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

October 2, 2024

Ms. April Furlow, Administrator
The Villa Rehab
7 Forest Hill Drive
St Albans, VT 05478-1615

Dear Ms. Furlow:

Enclosed is a copy of your acceptable revised plans of correction for the recertification survey conducted on **July 31, 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

PRINTED: 09/30/2024
FORM APPROVED
OMB NO. 0938-0391

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
	475055	A. BUILDING _______ B. WING _______	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA REHAB	**7 FOREST HILL DRIVE** **ST ALBANS, VT 05478**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 7/29/2024-7/31/2024. There were no regulatory violations identified.	E 000		
F 000	INITIAL COMMENTS An unannounced, onsite recertification survey was completed by the Division of Licensing and Protection from 07/29/2024 to 07/31/2024 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. es wil the course of the recertification survey, substandard quality of care was identified and an extended survey was completed. Deficiencies were cited as a result of the survey.	F 000		
F 585 SS=C	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information	F 585	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Blank Grievance forms and sealable envelopes have been placed in hanging file holders on each resident wing for easy access to all residents and families. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by this deficient practice. Grievance forms are available on all resident wings for easy access.	

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

09/03/2024

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 585	Continued From page 1 on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;	F 585	What measure will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The facility Grievance officer and/or Social worker will monitor grievance boxes on each week regularly to ensure supplies needed i.e. forms, envelopes are stocked and to obtain any grievances returned. How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? The facility Grievance officer and Social worker will monitor and document any grievances in the facility Grievance log. The logs will be shared with the QAA team quarterly and as needed. The date corrected action will be completed. The corrective action was completed on 8/05/2024 **Tag F 585 POC accepted on 10/2/24 by D. Hoffman/P. Cota**	

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F 585	Continued From page 2 (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to support the resident's right to file grievances anonymously. This has the potential to affect all residents in the facility.	F 585		

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F 585	Continued From page 3	F 585		

Continued From page 3

Findings Include:
Per observation, the facility's entryway on the first floor has a bulletin board with the grievance process posted on it. The process includes who the grievance officer is and the contact information, but it does not give details on anonymously filing a grievance. There is no evidence of grievance forms or information on submitting a grievance anonymously.

A review of the facility policy, titled "Resident and Family Grievances," revised on 2/2/24, #9. "A grievance may be filed anonymously," but it does not address a process to do it.

Per interview on 7/30/2024 at approximately 1:30 PM with two residents, it was revealed by Resident #5 that if a resident wants to file a grievance, they must contact the Social Services Department or the Administrator. S/he does not know of a system within the facility that allows the resident to file the grievance without revealing the writer's identity. Resident #9 has been at the facility for a few years, and s/he is familiar with the process. S/he indicates s/he would like the opportunity to choose whether the process is done anonymously or not. S/he does not recall grievance forms or a system to keep the process anonymous.

Per interview on 7/30/2024 at approximately 3:00 PM with the Administrator, S/he indicated the facility used to provide a binder in the common rooms with grievance forms. This process is no longer a practice of the facility. S/he confirmed that there is no process for filing a grievance anonymously.

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F 658	Continued From page 4	F 658		
F 658 SS=E	Services Provided Meet Professional Standards 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 upon interview and record review, the facility failed to provide care and services according to accepted standards of clinical practice regarding Physician Orders and notification for 2 residents [Res.#6 and #17] of 18 sampled residents. Findings include: Per review of the Lippincott Manual of Nursing, "Common Departures from the Standards of Nursing Care include: failure to follow physician orders, follow appropriate nursing measures, communicate information about the patient". [Lippincott Manual of Nursing Practice-11th Edition 2018] 1.) Per record review, Physician Orders for Res.#6 include: "Azithromycin Ophthalmic Solution 1 % -Instill 1 drop in both eyes two times a day for Severe Blepharitis". [According to the Mayo Clinic: "Blepharitis is inflammation of the eyelids that can cause irritation, redness, crusting and stickiness. Azithromycin ophthalmic solution belongs to a group of medicines called macrolide antibiotics and works by killing the bacteria causing the infection ...To help clear up your eye infection completely, keep using this medicine for the full treatment time ...Your infection may not clear up if you stop using the medicine too soon. Do not	F 658	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? All nurses have been re-educated on the facilities unavailable medication policy which includes notification of resident physicians and proper documentation of notification and actions taken. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents could be affected by the deficient practice. The DON or her delegate will complete chart reviews weekly over the next four weeks. She will continue this process beyond the four weeks on an as needed basis. What measure will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The DON will complete chart reviews as needed to include MAR and TAR reports. How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? The DON will complete chart reviews to ensure compliance. She will utilize audit forms to document findings of her review. The NHA will review audit forms completed by DON. The date corrected action will be completed. The corrective action was completed on 8/29/2024	

