AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

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

March 23, 2022

Ms. Nicole Fortier, Manager
The Village At White River Junction
101 Currier Street
White River Junction, VT 05001

Dear Ms. Fortier:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 16, 2022.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0660	A. BUILDING: ___ B. WING ___	C 02/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE AT WHITE RIVER JUNCTION	101 CURRIER STREET WHITE RIVER JUNCTION, VT 05001

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R100	Initial Comments: An unannounced on-site complaint investigation was conducted on 2/15/2022 & 2/16/2022 by the Division of Licensing and Protection. The following regulatory violations were identified:	R100	See attached	
R136 SS=G	V. RESIDENT CARE AND HOME SERVICES 5.7. Assessment 5.7.c Each resident shall also be reassessed annually and at any point in which there is a change in the resident's physical or mental condition. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the ALR (Assisted Living Residence) nurse failed to conduct an assessment of a resident who had demonstrated both physical and mental changes. (Resident # 4) Findings include: Resident #4 was admitted to the ALR on 7/31/21 sharing a room on the Assisted Living floor with his/her husband. Resident #4's past medical history included dementia; mild cognition impairment and a previous stroke. The Service Plan (Care Plan) last updated on 8/4/2021, states Resident #4 required 1 person assist for mobility/ambulation and "1 person stand by assistance for toileting tasks." Per telephone interview on 2/16/22 at 12:45 PM the QLS (Quality of Life Specialist) confirmed s/he was assigned as a float on 12/24/2021 working the 11:00 PM to 7:30 PM shift. During the shift at	R136		

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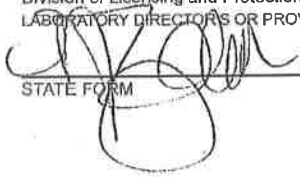
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Executive Director	3-16-22



R136 - R266 POC accepted 3/21/22 FMcintoshRN/PMC

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R136	Continued From page 1 approximately 1:00 AM the Staff member was paged to Resident #4's room on the 5th floor. Upon arrival, the husband of Resident #4 stated s/he had used his/her pendant to request assistance for his/her wife. The husband indicated Resident #4 wanted to use the bathroom but s/he was unable to assist due to physical limitations Resident #4 was now presenting. Having known Resident #4 from a previous admission, the staff person was familiar regarding what Resident #4 required for assistance noting the resident is routinely only a 1 person assist to get out of bed and then walking with stand by assist to the bathroom. However, on 12/24/21 the staff member stated "I attempted to sit her/him up....but resident fell backwards......and was unable to sit on side of the bed". Because the staff member could not safely transfer Resident #4 out of bed, a call for assistance was made. The RN who was assigned as charge nurse for the ALR for the 11:00 PM - 7:30 AM shift arrived to help the staff member assist Resident #4 to the bathroom. The RN transferred Resident #4 to a wheelchair, transported to the bathroom and upon completion in the bathroom, Resident #1 required total assistance of the RN when being transferred back to bed. The staff member stated s/he observed Resident #4 to have right sided weakness, "...s/he was not ambulating....right leg dragged....breathing was heavy..". Approximately 6.5 hours later on 12/24/2021, another staff member responded to a call from Resident 4's room. At 6:30 AM, Resident #4 was found on the floor beside the bed. There was vomit on a bed pillow and bed. Per interview on 2/15/22 at 2:40 PM the RN who assisted Resident #4 on 12/24/2021 stated upon arrival the resident "...needed medical intervention...was	R136		

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R136	Continued From page 2	R136		

incoherent, not moving and unable to follow instructions.." After contacting family and attending physician, Resident #4 was transported to the hospital. Further interview with the RN confirmed s/he failed to assess and evaluate Resident #4 when seen during the 1:30 AM visit to the resident's room despite the fact the resident was experiencing symptoms that required further follow-up. S/he further acknowledged, there was an assumption by the RN that Resident #4 may have been intoxicated. Alcohol is permitted in the ALR for those residents living independently and Resident #4's husband was known to partake in an alcohol beverage, but neither Resident #4 nor his/her husband had a known history of alcohol abuse. During further interview, the RN admitted " I blew it at 1:30 AM...the aides had it right...." S/he also confirmed there was no basis for assuming they were drunk.

