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

January 9, 2025

Ms. Brenda Thornton, Administrator
Burlington Health & Rehab
300 Pearl Street
Burlington, VT 05401-8531

Dear Ms. Thornton:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **December 4, 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, 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
	475014	A. BUILDING _____ B. WING _____	C 12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURLINGTON HEALTH & REHAB	300 PEARL STREET BURLINGTON, VT 05401

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E 000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey from 12/2/2024 through 12/4/2024. There were no regulatory deficiancies identified.	E 000	F000 The filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. The facility has prepared and executed a plan of correction as evidence of the facility's continued compliance with applicable federal and state laws.	
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey, complaint investigations (Intake # 23026, #22909, #23240, #22975, and #23100) and facility reported incidents (#23368, and #23402) from 12/2/2024 through 12/4/2024 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following deficiencies were identified:	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550	F550~E Resident Rights / Exercise of Rights • Residents # 3, #88, #19. #1, #81, #17, #39, #8 are being treated and cared for in a manner that maintains their dignity and respect. • A facility wide audit, (FWA) has been conducted through interview and observation to ensure that call bells are in place so the resident can reach them and that they are answered timely, that transfers and	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brenda K Thornton — TITLE: Administrator — (X6) DATE: 1/6/25

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 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to treat and care for each resident in a manner that maintains their dignity and respect for 8 out of 29 Residents in the sample (Residents #3, #88, #19, #1, #81, #17, #39, and #8) Findings include: Per interview with Resident #88 on 12/3/24 at approximately 10:05 AM, they stated that when they ring their call bell for assistance it takes over an hour most often before someone responds, and by then they have either wet or soiled themselves. Resident #88 stated it is very upsetting when this happens.	F 550	toileting can be addressed timely, that staff are knocking on doors of the residents looking for permission to enter prior to entering the residents room, allowing and encouraging residents to participate in personal care as able, staff is responding to their needs with a calm and respectful approach and assisting to meet the residents care needs, provide showers when it is preferred by the resident, and that even for residents who may not require assistance from the staff that the staff is checking in with them to offer support if needed. • The Staff Development Coordinator (SDC) or designee has provided education to all staff regarding the Resident Rights Policy while using the specific identified concerns as examples of what not to do and to discuss what is expected of	

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F 550	Continued From page 2 Review of Resident #88's call bell log for the week of 11/26/24 - 12/2/24 revealed 16 times when the resident rang their call bell and the response time was 20 minutes or more. Of those calls, there were 8 times when the call bell was not responded to for greater than 30 minutes, and 3 times when the response time was greater than 1 hour. Review of Resident #88's current care plan, revealed they have an incontinence care plan that states the following: "...is incontinent of urine at times and is unable to physically participate in a retraining program.....". The goal listed in this care plan is as follows: "...will have incontinence care needs met by staff to maintain dignity and comfort and to prevent incontinence related complications." This care plan was last revised on 11/22/2024. Review of Resident #88's ADL (Activities of Daily Living) flow sheets for 11/26/24 - 12/2/24 revealed the resident was incontinent on all these days. 2. Per observation on 12/2/2024 at 1:00 PM, Resident #3 was at his/her door with the call light on. The Licensed Nursing Assistant (LNA) answered the call light, and Resident #3 requested to use the bathroom. The LNA told Resident #3 in front of this surveyor that s/he could not take him/her to the bathroom and that his/her LNA was on break and would take the resident to the bathroom when s/he returned. Per further observation at 1:30 PM, Resident #3 remained sitting at the door in his/her wheelchair waiting to use the bathroom. Resident #3 put his/her call light on and requested the LNA take him or her to the bathroom. The same LNA approached the resident and told him/her that	F 550	the staff when faced with these situations. • Observations and interviews conducted by the DNS or designee of the staff and residents will be completed 6 times weekly across all shifts including, call bells being within reach, call bells answered timely supporting timely transfers and toileting, interactions between staff and residents are calm and respectful, when showers are provided at residents preferred times, staff knocking on the doors prior to entry, allowing those residents that can participate in care that they are allowed to do so, and that residents who don't require assistance are still checked in on should they need anything. • The DNS is responsible for overseeing this process. The results of the observations and audits will be brought to the QAPI	

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F 550	Continued From page 3 s/he would need to wait until his/her LNA returned. Resident #3 began yelling out that s/he needed to use the bathroom, across the common area of the unit with other residents present. The Unit Manager responded to the room, approached the LNA and directed him/her to bring Resident #3 to the bathroom. Per record review of Resident #3's care plan dated 3/7/2024, s/he has stress incontinence (incontinence is the loss of bladder control resulting in loss of urine). The following interventions were implemented on 3/7/2024 -Resident to use toilet upon awakening, after meals, nightly and as needed - respond promptly to the resident's request to use the toilet. Per Interview on 12/2/2024 at 1:45 PM with the Unit Manager, s/he confirmed that the LNA was responsible for the resident's care while the assigned LNA was on break and should have provided care to Resident #3 as requested by the resident. 3. A Resident Council meeting with the survey team occurred on 12/4/24 at 10:27 AM, and there were six attendees, Residents #19, #1, #81, #17, #39, and #8. Per record review, Resident #19's has a BIMS of 15 (brief interview for mental status; a cognitive assessment score indicating cognitive intactness) dated 11/12/24, Resident #1 has a BIMS of 14 (indicating cognitive intactness) dated 11/9/24, Resident # 81 has a BIMS of 15 dated 11/13/24, Resident #17 has a BIMS of 15 dated 10/8/24, Resident #39 has a BIMS of 15 dated 10/24/24, and Resident #8 has a BIMS of 15 dated 10/4/24. A collaborative conversation involving all six residents revealed that they do not feel that they are treated with dignity and respect by all staff.	F 550	meeting for a period of 3 months for review and recommendation to ensure substantial compliance has been achieved. **Tag F 550 POC accepted on 1/9/25 by K. Humphrey/P. Cota**	1/18/25

