VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
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AGENCY OF HUMAN SERVICES

July 25, 2025

Ms. Jennifer Combs-Wilber, Administrator
Green Mountain Nursing and Rehabilitation
475 Ethan Allen Avenue
Colchester, VT 05446

Provider ID #: 475040

Dear Ms. Combs-Wilber:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **June 6, 2025.** Please post this document in a prominent place in your facility.

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

Sincerely,

Pamela M Cota RN
Pamela M. Cota, RN, BS
Assistant Division Director
State Survey Agency Director

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475040	A. BUILDING _____ B. WING _____	C 06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN MOUNTAIN NURSING AND REHABILITATION	475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments The Division of Licensing and Protection conducted an onsite, unannounced survey of the facility's emergency preparedness program on 5/16/2025 during an annual recertification survey. There were no regulatory violations related to emergency preparedness as a result of this survey.	E 000	Preparation and/or execution of this plan do not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	
F 000	INITIAL COMMENTS READY An unannounced onsite recertification and investigation of two complaints, #23709 and #23989, was completed by the Division of Licensing and Protection on 5/12/2025 - 5/16/2025 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. On 5/15/2025, the survey team identified and notified the facility of deficiencies at the immediate jeopardy (IJ) level for F686 related to pressure ulcers, preventative interventions and treatment, ineffective provider and facility staff communication, care planning, and an effective wound monitoring system. A plan of correction was received on 5/15/25, however, on 5/15/25 the facility was notified onsite that their proposed plan had not been accepted. On 5/16/25 a revised plan of correction was submitted by the facility's Administrator and accepted. The facility is licensed for 73 beds and had a census of 55 at the time of this survey. This IJ determination also resulted in substandard quality of care. An unannounced onsite extended survey was conducted on 5/20/25 with offsite documentation review through 5/28/25. During the onsite extended survey, an onsite assessment of the IJ removal was conducted and the facility had	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	LNHA	7/16/25

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 000	Continued.From page 1 completed sufficient corrective actions to remove the IJ for F686 by implementing a plan to identify and monitor pressure ulcers/skin changes, improve communication between the medical team (physician's) and facility staff specific to pressure ulcers/skin changes, and staff education related to pressure ulcers/skin changes. During the offsite documentation review, three additional IJs were identified at F835 related to Administration, F841 related to Medical Director, and F865 related to QAPI (Quality Assurance Performance Improvement). The facility Administrator was notified on 5/28/25 at 10:01 AM. An onsite assessment of the IJ removal was conducted on 6/6/25 and the facility had completed sufficient corrective actions to remove the IJ for F835 by developing a tracking tool for new or worsening wounds, documentation of high-risk care areas to include pressure ulcers that an be used in the QAPI meeting, tracking of staff education and competencies completion with follow up for incomplete trainings and human resources to provide weekly report of training status for staff, the Administrator will address the performance improvement process of communication and tracking and they will review and analyze the data with nursing leadership and the Medical Director. The facility had also completed sufficient corrective action to remove the IJ for F841 by providing direction to the Medical Director on where policies and procedures are located, Medical Director met with the Administrator and DNS to develop a plan specific to the Medical Directors oversight and feedback, s/he will assist in the development of education/trainings for facility staff, will meet weekly with the DNS and Administrator to review	F 000		

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F 000	Continued From page 2	F 000		

and analyze the data collected on the newly created tracking logs of current wounds - pressure and non-pressure, pressure ulcers and other skins issues will be brought to the QAPI meetings for discussion. The Administrator provided education on the responsibilities of the Medical Director specific to involvement, oversight, and approval of policies related to resident care issues and clinical processes and addressing care areas through the QAA (Quality Assessment and Assurance); creation of a Medical Director Agenda tool will be used to address standards of care, physician orders, adverse events with the Medical Director weekly by the Administrator. The Administrator will oversee this process and monthly follow up reviews will be done by the Administrator, DNS and the Designated Wound Nurse to review pressure ulcers and non-pressure ulcer logs and these will be discussed in QAPI for 6 months. The facility had also completed sufficient corrective action to remove the IJ for F865 by implementing a QAPI program that is comprehensive, and data driven addressing resident care areas by discussing pressure ulcers and other skin issues through QAPI on 5/28/25, Interdisciplinary Team (IDT) wound rounds weekly, tracking pressure ulcers and other skin issues with Integrated Wound Technologies, creating a tool to index each performance improvement plan and which staff is responsible for overseeing each plan and weekly/monthly audits will be completed. Education was provided by the Administrator to nursing leadership and the. Medical Director on 5/28/25. A training plan was created for required trainings specific to all nurses, Medical Directors, and new hires for the prevention and management of pressure ulcers. A weekly meeting will be held with the Medical

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F 000	Continued From page 3 Director to review all care areas including pressure ulcers and other skin issues and an outside consultant will provide training and guidance on the QAPI Program. A staff training schedule had been developed for new employees and annually to include the required trainings. The results of the above noted initiatives will be brought to QAPI for 6 months. The following regulatory deficiencies were identified:	F 000	**F 550** It is the policy of the facility to validate that each resident has the right to self-determination and full access to persons, services, and activities outside of their room. The facility evaluated options to configure the room location to enable resident to pass freely, the resident decided on 7/09/2025 after multiple offers that she would like to move to another room.	
F 550 SS=D	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 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	F 550	Resident offered room change at time of survey after notification of concern. Resident #4 had not expressed this concern previously to the facility and had chosen the room after requesting a room change while in another room. Should resident have expressed her concern to facility we would have addressed the situation immediately. Policy review and in servicing on Resident Rights, independence has been completed with the IDT focusing on when choosing rooms for admissions the need to consider their independence and ability to move freely if they chose in morning stand up meeting 5/30/2025 Administrator and/or designee will verify during the morning meeting that new admissions or independent residents who require a room change are placed in a room that they can exit or enter independently when they choose. Administrator and/or designee is responsible for overseeing this process. The results of the review will be brought to the QAPI committee for further review and recommendation. **Completion Date: 7/10/2025 date of room change**	

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F 550	Continued From page 4 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 observation and interviews, the facility failed to ensure resident has a right to self-determination and access to persons and services outside of the resident's room, by locking the door exiting to main corridor 24 hours a day, 7 days a week. By creating a locked area, there is a failure to ensure the right of resident to exercise their rights as a citizen (or resident) of the United States or make personal choices about moving around the facility or going outside without interference for 1 of 17 residents in the sample (Resident #4). During observation on 5/12/25 at approximately 11:00 AM it was discovered there were two ways to gain access to and from Resident #4's room. One was to enter a four-bed ward (room) that is occupied by four Residents, the other was through two locked emergency fire doors. Inspection of the fire doors revealed that the outer doors had coded keypads and once opened they lead to a stair well with a second door that required the use of a push button. Signage on the door stated, "FIRE DOOR KEEP CLOSED AT	F 550	**Tag F 550 POC accepted on 7/25/25 by P. Cota**	

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F 550	Continued From page 5 ALL TIMES" and "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS." Per record review, a care plan dated 5/9/25 reveals that Resident #4 ambulates independently with 4 wheel walker and transfers independently. During observation on 5/13/25 at approximately 10:00 AM, Resident #4 was seen in the main corridor of Maple Heights receiving medication. After receiving medications, he/she requested to return to her/his room and waited by the locked door for staff assistance to access her/his room. Per interview on 5/15/25 at approximately 9:30 AM, Resident #4 stated that when s/he wants to leave her/his room s/he will "knock loud to get permission" and get staff's attention. Resident #4 stated the "men's unit" (room 204) is used "sometimes" to gain entry to the main corridor. The Resident also stated that when visitors are there, they must find staff to allow them through the locked access to their room. Per interview on 5/15/25 at approximately 9:45 AM, two Licensed Nursing Assistants (LNAs) assigned to Maple Heights stated that Resident #4 must utilize their call bell to leave their room and access the main corridor. They also stated when Resident #4 would like to return to their room the staff must enter the code for the Resident to gain access to their room. The LNAs explained that the reason for the locked doors is because of the stairwell being part of the locked area. Both LNAs confirmed that Resident #4 is independent for transfer and ambulation.	F 550		

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F 550	Continued From page 6 Per interview on 5/16/25 at approximately 2:30 PM with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) starting on Maple Heights, located by the emergency door area in question, regarding access for the Residents in room 203, the DON stated the resident would utilize their call bell to either exit or return to their room. When discussing further in the office, the ADON stated that Resident #4 can gain access in and out of room 203 by using the call bell "this is what we always do. [S/he] wouldn't be able to do the door by [her/himself]. [S/he'd] need our help to do both." Per interview on 5/16/25 at approximately 2:50 PM, the Administrator stated, "I usually have more independent and more cognitive residents there." When asked regarding resident notification of living in a locked area, the Administrator stated residents aren't notified regarding the locked doors. The Administrator stated that residents are shown the room but it's "not pointed out."	F 550		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.	F 552		

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F 552	Continued From page 7 §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that 1 resident of 5 sampled residents (Resident #2) was informed in advance of the risks and benefits of psychotropic medication use. Findings include: Per record review, Resident #2 was admitted to the facility for rehabilitation services on 4/16/25 after an acute hospital stay. S/He was admitted for with the goal to transition to long term care at the facility. Per Resident #2's physician orders, s/he was prescribed Seroquel (antipsychotic) 12.5 mg by mouth every 24 hours as needed for agitation and hallucinations on 5/5/25 which was updated to Seroquel 12.5 mg by mouth every morning and at bedtime for agitation and hallucinations on 5/7/25. Per interview with Resident #2 on 5/13/25 at 1:30 PM, s/he stated that s/he did not know what medication had been started and feels the medication "is making me not right." Per the facility policy titled "Psychotropic Drugs," last revised 5/16/23, the resident has the right to refuse medications families should be notified prior to starting an antipsychotic. Per record review, there is no evidence of consent to antipsychotic treatment in Resident	F 552	**F 552** It is the policy of the facility to inform residents in advance of the risks and benefits of psychotropic medication use. Resident #2 has been informed of the risks and benefits of the psychotropic medication ordered Residents who have a psychotropic medication have been informed of the risks and benefits of the medication ordered. Policy review and in servicing of the Psychotropic Drug Policy to the licensed nurses with a focus on residents having the right to be informed of the risk and benefits of the psychotropic medication has been completed. The facility had completed education on 5/1/2025 and 5/2/2025 to include psychotropic notification and documentation due to concerns that were identified through audits. The facility followed up with training on medications 5/15/2025 due to survey concern and 6/3/2025. Implemented ISTA audits on 6/3/2025 that monitors psychotropics. The DNS and/or designee will verify weekly that newly prescribed psychotropic medications have been reviewed with the resident in advance of the risks and benefits of proposed care. Audits will continue weekly for 4 weeks, then monthly X's 3 months Results of audits will be logged and reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting. Trends or repeat issues will trigger additional interventions or training Completion Date: 6/7/2025	

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F 552	Continued From page 8 #2's medical record. Per interview on 5/14/25 at 12:00 PM with the Unit Manager, she stated there was no evidence of a consent signed by the resident of family in Resident #2's medical record for start of treatment with an antipsychotic.	F 552	**Tag F 552 POC accepted on 7/25/25 by P. Cota**	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584	F 584 It is the policy of the facility to foster a homelike environment, including but not limited to receiving treatment and supports for daily living safely Residents #53 and #46 have been provided with a homelike environment. Policy review and in servicing of the Safe, Clean, Comfortable, Homelike, Environment Policy has been done with staff with a focus on the expectation of providing the residents with a homelike environment. The Administrator and/or designee will conduct weekly rounds of the residents living area to observe and validate that we provide a homelike environment. The facility is reviewing other locations the ice machine may be relocated to. The Administrator is responsible for overseeing this process. The results of the rounds will be brought to the QAPI committee for further review and recommendation. Compliance Date: 6/7/2025	

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F 584	Continued From page 9 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to provide a homelike environment for 2 of 18 residents who reside on Maple Heights (2nd Floor) (Residents #53 and #46). This is a repeat deficiency for this facility, with the violation cited during the previous recertification survey, dated 3/38/24. Findings include: Per observations made during the survey, Resident #53 was observed in her/his room in bed, in their wheelchair at the side of their bed, and at the nurse's station. During observation on 5/15/2025 at 9:20 AM, Resident #53 and Resident #46 were observed sitting at the nurse's station/kitchenette area. Resident #53 was sitting in their wheelchair, and Resident #46 was sitting in a straight back chair, both had over bed tables in front of them with nothing on them. They were facing the nurse's area which includes an old work desk and a table with a computer used by staff for charting. On both walls near the desk there are postings taped on the wall with infomation for staff. These postings include a paper with large print that states "Death Investigation Systems," instructions on how to order medications from the pharmacy, how to	F 584	**Tag F 584 POC accepted on 7/25/25 by P. Cota**	

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F 584	Continued From page 10 access policies, menus, daily therapy schedules, how to access email. There was a large ice machine that was very loud and when it dropped ice from the back it would make a very loud banging sound. The cabinets in the kitchenette area were left 1/2 open and there were postings on the cabinet doors as well. There was a three-tier cart with wheels in front of the ice machine. The overhead florescent light fixture was noted to be without the cover. Per interview with a Licensed Nursing Assistant (LNA) on 5/15/2025 at 9:28 AM, Resident #53 and #46 are assisted out of bed each morning and brought to the nurse's area for breakfast. The residents are both able to eat independently and they try to keep them up for lunch. When Resident #53 and Resident #46 eat their meals at the nurse's station, the meals are set up on overbed tables. The LNA reported that the staff do bring the residents downstairs for activities when they can, but there are no other areas on the second floor for them to gather. During an interview with the Activities Director (AD) on 5/14/25 at 1:47 PM, when asked if activities are provided on the second floor, the AD stated that there are a bunch of residents who sit out at the nursing area. The AD stated that the nurse's area is "not a good gathering spot up there." The AD confirmed that it was an institutional environment.	F 584		
F 605 SS=E	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:	F 605		