The RN failed to perform a physical assessment of Resident #4 after being called to the resident's room at 1:30 AM on 12/24/2021. Monitoring of blood pressure, pulse, respirations and oxygen saturation were not conducted and there was a failure to conduct a neurological assessment although the resident was presenting with new symptoms of right sided weakness; change in sensorium and a previous history of a stroke. There was also a failure by the RN over the following 5 hours to revisit Resident #4 during the early morning hours of 12/24/2021, to determine if the resident was experiencing a significant health event and required further assistance.

Per review of the RN's personnel record and job responsibilities states: "#2: Responds to resident calls to provide appropriate nursing intervention" and "#24: Responsible for identification of

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R136	Continued From page 3 resident medical and behavioral changes and the development and monitoring of care plans and reassessment". The ALR was notified by the hospital Resident #4 was admitted for End of Life Care and passed away on 12/25/2021.	R136		
R145 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (2) Oversee development of a written plan of care for each resident that is based on abilities and needs as identified in the resident assessment. A plan of care must describe the care and services necessary to assist the resident to maintain independence and well-being; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the ALR failed to update a written plan of care describing the care and services necessary to maintain one resident's well being based on abilities and needs. Findings include: Resident #9 was admitted to the facility's Memory Care Unit on 12/17/19 with diagnoses including Anoxic Brain Damage, Apraxia Following Unspecified Cerebrovascular Disease, Dementia, and Frontotemporal Dementia. On 9/19/21 pocketed food from the breakfast meal that morning was discovered in Resident #9's mouth during lunch. A plan was made for kitchen staff to prepare soft mechanical soup that evening and nursing staff to make a dietary plan the following day. The pocketing incident and signs of a fungal	R145	See attached	

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R145	Continued From page 4 mouth infection and pain were reported to his/her doctor the following day, and medications to treat infection and pain were ordered. On 9/21/21 mouth breathing, drooling, and lack of food/fluid intake for 48 hours raised concerns about dehydration, difficulty swallowing, and medication administration. Resumption of normal food consumption and medication administration was reported with resolution of the oral infection on 9/29/21. On 10/4/21 a nursing note stated Resident #9 was "coughing a lot trying to catch his/her breath after eating or drinking anything. His/her face turns bright red as s/he eats or drinks and is requiring someone to feed him/her to keep him/her from choking [himself/herself]." On 10/13 a nursing note documented a conversation during which his/her doctor stated s/he "feels at this time (Resident #9) should be fed not feeding [herself/himself] due to [her/his] impulsivity and choking hazard". A note on 10/26/21 stated Resident # 9 "... needs monitoring of meals as [s/he] will often eat too fast. Staff verbally cue and sometimes will give small portions to eat at one time." Facility Care Plans, referred to as Service Plans, dated 4/22/21, 10/11/21, and a version of the 10/11/21 plan modified on 2/15/22 identified Resident #9 's Meal Consumption needs as a Moderate Level of Assistance for Safety, and stated s/he requires cutting up of food, opening cartons/packages; may need encouragement to select menu items. Plans dated after the pocketing incident on 9/19/21 and updates thereafter failed to define need for Resident #9 to be fed and identify interventions to limit risk for pocketing and choking.	R145		