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F 550	Continued From page 4 Resident #1 stated that a lot of staff don't treat him/her like s/he is in his/her own home. Not all staff treat him/her with dignity. Foe example, not all staff knock on his/her door before coming in and a lot of staff give him/her an attitude. There are some staff that do all his/her personal care, even though s/he is able to wash up parts of his/her own body. S/He explained that s/he likes to wash the front of him/herself up and they won't let her which makes him/her upset because it would be faster and s/he would feel better to be able to participate in his/her own care. S/He has had aides yell at him/her and tell him/her to shut up. Sometimes staff won't put his/her call bell within reach and s/he ends up having to yell for help. S/He stated that s/he should be treated with dignity and respect in his/her own house but it doesn't feel like his/her home. Resident #17 explained that she was told by the LNA that they would not help him/her to bed because she could do it herself. S/he stated that s/he can see some staff pass his/her room when s/he has his/her call bell on and don't stop and if they do, they say they will be right back but end up coming back much later or with an attitude. Resident #8 stated that staff often rush his/her care. S/he explained that sometimes staff tell him/her s/he has to take a shower before dinner but that is not his/her preference; s/he would like to take a shower after dinner. They don't listen to him/her and staff have screamed at him/her for taking too long in the shower. Resident #19 said that staff never ask him/her what they need and don't help him/her at times and tell him/her it is because s/he is independent.	F 550		

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F 550	Continued From page 5 All six residents individually confirmed that they did not believe that all staff treated them with dignity and respect and this sentiment was brought up multiple times during the conversation.	F 550	F585~E Grievances • The facility has established a grievance reporting system that supports the residents right to voice any grievance without discrimination, reprisal, or the fear of discrimination or reprisal which has been reviewed with Residents #1, #19, #81, #17, #39 and #8. These 6 residents have also been asked in an individual 1:1 meeting with the administrator if there was any grievances that they had and if the grievance had been resolved or not should it need further follow up. • A FWA has been completed through interviews of residents to ensure grievances are ultimately in writing regardless as to who needs to put the grievance on paper and that they are presented timely to the administrator with timely follow up from the administrator or designee.	
F 585 SS=E	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 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	F 585		

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F 585	Continued From page 6 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; (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;	F 585	• The SDC or designee has provided education on Grievance Policy to all staff. A memo was distributed to all residents reassuring them that anyone can file a grievance with no fear of reprisal or discrimination. The administrator also met with Resident Council President and reviewed the grievance policy and form for submission to next resident council meeting. • A weekly review with the Administrator and Director of Nursing will be conducted ensuring that grievances were filed daily and discussed in morning stand up meeting and were followed up no later than 7 days of the complaint.	

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F 585	Continued From page 7 (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: Per interview and facility policy review, the facility failed to establish a grievance reporting system that supports the resident's right to voice any grievance without discrimination, reprisal, or the fear of discrimination or reprisal for 6 of 29 sampled residents (Residents # 1, #19, #1, #81, #17, #39, and #8). Findings include: Facility policy titled, "OPS204 Grievance/Concern," last revised on 10/15/24, reads, "The patient/resident (hereinafter "patient") has the right to voice grievances to the Center or any other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal."	F 585	• The Administrator is responsible for overseeing this process. The results of the observations and audits will be brought to the QAPI meeting for a period of 3 months for review and recommendation to ensure substantial compliance has been achieved. **Tag F 585 POC accepted on 1/9/25 by K. Humphrey/P. Cota**	1/18/25

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F 585	Continued From page 8 A Resident Council meeting with the survey team occurred on 12/4/24 at 10:27 AM, and there were six attendees, Residents #19, #1, #81, #17, #39, and #8. Per record review, Resident #19's has a BIMS of 15 (brief interview for mental status; a cognitive assessment score indicating cognitive intactness) dated 11/12/24, Resident #1 has a BIMS of 14 (indicating cognitive intactness) dated 11/9/24, Resident # 81 has a BIMS of 15 dated 11/13/24, Resident #17 has a BIMS of 15 dated 10/8/24, Resident #39 has a BIMS of 15 dated 10/24/24, and Resident #8 has a BIMS of 15 dated 10/4/24. A collaborative conversation involving all six residents revealed that they do not feel that they are treated with dignity and respect by all staff. See F550 for more information. They relayed that they all know how to file a grievance and the process is successful for issues like missing personal property. However, when asked if they have reported their concerns about not being treated with dignity or respect to the facility, all six residents explained that they did not feel comfortable reporting how they are treated to anyone because they are afraid of repercussions. Resident #81 reported that if residents report rude, disrespectful, or rough behavior from the staff, they will get yelled at or ignored. All six residents individually confirmed that this was true for them and this sentiment was brought up multiple times during the conversation.	F 585		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 677		