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GREEN MOUNTAIN NURSING AND REHABILITATION	475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446

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F 605	Continued From page 11 §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that 2 of 5 sampled residents were free from unnecessary psychotropic medications regarding not developing a behavioral care plan, including monitoring for side effects for Resident #2 and not implementing non-pharmacological interventions for Residents #2 and 46. This is a repeat deficient practice for this facility, with the violation cited during the previous recertification survey, dated 3/38/24, and	F 605	**F 605** It is the policy of the facility to have residents free from physical or chemical restraints A Care Plan has been developed for Resident #2 supporting the use of psychoactive medication. The Ativan order has been reviewed with the physician and a new order for Ativan has been obtained to support resident #46. A review of residents receiving psychoactive medications has been completed to identify care plans are developed by the IDT supporting the use of the medication ordered and a review of the psychoactive medication orders written have been reviewed by the licensed nurses validating that the order continues to support the needs of the resident. Psychotropic Drug Policy review and in servicing has been completed with the IDT and the licensed nurses with a focus on developing care plans for psychoactive medication, the reason for use, ensuring we are administering the lowest therapeutic dose and on reviewing the physician orders with the physicians and Nurse practitioners to update them if they no longer support the resident. The facility had completed education on 5/1/2025 and 5/2/2025 to include psychotropic notification and documentation due to concerns that were identified through audits. The facility followed up with training on 6/3/2025	

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F 605	Continued From page 12 during a revisit survey, dated 6/11/24. Findings include: 1. Per record review, Resident #2 was admitted to the facility for rehabilitation services on 4/16/25 after an acute hospital stay. Per the Minimum Data Set (MDS; a comprehensive assessment) dated 4/22/25, Resident #2 had no history of behaviors, hallucinations, or agitation on admission and had a BIMS of 14, (Brief Interview for Mental Status, indicating they were cognitively intact). Per Resident #2's physician orders, Resident #2 was prescribed Trazadone 25 mg at bedtime for insomnia on 4/29/25 and Seroquel (antipsychotic) 12.5 mg by mouth every 24 hours as needed for agitation and hallucinations on 5/5/25 which was updated to Seroquel 12.5 mg by mouth every morning and at bedtime for agitation and hallucinations on 5/7/25. Per interview with Resident #2 on 5/13/25 at 1:30 PM, s/he stated that the s/he is receiving medications that make him/her not feel well and was "seeing things that are not there." Resident #2 described trying to button his/her shirt and seeing "cobwebs stretching out of the buttonhole." S/he stated that s/he feels the medication "is making me not right, and unless you are the medication doctor, you can't help me. It's like I am asleep all the time and dreaming when I am awake." Per Resident #2, s/he was not taking any medications to treat his/her mental health prior to admission and is not aware of having hallucinations prior to them starting the new medications. Per the facility policy titled "Psychotropic Drugs,"	F 605	The DNS and/or designee will review weekly the residents on psychoactive medications, validating there is a comprehensive care plan developed and that the order supports the management of the residents. The DNS is responsible for overseeing this process. Audits will continue weekly for 4 weeks, then monthly X's 3 months Results of audits will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting. Trends or repeat issues will trigger additional interventions or training. Completion Date:6/7/2025 **Tag F 605 POC accepted on 7/25/25 by P. Cota**	

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F 605	Continued From page 13 last revised 5/16/23, non-pharmacological approaches should be tried first before taking to identify and rule out any medical condition. When an antipsychotic is prescribed to a resident, the facility will conduct an interdisciplinary team meeting to review the antipsychotics to establish a care plan that reflects appropriate medications related goals and parameters for monitoring the resident condition, including the likely medications effects and potential for adverse consequences. Per record review, there is no evidence in the medical record that non-pharmacological approaches were tried prior to starting antipsychotic medications for Resident #2, there was no evidence of monitoring for side effects, and their care plan was not updated to reflect the antipsychotic medication. Per interview on 5/14/25 at 12:00 PM with the Unit Manager, RN (UM), she confirmed that there was no evidence of monitoring order for the side effects of antipsychotic medications. The UM stated that Resident #2 sleeps most of the time and had little motivation to participate in his/her care. She stated she was not aware that Resident #2 was having hallucinations or possible side effects to his/her medication. She confirmed that there was not an IDT meeting and there were no care plan updates related to use of newly prescribed antipsychotic for Resident #2. 2. Per record review Resident #46 has diagnoses that include Alzheimer's disease, anxiety, and depression. Per Progress Notes s/he often becomes restless and cries and nursing administers physician ordered as needed Lorazepam (Ativan). A Medication Regimen Review, signed by the Pharmacist on 8/19/24 states, "Just a reminder that at least 2 non-pharmacological interventions need to be	F 605		

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F 605	Continued From page 14 attempted and documented prior to administering Resident's Lorazepam. In reviewing nursing documentation, it does not appear that this has been consistently done." A Medication Regimen Review, signed by the Pharmacist on 3/13/2025 again states, "Just a reminder that at least 2 non-pharmacological interventions need to be attempted and documented prior to administering Resident's Lorazepam. In reviewing nursing documentation it does not appear that this has been consistently done." Further review of Nurses Notes and the Medication and Treatment Administration Records reveals that between 8/1/24 and 3/24/2025 Resident #46 received the PRN Lorazepam 59 times with no evidence that any non-pharmacological interventions had been attempted prior to each use. A physician's order dated 3/24/2025 states, "Ativan Oral Tablet 0.5 MG (Lorazepam [antianxiety]) Give 0.25 mg by mouth as needed (PRN) for anxiety, restlessness for 90 Days once every 24 hours/MUST WRITE NOTE WITH 2 INTERVENTIONS USED PRIOR TO ADMINISTERING ATIVAN FOR COMPLIANCE." Further review of Nurses Notes and the Medication and Treatment Administration Records reveals that between 3/24/2025 and 5/16/2025 Resident #46 received the PRN Lorazepam 19 times with no evidence that 2 non-pharmacological interventions had been attempted prior to each use. During an interview on 5/20/25 at 5:56 PM the	F 605		

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F 605	Continued From page 15 Director of Nursing (DON) confirmed that there was no documented evidence that nursing attempted at least two non-pharmacological interventions prior to administering as needed Lorazepam.	F 605		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		

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F 655	Continued From page 16 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and policy review, the facility failed to develop a baseline care plan that includes the instructions needed to provide effective and person-centered care that includes identifying safety risks and interventions to protect a resident from accidents for 1 of 17 residents in the sample (Resident #53). This is a repeat deficiency for this facility, with the violation cited during the previous complaint survey, dated 10/22/25. Findings include: Per record review, Resident #53 was admitted to the facility on 8/15/2024 after a fall at home resulting in a left femur fracture. A Psychosocial Evaluation created on 8/20/24 reflects that it was reported that the resident "had 50 falls over the past month or so" prior to admission. A Nurse Progress note dated 8/25/2024 reads "a sound like a walker hitting the floor was heard from a resident's room that turn[ed] out to be resident found sitting on the floor with [her/his] back against the bedside nightstand. Resident unable to explain what happened due to baseline confusion..."	F 655	F 655 It is the policy of the facility to develop a baseline care plan that includes the instructions needed to provide effective and person-centered care that includes identifying safety risks and interventions to protect a resident from accidents A care plan was developed for resident # 53, care plan was reviewed and completed with the resident, representative and IDT. Review of admissions in the last 30 days has been completed to identify a baseline care plan was completed. Baseline Care plan policy review and in servicing has been reviewed with the IDT with a focus of providing effective and person-centered care that includes identifying safety risks and interventions within 48 hrs. Education provided 6/12/2025 by LC DON. The DNS and/or designee will audit each admission to validate that the baseline care plan is complete within 48 hrs. The DNS is responsible for overseeing this process. Audits will continue weekly for 4 weeks, then monthly X's 3 months Results of audits will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting. Trends or repeat issues will trigger additional interventions or training. Completion Date:6/12/2025 **Tag F 655 POC accepted on 7/25/25 by P. Cota**	

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F 655	Continued From page 17 Review of the Resident's Baseline Care Plan revealed that there were several areas, including safety and fall risks, that were not complete. Section 3 of the Base Line Care Plan, Health Conditions part H., Safety Risks, addresses the history of falls, skin integrity issues, restraints, alarms, other safety devices, and elopement risks. All areas in this section are blank with no goals or interventions identified to ensure safety. Further review of Resident #53's Base Line Care Plan revealed that sections related to advanced directives, health conditions, bowel and bladder, medications, pain, and medical conditions were also left blank. The Baseline Care Plan is also not signed or dated.	F 655	**F 658** It is the policy of the facility to provide services that meet Professional Standards by following physician's orders. Physician orders for Resident #20 blood glucose checks and insulin have been reviewed by the physician and have been updated. Residents who receive insulin and who have orders for blood glucose monitoring have their orders reviewed by the physician validating they are supportive of what the residents' needs are. A policy review and in servicing of blood glucose monitoring and insulin administration was completed with the nursing staff. Professional Standards. The DNS and/or designee will conduct weekly for audits on insulin orders & glucose monitoring to identify if an adjustment in treatment based on these results and other parameters. The DNS is responsible for overseeing this process. Audits will continue weekly for 4 weeks, then monthly X's 3 months Results of audits will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting. Trends or repeat issues will trigger additional interventions or training. Completion Date:6/7/2025 **Tag F 658 POC accepted on 7/25/25 by P. Cota**	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that physician's orders were followed for blood glucose monitoring and insulin administration for 1 of 17 residents in the sample (Resident #20). Findings include: Per record review, Resident #20 was admitted to the facility with a diagnosis of diabetes and Alzheimer's dementia. S/He is unable to manage his/her own blood sugar monitoring or insulin			

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F 658	Continued From page 18 administration. Resident #20 had the following insulin orders dated 12/3/24: "Insulin, lispro, sliding scale, administer every 24 hours with evening meal". Resident #20 also had the following glucose monitoring order dated on 1/23/24, " Blood Glucose Monitoring two times a day for Diabetes ... at breakfast and dinner". A nursing progress note dated 5/5/25 states " Resident is alert to self, pleasantly confused. Continues with daily wound care, tolerating well. Continues with TID (three times a day) glucose checks and within normal parameters only requiring coverage occasionally..." Per the facility administration record for May 2025, Resident #20 received a finger stick to check his/her blood sugar three times a day and received insulin with his/her lunchtime meal every day. Per interview on 5/13/25 at approximately 2:00 PM, with a Registered Nurses (RN) caring for the Resident #20 stated she had checked the resident's blood sugar twice on 5/13/25, at breakfast and at his/her lunch time meal. She stated that she administered sliding scale insulin at lunchtime on 5/13/25 without a physician's order. She stated she assumed the physician had missed placing an order for the lunchtime finger stick, and she did not call the provider to clarify the order. Per interview with the Director of Nursing on 5/14/25 at approximately 1:00 PM she confirmed that the resident had been receiving insulin daily	F 658		

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F 658	Continued From page 19 at lunch time and finger sticks three times a day without a physician's order. Per facility policy titled "Diabetes -Clinical Protocol" last reviewed 1/15/25 "The Physician will order appropriate lab test (for example, periodic fingersticks or A1C) and adjust treatment based on these results and other parameters..." American Nurses Association. (n.d.). Scope of practice. https://www.nursingworld.org/practice-policy/scope-of-practice/	F 658	F 679 It is the policy of the facility to provide an ongoing program of activities designed to meet the interests, and the physical, mental. and psychosocial well being of each resident. There are activities designed to meet the interests, physical, mental and psychosocial wellbeing for residents #53, #20 & #44. A review current residents' activity care plans has been completed to identify any others who may not have had their physical, mental, and psychosocial needs fully addressed through activities.	
F 679 SS=E	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 and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review the facility failed to provide an ongoing program of activities designed to meet the interests, and the physical, mental. and psychosocial well being for 3 of 5 residents in the sample (Resident #53, #20, and #44). Findings include: 1. Per record review, Resident #20 has a	F 679	Activity director was educated on care plans by DON on 4/9,5/4,5/9,5/13, and 6/12/2025. DON completed audits and recommendations on identified care plans. The facility policy on providing individualized, ongoing activity programs. The importance of integrating residents' preferences and strengths into care planning. The Administrator and/or designee will identify 2 residents weekly to follow them through validating that there is an activity plan designed to meet the interests, physical, mental and psychosocial wellbeing. The Activities is responsible for overseeing this process Audits will continue weekly for 4 weeks, then monthly X's 3 months, Results of audits will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting. Trends or repeat issues will trigger additional interventions or training. Completion Date:6/12/2025	

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F 679	Continued From page 20 diagnosis of Alzheimer's dementia. Per review of his/her care plan, Resident #20 is dependent on staff for all activities, including cognitive stimulation, related to his/her dementia. An intervention reads, "needs 1 to 1 bedside/in room visits and activities if unable to attend out-of-room events," dated 4/20/23. Per observation on 5/12/25 at approximately 11:00 AM, Resident #20 was sitting in a recliner in the common area of the unit. Resident #20 remained in the chair throughout the day without evidence of activity. Per observation on 5/13/25 at 9:55 AM, Resident #20 was lying in his/her bed, without activity. There was no one in the room. Per continued observation, the resident remained in bed without evidence of activities throughout the day. Resident #20 was not observed at any time during the recertification survey on 5/12/25 through 5/14/25 participating in activity, and no 1:1 activity was observed by the activity staff. The Activity Director was unable to provide the activity log or any other evidence that Resident #20 has been provided with 1:1 visits. 2. Per record review, Resident #44 has a diagnosis of Parkinson's and Alzheimer's dementia. His/her care plan activity focus dated 6/14/23 stated "The resident has little to no activity involvement due to dementia diagnosis. [S/He] is unable to engage in meaningful conversation, and often propels [his/her] w/c [wheelchair] for long periods of time." An intervention dated 9/11/24 reads, "The resident's preferred activity are: ambulating throughout the facility [sic]."	F 679	**Tag F 679 POC accepted on 7/25/25 by P. Cota**	