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R146	Continued From page 5	R146		
R146 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (3) Provide instruction and supervision to all direct care personnel regarding each resident's health care needs and nutritional needs and delegate nursing tasks as appropriate; This REQUIREMENT is not met as evidenced by: The facility failed to provide instruction and supervision to all direct care personnel regarding Resident #9's health care and nutritional needs. Findings include: Per observation on 2/15/22, Resident #9 was observed feeding herself/himself during lunch. Per interview on the afternoon of 2/16/22, the Director of Health Services stated staff know each resident's dietary needs by referring to a white board in the serving area where residents' dietary needs are listed. For Resident #9, the only directive listed for staff is the resident requires "small bites". A previous note dated 12/21/21 described a Plan of Care Meeting during which Resident #'9's nutritional needs were reviewed. The note states "Staff observed that there is a question of his/her pocketing food. S/he has a history of choking and needing monitoring." Refer to Tag: R145	R146	See attached	
R154 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (11)	R154		

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R154	Continued From page 6 Implement assistive therapy as necessary to maintain or improve the resident's functional status, with consultation from a licensed professional as needed; and This REQUIREMENT is not met as evidenced by: The ALR failed to implement assistive therapy necessary to maintain a resident 's functional status defined in consultation with a licensed professional for 1 applicable resident. (Resident #9) Findings include: Per record review a Nursing note dated 10/13/21 documents a conversation during which Resident #9's doctor stated she "feels at this time (Resident #9) should be fed not feeding [herself/himself] due to ".... impulsivity and choking hazard", followed by a note on 10/26/21 stating s/he "needs monitoring of meals as [s/he] will often eat too fast. Staff verbally cue and sometimes will give small portions to eat at one time." Per review of the Service Plan dated 2/15/21, current Dietary order in the Electronic Health Record, and a Fall Assessment Risk performed by the Director of Health Services on 2/12/22 all stated Resident #9/s dietary order is "Regular Diet- no additional salt (NAS)". The dietary order failed to address difficulty swallowing, risks for pocketing and choking, and need for texture modification of food (cutting up food) as defined in Service Plans, nursing notes, and his/her doctor's instructions. Refer to Tag: R 145	R154	See attached	

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R179	Continued From page 7	R179		
R179 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on staff interview, the ALR administration failed to ensure all staff received the required 12 hours of training each year. Findings include: During the course of the complaint survey on 2/15 - 2/16/2022, Administrative staff were requested to demonstrate via training records that staff	R179	See attached	

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R179	Continued From page 8 employed at the ALR who provide direct care to residents had received the 12 hours of required yearly training to include: Resident Rights; Fire Safety; Mandatory Reporting; Infection Control; Emergency Response; Respectful Interactions and General Supervision. Per interview on the afternoon of 2/16/2022 the Administrator confirmed 2 of 5 staff members had not completed all 12 hours of training.	R179		
R181 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.d The licensee shall not have on staff a person who has had a charge of abuse, neglect or exploitation substantiated against him or her, as defined in 33 V.S.A. Chapters 49 and 69, or one who has been convicted of an offense for actions related to bodily injury, theft or misuse of funds or property, or other crimes inimical to the public welfare, in any jurisdiction whether within or outside of the State of Vermont. This provision shall apply to the manager of the home as well, regardless of whether the manager is the licensee or not. The licensee shall take all reasonable steps to comply with this requirement, including, but not limited to, obtaining and checking personal and work references and contacting the Division of Licensing and Protection in accordance with 33 V.S.A. §6911 to see if prospective employees are on the abuse registry or have a record of convictions. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the	R181	See attached	

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R181	Continued From page 9 ALR failed to ensure a complete screening for criminal and abuse checks were conducted by the agency who provides contracted staff. Findings include: Per review of personnel records for a previous contracted "traveler" employee hired until the end of 12/2021 had been screened by the contracted agency prior to his/her assignment at the ALR. However, there was a failure of the ALR to ensure screening for criminal and adult/child abuse for the State of Vermont was also included in the screening process. The Administrator on the afternoon of 2/16/2022 confirmed although screenings in other states had been conducted for this individual, the required State of Vermont screenings had not been conducted.	R181		
R266 SS=G	IX. PHYSICAL PLANT 9.1 Environment 9.1.a The home must provide and maintain a safe, functional, sanitary, homelike and comfortable environment. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the ALR failed to ensure a safe environment was provided to all residents residing at the facility. (Residents # 1; 2; 7; 8; 12; 13; 14) Findings include: Per review on 2/15/2022 of the ALR's Resident Incident Log, it identified 87 falls experienced by residents over the past 90 days from 11/15/2021	R266	See attached	