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F 677	Continued From page 9 services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that a resident who is unable to carry out activities of daily living (ADLs) without assistance receives the proper level of assistance for 3 of 29 sampled residents (Residents #18, #145, and #73) related to transferring and toileting. Findings include: 1. Per record review, Res.#145 was admitted to the facility with diagnoses that included a fracture of the right tibia and fibula [The lower leg is made up of two bones: the tibia and fibula. The tibia is the larger of the two bones]. Res.#145's Care Plan identified the resident as "requires assistance/is dependent for ADL [Activities of Daily Living] care in personal transfer, toileting" with interventions that include "Provide with assist of one using the bedside commode with walker and gait belt for toileting". An interview was conducted with Res.#145 on 12/2/24 at 5:49 PM. The resident stated that "I have been left sitting on the bedpan for 45 minutes, balling my [expletive] eyes out". The resident reported that due to h/her fracture, she needed assistance with toileting, and despite using the call bell and staff having placed h/her on the bedpan in the first place, s/he was left on the bedpan for an extended period of time which was "painful". 2. Per record review, Resident #18's care plan reads, "[Resident #18] has an ADL Self Care Performance Deficit [related to] Activity Intolerance/weakness, Spondylopathy Lumbar [degeneration of the vertebrae and disks of the	F 677	F677~E ADL Care Provided for Dependent Residents • Residents #18, 145, and #73 are receiving the proper level of care for ADL needs relating to transferring and toileting. • A FWA has been conducted through interview and observation to ensure that call bells are in place so the resident can reach them and that they are answered timely, that transfers and toileting can be addressed timely, that staff are knocking on doors of the residents looking for permission to enter prior to entering the residents room, allowing and encouraging residents to participate in personal care as able, staff is responding to their needs with a calm and respectful approach and assisting to meet the residents care needs, provide showers when it is preferred by the resident, and that even for residents who may not require assistance from the	

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F 677	Continued From page 10 lower back], Morbid Obesity and Intervertebral Disc Degeneration Lumbar [condition that occurs when discs in lower back break down causing pain and stiffness]," revised on 7/18/23, with interventions that include staff assistance for transferring and toileting. Resident #18 has a BIMS of 14 (brief interview for mental status; a cognitive assessment score indicating cognitive intactness) dated 11/27/24. Per interview on 12/3/24 at 9:29 AM, Resident #18 explained that when s/he uses the commode, s/he sometimes has to wait an hour or longer to have a staff help him/her off the commode if it is during meals. Staff report to him/her that s/he will have to wait until after meals are served because it is unsanitary to provide care while passing meal trays, S/he explained that this makes him/her upset because it begins to hurt when s/he sits for so long, and s/he also has to look at his/her food that was delivered get cold. S/He explained that it happens "often enough" for it to be a problem. Per interview on 12/4/24 at approximately 11:00 AM, a Licensed Nursing Assistant explained that s/he does not provide patient care, like toileting, while s/he is passing meal trays because it is unsanitary. 3. Per record review, Resident #73's care plan reads, "[Resident #73] has an ADL Self Care Performance Deficit r/t [related to] Spinal Stenosis [condition putting pressure on spinal cord and nerves], C5-6 Myelopathy [compression of spinal cord]," last revised on 4/10/23, and includes interventions revealing s/he requires assistance of 2 staff for transferring and toileting. Resident #73's care plan also states they are sometimes incontinent of bladder and bowel and has an intervention to "encourage [Resident #73]	F 677	staff that the staff is checking in with them to offer support if needed. • The SDC or designee has provided education to the LNAs on providing the proper level of assistance being provided for their ADLs to those residents who are dependent or require assistance in completing their ADLs. • Observations and interviews conducted by the DNS or designee of the staff and residents will be completed 6 times weekly across all shifts including, call bells being within reach, call bells answered timely supporting timely transfers and toileting, interactions between staff and residents are calm and respectful, when showers are provided at residents preferred times, staff knocking on the doors prior to entry, allowing those residents that can participate in care that they are allowed to do so, and	

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F 677	Continued From page 11 to toilet upon awakening, after meals, nightly, and PRN [as needed]," revised on 4/10/23. Resident #73 has a BIMS score of 13 (brief interview for mental status; a cognitive assessment score indicating cognitive intactness) dated 11/5/24. Per interview with Resident #73 and Resident #73's family member on 12/3/24 at 2:30 PM, Resident #73 stated that s/he is not being assisted with toileting as frequently as s/he needs. "I ring the bell and sometimes it takes a very long time to get someone to help me." When asked to clarify what a long time is, Resident #73 stated "sometimes an hour or more." Resident #73 stated that many times when they call for help toileting, help does not arrive until long after they have soiled themselves, causing them distress. Resident #73 also stated that if they could get the help they need in a timely manner, they would not have so many episodes of incontinence. Resident #73's family member stated that they visit Resident #73 almost daily and confirmed that they have witnessed wait times of 1-2 hours for Resident #73's call bell to be answered.	F 677	that residents who don't require assistance are still checked in on should they need anything. • The DNS is responsible for overseeing this process. The results of the observations and audits will be brought to the QAPI meeting for a period of 3 months for review and recommendation to ensure substantial compliance has been achieved. **Tag F 677 POC accepted on 1/9/25 by K. Humphrey/P. Cota**	1/18/25
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence	F 679	F679~D Activities Meet Interest / Needs for Each Resident • Resident #29 has met with the Activities Director to discuss a schedule for going outside weather permitting.	