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F 679	Continued From page 21 Per a facility activity assessment dated 2/26/25, "Resident is unable to effectively communicate or focus on an activity due to his dementia." According to the assessment, Resident #44's favorite activity is "walking the hallways." There are no other activities or interventions included in Resident #44's care plan. Per interview on 5/14/25 at 4:15 PM, the Activity Director, explained that s/he had been at the facility for about a year. She stated she is aware of how important it is to have all residents participate in activity's. She stated she has not had the staff to be able to complete 1:1 activity for the residents including, Resident #20 and #44. She stated that she is not always able to have residents with behaviors or that require more care in the activity area alone and she has had not assistant. She confirmed she has not had the assistance to meet the individual resident needs. She stated often residents that require more help in the mornings are not ready for activities and therefore are unable to attend. She stated she is unable to leave the group to bring people to the activity area or return them to the unit and cannot always meet the needs of a resident in a group setting. 3. Per observations made during the survey Resident #53 was observed in her/his room in bed, in their wheelchair at the side of their bed, and at the nurse's station. During observation on 5/15/2025 at 9:20 AM, Resident #53 was observed sitting at the nurse's station/kitchenette area. Resident #53 was sitting in their wheelchair with an over bed table in front of them with nothing on it. S/He was facing the nurse's area which includes an old work desk and a table with a computer used by staff for charting.	F 679		

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F 679	Continued From page 22 Per interview with a Licensed Nursing Assistant (LNA) on 5/15/2025 at 9:28 AM. Resident #53 is assisted out of bed each morning and brought to the nurse's area for breakfast. The Resident can eat independently, and they try to keep her/him up for lunch. When Resident #53 eat their meals at the nurse's the meals are set up on overbed tables. The LNA reports that the staff do bring the resident downstairs for activities but there are no activities offered on the second floor that she is aware of. Per interview with the Activity Director (AD) on 5/14/2025 at 1:47 PM, she explained that one-to-one visits are made between 8:00 AM - 10:00 AM. She spends 15-20 minutes with each resident she sees. When asked if activities are provided on the second floor the AD stated that there are a bunch of residents who sit out at the nurse's area and sometimes the iPad is used to enjoy funny videos, singing, and virtual concerts. The AD stated that the nurse's area is "not a good gathering spot up there." Some of the residents on the second floor do go downstairs for activities if they are not having a bad day.	F 679		
F 686 SS=K	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 686		

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F 686	Continued From page 23 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that 5 of 11 residents in the applicable sample (Residents #62, #9, #25, #57, #555) received necessary treatment and services consistent with professional standards of practice to promote healing and prevent infection. As a result, Resident #62 developed a stage two pressure ulcer that worsened to an unstageable pressure ulcer injury, requiring hospitalization and surgical intervention due to osteomyelitis and Sepsis of the pressure injury. Additionally, Resident #25 developed deep tissue injuries to both heels. This citation is at the immediate jeopardy level due to the facility's failure to prevent and treat a pressure injury, which resulted in a life-threatening infection for 1 resident, harm for 1 resident, and put all residents who have pressure ulcers or are at risk for pressure ulcers at risk for serious harm or death. Findings include: 1. Per review of Resident # 62's medical record, s/he was admitted to the facility with a diagnosis of congestive heart failure and a goal of discharge home. On 3/10/2025, a nursing assessment revealed a score of 16 on the Braden scale (total scores range from 6-23) for predicting pressure risk, identifying Resident #62 as being at risk for pressure injury. A Skin Assessment by an LPN (Licensed Practical Nurse) with a date of 3/10/2025	F 686		

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F 686	Continued From page 24 indicates "Redness/blanchable to coccyx area, skin warm to touch, no Edema [swelling] no dryness, redness to coccyx area ...came in with Mepilex border [a dressing often used as preventative measure for pressure ulcers], I removed it, no opening noted." Per the Admission Minimum Data Set (MDS) (a comprehensive assessment of each resident's functional capabilities), submitted on 3/14/2025 by the MDS coordinator, Resident #62 had a BIMS (a brief interview for mental status; a cognitive assessment) of 10, indicating s/he is moderately cognitively impaired. S/he required substantial assistance with ADLs (Activities of Daily Living), which included turning and positioning in bed, and was rarely incontinent of urine and bowel. The MDS revealed that Resident #62 had no unhealed or open pressure ulcer injuries at the time of admission but was at significant risk. A "Skin Only Evaluation" completed on 3/17/25 by the same LPN as the 3/10/25 assessment states "no skin issues." Per review of Resident #62's care plan, initiated on 3/18/2025, states "[Resident #62] was admitted without pressure ulcers but remains at risk due to decreased mobility and occasional urinary incontinence." An initial goal reads "[Resident] will maintain [his/her] current skin integrity AEB [as evidenced by] allowing assistance with toileting and mobility with any treatments as ordered" with a date of 3/18/2025. Care plan interventions include following facility policies/protocols for the prevention/treatment of skin breakdown, monitoring/documenting/reporting any changes in skin status: appearance, color, wound healing,	F 686	F 686 It is the policy of the facility to provide treatment and services to prevent and heal pressure ulcers Resident #62 was transferred to the hospital on 4/22/2025; wound care history and documentation were provided at the time of transfer. Residents #9, #25, and #555 are currently receiving appropriate treatment and services consistent with clinical best practices and provider orders to promote wound healing and prevent infection. Resident #57, was discharged to assisted living on 6/12/2025, was receiving consistent wound care in line with professional standards at the time of discharge, with documented improvement noted. 5/15/2025 – 5/16/2025: Facility-wide skin checks were completed on all current residents by two licensed nurses. Braden Scales were completed to assess risk for pressure ulcer development. Pressure injury evaluations were conducted by Integrated Wounds PA in collaboration with a designated facility nurse. Nutritional evaluations were conducted for residents with pressure ulcers to validate optimal dietary support for wound healing. Care plans were reviewed and/or developed for at-risk residents and those with pressure injuries, including appropriate interventions and measurable goals.	

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F 686	Continued From page 25 signs and symptoms of infection, wound size (length, width, and depth), and stage to the medical provider. Review of a facility policy titled "Pressure Injury Prevention and Management", dated 1/15/25, reads "The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt evaluation and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate ...after completing a thorough evaluation, the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions. Interventions will be documented in the care plan and communicated to all relevant staff. Compliance with the interventions will be documented in the weekly summary charting ... The charge nurse will review all relevant documentation regarding skin evaluations, pressure injury risks, progression toward healing, and compliance at least weekly, and document a summary of findings in the medical record." The facility failed to follow its policy by failing to develop a person-centered care plan with measurable goals to prevent pressure ulcers. The care plan did not include interventions specific to the resident's individual risk and needs. The weekly skin assessments were all incomplete and did not convey the relevant information. Dressing change orders for this resident, written by the Wound Provider, were not implemented for two weeks, resulting in a worsening of the wound. The nursing staff noted the deterioration of the	F 686	A full policy review and re-education on pressure ulcer prevention and treatment was conducted with nursing staff between 5/15/2025 and 5/19/2025. Using tools like the Braden Scale to assess risk. Performing weekly skin checks. Turning and repositioning protocols, nutritional consults, documentation expectations post-dressing changes, and timely care plan updates. New hire orientation was updated to include mandatory training on pressure ulcer prevention and wound care management. The facility has implemented the PointClickCare (PCC) Wound and Skin Module to streamline documentation, photograph tracking, trend monitoring, and clinical alerts for early intervention and healing progression.	

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F 686	Continued From page 26 wound but failed to alert the provider for several days. According to a physician's progress note, on 3/19/2025, he identifies a stage 2 pressure ulcer (partial-thickness skin loss, which may appear as a shallow, open wound or a blister filled with clear or yellow fluid) on the gluteal cleft. He says that the resident is at high risk due to their decreased mobility and provides the following orders. "Start Mepilex border bandage today, frequent repositioning, air mattress, daily dressing changes until wound care RN consult ..." Per review of the Medication Administration Record (MAR), there is an order for a Mepilex border bandage to the left sacral gluteal cleft, with directions to change the dressing every day until wound care evaluation, with a start date of 3/21/2025, and a discontinued date of 4/2/25. On 3/21/25, an "Initial Progress Note" by the Wound Provider documents a Stage three Pressure Ulcer on the Coccyx that measures 7 cm length (l) by 3 cm width (w) x 0.1 depth (d). She indicates the wound is tender with examination and with prolonged pressure to the area, but it gets better with turning and offloading. Her treatment recommendations include cleaning and gently drying the area, applying Thera honey (a wound gel containing honey) to the wound bed, applying skin prep to the peri-wound area, and applying a dry protective dressing (DPD) daily and as needed (PRN). Additionally, the resident should be turned frequently with each incontinent care. Recommendations include continuing pressure relief offloading, utilizing the Facility Pressure Ulcer Prevention protocol, and turning and repositioning according to the facility's protocol.	F 686	Weekly Wound Team Review meetings include: DNS, ADON, and wound care staff. Focus on identifying new wounds, evaluating healing progress, and ensuring appropriate changes to treatment plans. Coordination with attending physicians for timely input and order adjustments. Admission and Braden Score Monitoring: New admissions will have their Braden Scores monitored weekly for 4 weeks post-admission. Any increase in risk will prompt an care plan update and notification to the IDT, and physician. DNS is responsible for implementation and oversight of this plan, including audit completion, care plan updates, and staff adherence to professional standards for wound care. Weekly audits for 4 weeks, followed by monthly audits for 3 months. DNS will review the 24 hr Ista audit/ PCC 24-Hour Report to validate timely identification and care planning for pressure injury risks. All audit outcomes and wound care trends are reviewed during monthly QAPI meetings. Recurrent issues or patterns will prompt targeted re-education or process revisions to validate sustained improvement. Compliance Date: May 20th 2025- IJ 6/7/2025 **Tag F 686 POC accepted on 7/25/25 by P. Cota**	

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F 686	Continued From page 27 A "Skin Only Evaluation" dated 3/24/2025, states that Resident #62 has a current skin issue, a Pressure Ulcer that is a stage three. The evaluation requires descriptors of the wound bed, wound exudate, peri-wound condition, dressing saturation amount, wound odor, tunneling, undermining, tissue condition, and pain; however, no information is provided about these areas on the form. In a follow up progress note by the Wound Provider dated 3/28/25, she notes the wound is now unstageable and measures 8 cm L x 6 cm W x 0.1 D, it has light serosanguinous (watery/blood) drainage and a mild odor, it demonstrates 20% slough, 20% granulation, and 60% Eschar (a hardened, dry, black or brown dead tissue that forms a scab-like covering over deep wounds.) She recommends treatment that includes applying Thera honey to the wound bed, skin preparation to the peri-wound area, and a dry, protective dressing applied daily and as needed. Turn the patient frequently with each incontinence care. A "Skin Evaluation Only" dated 3/31/2025, documents that Resident #62 does not have a current skin issue; however, under the skin note section, it reads, "Treatment continues to the coccyx area for pressure ulcer." There is no further information provided. A "Progress Note" dated 4/2/2025 from the medical provider states that he visited the resident on 4/2/2025 and noted that the resident's condition had worsened, her/his wound had progressed from a stage two to a stage three, he suggests that resident may benefit from inpatient	F 686		

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F 686	Continued From page 28	F 686		

level of care for frequency of repositioning and mobilizing. He notes that there are wound care instructions to apply Thera honey to the wound bed and use a dry protective dressing, changing daily. He noted that the wound care orders written by the Wound Provider on 3/28/25 for Thera honey to the wound bed had not been implemented.

Per record review of the Medication Administration Record (MAR), there is no evidence the new 3/21/25 wound care orders or the 3/28/25 wound care orders were implemented until 4/2/25.

On 4/2/25, an order entered on the MAR states, "Clean the sacral area with normal saline, pat it dry, and apply Thera honey to the wound bed. Cover it with a Mepilex border every shift for a pressure ulcer." There is an end date of 4/4/25. The initial order for Thera honey was written on 3/21/25 by the Wound Care provider, but it was not implemented until 4/2/25.

Per interview on 5/14/25 at 9:50 AM, the Unit Manager (UM) states that the change in wound orders written on 3/21/25 and 3/28/25 by the wound provider for Thera honey to the wound bed were not implemented. She attributes this to many new staff, including travelers, and information is "all over the place."

Per interview with the Director of Nursing (DON) at 10:40 AM, she revealed that the orders written by the Wound Provider on 3/21/25 and 3/28/25 were not implemented until 4/2/2025. She confirms that the orders were missed, stating "the Wound Consultant sometimes tells the cart nurse there are new orders, and sometimes whoever is

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F 686	Continued From page 29	F 686		

at the desk". She reveals that the facility does not make rounds with the Wound Provider and lacks processes such as Interdisciplinary meetings to ensure that care is coordinated among providers.

Per interview with Resident #62's primary medical provider, on 5/14/2025 at 1:41 PM, he explained that he covers the facility with two other providers. All three of them are employed by the University of Vermont Medical Center. He does access the Point Click Care system that the facility uses to read nursing progress notes. He found the pressure ulcer on 3/19/25, and ordered a Wound Consult, noting that the orders given by the Wound Provider on 3/21/2025 and 3/28/2025 were not implemented, and the wound was worse. He states that the resident was less mobile and spent most of the day in bed. He spoke with the DON about the orders and his concerns; he would like a process to communicate with the consulting Wound Care provider.