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R266	Continued From page 10	R266		

through 2/15/2022. Included in the accounting of falls were residents "found on the floor"; "falls while ambulating without an assistive device"; "falls from bed and/or chair"; and "falls while transferring or repositioning". Per record review of the 87 falls, 1 resident experienced 18 falls (Resident #14); another resident experienced 7 falls (Resident #13) and 5 residents were identified to have sustained significant injury (Residents #1; 2; 7; 8; 12:)

1. Resident # 7 was admitted to the ALR Memory Care Unit with vascular dementia on 11/24/21. Prior to admission s/he had a history of falls due to deconditioning. A fall assessment was completed on 11/24/2021 with a Service Plan goal to included a decrease of "Actual Risk for Falls/Injuries". Resident #7 required "standby assist for toileting tasks". However, on 1/4/2022 Resident #7 was found on their bathroom floor sitting up and per progress note "The resident did not know exactly how long s/he had been there, s/he did not have his/her walker, s/he stated s/he slipped and fell landing on his/her right side, hitting the right side of his/her head on the floor, right shoulder and right hip on the floor." The resident complained of pain when moving right leg and right shoulder and was unable to move right arm. Resident #7 was transported to ED and has required hospitalization. Presently the resident has not returned to the ALR.

2. Resident #12, who resides in the Memory Care Unit experiences frequent changes in cognition and memory on a day by day basis. S/he ambulates around the unit and on 1/6/2022 sustained a fall. Staff had heard a loud bang and found the resident on the floor, laying on her/his left side. Resident #12 had walked by a chair with wheels and leaned on it, resulting in the chair to

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tip over, causing the resident's fall. The resident reported s/he hit her head and had right hip pain. The resident was transported to an ED and was admitted for a repair of a fractured right hip requiring ongoing hospitalization and rehabilitation.

3. Resident #8 was admitted to the Assisted Living unit of the facility on 10/31/21 with diagnoses of Orthostatic Hypotension, Benign Hypertrophic Prostate with lower urinary tract symptoms, Mild Cognitive Impairment, Generalized Anxiety Disorder, Vertigo, and Adult Failure to Thrive. An Occurrence Note on 12/14/21 reported Resident #8 lost his/her balance and fell while ambulating using a cane and struck his/her left temple and cheek. Per Nursing Note on 12/14/2 Resident #8 was "observed walking using cane very fast in hallway on 4th floor." The writer reported hearing a large bang then found him/her lying on his/her left side on floor moaning. An additional Nursing Note on 12/14/21 documented the writer assisted Resident#8 who had fallen but was sitting on bench in hallway 4th floor and described Resident #8 as "shaking with chills, hands cyanotic, cold. Resident complained of being cold prior to fall in room". On the same day a Neuro Check Assessment documented Resident had a fall while ambulating with or without assistive device at 4:30 PM. Resident #8 sustained injuries including a half inch laceration of his/her left eye, a chin abrasion, and a neck fracture of his/her 6th cervical vertebrae. S/he was transported and hospitalized for a two week period during which s/he also required IV (intravenous) antibiotics for Bacterial Pneumonia.

4. Resident #5 who had resided on the Memory Care Unit and was receiving Hospice services

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(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) COMPLETE DATE
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and also had a history of falls to include falls in the bathroom; fall during transfer from toilet to wheelchair; and finally a fall from her bed on 12/12/2021 resulted in facial bruising. The resident was not transported for evaluation and remained on Hospice services at the ALR until s/he passed on 12/25/2021.