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F 679	Continued From page 12 and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide activities that support the physical, mental, and psychosocial well-being of each resident for 1 of 29 sampled residents (Resident #29). Findings include: Per record review, Resident #21 has a diagnosis of Parkinson's disease. Per a 10/5/24 Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool), Resident #21 has a BIMS of 14 (brief interview for mental status; a cognitive assessment score indicating cognitive intactness) and expressed for activity preferences that it is very important for him/her to do his/her favorite activities and go outside. Resident #21's care plan reads, "While in the facility, [Resident #21] states that it is important that [s/he] has the opportunity to engage in daily routines that are meaningful relative to [his/her] preferences," created 10/3/23, and an intervention reads, "It is important for me to go outside when the weather is good, staff, family and friends to assist outdoors weather permitting. I have my rock collection on the patio," revised on 1/3/24. Per interview on 12/2/24 at 2:16 PM, Resident #21 stated that s/he wants to go outside every day and the staff won't let him/her go out every day because there are not enough staff and s/he needs to be supervised when s/he goes outside. S/He explained that staff also tell him/her that it is too cold to go outside. Resident #21 explained that it is very important to him/her to go outside as much as possible and said that if s/he's "going to be stuck here" s/he wants to enjoy his/her time and go out into nature because it is very	F 679	• A FWA has been completed regarding those residents who would like to go outside and are offered an opportunity to do so with appropriate supervision, weather permitting. • The Administrator has provided education to the Activities Director to include outdoor activities on the calendar routinely and if weather permitting work with activity assistants and other supportive staff to allow residents who prefer to go outside time to be outside weather permitting. • A weekly review of when the times are to support residents who prefer to go outside are scheduled, validate that the residents are aware of the time for them to be ready to go outside, what the weather is like to support their involvement in deciding if they chose to continue to go outside and to then to validate that even if they now decided not to go	

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F 679	Continued From page 13 important. Resident #21 was not observed outside at any time during the recertification survey on 12/2/24 through 12/4/24. Activity logs dated 11/1/24 through 12/3/24 reveal that Resident #21 spent time outdoors on just 11/1/24; only once in 33 days. An 8/30/24 Advanced Practice Registered Nurse note reads, "The patient says, 'I feel like I'm trapped in prison'. 'I can't get anyone to bring me outside'." Per interview on 12/4/24 at 3:14 PM an Activity Aide explained that s/he was aware of how important it is for Resident #21 to go outside as much as possible but is not sure there are enough staff to make that happen. S/He stated that Resident #21 should be able to go outside when s/he wants to but doesn't think there is anything in place to ensure that it happens.	F 679	outside that it was their choice to not go outside for a reason they provide weather or otherwise. • The Administrator is responsible for overseeing this process. The results of the observations and audits will be brought to the QAPI meeting for a period of 3 months for review and recommendation to ensure substantial compliance has been achieved. **Tag F 679 POC accepted on 1/9/25 by K. Humphrey/P. Cota**	1/18/25
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 interview and record review, the facility failed to ensure that resident environments were free of accident hazards related to smoking for	F 689	F689~D Free of Accidents Hazards / Supervision / Devices • Resident #86 has agreed to lock her smoking paraphernalia up at the nursing station. • No other resident smokes at the facility. • The SDC has provided education on the smoking policy which includes smoking paraphernalia is to	

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F 689	Continued From page 14 one sampled resident (Resident # 86). Findings include: Per record review, Resident #86 was admitted to the facility on 4/22/24 and readmitted on 8/22/24 with diagnoses of osteomyelitis (infection of the bone), peripheral vascular disease and chronic kidney disease. Review of Resident #86's care plan states: "[Resident #86] may not smoke per smoking evaluation/policy. [Resident 86] has been signing out and taking self-off property to smoke." The care plan interventions include, "Educate patient/health care decision maker on the facility's smoking policy," "Inform of and reinforce smoking restriction," "Monitor patients [sic] compliance with non-smoking," "Provide education/material regarding smoking cessation," and "Provide smoking cessation medications if ordered." Per interview with Resident #86 on 12/4/24 at 9:29 AM Resident #86 stated that s/he signs him/herself out of the facility and goes out to smoke. S/he stated that s/he is not accompanied by a staff member. S/he stated that yesterday, 12/3/24, s/he went out to smoke a cigarette three times and did not sign out of the building. S/he stated that s/he does not keep his/her cigarettes and lighter in a locked box or with staff but that they are "out of the way" in his/her bedroom. S/he refused to tell surveyor where s/he kept his/her cigarettes in his/her bedroom. Per record review of the facility's "OPS137 Smoking" policy states, "2.6 Smoking supplies (including, but not limited to, tobacco, matches, lighters, lighter fluid, batteries, refill cartridges etc.) will be labeled with the patient's name, room number, and bed number, maintained by staff,	F 689	be kept locked up at the nurse's station. • Weekly observations by the Administrator or Designee validating that resident #88 smoking materials are locked at nursing station. • The Administrator is responsible for overseeing this process. The results of the observations and audits will be brought to the QAPI meeting for a period of 3 months for review and recommendation to ensure substantial compliance has been achieved. **Tag F 689 POC accepted on 1/9/25 by K. Humphrey/P. Cota**	1/18/25

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F 689	Continued From page 15 and stores in a suitable cabinet kept at the nursing station." Per interview with Unit Manager on 12/4/24 at 9:35 AM it was confirmed that Resident #86's cigarettes and lighter are kept in his/her room and not kept at the nursing station. The Unit Manager stated that approximately 15 residents on the floor have dementia and are ambulatory.	F 689		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge	F 725	F725~F Sufficient Staff • There is sufficient nursing staff scheduled to meet the ADL requirements of the resident including transfers and toileting needs, support attendance to the activity choices of resident, receive medications timely as ordered and when requesting them, food delivered while within appropriate temperature, #44, #145, #88, #73, #1, #18, #70, #87, #90, #145, #295, #89, #309, and residents #6 family member, resident #18, #73 #21, and #90.	