A follow-up progress note from the Wound Provider dated 4/4/2025 reads, "unstageable wound measuring 5 cm x 4.5 cm, 80% eschar and 20% granulation, no odor." She orders Honey Alginate to the wound bed and covers the wound with a dry protective dressing daily.

A "Skin Only Evaluation" dated 4/7/25 notes that Resident #62 has a skin issue, a Pressure Ulcer, stage three, treatment continues; no other information about the wound, drainage, odor or condition of the wound is documented in the evaluation, there is no description of the wound, drainage, or peri-wound tissue.

A review of the Care Plan reveals that a revision

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F 686	Continued From page 30	F 686		

was initiated on 4/9/25. A focus note indicates that the Resident has a stage three pressure ulcer to the coccyx. Interventions include assess for pain every shift prior to dressing change, consult and treatment by Certified Wound provider as needed. Encourage frequent position changes, follow physician orders for skin care and treatment, monitor for signs and symptoms of infection, and report to a physician for care and treatment." The wound was discovered on 3/19/25; there was no update to include the wound and any interventions in the care plan until 4/9/25.

A Follow-up Progress Note written by the Wound Provider, dated 4/11/2025, notes that the wound is unstageable, measuring 6 cm x 4 cm x 0.1 cm. She also notes that these measurements are after instruments have been used to debride (remove dead tissue) from the wound. She notes a mild odor, 40% granulation, 30% Eschar, and 30% slough. She notes that the wound measurements are post-debridement, and debridement will be continued weekly as needed to remove devitalized tissue, decrease the risk of infection, and expose viable tissue to promote wound healing.

A progress note dated 4/14/2025 that includes a Skin Only Evaluation by an LPN reads "Pressure ulcer to coccyx area is getting worse, odor and tunneling noted." There is no documentation in the record indicating that the provider was notified of the wound's deterioration.

A "SNF Acute/Follow-Up Visit", dated 4/22/2025, written by the primary medical provider, "generally sacral pressure now seems stage four- dramatic worsening in 2 weeks." The plastic surgeon

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F 686	Continued From page 31 advised urgent surgical evaluation for possible debridement. According to progress notes dated 4/22/2025 at 3:57 PM, Resident #62 was transferred to the Emergency Department of the local hospital for emergent evaluation of the coccyx. Per review of hospital records, a hospital progress note dated 4/24/2025 reads "admitted from rehab., with sacral osteomyelitis [infection of the bone] and MRSA bacteremia [type of staph infection that can be resistant to several antibiotics], taken to the operating room for debridement of the wound, admitted to Surgical Intensive Care." Per interview on 5/13/2025 at 11:21 AM with the Attending Provider, he states he was not notified of the wound deterioration until days later, when he made his scheduled visit on 4/17/25. Had he been informed, he would have transferred Resident # 62 to the hospital earlier. He relates inconsistent communication between the facility's nursing staff and providers. He stated the facility lacks a process to ensure communication and coordination of care among the medical team. He states that the facility does not hold interdisciplinary team meetings to discuss issues such as wounds. He feels it is challenging as the providers document their notes in a system different from the facility's system. He does not think the current system, which includes a consultant Wound Provider, is effective, as communication between providers is limited. Per interview on 5/15/2025 at 2:40 PM, the Director of Nursing confirmed that the dressing change orders written by the Wound Care	F 686		

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F 686	Continued From page 32 Provider on 3/21/2025 and 3/28/2025 were not implemented until 4/2/25. She confirmed that the provider was not notified on 3/14/2025 when the wound was noted to be deteriorating. She stated the facility does not implement interdisciplinary meetings regularly to facilitate resident care, they were not following their Pressure Ulcer Prevention and Management Policy, and they were not documenting a weekly summary. She confirmed the resident's care plan did not contain person-centered interventions to prevent pressure ulcers until days after there was evidence s/he had one. She confirmed that the skin assessments are incomplete, and the Unit Managers are not documenting a weekly summary of the wounds, as is the facility's policy. tcs.pressbooks.pub/nursingfundamentals/chapter/10-5-braden-scale/ (n.d.). Understanding Eschar in Wounds and Its Distinction from Slough. Westcoast Wound.com. Retrieved May 19, 2025, from westcoastwound.com/eschar-in-wounds TheraHoney® Gel | Manuka Honey Wound Care Dressing https://www.cdc.gov/mrsa/about/index.html 2. Per record review a hospital discharge summary dated 8/9/2024 reflects that Resident #9 was discharged to the facility on 8/9/2024 with pressure ulcers to their right heel, left heel, lower back, and various other wounds and abrasions. The Discharge Summary also reflects that the right heel pressure ulcer peri wound was brown and there was a clean, dry, intact foam dressing applied. The left heel pressure ulcer also had a clean, dry, intact foam dressing. An Admission Skin note dated 8/9/2024 states "Resident has current skin issues." The skin	F 686		

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F 686	Continued From page 33 issues described in the note include discoloration of bilateral tops of feet, Pressure Ulcer Injury right low back, Stage II pressure ulcer - Partial thickness skin loss. Length: 1.8 Width: 1.5 with no odor or tunneling, a scab on the right heel with no measurements, an open lesion on the left thigh Length: 6 Width: 5, unstageable sacrum, left leg ulcer, mid low back pressure injury. A Wound Care Consultant (WCC) progress note dated 8/13/24 notes an unstageable pressure ulcer on the right and left heels, a burn on the upper left thigh, a stage 3 pressure ulcer on the back, and a stage 2 of the coccyx. Treatment recommendations for all the wounds were made to cleanse, apply Medihoney to ulcers, skin prep to peri-wound, cover with 4 x 4, foam border gauze QD (once a day) and PRN (as needed). The wound care note states that the plan of care was discussed with facility staff. Review of the Medication Administration and Treatment Records and review of Progress Notes for the month of August 2024 reveal that there were no documented wound treatments completed until 8/16/2024, seven days after admission. A WCC progress note dated 12/6/24 reflects recommendations to "Gently clean heel and pat dry. Apply A&D to lateral heel. and over wound daily and PRN." Review of the December TAR reveals that this recommendation was not implemented. On 12/13/24 the WCC recommended the right heel and left great toe treatment "Apply Skin prep daily and PRN." Review of Resident #9's December 2024 Medication and Treatment Administration Records revealed that there were no treatments	F 686		

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	475040	A. BUILDING _____ B. WING _____	C 06/06/2025

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GREEN MOUNTAIN NURSING AND REHABILITATION	475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 34	F 686		

in place through the month of December 2024.

A WCC progress note dated 1/10/2025 reveals an unstageable pressure ulcer to the right heel that measured 0.2 cm x 0.5 cm 100% eschar. Treatment recommendations included skin prep daily and PRN (as needed) and off load heels. The progress note also reveals a stage three pressure area to the left great toe that measured 0.5 cm x 0.5 cm x 0.1 cm. Treatment recommendations made include "Apply collagen to wound bed, dry protective dressing daily and PRN [as needed]." Another WCC progress note dated 1/17/25 states that the wound on the right heel is improving , however measurements reveal that the wound is now 1 cm x 4 cm x 0.1 cm. Treatment recommendations for the right heel pressure ulcer include apply collagen to open wounds and skin prep to peri wound, dry protective dressing daily and PRN. The treatment recommendation for the left great toe included apply skin prep daily.

Review of the January TAR reveals there were no wound treatments for the right heel or left great toe pressure ulcers implemented until 1/21/25, 11 days after the 1/10/25 recommendations, which are "Great left toe: Gently clean and pat dry. Apply skin prep daily and PRN. No pressure to area. one time a day for Wound Care, and "[right] Heel: Gently clean and Pat dry. Apply collagen to open wounds/skin prep to perimeter, offload RT heel w/ bordered gauze. DPD daily and PRN one time a day for Wound Care."

A WCC progress note dated 2/7/2025 reveals that Resident #9 had developed a new deep tissue injury to their left heel measuring 3 cm x 4.8 cm x 0 cm. The right heel wound was

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F 686	Continued From page 35 surgically debrided (the removal of dead, damaged, or infected tissue from a wound) at this visit and now measured 2.3 cm x 5 cm x 0.1 cm. A WCC progress note dated 2/14/2025 states Resident "was seen today for evaluation and treatment recommendation for Pu [pressure ulcer] to the Rt [right] lateral heel and Lt [left] great toe and DTI [deep tissue injury] to the LT heel."..."[S/He] says that the right heel does feel more sore this week, mainly when [s/he] has pressure on the area. PU to right lateral heel appears worsened this week with odor present; left great toe PU is generally unchanged; PU to left heel is smaller in size; otherwise skin appears warm, dry, and intact." Recommendations include "Apply skin prep to periwound and honey alginate to wound bed only and DPD daily and prn...Osteomyelitis work up. Ordering labs: ESR [erythrocyte sedimentation rate], CRP [C-reactive protien], CBC [complete blood count] and xray. Staff made aware." Physician progress notes dated 2/24/2025 and 4/17/2025 do address the pressure ulcers on both heels, but does not mention the WCC's recommendations or orders for the osteomyelitis work up. A WCC progress not dated 3/10/2025 states that Resident #9 reports that the right heel typically bothers her/him more than the left. The wound now measures 2.5 x 3 x 0.1. The left heel pressure ulcer measurements are now 3 x 3 x 0 with 100% eschar. On 3/21/2025 the WCC documents that the Resident reports that her/his heels really tend to bother her/him the most of all the wounds and that the right is worse than the	F 686		

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F 686	Continued From page 36 left. The right heel wound appears smaller but has a slight odor. On 3/28/2025, 4/4/2025, and 4/11/2025, the WCC documents that the lab work and x-ray to rule out osteomyelitis have not yet been completed. A Physician's progress note dated 5/20/2025, three months after the original documented recommendation, states "review of heel ulcers-improved, wound nurse suggests x-ray r/o [rule out] osteo [osteomyelitis] because of pain-ordered." On 5/26/2025 the facility Administrator confirmed via email that the above recommendations had not been implemented. Per phone interview on 5/28/2025 at 9:20 AM, the WCC stated that she was not aware that the treatment changes that she had been recommending weekly were not being implemented. She stated that she does not have access to the electronic health record therefore she would not know what orders were or were not implemented. The Wound Care Nurse confirmed that she had requested the osteomyelitis work up since 2/14/2025 and that it had not been done until May of 2025. 3. Per record review, Resident #25 has diagnoses that include Parkinson's disease, history of stroke, and vascular dementia. Per Resident # 25's care plan, s/he requires assistance with all ADLs (activities of daily living), last revised on 4/29/25, and is at risk for pressure ulcers due to decreased mobility, need for assistance, and incontinence. The care plan indicated that s/he has a history of redness to	F 686		

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F 686	Continued From page 37 his/her heels. A 4/3/25 skin assessment indicates that Resident #25 does not have any current skin issues. There are no completed weekly skin assessments in Resident #25's medical record after this date. Review of a 5/16/25 facility skin sweep, implemented as a result of the notification of immediate jeopardy related to pressure ulcer prevention and treatment deficiencies, reveals that Resident #25 has bilateral heel deep tissue injuries. A 5/16/25 wound assessment indicates that his/her left heel deep tissue injury (DTI) measures 2 cm x 2.5 cm and his/her right heel DTI measures 1.5 cm x 1 cm. A review of Resident #25's care plan reveals that s/he did not have interventions for weekly skin assessments or offloading heels until 5/17/25. 4. Per record review, Resident #57 was admitted to the facility for rehabilitation services with diagnoses that include cerebral palsy and malnutrition on 4/11/25. Per a 4/16/25 admission MDS, Resident #57 has 0 pressure ulcers and is at risk for developing pressure ulcers. A 4/12/25 skin assessment reveals his/her skin to be intact other than a hole mark on his/her coccyx and bruises on his/her lower belly. Review of a 5/16/25 facility skin sweep, implemented as a result of the notification of immediate jeopardy related to pressure ulcer prevention and treatment deficiencies, reveals that Resident #57 has a stage 1 4 x 4 pressure ulcer on the coccyx, and the note indicated to turn resident frequently with each incontinence change, use barrier cream every shift and as	F 686		

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F 686	Continued From page 38 needed. Per interview on 5/20/25 at approximately 5:00 PM, Resident #57 stated that s/he has a sore on his/her bottom which is painful when it is touched or is sitting on it for a while . Per record review, there is no evidence of a full assessment of Resident #57's pressure ulcer discovered on 5/16/25, including an assessment for pain of the ulcer. A 5/20/25 pressure ulcer evaluation reveals that Resident #57 now has a right gluteal fold suspected deep tissue injury that measures 5 X 8 and has pain with palpitation. While Resident #57's care plan was updated to reflect skin impairment on 5/16/25, no interventions were put into place to offload the area on his/her coccyx until 5/20/25. Per interview on 5/20/25 at approximately 6:00 PM, the Director of Nursing confirmed that a full wound assessment had not been completed for Resident #57 pressure ulcer. 5. Per record review, Resident # 555 was admitted to the facility on 5/12/25 for rehabilitation services with the diagnoses of pubis fractures, failure to thrive, and dementia. An admission skin assessment indicated that Resident #2 has a 3 cm x 3 cm on his/her coccyx. Review of a 5/16/25 facility skin sweep, implemented as a result of the notification of immediate jeopardy related to pressure ulcer prevention and treatment deficiencies, reveals that Resident #555's pressure ulcer had	F 686		