Tag F 658 POC accepted on 10/2/24 by D. Hoffman/P. Cota

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F 658 Continued From page 5 F 658

miss any doses."]
(https://www.mayoclinic.org/diseases-conditions/blepharitis/symptoms-causes/syc-20370141)
(https://www.mayoclinic.org/drugs-supplements/azithromycin-ophthalmic-route/description/drg-20070979)

Review of the Medication Administration Record [MAR] of Res.#6 reveals the Azithromycin Ophthalmic Solution was not administered as ordered 7 times over 9 days [6/24/24 - 7/2/24] including 5 consecutive times over 3 days [6/24-6/26/24].

Nursing Notes regarding the missed doses record "Medication not available", "on order", "medication unavailable", "pharmacy sending tonight" [later when the medication did not arrive] "Medication not available", "Not available, pharmacy is aware", "no eyedrops available, reordered". Further review revealed no documentation that Res.#6's physician was notified that the eye medication was not given as ordered on any of the instances.

An interview was conducted with a staff Registered Nurse [RN] on 7/30/24 at 8:14 AM. The RN stated that if the medication is not available through the medication cart or through the back up supply, Nursing notifies the provider that the ordered medication cannot be given as ordered and see if an alternative can be used or if the physician wants to hold or discontinue the medication. The RN reported that missing or unavailable medications are prompted to be documented in the medical record along with physician notification. The RN also stated that the pharmacy can be contacted through the resident's electronic medical record system and

F 658 Continued From page 6

Nursing can call the pharmacy to confirm if a medication order was received.

2.) Per record review, Physician Orders for Res.#17 include:
"Erythromycin Ophthalmic Ointment- Instill 1 centimeter in both eyes two times a day for Blepharitis for 30 Days". [Blepharitis is inflammation of the eyelids that can cause irritation, redness, crusting and stickiness Erythromycin ophthalmic preparations are antibiotics used to treat infections of the eye.] (https://www.mayoclinic.org/drugs-supplements/erythromycin-ophthalmic-route/description/drg-20068673)
Review of the Medication Administration Record [MAR] of Res.#17 reveals the Erythromycin Ophthalmic Ointment was not administered as ordered 9 times over 18 days [6/8-6/25/24], including 6 consecutive times over 3 days [6/23-6/25/24].
Nursing Notes regarding the missed doses record "waiting for pharmacy", "on order", "Medication not available", "eye ointment not available, reordered", "Medication unavailable", "Unavailable Pharmacy has been made aware", "eyedrops unavailable". Further review revealed no documentation that Res.#17's physician was notified that the eye medication was not given as ordered on any of the instances.

An interview was conducted with the Director of Nursing [DON] on 7/30/24 at 2:30 PM.
The DON confirmed the Medication Administration Records [MARs] and progress notes of Res.#6 & #17 demonstrated multiple dates where medication was not given as ordered. Review of the facility's "Medication Administration" policy [2024] reads "Medications

F 658

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F 658	Continued From page 7 are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice". The DON further stated the facility's process is to contact the resident's provider for missed/unavailable medication[s]. Per review of the facility's "Notification of Changes" policy [2023], "Circumstances requiring notification include: ...circumstances that require a need to alter treatment". The DON confirmed the Medication Administration Records [MARs] and progress notes of Res.#6 & #17 demonstrated multiple dates where medication was unavailable and not given as ordered and the physician was not notified. Further record review revealed that regarding the missed medications between the two residents [Res.#6 & #17], five different nurses, including the DON, failed to administer medications as ordered and failed to notify the physician as required.	F 658		
F 689 SS=F	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that resident environments were free of accident hazards	F 689	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility water temperatures were immediately adjusted by lowering the temperature on the facility mixing valve. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;	