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F 725	Continued From page 16 nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71 regarding 13 residents [Res.#44, #145, #88, #73, #8, #1, #70, #87, #90, #295, #89, #21 and #6] of 44 sampled residents. Findings include: 1). Per record review, Res.#44 was admitted to the facility with diagnoses that included Right leg below knee amputation, anxiety disorder, and major depressive disorder. Res.#44's Care Plan identifies the resident as "at risk for decreased ability to perform Activities of Daily Living [ADLs]" requiring "extensive assist of 2 with sit to stand for transfers". Per interview with Res.#44 on 12/02/24 at 12:01 PM, the resident reported s/he is unable to transfer out of bed into a wheelchair or onto a bedside commode without the assistance of 2 staff members for safety. The resident stated that unless s/he is transferred out of bed, s/he is unable to attend the group activities which are located on a different floor in the facility. Further review of Res.#44's Care Plan reveals the resident "states that it is important that he has the	F 725	• A FWA has been conducted through interview and observation to ensure that call bells are in place so the resident can reach them and that they are answered timely, that transfers, and toileting can be addressed timely, supporting attendance to activities per resident choice, receiving medications on time as scheduled and when requested. • The SDC or Designee has provided education on the definition of sufficient staff to all staff so that there is an understanding of the impact of call outs vacation time and open positions (including other departments) not just in nursing can impact residents having their needs met if an IDT does not work together to support each other to meet the resident's needs. Examples; during breaks and staff lunches all staff need to support the residents regardless as to	

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F 725	Continued From page 17 opportunity to engage in daily routines that are meaningful relative to [h/her] preferences" including "I like to participate in bingo and music with groups of people". The Care Plan also identifies the resident as "at risk for distressed/fluctuating mood symptoms related to: anxiety & depression", with interventions that include "participation in activity preferences", "Provide [Res.#44] with opportunities for choice during care/activities to provide a sense of control" and "Encourage [Res.#44] to attend activities that maximize [h/her] full potential while meeting [h/her]need to socialize". Review of Res.#44's quarterly Recreation Evaluation dated 10/4/24 identifies the resident "has the following needs for special adaptation in order to participate in desired engagement opportunities: use of adaptive equipment- electric wheelchair for physical limitations". Per interview with Res.#44 on 12/02/24 at 12:01 PM, the resident stated, "I miss activities because staff don't get here to get me out of bed in time. Sometimes my lunch doesn't get delivered until 2:00 o'clock, and Bingo is at 2:00. I have to choose: do I go [to activities] or do I eat? Sometimes they save me my lunch, other times I come back to my room and there is nothing there." An observation and interview were conducted with Res.#44 on 12/4/24 at 10:46 AM. Per observation, 2 staff were in the room with the resident, with the resident being transferred out of bed at 10:45 AM. The resident reported that staff transferring h/her out of bed happens "a lot of times later than it is now." Per review of the facility's Activities Calendar for December 2024, Bingo is offered as an activity at	F 725	who they may be assigned to, activities communicating with nursing when a resident has a specific activity they need to get to today, and also checking with the residents ensuring they have no needs before you exit the room vs a light going on as soon as you leave. • Observations and interviews conducted by the Administrator or designee of the staff and residents will be completed 6 times weekly across all shifts including, call bells being within reach, call bells answered timely supporting timely transfers and toileting, ability to attend preferred activities, receiving medications timely as ordered and when asked for and receiving meal trays within appropriate temperatures. • The Administrator is responsible for overseeing this process. The results of	

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F 725	Continued From page 18 2:00 PM on Wednesdays and 10:30 AM on Saturdays. 2). Per record review, Res.#145 was admitted to the facility with diagnoses that included a fracture of the right tibia and fibula [The lower leg is made up of two bones: the tibia and fibula. The tibia is the larger of the two bones]. Res.#145's Care Plan identified the resident as "exhibits or is at risk for alterations in comfort related to fracture of right tibia, fibula". An interview was conducted with Res.#145 and a friend visiting the resident on 12/03/24 at 2:25 PM. The resident's friend stated s/he was present on 12/2/24 at approx. 4:00 PM when the resident requested a muscle relaxant medication from nursing staff and stated that the resident had not received it when the friend left at 5:00 PM. An observation and interview were conducted with Res.#145 at 5:49 PM on 12/2/24, shortly after the friend had left. Res.#145 was observed yelling in h/her room stating that s/he had been waiting "2 1/2 hours" for the muscle relaxant medication. Per interview, the resident stated that s/he had yet to receive the medication s/he had requested at 4:00 PM. A follow up interview on 12/3/24 with the resident revealed the resident reported s/he received the muscle relaxant medication at approximately 6:00 PM on 12/2/24, approximately 2 hours after requesting it. An interview was conducted with the Unit Manager [UM] of Res.#145's unit on 12/03/24 at 2:35 PM. The UM confirmed a wait time of approx. 2 hours for medication to relieve a resident's discomfort was "too long". The UM stated staffing level "was enough" but could not explain why with "enough staffing" a resident would have to wait 2 hours for a medication.	F 725	the observations and audits will be brought to the QAPI meeting for a period of 3 months for review and recommendation to ensure substantial compliance has been achieved. **Tag F 725 POC accepted on 1/9/25 by K. Humphrey/P. Cota**	1/18/25

