facility has and will continue to comply with CFR(s): 483.25(g)(1)-(3), Nutrition/Hydration Status Maintenance. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** Resident #25 expired on 11/16/2024 **How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** An audit was completed of dietitian recommendations to ensure that recommendations were addressed by the physician and implemented as ordered. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** • Education provided to nursing staff regarding addressing dietitian recommendations. • Dietitian recommendations will be audited weekly x 3 months to ensure they are addressed by the physician. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** • Results of the audits will be discussed at monthly QAPI meetings for further recommendations. • The Director of Nursing and/or designee will oversee compliance of the plan of correction. **Tag F 692 POC accepted on 11/21/24 by K. Humphrey/P. Cota**	12/15/24 12/15/24 12/15/24

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F 692	Continued From page 15 Registered Dietician's Progress Note dated 9/11/2024 states "Recommend increase in supplement to TID [three times per day] to provide 750 cal/27 gm pro., and Centrum silver QD [every day] to support wound healing and deter weight loss..." Further review of the record revealed a Dietician Progress Notes dated 10/28/2024 that states that Resident #25 had "not started centrum tab or had any increase in her/his dietary supplement; this [was] recommended by dietician to support wound healing; sent fax to Doctor [name omitted] r/t [related to] this;." Review of Resident #25's October 2024 Medication Administration Record (MAR) revealed that the increase in dietary supplement and the administration of the Centrum Silver did not start until 10/29/2024. During an interview on 10/30/2024 at 3:33 PM the Director of Nursing confirmed that the the recommendations made by the dietician on 9/11/2024 had not been implemented until 10/29/2024.	F 692		
F 758 SS=E	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	F 758	The facility has and will continue to comply with CFR(s): 483.45(c)(3)(e)(1)-(5), Free from Unnecessary Psychotropic Meds/PRN Use. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice;** • Resident #24 14 day stop date implemented for PRN psychotropic medication • Resident #205 14 day stop date implemented for PRN psychotropic medication • Resident #45 rationale for extending stop date was documented	11/15/24

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F 758	Continued From page 16 (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. §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:	F 758	**How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** • Audit completed to ensure stop dates implemented for psychotropic medication. • Audits completed to ensure that documentation is in place for stop dates for psychotropic medications that are beyond 14 days. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;** • Education provided to Licensed Nurses regarding implementation of stop dates for psychotropic medications. • Education provided to Medical Providers regarding documentation to support a prescribed as needed order stop date beyond 14 days. **How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** • Results of the audits will be discussed at monthly QAPI meetings for further recommendations. • The Director of Nursing and/or designee will oversee compliance of the plan of correction. **Tag F 758 POC accepted on 11/21/24 by K. Humphrey/P. Cota**	12/15/24 12/15/24 12/15/24

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Based on record review and interview, the facility failed to implement 14 day stop dates on prescribed as needed (PRN) psychotropic medications for 3 out of 5 residents in the sample (Resident's #24, #205 and #45). Findings include

1. Per record review, Resident #24 was admitted with a diagnosis of Alzheimer dementia and had the following medication orders written by the facility Provider on 10/7/2024:
"Quetiapine tablet; 25 mg; amt: 1 tab; oral...Twice A Day - PRN" There was no documented evidence in the orders of a stop date for the antipsychotic medication as required or rationale by the Provider to extend the medications.

2. Per record review, Resident #205 was admitted on 10/22/2024 with a diagnosis of lewy body dementia. S/He had the following PRN medication orders written by the facility Provider on 10/22/2024: Trazodone tablet; 50 mg: 1/2 tablet PRN three times a day without a stop date and Risperidone 0.25 mg, 1 tablet as needed without evidence of a stop date.

Per interview with the Director of Nursing [DON] on 10/30/2024 at 10:20 AM. The DON stated and confirmed that PRN medications for Resident #24 and #205 did not have a stop date and should have.

Per facility policy titled (PRN Psychotropic Medications) reviewed on 7/11/2024 "PRN orders for psychotropic drugs are limited to 14 days. If the attending physician or prescribing practitioner believes it is appropriate for the PRN order to be extended beyond 14 days, the following must be met

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i. The attending physician or prescribing practitioner evaluates the resident for appropriateness of that medication and
ii. The rationale for extending the PRN order for more than 14 days is documented in the resident ' S medical record. The duration of the PRN order must also be documented.
5. PRN orders for antipsychotic 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."
3. Per record review, Resident #45 was admitted to the facility on 5/3/24 with diagnoses of bipolar disorder (a mental illness causing extreme mood swings) and vascular dementia (chronic cognitive impairment due to decreased blood flow to the brain).

Per further record review Resident #45 had the following medication order: Lorazepam (a medication used to treat anxiety) 0.5 milligram (mg) tablet: Take one tablet by mouth once daily as needed. The medication order was placed on 9/19/24 with a stop date of 12/15/24. There is no Medical Provider documentation to support a prescribed as needed order beyond 14 days for Resident #45.

Per interview with Registered Nurse #1 on 10/29/24 at 3:43 PM it was confirmed that Resident #45's order for Lorazepam had been extended past 14 days with no physician rationale.