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F 689	Continued From page 8 related to safe handwashing water temperatures. Findings include: During unit observations on 7/29/2024 at 2:45 PM, the hot water was assessed from a faucet in an unlocked, common area bathroom, accessible to all residents. The water was too hot to hold a hand under comfortably, so a thermometer was used to take the temperature of the water. The highest reading was 124.1 degrees Fahrenheit (F). The sample was then expanded to include other common areas sinks and resident rooms. The left hallway sink read 121.8 degrees F, a right hallway sink read 121.7 degrees F, a second common area bathroom read 121.1 degrees F. The Resident in room #7 is independent with care and uses the bathroom for toileting and bathing. The water temperature in their bathroom sink read 123.4 degrees F. The above temperatures were confirmed by the facility Dietary Manager who was accompanying the surveyors at the time. Per interview with the facility Administrator (LNHA) on 7/29/24 at 3:45 PM there have been no issues with water temperatures throughout the facility. The LNHA was able to produce a water temperature monitoring log that that s/he maintains. There were no documented water temperatures above 119 degrees F. At 3:49 PM the water temperatures were rechecked by the surveyor and the LNHA using the thermometer that they use to monitor the water temperatures for the logs. The water temperature from the Hall 1 bathroom sink read 121.2 degrees F. Room number #7 read 123 degrees F, and the Hall 2 bathroom read 121.8. The LNHA confirmed all of the above water temperatures.	F 689	All residents of the facility have the potential to be affected by the deficient practice. Mixing valve water temperatures were immediately adjusted to temperature not to exceed 119 degrees Fahrenheit. What measure will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Staff will be educated on safe water temperatures and procedures to temp water. Thermometers will be left in nurses station for nurses to take temperature of water if they have concerns of it being too cold or too hot. Nurses will then notify facility Administrator if water temperature is above 120 degrees. Residents will not bathe until the Administrator or her delegate have evaluated and cleared any concerns. How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? NHA or her delegate will test water temperatures several times per week in multiple locations. The date corrected action will be completed. The corrective action was completed on 7/31/2024 **Tag F 689 POC accepted on 10/2/24 by D. Hoffman/P. Cota**	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		

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F 812

Continued From page 9

CFR(s): 483.60(i)(1)(2)

§483.60(i) Food safety requirements.
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure that food was stored in accordance with professional standards for food safety. The facility failed to document the temperatures of 1 of 3 freezers and the temperatures of 2 of 3 refrigerators, served food items to residents outside of the facility's standard for food temperatures, and failed to discard expired food items. Findings include:

A Meat Freezer log was provided to surveyors. Per the facility's "Equipment Temperature Log" the accepted freezer temperature is -10 [degrees Fahrenheit] to 0 [degrees Fahrenheit]. In addition to one abnormal temperature of -12 [degrees Fahrenheit] recorded there was no month

F 812

What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

Facility NHA and Dietary team have started a PIP focusing on auditing of temperature logs, penmanship of logs and food expiration dates weekly. The PIP team meets weekly to review findings.

How will you identify other residents having the potential to be affected by the same deficient practice and what corrective
action will be taken;

All residents have the potential to be affected by the deficient practice. Corrective action taken is NHA and Dietary Manager have re-educated dietary staff on temperature logs, Importance of good penmanship and reviewing food items for expiration dates. All dietary staff is included in the PIP team.

What measure will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

All dietary staff will audit daily logs and food items. They will document any concerns and corrective action for review at PIP meeting.

How the corrective actions will be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place.

Corrective actions are monitored through PIP meeting with the PIP team i.e. Dietary staff and NHA.

The date corrected action will be completed.