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F 725	Continued From page 19 3. During Resident interviews conducted throughout the initial survey screening process, Residents #88, #73, #8, #1, #18, #70, #87, #90, #145, #295, #89, #309, and Resident #6's family member expressed concerns related to insufficient staffing leading to long wait times for care, and excessive call light times up to 45 minutes. Review of the facility call bell history for 11/26/24 - 12/3/2024 revealed call wait times for the above Residents and multiple other Residents on all open units up to an excess of 7 hours and 46 minutes making this a wide spread concern. Extended wait times of over 30 minutes after a call light was activated by the specific Residents in the sample are as follows: 11/26/24: Room 413(Resident #89) activated at 6:29 PM - 111 minutes Room 318 (Resident #70) activated at 8:05 PM - 62 minutes 11/27/2024: Room 318 (Resident #70) activated at 5:32 AM - 68 minutes Room 319 (Resident #88) activated at 5:32 AM - 69 minutes Room 519 W (Resident #18) activated at 8:12 AM - 75 minutes Room 318 (Resident #70) activated at 12:33 PM - 44 minutes Room 513(Resident #295) activated at 12:54 PM - 36 minutes Room 318 (Resident #70) activated at 2:15 PM - 43 minutes Room 504 (Resident #8) activated at 3:45 PM - 41 minutes	F 725		

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F 725	Continued From page 20 Room 519 (Resident # 73) activated at 7:13 PM - 81 minutes Room 303 (Resident #145) activated at 9:32 PM - 38 minutes 11/28/24: Room 413 (Resident #89) activated at 4:15 AM - 90 minutes Room 318 (Resident #70) activated at 5:07 AM - 94 minutes Room 319 (Resident #88) activated at 9:34 AM - 42 minutes Room 519(Resident #18) activated at 10:12 AM - 56 minutes Room 318 (Resident #70) activated at 1:06 PM - 40 minutes Room 519 (Resident #18) activated at 3:13 PM - 40 minutes Room 413 (Resident #89) activated at 4:41 PM - 55 minutes Room 410 (Resident #3) activated at 7:24 PM - 45 minutes Room 303 (Resident #145) activated at 8:24 PM - 49 minutes 11/29/24: Room 318 (Resident #70) activated at 5:23 AM - 56 minutes Room 406 (Resident #5) activated at 6:58 AM - 48 minutes Room 309 (Resident #44) activated at 9:01 AM - 316 minutes Room 318 (Resident #70) activated at 9:02 AM - 44 minutes Room 413 (Resident #89) activated at 12:26 PM - 51 minutes Room 305 (Resident #77) activated at 1:48 PM - 47 minutes Room 413 (Resident # 89) activated at 6:07 PM	F 725		

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F 725	Continued From page 21 -103 minutes Room 413 (Resident # 89) activated at 7:50 PM - 131 minutes 11/30/24: Room 513 (Resident #89) activated at 6:05 AM - 149 minutes Room 513 (Resident #89) activated at 8:36 AM - 466 minutes Room 519 (Resident #18) activated at 8:56 AM - 52 minutes Room 309 (Resident #44) activated at 10:26 AM - 37 minutes Room 519 (Resident #73) activated at 10:49 AM - 36 minutes Room 504 (Resident #8) activated at 12:22 PM - 42 minutes Room 309 (Resident #44) activated at 12:25 PM - 66 minutes Room 413 (Resident #89) activated at 12:42 PM - 106 minutes Room 319 (Resident #88) activated at 1:25 PM - 42 minutes Room 519 (Resident #18) activated at 1:31 PM - 44 minutes Room 318 (Resident #70) activated at 3:33 PM - 73 minutes Room 309 (Resident #44) activated at 6:08 PM - 44 minutes Room 318 (Resident #70) activated at 6:35 PM - 42 minutes Room 413 (Resident #89) activated at 6:35 PM - 83 minutes Room 305 (Resident #77) activated at 7:33 PM - 58 minutes Room 307 (Resident #37) activated at 8:14 PM - 41 minutes 12/1/24:	F 725		

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F 725	Continued From page 22 Room 519 (Resident #18) activated at 4:51 AM - 48 minutes Room 318 (Resident #70) activated at 6:41 AM - 52 minutes Room 319 (Resident #88) activated at 6:58 AM - 41 minutes Room 519(Resident #18) activated at 7:32 AM - 45 minutes Room 406 (Resident #5) activated at 8:17 AM - 43 minutes Room 309 (Resident #44) activated at 9:21 AM - 69 minutes Room 318 (Resident #70) activated at 10:28 AM - 42 minutes Room 318 (Resident #70) activated at 12:47 PM - 44 minutes Room 318 (Resident #70) activated at 1:55 PM - 70 minutes Room 519 (Resident #18) activated at 2:35 PM - 77 minutes Room 319 (Resident #88) activated at 5:49 PM - 90 minutes Room 319 (Resident #88) activated at 7:25 PM - 56 minutes 12/2/24: Room 413 (Resident #89) activated at 6:10 AM - 41 minutes Room 410 (Resident #3) activated at 6:35 AM - 66 minutes Room 413 (Resident #89) activated at 12:44 PM - 41 minutes Room 504 (Resident #8) activated at 2:29 PM - 126 minutes 12/3/24: Room 309 (Resident #44) activated at 10:02 AM - 38 minutes Room 413 (Resident #89) activated at 12:47 PM -	F 725		

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F 725	Continued From page 23 35 minutes Review of the facility policy titled "NSG101 Call Lights" states: Policy All Genesis HealthCare patients will have a call light or alternative communication device within their reach at all times when unattended. Staff will respond to call lights and communication devices promptly. Purpose To ensure safety and communication between staff and patients. During an interview on 12/4/24 2:00 PM the Market Clinical Advisor confirmed that the call light log reflected excessively long wait times. 4. Per record review, Resident #18's care plan reads, "[Resident #18] has an ADL Self Care Performance Deficit [related to] Activity Intolerance/weakness, Spondylopathy Lumbar [degeneration of the vertebrae and disks of the lower back], Morbid Obesity and Intervertebral Disc Degeneration Lumbar [condition that occurs when discs in lower back break down causing pain and stiffness]," revised on 7/18/23, with interventions that include staff assistance for transferring and toileting. On 11/27/24, the residents was assessed as having a BIMS of 14, indicating the resident is cognitively intact. Per interview on 12/3/24 at 9:29 AM, Resident #18 explained that when s/he uses the commode, s/he sometimes has to wait an hour or longer to have a staff help him/her off the commode if it is during meals. Staff report to him/her that s/he will have to wait until after meals are served because	F 725		