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F 686	Continued From page 39 increased in size to 4 cm x 6 cm x 0.1 cm and has a pink, spongey right heel. There is no additional assessment information about these two wounds, even though one had worsened, and one was newly discovered. Per interview on 5/20/25 at approximately 6:00 PM, the Director of Nursing confirmed that a full wound assessment had not been completed for Resident #555's two pressure ulcers. The wound assessments completed after this interview revealed that Resident #555's right heel pressure ulcer measured 3 cm x 3 cm.	F 686	F 687 It is the policy of the facility to validate that residents received proper treatment and care to maintain good foot health and follow podiatry recommendations for treatment Resident #20 has received proper treatment and care to maintain good foot health. The recommendation from podiatrist has been obtained and followed. A review of all residents who have been seen by the podiatrist has been completed, any recommendations made by the podiatrist has been reviewed with the primary physician and treatment implimented if approved.	
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that residents received proper treatment and care to maintain good foot health and follow podiatry recommendations for treatment, for 1 of 17 residents sampled (Resident # 20). Findings include:	F 687	In service training has been completed to the licensednurses and providers regarding outside consultant recommendations , to notify the of the recommendations and if the physician agrees with the recommendations, then orders need to be obtained and written in the medical record so they can be followed. 5/15/2025-5/16/2025 outside consultant in servicing included all outside consultant recommendations from IJ. The DNS and/or designee will review all ancillary consultations to validate for recommendations and provider notification and any recommendations are followed if approved by physician. The DNS is responsible for overseeing this process. Audits will continue weekly for 4 weeks, then monthly X's 3 months Results of audits will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting. Trends or repeat issues will trigger additional interventions or training. Completion Date:6/7/2025 **Tag F 687 POC accepted on 7/25/25 by P. Cota**	

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F 687	Continued From page 40 Per record review, Resident #20 was admitted with a diagnosis of diabetes, cognitive impairment, and a history of pain and neuropathy in both feet. Resident #20 has a care plan with a focus related to diabetes with an intervention dated 4/20/23 that reads, "Refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails." Per record review, a podiatrist note dated 4/4/25 read the following "Patient admits painful bilateral feet with symptomatic nail changes that the patient is unable to care for... Plan: Failure to debride nails can lead to complications due to conditions... can lead to bilateral foot pain... [sic]" The podiatrist made the following recommendations related to a new diagnosis of fungus on his/her toenails: Apply cloritrimazole 1% (antifungal medication) to toenails daily for 10 days if not available may apply VICKS vapor rub daily to his/her toe nails. Per review of Resident #20's orders and his/her medication and treatment administration record for April and May there was no evidence that the facility followed the treatment recommendations made by the podiatrist, or implemented a care plan for treatment of fungal infection of bilateral toes. Per email communication with the Director of Nursing on 5/24/25, she confirmed that podiatry did complete a consult for Resident #20 on 4/4/25 and that the orders were not implemented to treat fungus on Resident #20's toenails.	F 687		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		

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F 689	Continued From page 41 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide adequate supervision for 1 of 17 sampled residents (Resident #44). This is a repeat deficiency for this facility, with the violation cited during the previous revisit survey, dated 6/11/24. Findings include: Per the medical record, Resident #44 has a diagnosis of Parkinson and Alzheimer dementia, unsteady gait, and difficulty walking. A facility fall risk assessment dated 3/16/25 identified him/her at risk for falls scoring a total of 15. Per the facility "Fall Risk Assessment," a score greater than 10 is considered high fall risk and interventions should be in place and the care plan updated. Per Resident #44's care plan dated 6/14/23, Resident #44 requires 1 assist for all transfers and ambulation. Per record review, Resident #44 had an actual fall on 8/6/24 and suffered a head laceration that required an emergency room visit. . Per a nursing note dated 5/10/25, titled post fall investigation, Resident #44 had an actual fall on 5/10/25 out of their wheelchair. Per the investigation, contributing factors included unsteady gait, history of falls and cognitive impairment. Per observation on 5/12/25 at approximately 4:30	F 689	**F 689** If is the policy of the facility to provide adequate supervision Resident #44 care plan was reviewed and updated to reflect current fall prevention interventions. The unlocked medication cart incident was addressed immediately. To identify other residents at risk, Resident care plans were reviewed to validate current fall prevention interventions are being followed, any discrepancies found were corrected and communicated to staff responsible for resident care. Re-education for all nursing staff (RNs, LPNs, LNAs) on the importance of following individualized care plans, fall prevention protocols, and medication cart security was completed. All staff were re-educated on the residents' care plan requirements and supervision needs and reminded where to find the information. Charge nurses perform frequent rounding to monitor high-risk residents. Fall IDT review facility falls to identify patterns of cause.	

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F 689	Continued From page 42 PM on the unit, Resident #44 stood up and began ambulating in the common area. Per interview with the Licence Practical Nurse (LPN) on 5/12/25 at 4:31 PM, standing near the resident, the LPN stated "s/he is able to ambulate by themselves and often leaves their wheelchair in all different places, s/he is care planned for wandering." Resident #44 continued to ambulate on his/her own toward a cast iron wall mounted heater. Per interview with the Licence Nursing Assistant (LNA) on 5/12/25 at approximately 4:35 PM, she confirmed Resident #44 walks on his/her own and with or without his/her wheelchair and sometimes s/he wanders off the unit. Per observation on 5/13/25 at 5:55 PM, on the unit, Resident #44 walked out of another resident's room and stood next to the nurse's medication cart that was unlocked. There were no staff near the medication cart or in the hall to supervise. Resident #44 was able to make his/her way to a chair and sit down. Per continued observation staff did not return to the area of the cart or the Resident until 6:03 PM. Per interview on 5/13/25 at 6:05 PM, the Unit Nurse stated that she left her cart unlocked when she went to administer medications to another resident. She noted that her cart should have been locked. She stated that Resident #44 often ambulates on the unit without assistance. Per interview with the Licence Nursing Assistant, (LNA) on 5/14/25 at approximately 3:30 PM, she stated that Resident #44 requires one assist for ambulation per his/her care plan. She stated at times s/he is difficult to redirect and there is not	F 689	The DON and/or designee will complete random audits to identify Staff adherence to care plan interventions. Appropriate supervision during ambulation. Proper medication cart security to be done with med cart audit. The DNS is responsible for overseeing this process. Audits will continue weekly for 4 weeks, then monthly X's 3 months Results of audits will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting. Trends or repeat issues will trigger additional interventions or training. **Completion Date: 6/7/2025** **Tag F 689 POC accepted on 7/25/25 by P. Cota**	

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F 689	Continued From page 43 always enough staff to monitor him/her.	F 689	**F 710** It is the policy that the facility to monitor resident's physician to validate the medical care is being provided related to pressure injuries Physician and wound team are monitoring resident # 9 pressure areas resident has had 3 hospital visits due to non pressure related medical treatments since 5/29/25. Residents with wounds are reviewed by a physician, and wound team to include DNS and ADNS to evaluate that the current recommendations have been addressed. The Administrator provided education to the DNS , ADNS, Medical Director and/or designated physician that weekly wound meeting is to be done to review rounds documentation and based on the discussion of changes in condition orders will be provided and implemented. 5/16/2025 included with F686 edu. The DNS will review the weekly wound log with the medical director and/or designated physician in the absence of medical director, to validate any changes are implemented in a timely manner. The DNS is responsible for overseeing this process. Audits will continue weekly for 4 weeks, then monthly X's 3 months Results of audits will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting. Trends or repeat issues will trigger additional interventions or training. **Completion Date:6/7/2025** **Tag F 710 POC accepted on 7/25/25 by P. Cota**	
F 710 SS=G	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that the resident's physician supervised the medical care that was being provided related to pressure injuries for 1 of 11 residents in the applicable sample (Resident #9). As a result, Resident #9's pressure injuries worsened. Findings include: 1. Per record review a hospital discharge summary reflects that Resident #9 was discharged to the facility on 8/9/2024 with pressure ulcers to their right heel, left heel, lower back, and various other wounds and abrasions. The Discharge Summary also reflects that the	F 710		

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F 710	Continued From page 44	F 710		

Right heel pressure ulcer peri wound was brown and there was a clean, dry, intact foam dressing applied. The left heel pressure ulcer also had a clean, dry, intact foam dressing. An Admission Skin note dated 8/9/2024 states "Resident has current skin issues." The skin issues described in the note include discoloration of bilateral tops of feet, Pressure Ulcer Injury right low back, Stage II pressure ulcer - Partial thickness skin loss. Length: 1.8 Width: 1.5 with no odor or tunneling, a scab on the right heel with no measurements, an open lesion on the left thigh Length: 6 Width: 5, unstageable sacrum, left leg ulcer, mid low back pressure injury.

Resident #9 was seen by the Wound Care Consultant (WCC) on 8/13/24 noting an unstageable pressure ulcer on the right and left heels, a burn on the upper left thigh, a stage 3 pressure ulcer on the back, and a stage 2 of the coccyx. Treatment recommendations for all the wounds were made to cleanse, apply Medihoney to ulcers, skin prep to peri-wound, cover with 4 x 4, foam border gauze QD (once a day) and PRN (as needed). Consider air mattress, float heels, reposition per facility protocol. The wound care note states that the plan of care was discussed with facility staff.

Review of documented physicians' visits revealed that Resident #9 was seen by a physician on 8/9/2024 who noted "Extremities with scattered healing leg wounds bilateral lower extremities, no ulcers."

On 9/27/2024 Resident #9 was seen by the physician again who documented "stage 2 decubitus ulcer Pressure ulcer: Over the years reviewing [her/his] medical record [s/he] has had

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	475040	A. BUILDING _____ B. WING _____	C 06/06/2025

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F 710	Continued From page 45	F 710		

a variety of sacral and buttock skin breakdown episodes. Current examination reveals the following protective border protecting a stage II skin breakdown symmetric on both cheeks of [her/his] buttocks spanning the rectal area without apparent superinfection. Will continue protective measures, continue repositioning, and wound care consultation." A physician's progress note dated 10/22/2024 states "wounds on buttocks healing." There is no mention of the bilateral heel wounds.

Per weekly notes dated 10/24/24 that were provided to the facility by the WCC the right heel pressure ulcer was resolved per facility. Another weekly note dated 12/20/24 states "Pressure ulcer Stage 3 Heel right lateral measuring 0.2 x 0.5 x 0 [0.2 cm length x 0.5 cm width x 0 depth]. "Treatment recommendations include skin prep daily and as needed (PRN).

A Physician's progress note dated 12/23/2024 states "stage 2 pressure injury of right heel. Pressure injury of heel, stage 3, Heel [Left] less severe; [Right] clean to base- stage 3- Reinforced education NOT have heels resting on any surface but must have protectors." This is the first time that the physician documents the bilateral heel wounds that were present on admission.

A WCC progress note dated 2/7/2025 reveals that Resident #9 had developed a new deep tissue injury to their left heel measuring 3 cm x 4.8 cm x 0 cm. The right heel wound was surgically debrided (the removal of dead, damaged, or infected tissue from a wound) at this visit and now measured 2.3 cm x 5 cm x 0.1 cm.

On 2/14/2025 Resident #9 was seen by the WCC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475040	A. BUILDING _____ B. WING _____	C 06/06/2025

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GREEN MOUNTAIN NURSING AND REHABILITATION	475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446

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F 710	Continued From page 46 who documented that the deep tissue injury on the left heel is now an unstageable pressure area that measured 2.5 cm L x 3 cm W. The tissue type is documented as 100% eschar (dead tissue). The Wound Care Nurse documented a recommendation for an osteomyelitis (infection of the bone) work up and labs and x-ray to rule out osteomyelitis. The right heel wound continues to deteriorate with odor present. Measurements are documented at 5 cm length, 3 cm width, and 0.1 depth. Physician progress notes dated 2/24/2025 and 4/17/2025 do address the pressure ulcers on both heels, but do not mention the WCC's recommendations or orders for the osteomyelitis work up. A WCC progress not dated 3/10/2025 states that Resident #9 reports that the right heel typically bothers her/him more than the left. The wound now measures 2.5 x 3 x 0.1. The left heel pressure ulcer measurements are now 3 x 3 x 0 with 100% eschar. On 3/21/2025 the WCC documents that the Resident reports that her/his heels really tend to bother her/him the most of all the wounds and that the right is worse than the left. The right heel wound appears smaller but has a slight odor. On 3/28/2025, 4/4/2025, and 4/11/2025, the WCC documents that the lab work and x-ray to rule out osteomyelitis have not yet been completed. A Physician's progress note dated 5/20/2025, three months after the original documented recommendation, states "review of heel ulcers-improved, wound nurse suggests x-ray r/o [rule	F 710		

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F 710	Continued From page 47 out] osteo [osteomyelitis] because of pain-ordered." Further review of the WCC progress notes and Resident # 9's Treatment Administration Records from August 2024 - April of 2025 revealed the following: On 8/13/24 and 8/28/24, 9/11/24, and 10/7/24 the WCC recommended skin prep to peri wound. The skin prep was not implemented on the TAR. On 8/21/2024 the WCN recommended Medihoney to left thigh. This was not implemented until 8/31/24, ten days after the recommendation. On 12/6/24, there is no evidence that wound recommendations were implemented, and no treatments were implemented on the TAR for the right heel and left great toe wounds. On 12/13/24, there is no evidence that wound recommendations were implemented and no treatments were implemented on the TAR for right heel and left great toe wounds. On 1/10/25 there is no evidence that wound recommendations were implemented. On 1/17/25 the right heel worsened. Recommendations for left thigh treatment were not implemented. 1/30/25, 2/7/25, 2/14/25, 3/10/25, 3/28/25 there is no evidence that wound recommendations were implemented. On 4/4/25 and 4/14/25 the WCC recommended skin prep to peri wound that was not implemented on the TAR. On 5/26/2025 the facility Administrator confirmed via email that the above recommendations.had not been implemented. Per phone interview on 5/28/2025 at 9:20 AM, the	F 710		