The corrective action was completed on 8/06/2024

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F 812	Continued From page 10 documented for the Meat Freezer log. An interview was conducted with the Dietary and Housekeeping Manager on 7/30/24 at 1:35 PM. The Dietary and Housekeeping Manager confirmed on 7/30/24 that there was no documentation identifying the month where temperature of -12 [degrees Fahrenheit] was recorded. The Dietary and Housekeeping Manager confirmed s/he did not know the month of the Meat Freezer log provided. Per the facility's "Equipment Temperature Log" the facility's accepted refrigerator temperatures are 33 [degrees Fahrenheit] to 41 [degrees Fahrenheit]. Per record review of the milk refrigerator for May 2024 revealed ten temperatures for the refrigerator that were below accepted limits. The milk refrigerator had abnormally high temperatures on 6/3/24 and 7/11/24 with no intervention documented. In addition to the milk refrigerator, the facility also utilizes what is labeled a "Milk Cooler." Per record review of the Milk Cooler temperatures for May 2024, there were seventeen Milk Cooler temperatures that were abnormally low with no intervention "corrective action" documented on the Equipment Temperature Log. On 7/30/24 at 1:35 PM the Dietary and Housekeeping Manager confirmed that the temperatures of the milk refrigerator and milk cooler temperatures were out of the facility's accepted range for the internal temperature of the refrigerator. 2.) Per the facility's "Temperature Log and Checklist," Ground entrees are to be 170 [degrees Fahrenheit]. Entrees, Meats, Starch, Soup, Vegetables should be at 160 [degrees Fahrenheit]. Per record review from March 2024 to July 2024 there were thirteen abnormally low	F 812	**Tag F 812 POC accepted on 10/2/24 by D. Hoffman/P. Cota**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475055	A. BUILDING ______ B. WING ______	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLA REHAB	7 FOREST HILL DRIVE ST ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 11 temperatures for ground entrees. From March 2024 to July 2024 there were twelve entrees, and three vegetable temperatures documented that were below the accepted temperature. 3.) On 7/29/24 a facility assessment of the kitchen was conducted. Per observation, one of two freezers in the basement had thirty Magic Cup ice cream cups that were expired on 12/2/23. On 7/30/24 at 1:35 PM the Dietary and Housekeeping Manager confirmed the box of 30 Magic Cup ice cream cups that expired on 12/2/23 should have been discarded but were not.	F 812		
F 838 SS=F	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,	F 838	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The facility has added individual competencies to the facility assessment. How will you identify other residents having the potential to be affected by the same deficient practice and what correct action will be taken; No residents were affected by this deficient practice. All competencies were charted individually for all staff on competency evaluation forms. What measure will be put into place or what systemic changes you will be made to ensure that the deficient practice does not recur? Facility assessments will be evaluated by the IDT team annually and as needed to include staff competency review and lists.	

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F 838	Continued From page 12 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 (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:	F 838	How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what assurance program will be put into place? Corrective action plan will be monitored through IDT Meeting annually and as needed for changes. The dates corrective action will be completed. Corrective action was completed on 8/01/2024. **Tag F 838 POC accepted on 10/2/24 by D. Hoffman/P. Cota**	

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F 838	Continued From page 13 Based on interview and record review, the facility failed to address in their facility assessment what the staff competencies that are necessary to provide the level and types of care needed for the resident population identified in the assessment. This deficient practice has the potential to affect all 20 residents residing in the facility. Findings include: Per review of the 2024 Facility Assessment does not indicate what specific competencies are necessary to provide care to the Residents who reside in the facility. The facility assessment also fails to indicate which competencies will be evaluated. Per interview on 7/31/24 at 2:37 PM with the Licensed Nursing Home Administrator (LNHA) the licensed staff are evaluated for competency during orientation and annually. Additional training is provided to staff when a skill is needed that is not something that they routinely care for. The LNHA confirmed that the facility assessment does not identify the specific training or competencies to be evaluated that are needed to provide care to the residents.	F 838		
F 949 SS=E	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop, implement, and maintain an	F 949		

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F 949	Continued From page 14 effective training program related to behavioral health or trauma informed care and services, as determined by resident needs and the facility assessment for 7 of 8 sampled staff. Review of the 2024 Facility Assessment indicates that the facility has had 27 residents with the diagnosis of anxiety disorder, 37 residents with depression, 2 residents with manic depression, 2 residents with psychiatric disorder, and 1 resident with Post Traumatic Stress Disorder. Review of employee training and competency files revealed that 4 Licensed Nursing Assistants and 3 Registered Nurses had no documented evidence that they received behavioral health and trauma informed care training on hire or annually for 2024. During an interview on 7/31/24 at 12:31 PM the Director of Nursing (DON) confirmed that there was no documented evidence that staff had received behavior health or trauma informed care training. The facility Administrator was able to produce a training log for behavioral health and trauma completed on 7/27/23 however, only one of sampled staff members had attended.	F 949	What corrective action will be accomplished for those residents found to be affected by the deficient practice? All staff have been educated and trained on behavioral health and trauma care. 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 have the potential to be affected by the deficient practice. All staff have been educated and trained on behavioral health and trauma care. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Behavioral health and trauma care educational packets have been included in all new hire orientation packets and is added to annual training fair for all staff. How the corrective actions will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place? Corrective actions put in place will be monitored through training and education audits. The DON will audit training charts at completion of orientation for all new staff and annually and as needed for all staff. The dates corrective action will be completed. Corrective action will be completed on 09/03/2024 **Tag F 949 POC accepted on 10/2/24 by D. Hoffman/P. Cota**	