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F 725	Continued From page 24 it is unsanitary to provide care while passing meal trays. S/he explained that this makes him/her upset because it begins to hurt when s/he sits for so long, and s/he also has to look at his/her food that was delivered get cold. S/He explained that it happens "often enough" for it to be a problem. Review of the facility call bell history for 11/26/24 - 12/3/2024 revealed the following excessive wait times after the call light was activated in Resident #18's room: 11/27/24 - wait times of 75 minutes, 81 minutes, and 25 minutes. 11/28/24 - wait times of 36 minutes 56 minutes, and 25 minutes. 11/29/24 - wait times of 40 minutes and 32 minutes. 11/30/24 - wait times of 38 minutes and 36 minutes. 12/1/24 - wait times of 48 minutes, 45 minutes, 25 minutes, and 77 minutes. 12/2/24 - wait time of 97 minutes. 5. Per record review, Resident #73's care plan reads, "[Resident #73] has an ADL Self Care Performance Deficit r/t [related to] Spinal Stenosis [condition putting pressure on spinal cord and nerves], C5-6 Myelopathy [compression of spinal cord]," last revised on 4/10/23, and includes interventions revealing s/he requires assistance of 2 staff for transferring and toileting. Resident #73's care plan also states they are sometimes incontinent of bladder and bowel and has an intervention to "encourage [Resident #73] to toilet upon awakening, after meals, nightly, and PRN [as needed]," revised on 4/10/23. Resident #73 has a BIMS score of 13 (brief interview for	F 725		

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F 725	Continued From page 25	F 725		

mental status; a cognitive assessment score indicating cognitive intactness) dated 11/5/24.

Per interview with Resident #73 and Resident #73's family member on 12/3/124 at 2:30 PM, Resident #73 stated that s/he is not being assisted with toileting as frequently as s/he needs. "I ring the bell and sometimes it takes a very long time to get someone to help me." When asked to clarify what a long time is, Resident #73 stated "sometimes an hour or more." Resident #73 stated that many times when they call for help toileting, help does not arrive until long after they have soiled themselves causing them distress. Resident #73 also stated that if they could get the help they need in a timely manner, they would not have so many episodes of incontinence. Resident #73's family member stated that they visit Resident #73 almost daily and confirmed that they have witnessed wait times of 1-2 hours for Resident #73's call bell to be answered.

Record review of facility call bell wait times for Resident #73 from 11/27/24-12/2/24, there are wait times including 81 minutes on 11/27/24, 36 minutes on 11/30/24 and 97 minutes on 12/2/24.

6. Per record review, Resident #21 has a diagnosis of Parkinson's disease. Resident #21 has physician orders for the following Parkinson's medications: Carbidopa-Levodopa Oral Tablet 25-100 milligram (mg), to be given at 6:00 AM, 9:00 AM, 12:00 PM, 3:00 PM, 6:00 PM, and 9:00 PM daily; Carbidopa-Levodopa ER 25-100 mg Tablet extended release, to be given at 6:00 AM, 9:00 AM, 12:00 PM, 3:00 PM, 6:00 PM, and 9:00 PM daily; and Entacapone Oral Tablet 200 mg, to be given at 6:00 AM, 9:00 AM, 12:00 PM, 3:00

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F 725	Continued From page 26 PM, and 6:00 PM daily. Per interview on 12/2/24 at 2:16 PM, Resident #21 explained that s/he is frustrated because s/he often does not get his/her Parkinson's medications when they are scheduled. S/He stated that it is important for him/her to get them when they are scheduled because the medication wears off and s/he starts to have more symptoms including tremors and difficulty speaking, which makes it difficult to do things. Per review of Resident #21's Medication Administration Audit Report from 11/1/24 through 12/4/24, Resident #21 had 8 of their Parkinson's medications administered an hour or more before or after the physician order scheduled time on the following dates: 11/15/24 (Carbidopa-Levodopa Oral Tablet 25-100 mg and Carbidopa-Levodopa ER 25-100 mg Tablet extended release), 11/18/24 (Carbidopa-Levodopa Oral Tablet 25-100 mg, Carbidopa-Levodopa ER 25-100 mg Tablet extended release, and Entacapone Oral Tablet 200 mg), and 11/25/24 (Carbidopa-Levodopa Oral Tablet 25-100 mg, Carbidopa-Levodopa ER 25-100 mg Tablet extended release, and Entacapone Oral Tablet 200 mg). 7. Per interview on 12/2/24 at 11:46 AM, Resident #90 stated that s/he is upset that his/her Parkinson's medications are not always on time. S/He explained that it is important to have his/her medications on time so his/her symptoms do not get worse. Per record review, Resident #90 has a diagnosis of Parkinson's disease. Resident #90 has physician orders for the following Parkinson's medications: Carbidopa-Levodopa ER 25-100 mg	F 725		