5. Resident #2 was admitted on 6/30/21 with a diagnosis of Alzheimer's and had resided in the Memory Care Unit. On 10/17/2021 the resident was found in the doorway of their room on the floor sustaining a contusion to his/her occipital (back and lower part of skull) with a small laceration and left hip injury (without fracture). The resident was sent to the hospital and returned within 24 hours. On 12/6/2021 Resident # 2 was again found on the floor beside his/her bed sustaining a contusion on the left side of his/her head. The resident was on Hospice and passed on 1/30/2021.

Per interview on 2/16/2022 at 2:40 PM, the Administrator of the ALR confirmed falls are a significant issue. A falls committee has been initiated and are meeting monthly. No clear plan was presented for fall prevention with the exception of a collaboration with a Home Health Agency to utilize Physical Therapist and Occupational Therapist to conduct safety assessments after a resident sustains a fall. However, many residents are admitted with a history of falls and although a fall assessment is conducted, no distinct individual interventions have been incorporated for fall prevention.

Plan of Correction Outline

Preparation and execution of this plan of correction in no way constitutes an admission or argument by The Village at White River Junction of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law. The Village at White River Junction reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts, and conclusions that form the basis of the deficiency.

Response to Survey ending February 16, 2022

Tag: R136 V. Resident Care and Home Services

1. **The corrective actions to be accomplished to correct the deficient practice.**

   The facility will reassess all residents annually and at any point in which there is a change in the resident's physical or mental condition.

2. **The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**

   The facility will educate all licensed nurses that they are expected and required to reassess annually and at any point in which there is a change in the resident's physical or mental condition.

3. **The facility will monitor the corrective action by implementing the following measures.**

   The Executive Director or Business Office Manager will ensure that all current and future nurses have reviewed and signed a full job description that includes duties and responsibilities. The DOHS and/or designee will monitor EHR daily for completion of assessments.

4. **Plan of Correction completion date: 03-31-2022**

Tag: R145 V. Resident Care and Home Services

1. **The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**

   The facility has corrected the care plan for resident #9 - completed 03-04-2022

2. **The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**

   To prevent recurrence of deficient practice, the Director of Health Services or designee shall review care plans per the community policy; at admission, change of condition, and quarterly (Memory Care) or Biannually (Assisted Living) to ensure the care plan reflects the current care needed so that staff have instruction regarding the residents' healthcare needs.

   All nurses will be educated and trained on how to update a care plan to reflect care and services necessary to maintain a resident's wellbeing based on abilities and needs.

3. **The facility will monitor the corrective action by implementing the following measures.**

   The DOHS will conduct a facility-wide audit of all care plans to ensure accuracy. Thereafter, the DOHS or designee will utilize an audit tool for care plan updates. This audit will be completed weekly for 4 weeks, monthly for 3 months and reviewed by the QAPI team to ensure completion and effectiveness.

4. **Plan of Correction completion date: 04-01-2022**

Tag: R146 V. Resident Care and Home Services

1. **The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**

   The facility will develop and/or correct the care plan for resident #9. The updated care plan reflects the Care Stream tasks that are required to be performed and charted by direct care staff on every shift. Completed 02-16-2022.

2. **The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**

   To prevent recurrence of deficient practice, the Director of Health Services or designee shall review care plans per the community policy; at admission, change of condition, and quarterly (Memory Care) or Biannually (Assisted Living) to ensure the care plan reflects the current care needed so that staff have instruction regarding the residents' healthcare needs.

   The charge nurse in Memory Care will be responsible for oversight and supervision of direct care staff during meals.

3. **The facility will monitor the corrective action by implementing the following measures.**

   The DOHS will conduct a facility-wide audit of all care plans to ensure accuracy. This audit will be completed by 04-01-2022. Thereafter, the DOHS or designee will utilize an audit tool for care plan updates. This audit will be completed weekly for 4 weeks, monthly for 3 months and reviewed monthly by the QAPI team to ensure completion and effectiveness.