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	475040	A. BUILDING _____ B. WING _____	C 06/06/2025

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F 710	Continued From page 48 WCC stated that she was not aware that the treatment changes that she had been recommending weekly were not being implemented. She stated that she does not have access to the electronic health record therefore she would not know what orders were or were not implemented. The Wound Care Nurse confirmed that she had requested the osteomyelitis work up since 2/14/2025 and that it had not been done until May of 2025.	F 710	F 711 It is the policy of the facility to monitor physician activity to ensure they are reviewing and addressing recommendations made by outside consultants. Residents #9 and #20 had consultant recommendations that were appropriately addressed. A review of residents seen by the consulting podiatrist has been completed by the Director of Nursing Services, and Medical Providers to verify that all recommendations have been addressed.	
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that 1 of 26 residents in the applicable sample (Resident #20) followed the podiatry recommendations for treatment related to new fungal infection of bilateral toes. The facility also failed to ensure that the resident's physician reviewed their total	F 711	The Administrator has provided education to the Medical Director regarding the Physician Visit and reviewing recommendations from outside services, emphasizing that follow-up and documentation of consultant recommendations are integral components of the total program of care, education 5/16/2025. The DNS is responsible for overseeing this process. The DNS is reviewing Medical Provider visit documentation records when gathering them from EPIC to transfer to PCC. Audits will be conducted weekly for 4 weeks, followed by monthly audits for 3 additional months. Results of these audits will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meetings. Any identified trends or repeat issues will result in additional interventions or targeted training. Completion Date:6/7/2025 **Tag F 711 POC accepted on 7/25/25 by P. Cota**	

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F 711	Continued From page 49 program of care related to pressure injuries that were present on admission for 1 of 11 residents in the applicable sample (Resident #9). Findings include: 1. Per record review a hospital discharge summary reflects that Resident #9 was discharged to the facility on 8/9/2024 with pressure ulcers to their right heel, left heel, lower back, and various other wounds and abrasions. An Admission Skin note dated 8/9/2024 states "Resident has current skin issues." The skin issues described in the note include discoloration of bilateral tops of feet, Pressure Ulcer / Injury right low back, Stage II pressure ulcer - Partial thickness skin loss. Length: 1.8 Width: 1.5 with no odor or tunneling, a scab on the right heel with no description or measurements, an open lesion on the left thigh Length: 6 Width: 5, unstageable sacrum, left leg ulcer, mid low back pressure injury. There was no mention of the left heel wound that was documented in the hospital discharge summary. Resident #9 was seen by the Wound Care Consultant on 8/13/24 who noted an unstageable pressure ulcer on the right and left heels, a burn on the upper left thigh, a stage 3 pressure ulcer on the back, and a stage 2 of the coccyx. Treatment recommendations for all the wounds were made to cleanse, apply Medihoney to ulcers, skin prep to peri-wound, cover with 4 x 4, foam border gauze QD (once a day) and PRN (as needed). Consider air mattress, float heels, reposition per facility protocol. The wound care note states that the plan of care was discussed with facility staff. Review of documented physicians' visits revealed	F 711		

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F 711	Continued From page 50 that Resident #9 was seen by a physician on 8/9/2024 who noted "Extremities with scattered healing leg wounds bilateral lower extremities, no ulcers." On 9/27/2025 the Resident was seen by the physician again who documented "stage 2 decubitus ulcer Pressure ulcer: Over the years reviewing [her/his] medical record [s/he] has had a variety of sacral and buttock skin breakdown episodes. Current examination reveals the following protective border protecting a stage II skin breakdown symmetric on both cheeks of [her/his] buttocks spanning the rectal area without apparent superinfection. Will continue protective measures, continue repositioning, and wound care consultation." A physician's progress note dated 10/22/2024 states "wounds on buttocks heeling." There is no mention of the bilateral heel wounds. A Physician's progress note dated 12/23/2025 states "stage 2 pressure injury of right heel. Pressure injury of heel, stage 3, Heel L less severe; R clean to base- stage 3- Reinforced education NOT have heels resting on any surface but must have protectors." This is the first time that the physician documents the bilateral heel wounds that were present on admission. Review of the Wound Care Nurse consultant's progress notes dated 2/14/2025 revealed that Resident #9's right heel wound continues to deteriorate with odor present. The Wound Care Nurse documented a recommendation for an osteomyelitis (infection of the bone) work up and she was ordering labs and X-ray to rule out osteomyelitis.	F 711		

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F 711	Continued From page 51 Physician progress notes dated 2/24/2025 and 4/17/2025 do address the heel wounds but do not mention the Wound Care Nurse's recommendations or orders for the osteomyelitis work up. On 3/28/2025, 4/4/2025, and 4/11/2025 The Wound Care Nurse documents that the lab work and x-ray to rule out osteomyelitis have not been completed. A Physician's progress note dated 5/20/2025 states "review of heel ulcers- improved, wound nurse suggests X-ray r/o osteo because of pain- ordered." Per interview on 5/20/2025 at 5:04 PM the Director of Nursing (DON) stated that she or the Administrator prints off a list of residents who are due for physician visits and the providers use the list to identify who needs visits. The DON stated that she reviews all Physicians' progress notes then copies and pastes them into a progress note in the facility's electronic medical record. Per phone interview on 5/28/2025 at 9:20 AM the Wound Care Nurse confirmed that she had requested the osteomyelitis work up since 2/14/2025 and that it had not been done until May of 2025.	F 711		
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	F 725		

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F 725	Continued From page 52 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 nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, and record review, the facility failed to ensure there was a sufficient number of skilled licensed nurses, nurse aides, and other nursing personnel to provide care and respond to each resident's basic needs and individual needs as required by the resident's diagnoses, medical condition, or plan of care, potentially impacting all residents of the facility. Findings include: 1. Per record review, Resident #20's care plan dated 4/20/23, states that s/he requires assistance in all aspects of care due to dementia. Per care plan focus dated 4/20/23, "[Resident #20]'s ability to participate in receptive and	F 725	F 725 It is the policy of the facility to supply sufficient number of skilled licensed nurses, nurse aides, and other nursing personnel to provide care and respond to each resident's basic needs and individual needs as required by the resident's diagnoses, medical condition, or plan of care, The facilities average PPD for the week of 5/11 to 5/17 was 4.65. Resident #20 received care that maintained personal privacy. Resident #44 is appropriately monitored for 1-person assist supervision during ambulation. Immediate Corrective Actions: Resident privacy was immediately reinforced with nursing staff through re-education and direct observation. Supervision of ambulation for residents requiring assistance has been verified and staff reminded of care plan compliance. Timeliness of medication administration is being reviewed in collaboration with pharmacy to revise the current medication pass schedule administration times to allow for timeliness medication administration. Clarification of Audit Data: A report with 2,900 entries includes a mix of medication and non-medication orders such as assessments, supplements, reminders (e.g., fall or elopement risk, labs, compression stockings).	

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F 725	Continued From page 53 expressive communication is minimal to non-existent r/t [related to] [his/her] Dementia DX [diagnosis]. All wants and needs are anticipated and met by staff." An intervention dated 4/20/23 reads, "Anticipate and meet needs ... Per further care plan review, interventions also include 2 assist for all transfers, bed mobility, and repositioning." Per observation on 5/13/25 at 10:30 AM, the door to the resident's room was open, no privacy curtain was drawn, Resident #20 was lying in bed, his/her pants were pulled down to his/her thighs, his/her entire abdomen exposed, and his/her protective underwear brief visible. At 11:15 AM, Resident #20 remained in bed in the same position with no staff observed in the area. Per interview with an LNA on 5/13/25 at 11:30 AM, she observed Resident #20 and stated she had not been able to check on the resident due to "not having enough time. It has been really busy this morning." She stated that she was preparing to go in and provide care before lunch. At 2:00 PM, the surveyor observed that Resident #20 remained in his/her bed in his/her room. 2. Per record review Resident #44 has a diagnosis of Parkinson and Alzheimer's dementia, unsteady gait, and difficulty walking. A facility fall risk assessment dated 3/16/25 identified him/her at risk for falls, scoring a total of 15. Per the facility "Fall Risk Assessment" a score greater than 10 is considered high fall risk and interventions should be in place and the care plan updated. Per Resident #44's care plan dated 6/14/23, s/he required 1 assist for all transfers and ambulation.	F 725	Facility leadership is actively working to differentiate between true late/missed medication administrations and routine non-medication tasks to validate a accurate analysis. The DON and/or designee will conduct random rounds twice weekly for 4 weeks to ensure privacy is maintained during care and that residents are not left exposed. The DON and/or designee will review compliance with ambulation assistance. Weekly audits of MARs, medication pass schedules will be completed by DNS and/or designee and negative findings will be addressed immediately. Random audits of medication carts have been implemented to validate they are locked when unattended. All staff have been re-educated on the policy requiring carts to remain locked at all times Audits will continue weekly for 4 weeks, then monthly for 3 months. Results will be reviewed during monthly QAPI meetings. Trends or repeat deficiencies will result in further staff training or revised interventions. Completion Date: 6/7/2025 **Tag F 725 POC accepted on 7/25/25 by P. Cota**	

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F 725	Continued From page 54 Per observation on 5/12/25 at approximately 4:30 PM on the unit, Resident #44 stood up and began ambulating in the common area. Per interview with the Licensed Practical Nurse (LPN) on 5/12/25 at 4:31 PM, who was standing near the resident stated "s/he is able to ambulate by themselves and often leaves their wheelchair in all different places, s/he is care planned for wandering." Resident #44 proceeded to ambulate on his/her own toward a cast iron wall mounted heater; and was eventually redirected by an LNA to his/her seat in the wheelchair. On 5/12/25 at 5:55 PM Resident #44 was observed walking out of another resident's room and was standing next to the nurses 'medication cart which was unlocked. The surveyor observed the Resident make his/her way to a chair to sit down; however, no staff were observed near the medication cart or in the hall until 6:03 PM. Per interview on 5/13/25 at 6:05 PM, the Unit Nurse stated that she left her cart unlocked when she went to administer medications to another resident. She confirmed that her cart should have been locked and that Resident #44 often ambulated on the unit without assistance. She stated that she had "only one LNA on the unit and they are trying to keep up." Per interview with the Licensed Nursing Assistant, (LNA) on 5/14/25 at approximately 3:30 PM, she stated that Resident #44 requires one assist for ambulation per his/her care plan. She stated at times s/he was difficult to redirect and there were not always enough staff to monitor him/her.	F 725		

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F 725	Continued From page 55 Jane Kendall 3. Per review of facility generated report titled, "Medication Admin Audit Report" consisting of 293 pages for the period of 4/16/25 through 5/16/25 (30 days) revealed approximately 2900 late and missed medications for approximately 50 residents. Per interview on 5/16/25 at approximately 10:00 AM, the Administrator confirmed this report to be accurate. Per interview on 5/23/25 at 9:16 AM, the Medical Director was asked if s/he believes there are medications that need to be administered timely and if so, which ones. The Medical Director stated that there was a patient s/he sees at this facility that had told her/him that they were not getting their scheduled 6 AM dose of Sinemet for Parkinson's and this was causing the patient much distress. The Medical Director stated they spoke with nursing about this and they felt that the issue was addressed. The Medical Director was asked if s/he was aware that a 293 page report was provided by the facility of late and missed medications for a 30 day period of 4/16/25 through 5/16/25 affecting approximately 50 residents and approximately 2,900 medications. The Medical Director stated they were not aware that the issue of missed or late medications was this significant.	F 725		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a	F 756		

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F 756	Continued From page 56 licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to act upon the consulting pharmacist's Medication Record Review notification that staff	F 756	**F756** It is the policy of the facility to act upon the consulting pharmacist's Medication Record Reviews Resident # 45 lorazepam order has been reviewed. The most recent MRR has been completed to validate the recommendations are being followed up on by the physician and/or the nursing staff. Licensed nursing staff have been re-educated on the requirement to attempt and document non-pharmacological interventions prior to administering Lorazepam or any PRN (as-needed) psychotropic medications. Education was provided on 5/15/2025 due to facility identifying concerns in an audit staff re educated on 6/3/2025 and 7/15 & 7/16 as repeat concerns triggered further education and reminders. Physicians have been reminded to clearly indicate behavioral indications and PRN frequency limits on orders for Lorazepam and similar medications. Medication Administration Record (MAR) has been updated to include a prompt requiring nurses to document: The DON and/or designee will conduct weekly audits of psychotropic PRN use to validate non-pharmacological measures were attempted/ documented PRN use is consistent with physician orders and regulatory guidance. The DNS is responsible for overseeing this process. Audits will continue weekly for 4 weeks, then monthly X's 3 months Results of audits will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting. Trends or repeat issues will trigger additional interventions or training. Completion Date: 6/7/2025	

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	475040	A. BUILDING _____ B. WING _____	C 06/06/2025