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F 725	Continued From page 27 Tablet extended release, to be given at 8:00 AM and 8:00 PM. Resident had a physician order for Carbidopa-Levodopa Oral Tablet 25-250 mg, to be given at 4:00 AM, 8:00 AM, 1:00 PM, 6:00 PM, and 11:00 PM, which ended 11/8/24. Per review of Resident #90's Medication Administration Audit Report from 11/1/24 through 12/4/24, Resident #90 had 7 of their Parkinson's medications administered an hour or more before or after the physician order scheduled time on the following dates: 11/1/24 (Carbidopa-Levodopa Oral Tablet 25-250 mg), three times on 11/2/24 (Carbidopa-Levodopa Oral Tablet 25-250 mg), 11/3/24 (Carbidopa-Levodopa Oral Tablet 25-250 mg), 11/6/24 (Carbidopa-Levodopa Oral Tablet 25-250 mg), and 11/15/24 (Carbidopa-Levodopa ER 25-100 mg Tablet extended release). Facility policy titled "Medication Administration and Documentation- General Policy #PHNE69," which is not dated, reads, "Medication Administration and Documentation occurs in a timely and accurate manner. . . 2. Medications are to be administered within a two-hour time frame (i.e. one hour before or after the medication order time." Per interview on 12/4/24 at 9:00 AM, the Unit Manager explained that Parkinson's medications should be administered as close to the administration time as possible.	F 725		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental	F 758	F758~D Free from Unnecessary Psychotropic Meds/PRN Use • Resident #51 had an appropriate evaluation to receive PRN psychotropic medications for over 14 days.	

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F 758	Continued From page 28 processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.	F 758	• A FWA of residents on PRN psychotropic medications has been completed validating that residents were appropriately evaluated for a psychoactive PRN medication beyond 14 days. • The SDC or Designee has provided education to the licensed nursing staff on the Unnecessary Psychotropic Medications/PRN Use focusing on an appropriate evaluation needing to be completed by the physician if the PRN psychoactive medication was to be prescribed for over 14 days. • A weekly audit of PRN psychoactive medications by the DNS or Designee will be audited to ensure an appropriate evaluation was completed if this medication is to be administered over 14 days.	

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F 758	Continued From page 29 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure residents receiving PRN (as needed) medications were appropriately evaluated for psychoactive drug use beyond 14 days for 1 resident in a standard survey sample of 7 (Resident #51). Findings include: Record review revealed an as needed (PRN) order for "Ativan Oral Tablet 0.5 MG (Lorazepam) Give 0.5 mg by mouth every 4 hours as needed for restlessness/agitation for 90 Days". This order had a start date of 11/4/24 and an end date of 2/2/25 (90 day order) signed by the ordering physician on 11/6/24. Interview on 12/4/24 at approximately 11:50 AM with the Unit Manager, who stated the ordering physician ordered this mediction for 90 days. They acknowledged the requirement for as needed (PRN) medications is to have physician documentation stating the medical rationale for an extended PRN order of greater than 14 days. There was no physician note providing a medical rationale for the extended 90 day order for this PRN medication or a documented resident evaluation for the appropriateness of this medication for greater than 14 days.	F 758	• The DNS is responsible for overseeing this process. The results of the observations and audits will be brought to the QAPI meeting for a period of 3 months for review and recommendation to ensure substantial compliance has been achieved. **Tag F 758 POC accepted on 1/9/25 by K. Humphrey/P. Cota**	1/18/25
F 806 SS=B	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5)	F 806		

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F 806	Continued From page 30 §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to provide residents with food that accomodates preferences regarding drink options. Findings include: Per interview on 12/3/24 at 10:06 AM, Resident #40 expressed frustration that ginger ale is no longer available to residents as a beverage option. Per interview on 12/4/24 at 10:27 AM with active resident council members, all 6 residents interviewed (Residents #19, #1, #81, #17, #39, and #8) expressed that it is a problem that the facility "took away the ginger ale." Facility policy titled "FNS304 Person- Centered Choice," effective 5/1/23, reads, "Drinks are provided, including water and other liquids consistent with resident needs and preferences." Per interview on 12/4/24 at 8:52 AM, a Licensed Nursing Assistant (LNA) explained that the facility has not had ginger ale as a drink option for about 6 months and residents continue to ask about it's	F 806	F806~B Resident Allergies, Preferences, Substitutes • Resident #40, #19, #1, #81, #17, #39 and #8 have been made aware that ginger ale is now available for them. • A FWA of those who might have a preference for Ginger Ale has been completed reassuring those residents that Ginger Ale has now been made available. • The SDC has provided education to the staff that when a resident or residents have food preferences to report to their supervisor so we can address with them what the possibilities could be. • A weekly audit will be completed by the Administrator or Designee of 10 residents (these 10 residents will rotate through the facility) validating that their food preferences have been met will be completed.	

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F 806	Continued From page 31 availability. This LNA explained that they offer orange juice, lemonade, cranberry and fruit punch drink, coffee, and water but do not have ginger ale or any other type of soda beverage for the residents. Per observation, the drink cart did not have ginger ale or any soda products stocked. Per interview on 12/4/24 at approximately 3:45 PM, the Assistant Activities Director explained that residents do ask him/her about ginger ale but they just don't have it. Per interview on 12/4/24 at 5:25 PM, the Assistant Kitchen Manager confirmed that ginger ale is not offered and there are no alternatives to ginger ale, including soda products or carbonated drinks, available for the residents.	F 806	• The Administrator or Designee will be responsible for overseeing this process. The results of the observations and audits will be brought to the QAPI meeting for a period of 3 months for review and recommendation to ensure substantial compliance has been achieved. **Tag F 806 POC accepted on 1/9/25 by K. Humphrey/P. Cota**	1/18/25