4. **Plan of Correction completion date: 04-01-2022**

Tag: R154 V. Resident Care and Home Services

1. **The corrective actions to be accomplished for those residents found to have been affected by the deficient practice.**

   The facility has obtained a physician's order that accurately reflects resident #9's current nutritional needs. The facility has obtained an order for Speech Therapy for resident #9. The care plan for resident #9 was be adjusted to properly reflect level of care for feeding assistance. – Completed 03-04-2022

2. **The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**

   The facility will identify other residents who may potentially be affected by the deficient practice. The facility has performed an audit to ensure that every resident has an accurate dietary order to meet their nutritional needs. Diet orders will be obtained at admission and with applicable change of condition. Any change of diet orders will be updated into the EHR and care planned appropriately.

3. **The facility will monitor the corrective action by implementing the following measures.**

   The DOHS or designee will perform a quarterly audit of dietary orders for all residents.

4. **Plan of Corrections completion date: 03-16-2022**

Tag: R179 V. Resident Care and Home Services

1. **The corrective actions to be accomplished to correct the deficient practice.**

   The facility will ensure that all direct care staff have completed their twelve (12) hours of training each year. Training to include: Resident Rights, Fire Safety, Mandatory Reporting, Infection Control, Emergency Response, Respectful Interactions and General Supervision.

2. **The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**

   The facility will ensure that all direct care staff complete their twelve (12) hours of mandatory training during the orientation process and before providing direct care.

3. **The facility will monitor the corrective action by implementing the following measures.**

   The Business Office Manager and/or Executive Director will be responsible for ensuring that appropriate trainings have been conducted.

4. **Plan of Corrections completion date: 04-30-2022**

Tag: R181 V. Resident Care and Home Services

1. **The corrective actions to be accomplished to correct the deficient practice.**

   The facility will ensure that all agency staff are screened for criminal and abuse checks.

2. **The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**

   The facility provided the proper consent form for Vermont Abuse Registry Checks to all agencies on 3/3/2022. The facility will require criminal and Vermont abuse check results prior to any agency staff providing direct care.

3. **The facility will monitor the corrective action by implementing the following measures.**

   The Executive Director and/or Director of Health Services or designee will maintain a file of all agency staff to include criminal and Vermont abuse check results.

4. **Plan of Corrections completion date: 03-31-2022**

Tag: R266 IX. Physical Plant

1. **The corrective actions to be accomplished to correct the deficient practice.**

   The facility will identify all residents who may potentially be affected by the deficient practice. The facility will perform an audit to ensure that every resident has an accurate, up-to-date fall assessment and any associated individual interventions that are identified will be incorporated into the individualized care plan. The facility conducted a full building safety assessment to identify potential environmental hazards that could lead to falls (completed 02-28-2022).

2. **The facility will put into place the following systematic changes to ensure that the deficient practice does not recur.**

   The Director of Health Services or designee will continually monitor residents to track and trend falls. All new admissions will be reviewed for fall risk and prevention at admission and with change of condition. For all new admissions a fall assessment and any associated individual interventions that are identified will be incorporated into the individualized care plan. The facility will obtain orders for PT/OT as appropriate.

3. **The facility will monitor the corrective action by implementing the following measures.**

   The Director of Health Services or designee and Executive Director will perform an audit quarterly for Memory Care and biannually for Assisted Living to ensure that all residents have an individualized care plan that reflects individual fall risk and individualized interventions.

   The DOHS will conduct a facility-wide audit of all care plans to ensure accuracy. This audit will be completed by 04-01-2022. Thereafter, the DOHS or designee will utilize an audit tool for care plan updates. This audit will be completed weekly for 4 weeks, monthly for 3 months and reviewed by the QAPI team to ensure completion and effectiveness.

4. **Plan of Corrections completion date: 04-01-2022**