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F 756	Continued From page 57 were not documenting non-pharmacological interventions prior to the administration of as needed Lorazepam (a psychotropic medication) for 1 of 5 residents in the sample (Resident #46). Findings include: Per record review Resident #46 receives Ativan as needed for anxiety. A Medication Regimen Review dated 8/19/24 states "Just a reminder that at least 2 non-pharmacological interventions need to be attempted and documented prior to administering Resident's Lorazepam. In reviewing nursing documentation it does not appear that this has been consistently done." There is no documented evidence in the record that this recommendation was addressed by nursing or the physician. Further review of Nurses Notes and the Medication and Treatment Administration Records reveals that between 12/1/24 and 3/24/2025 Resident #46 received the PRN Ativan 46 times with no evidence that any non-pharmacological interventions had been attempted prior to each use. . A Medication Regimen Review signed by the Pharmacist on 3/13/2025 again states "Just a reminder that at least 2 non-pharmacological interventions need to be attempted and documented prior to administering Resident's Lorazepam. In reviewing nursing documentation it does not appear that this has been consistently done." A physicians order dated 3/24/2025 states "Ativan Oral Tablet 0.5 MG (Lorazepam [antianxiety]) Give 0.25 mg by mouth as needed (PRN) for anxiety, restlessness for 90 Days once every 24 hours/MUST WRITE NOTE WITH 2 INTERVENTIONS USED PRIOR TO ADMINISTERING ATIVAN FOR COMPLIANCE." However, further review of Nurses Notes and the	F 756	**Tag F 756 POC accepted on 7/25/25 by P. Cota**	

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F 756	Continued From page 58 Medication and Treatment Administration Records reveals that between 3/24/2025 and 5/16/2025 Resident #46 received the PRN Ativan 19 times with no evidence that 2 non-pharmacological interventions had been attempted prior to each use. Per interview with the Director of Nursing (DON) on 5/20/2025 at 5:56 PM she confirmed that nursing staff had not been documenting non-pharmacological interventions prior to the administration of as needed Lorazepam.	F 756	**F 760** It is the policy of the facility that medications are given according to physicians orders. Investigations were completed regarding the medication errors identified for resident #53 and #9. Physicians were notified. A review of medication administration for the last 30 days was completed validating that residents received medications as ordered and that physicians were notified if medications were not available, a review of the last 30 days of antibiotic usage was completed to validate stop dates were entered into the EMR.	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that 2 of 17 residents in the sample (Resident #53 and Resident #9) were free from significant medication errors as evidenced by the omission of psychotropic medication causing withdrawal symptoms, the incorrect medication ordered and given, and prolonged antibiotic administration. Findings include: 1. Per record review Resident #53 has diagnoses that include Parkinson's with dementia, psychotic disorder, depression and anxiety disorder. Review of physician's orders reveals a physician's order dated 8/16/24 for Clozapine 37.5 mg one time a day for psychotic disorder with hallucinations and a physician's order dated 8/15/2024 for Clozapine 50 mg at bedtime for psychotic disorder with hallucinations.	F 760	DNS and/or ADNS has provided education to the nursing staff regarding rights of medication administration, data entering stop dates into PCC to short term medications like antibiotics that are ordered and notification to the physician if medication is not available. Education provided on 4/7, 6/3 additional education provided on and 7/15 and 7/17 due to audit findings. Audits are completed to validate stop dates are entered, residents received medications as ordered and that physicians were notified if medications not available. Medication errors are documented and reviewed by DNS, Administrator, and Medical Director and/or designated physician. The DNS is responsible for overseeing this process. Audits will continue weekly for 4 weeks, then monthly X's 3 months Results of audits will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting. Trends or repeat issues will trigger additional interventions or training. Completion Date:6/7/2025	

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F 760	Continued From page 59 A Nurses Note dated 9/5/2024 states "Clozapine unavailable this shift. And new order for Depakote has not arrived from Pharmacy yet this evening. Call placed to third eye health Provider [name omitted]. Stated that it was ok to hold medication for the evening." A physician's order dated 9/5/2024 states "Notify a clinician of any change in condition. Hold Clonazipine [Clozapine] until available from pharmacy." Per review of the MAR from September of 2024, the resident did not consistently receive the medication as ordered on 9/6/24, 9/9/24, 9/13/24, 9/14/24, 9/15/24, 9/16/24, and 9/19/24. A Nurses Note dated 9/19/2024 states "Resident very lethargic this am, not responding to verbal commands VS [vital signs] stable, pupils equal and reactive to light, no s/s of pain or discomfort... Resident unable to move legs but able to move hands. Dr. [name omitted] notified, stat labs and [urinalysis with culture and sensitivity] ordered and obtained and sent stat to lab, results pending." A Medication Administration Note dated 9/19/2024 states that the Resident was "too lethargic to take meds safely." A Physician Epic Note dated 9/19/2024 states "Primary diagnosis: Acute encephalopathy [a sudden brain dysfunction] Reason for Visit: Other lethargic ASSESSMENT/PLAN: 1. Acute encephalopathy Suspect delirium of unknown etiology, potential causes include electrolyte derangement, infection, and withdrawal from medications. High suspicion that [s/he] missed 3 doses of clozapine in a row in the morning and evening of the 15th and the morning	F 760	**Tag F 760 POC accepted on 7/25/25 by P. Cota**	

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F 760	Continued From page 60	F 760		

of the 16th and her agitation increased and then [s/he] eventually became tired out and we are seeing the results now. Reviewed that withdrawal of clozapine can cause catatonia, agitation, sleep disturbance, confusion, autonomic dysfunction, neuromuscular and gastrointestinal symptoms as well as psychotic symptoms. [S/he] seems to be more in a catatonic state at this time, however since [s/he] recently had doses on the 17th, 18th and this morning on the 19th, I would left suspect her symptoms to be related to withdrawal and more think she is tired out from the time that [s/he] did not have the medications on board." ... "Per the MAR, [s/he] takes carbidopa levodopa 25-100 mg 1 tablet in the morning and 0.5 tablets 3 times daily at 12/16/1200 [12:00 AM, 4:00 PM, 1200 PM]. [S/he] takes clozapine 37.5 mg at 8:00 AM, [s/he] missed a dose on 9/15 [S/he] takes clozapine 50 mg in the evening at 8:00 PM, and missed doses the 13th, 14th and 16th"

According to the National Library of Medicine "Clozapine is an atypical antipsychotic... The abrupt withdrawal of clozapine has been associated with cholinergic rebound and rapid onset of psychosis..."

On 5/20/25 at 6:29 PM the Director of Nursing confirmed the progress notes, and the Medication Administration Record reflected that Resident #53 did not receive the scheduled clozapine.

2. Per the consultant pharmacist's review on 8/19/24 of Resident #9's Medication Regimen Review, Resident #9 was prescribed Metoprolol Succinate (An extended-release medication used to treat cardiovascular conditions.) and Metoprolol Tartrate (A beta-blocker medication used to treat cardiovascular conditions that is not

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F 760	Continued From page 61 interchangeable with Metoprolol Succinate.) was entered into the electronic medical record. Review of the August 2024 Medication Administration Record (MAR) shows that the Resident received 6 doses of the Metoprolol Tartrate. A Medication Regimen Review signed on 9/12/2024 revealed that Resident #9 had a physician's order for Amoxicillin 500 mg three times per day for 7 days that started on 8/31/2024. The review states "When the order was entered into the EMAR [Electronic Medication Administration Record] there was no stop date entered, so [s/he] has received 5 extra days of therapy." The Consulting Pharmacist states that they notified the cart nurse and she discontinued the order. Upon further review, the order was not discontinued in the EMAR until 9/20/2024 prolonging the resdient's therapy. An email sent from the Administrator on 5/26/2025 confirmed that she did not have copies of the Medication Error Reports for the weeks 8/10/24 to 8/15/2025 and 8/31/24 to 9/20/24 and that the facility was not aware of the medication errors.	F 760		
F 761 SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 761		

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F 761	Continued From page 62 instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure drugs and biological's were stored in accordance with currently accepted professional principles for 3 of 4 medication carts observed and 1 medication room. Findings include: 1. Observation on 5/13/25 at 5:40 PM of the Cabot Cove Unit medication cart, the following medications were noted to have expired: Entresto expired 11/2024 Folic Acid 1000 mcg expired 10/2024 ASA low dose 81 mg unreadable expiration date Ibuprofen 200 mg unreadable expiration date Ear Was removal carbamide peroxide bottle 6.5% expired 4/2024	F 761	**F 761** It is the policy of the facility to store all drugs and biologicals in accordance with currently accepted professional standards and principles. All expired medications were removed immediately upon notification by the surveyor. Replacement insulin pens were ordered immediately. The medication storage room on the MH unit was secured immediately by ensuring the door remained shut and locked. A facility-wide audit of all medication carts and medication storage areas was completed immediately to identify and remove any expired medications and to ensure compliance with storage requirements. Nursing staff were immediately re-educated on the following practices All new nursing staff will receive training on the facility's medication storage procedures during orientation. Unopened insulin pens must be stored in a refrigerator until ready for use.	

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F 761	Continued From page 63 Orajel 2X Toothache and gum medicated expired 1/2025 Albuterol Sulfate Inhalation Solution 0.083%, 2.5 mg/3 ml expired 11/2024 Meclizine 12.5 mg 6 tablets expired 3/13/24 Meclizine 12.5 mg 28 tablets expired 5/8/25 Per interview on 5/13/25 at 6:00 PM with the Licensed Practical Nurse (LPN) assigned to this medication cart, they confirmed that the above medications were either expired or did not have an expiration date or the expiration date was not readable. Observation on 5/13/25 at 6:10 PM on the Maple Heights Unit medication cart, the following medications were noted to have expired: Hycosamine 0.125 mg expired 7/2/2024 Loperimide 2 mg expired 3/24/2025 Guifenesin 200 mg expired 12/11/2024 Liquid Pain Relief/Acetaminophen 160 mg/5 ml expired 2/2025 Geri-Tussin expired 1/2025 Artificial Tears expired 9/2024 Artificial Tears expired 11/2024 Epinephrine Injection expired 12/2024 Compro expired 9/30/2024 Naloxone Hydrochloride Nasal Spray 4 mg expired 8/2024 Acetaminophen Suppositories USP 650 mg (5) supps expired 9/2023 Simethicone CHW (chews) (100) tablets no expiration date (came with the resident from home) Simethicone CHW (chews) (80) tablets no expiration date (came with the resident from home) Simethicone CHW (chews) (90) tablets no	F 761	Only one insulin pen per resident is permitted in the medication cart at any given time. Expired medications must not be used and must be removed from all storage areas promptly. The medication storage room on MH must remain locked when not in use. Medication carts must be locked at all times when not under direct staff supervision. Ongoing audits are being conducted to ensure unopened insulin pens are properly refrigerated. Regular checks confirm that only one insulin pen per resident is kept in the medication cart. All medication carts and storage areas are routinely audited to verify that no expired medications are present. The storage rooms and all medication carts are monitored to validate they remain locked when unattended. Audits will continue weekly for 4 weeks, then monthly X's 3 months Results of audits will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting. Trends or repeat issues will trigger additional interventions or training. Completion Date:6/7/2025 **Tag F 761 POC accepted on 7/25/25 by P. Cota**	

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F 761	Continued From page 64 expiration dates (came with the resident from home) Bisacodyl 5 mg tablets expired 9/2024 Mucus DM expired 2/2025 (4) Novolog Flexpens were found in this medication cart for the same resident. One Novolog Flexpen was opened and dated for 28 days (not expired) and the other 3 pens the LPN took and put them in their pocket. Per interview on 5/13/25 at 6:40 PM, the surveyor asked the LPN why they put the extra Novolog Flexpens in their pocket. The LPN stated that they (staff) are not suppose to have more than one insulin pen in the medication cart at a time for any one resident. The LPN stated that additional insulin pens are required to be stored in the refrigerator and only one is to be removed at a time. The LPN pointed to the pharmacy label on the plastic bag that contained 3 Novolog Flexpens that stated, "REFRIGERATE". The LPN reiterated that these extra insulin pens need to be in the refrigerator and not in the medication cart. Per interview on 5/13/25 on 6:43 PM with the LPN assigned to this medication cart, they confirmed that the above medications were expired, had no expiration date, or should have been stored in the refrigerator. 2. Per observation on 5/14/25 at 3:15 PM of the Medication Cart on Maple Heights Unit, with the LPN on duty, the following medications were found expired: Tramadol 50 mg tablet expired 10/24/24 Lorazepam 0.5 mg tablet expired 12/24 Morphine 15 mg tablet expired 3/25	F 761		

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F 761	Continued From page 65 Tramadol 50 mg tablet expired 3/25 Lorazepam 0.5 mg tablet expired 4/11/25 Morphine 15 mg tablet expired 2/28/25 Codeine Liquid 12/28/23 Naloxone HCL 0.4 mg expired 8/12/24 Bisacodyl suppository 10 mg expired 2/4/25 Per interview on 5/14/25 at 3:20 PM the LPN on duty confirmed the above medications were expired. 3. Per observation of the Champlain West medication cart on 5/13/25 at 6:03 PM the following medications were found to be expired: 1 Bottle of CBD expired 5/4/24 1 vial Azelastine Nasal Solution expired on 8/5/2023 1 bottle of Hydroxyzine HCL 25 mg tabs 1 expired on 2/1/2024 1 bottle of Loratadine 10 mg tab expired 2/2025 2 bottles of Fish Oil 1000 mg expired 2/25 On 5/13/2025 at 6:20 PM during an interview with the Licensed Practical Nurse who was passing medications on Champlain West, she confirmed that the medications listed above were expired and that they should not be in the medication cart. 4. During observations on the Maple Heights Unit on 5/12/25 at 5:22 PM, the door to the medication room was noted to be unlocked and slightly ajar. There were no staff observed in-sight of the medication room. On 5/12/25 at 5:31 PM the Licensed Practical Nurse working on the unit arrived in the area and confirmed that the medication room was not locked and it should be.	F 761		

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F 812	Continued From page 66	F 812	It is the policy of the facility to take all necessary measures to prevent contamination of food by ensuring that kitchen staff wear appropriate hair and beard restraints and that meals are delivered with protective covers in place. Upon notification staff were immediately reminded of the hair and beard restraint policy. Staff were re educated on the policy to keep plate covers on plates until tray reaches resident. A facility-wide audit was immediately conducted to validate compliance with the use of hair/beard restraints in the kitchen on 5/12/2025 after notification from surveyor. **(Administrator not aware surveyor was at the facility on Saturday May 24th 2025)** Per observations of meal tray delivery on Maple Heights (second floor) on **5/24/2025** at 8:10 AM, a Licensed Nursing Assistant (LNA) was seen removing a food tray from the food cart, removing the meal cover, and transporting it down the hall uncovered and delivering it to a resident. All dietary staff were re-educated on proper food contamination prevention practices, including the requirement to wear hair and beard nets. Staff responsible for passing meal trays—both dietary and non-dietary—were re-educated on maintaining protective covers on trays until they are delivered to residents.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: READY Based on observation, interview, and policy review, the facility failed to take measures to prevent contamination of food as evidenced by not using hair and beard restraints while preparing resident meals; and failing to deliver meals with protective covers. This deficiency has the potential to affect all residents. Findings include: Per observation on 5/12/25, at approximately 11:00 AM, two kitchen staff members preparing the lunchtime meal were not wearing hair or beard restraints. One staff member was observed leaning over a boiling pot of water, his/her hair	F 812		

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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) COMPLETION DATE
F 812	Continued From page 67 was pulled back, without a hair restraint in place. The second staff member was also preparing food and had no beard or hair restraint in place. Per interview with the Dietary Manager on 5/12/25 at 11:15 AM, he stated that all staff should be wearing hair restraints and/or beard restraints while preparing food and that both staff should have hair restraints in place. Per observation on 5/12/25 at approximately 6:00 PM, the evening cook was seen in the kitchen standing near the stove area where food was being prepared without a hair and/or beard restraint. Per facility policy titled "Food Safety Requirements," last reviewed on 1/15/25, revealed that all employees must restrain their hair, including beard restraints, when preparing food to prevent contamination of the resident food. Per the policy "hair restraints must be worn when cooking, preparing, or assembling food such as stirring pots or assembling the ingredients of a salad." 2. Per observations of meal tray delivery on Maple Heights (second floor) on 5/24/2025 at 8:10 AM, a Licensed Nursing Assistant (LNA) was seen removing a food tray from the food cart, removing the meal cover, and transporting it down the hall uncovered and delivering it to a resident. Another LNA was observed removing a tray from the food cart, removing the meal cover, then walking down the hall with the meal uncovered. The LNAs confirmed that they always deliver meals from the meal cart to the residents after removing the covers.	F 812	The Dietary Manager will conduct weekly observations to validate continued compliance with hair/beard net usage and proper meal delivery practices. Any instances of non-compliance will be addressed immediately with re-education and corrective action as necessary. The Dietary Supervisor and Administrator are responsible for overseeing this process. Audits will continue weekly for 4 weeks, then monthly X's 3 months Results of audits will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting. Trends or repeat issues will trigger additional interventions or training. Completion Date: 6/7/2025 **Tag F 812 POC accepted on 7/25/25 by P. Cota**	

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	475040	A. BUILDING _____ B. WING _____	C 06/06/2025

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F 812	Continued From page 68 Per facility policy titled "Food Safety Requirements" the definition of contamination reads "'Contamination' means the unintended presence of potentially harmful substances including, but not limited to microorganisms, chemicals, or physical objects." Section 5. reads "Foods and beverages shall be distributed and served to residents in a manner to prevent contamination and maintain food at the proper temperature and out of the Danger Zone. Strategies include, but are not limited to: a. Covering all foods when traveling a distance (i.e., down a hallway, to a different unit or floor)."	F 812		
F 835 SS=L	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility was not administered in a manner that enables it to maintain the physical well-being of each resident, whereby actions and decisions by the facility's leadership team directly contributed to multiple deficiencies that resulted in harm and immediate jeopardy. In addition, there are several repeat deficiencies. This citation is at the immediate jeopardy level due to the identified failures by the lack of administrative oversight. As a result, Resident #62 developed an in-house acquired stage two pressure ulcer that worsened to an unstageable pressure ulcer injury, requiring	F 835		

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F 835	Continued From page 69 hospitalization and surgical intervention due to osteomyelitis and sepsis of the pressure injury. The identified failures by the lack of administrative oversight for a large amount of regulatory requirements in multiple areas of compliance put all residents at risk for serious harm, injury, or death. For this survey, there are 16 widespread citations that have the potential to cause more than minimal harm to all residents of the facility. Findings include: During a recertification survey with 2 complaints on 5/12/25 through 5/16/25, the facility was found to have deficient practices that resulted in 1 citation at immediate jeopardy level at F686, 1 harm level citations at F710, and 27 for more than minimal harm at citations at F550, F552, F584, F605, F655, F658, F679, F687, F689, F711, F725, F756, F760, F761, F812, F840, F843, F880, F940, F941, F942, F943, F944, F945, F946, F947, and F949. On 5/20/25, during an onsite extended survey, the team identified additional resident care issues. During offsite interview with the Medical Director on 5/22/25 and 5/23/25 and offsite record review on 5/28/25, the survey team identified and notified the facility of deficiencies at the immediate jeopardy level for violations around F835 related to administration, F841 related to medical director, and F865 related to the QAPI Program. On 6/6/25 a revisit was made to the facility and the IJ was removed for the above three deficiencies. Multiple repeat deficiencies were identified during this survey. F686 was cited during an onsite revisit survey dated 6/11/24 at a harm severity. F584 was cited during a recertification survey dated 3/28/24. Deficient practices related to unnecessary psychotropic medications (currently	F 835	F 835 The facility is effectively administered by the facility's leadership, including the Administrator, DNS, Medical Director and management company. 5/28/2025 A tool has been developed to track new or worsening wounds daily through morning clinical review including both pressure ulcers developed in house or admitted with to support analysis and discussion with the assigned physician medical director & timely. 5/28/2025 A tool was developed to ensure documentation of high-risk care areas including pressure injuries and other skin issues completed by the DNS can be brought to the QAPI meeting for review with the medical director and QAPI committee members identifying # of incidence and prevalence of wounds and what the analysis of the data shows. 5/28/2025 The Administrator provided education to nursing leadership (to but not limited to the DNS, ADNS, Unit Managers) on tracking and analyzing pressure injuries or other skin issues for the purpose of trending and analyzing the healing of the skin issues including the use of the new tools to support this process. At the direction of the Administrator the Human Resources Coordinator will review education completion and report findings to Administrator. The Human Resources Coordinator will follow up with each department and their staff who have not attended or returned education packages or competencies to the HR office. HR will report weekly to the team on the status of education completion.	

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F 835	Continued From page 70 F605) were cited during both the recertification survey dated 3/28/24 and the onsite revisit survey dated 6/11/24. F689 was cited during an onsite revisit survey dated 6/11/24. F880 was cited during a recertification survey dated 3/28/24. F940 was cited during a recertification survey dated 3/28/24. The facility's plans of correction for all repeat deficiencies above identified that either the nursing leadership team (Director of Nursing/Assistant Director of Nursing) and/or the Administrator were responsible for both auditing to ensure that regulatory requirements were met and reporting the audit results to the Quality Assurance Committee. Also refer to F841 regarding failure to provide administrative oversight to the Medical Director.	F 835	The Administrator is responsible for overseeing this process. Through the QAPI process the Administrator will address the performance improvement process of communicating the tracking, reviewing and analyzing the data for pressure injuries and other skin issues amongst nursing leadership and the medical director. The administration has implemented an additional audit layer for QAPI purposes by partnering with an external audit company. Audits are designed to enhance the quality of care and ensure compliance with regulatory standards The administrative team has started implementing PointClickCare Skin and Wound Module to document and monitor resident skin integrity effectively. This system supports comprehensive wound tracking, promotes consistency in care, and aids in early detection and intervention.	
F 840 SS=D	Use of Outside Resources CFR(s): 483.70(f)(1)(2) §483.70(f) Use of outside resources. §483.70(f)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. §483.70(f)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional	F 840	The results of these reviews and discussions will be brought to the QAPI for 6 months for further review and recommendation to ensure substantial compliance has been achieved. Completion Date:5/28/2025 IJ-6/7/2025 **Tag F 835 POC accepted on 7/25/25 by P. Cota**	

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F 840	Continued From page 71 standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure accurate and timely implementation of the Wound Care Consultant's orders and recommendations for treatment of pressure ulcers for 1 of 11 residents in the applicable sample (Resident #9). Per record review Resident #9 was admitted to the facility in August of 2024 with pressure ulcers to their right heel, left heel, lower back, and various other wounds and abrasions. An Admission Skin note dated 8/9/2024 states "Resident has current skin issues." The skin issues described in the note include discoloration of bilateral tops of feet, Pressure Ulcer / Injury right low back, Stage II pressure ulcer - Partial thickness skin loss. Length: 1.8 Width: 1.5 with no odor or tunneling, a scab on the right heel, an open lesion on the left thigh Length: 6 Width: 5, unstageable sacrum, left leg ulcer, mid low back pressure injury. Review of the Wound Care Consultant's notes and Resident #9's Treatment Administration Records (TARs) revealed that wound care orders and recommendations made at the following dates were not implemented: 8/13/2024, 8/21/24, 8/28/24, 9/11/24, 10/7/24, 12/6/24, 12/13/2024, 1/10/2025, 1/17/25, 1/30/25, 2/7/25, 2/14/25, 3/10/25, 3/28/25, 4/4/25, and 4/14/2025.	F 840	**F 840** It is the policy of the facility to validate accurate and timely implementation of the Wound Care Consultant's orders and recommendations for treatment of pressure ulcers. Resident #9 pressure ulcers are being monitored. Resident # 9 has had 3 hospital visits since 5/29/2025 for non pressure related conditions The wound care consultant PA left IWC and currently are recruiting for a replacement. IWC last day was May 28th 2025 recommendations were implemented. When a new consultant is available the facility will validate recommendations are presented to the physician overseeing the residents care. A review of the current residents with wounds has been reviewed by the medical director and or designated physician, DNS, in house wound team. Education was provided to the DNS, ADNS, medical director wound rounds recommendations will be reviewed and based on the discussion of changes in condition orders will be provided. Education as part of the IJ removal on 5/28/2028. The DNS will review the weekly wound log with the medical director and/or designated physician validating that all recommendations have been made. The DNS is responsible for overseeing this process. The results of the weekly audits will be brought to the QAPI committee for further review and recommendation to ensure substantial compliance is achieved for 6 months **Completion Date:5/28/2025 IJ 6/7/2025** **Tag F 840 POC accepted on 7/25/25 by P. Cota**	

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F 840	Continued From page 72 On 5/26/2025 the Administrator confirmed via email that wound care orders and recommendations were not implemented either timely or accurately. Per phone interview on 5/28/2025 at 9:20 AM the Wound Care Nurse does not have access to the residents' electronic medical records therefore she cannot look to see if the orders and recommendations that she gives are implemented or if they are accurate. The Wound Care Nurse stated that she completes a paper document while she is on site that has the wound characteristics, adds orders and recommendations to the form, and gives it to the nurses on the unit to address. Her typed wound care notes are provided to the facility later. The Wound Care Nurse did confirm that she had requested an osteomyelitis work up each visit since 2/14/2025 and that it had not been done until May of 2025.	F 840		
F 841 SS=L	Responsibilities of Medical Director CFR(s): 483.70(g)(1)(2) §483.70(g) Medical director. §483.70(g)(1) The facility must designate a physician to serve as medical director. §483.70(g)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on document review and interview, it was determined that the facility failed to ensure the Medical Director duties per the Medical Director Agreement and Medical Director facility policy	F 841		

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F 841	Continued From page 73 were performed, including ensuring resident care policies were implemented and coordination of care was provided to ensure resident care and services were provided to all resident that were consistent with current professional standards of practice for 3 of 3 units. As a result, a resident developed in-house pressure ulcers requiring 2 surgical interventions due to delay in identification and treatment and put all residents at risk for serious harm and/or death. On 5/28/25 the facility was notified of non-compliance at the immediate jeopardy (IJ) level for Medical Director. On 5/29/25 the facility's IJ plan of correction was accepted. An unannounced onsite assessment of the IJ removal was conducted on 6/6/25 and the IJ was removed. Findings include: 1. A document titled, "Medical Director Responsibilities", date implemented 8/2024, last reviewed/revised on 1/15/2025 and reviewed/revised by QAPI/Administrator initials revealed the Medical Director's responsibilities include: "a. Implementation of resident care policies, such as ensuring physician's and other practitioners adhere to facility policies on diagnosing and prescribing medications and intervening with a health care practitioner regarding medical care that is inconsistent with current professional standards of care. b. Participation in the Quality Assessment and Assurance (QAA) committee or assign a designee to represent them. c. Addressing issues related to the coordination of medical care and implementation of resident care policies identified through the facility's quality assessment and assurance committee and other activities. d. Active involvement in the process of	F 841	**F 841** It is the policy of the facility to validate that the Medical Director duties per the Medical Director Agreement and Medical Director facility policy are performed. Including ensuring resident care policies were implemented and coordination of care was provided to ensure resident care and services were provided to all resident that were consistent with current professional standards of practice Medical Director has attended all QAPI meeting 2024/2025. Email receipts validate Medical Director has received policies from administrator to review and receive input. The following immediate action was taken by the administrator. 5/28/2025 The Medical Director has been reminded of where the policies are located with his user access, a log is kept of current policies reviewed. 5/28/2025 The medical director has met with the administrator and DNS and developed a plan to ensure: He /she provides oversight and feedback to the other health care providers working at the facility. Medical Director will assist in the review/ development of educational & training programs from the facility staff. The medical director, Admin and DNS will meet weekly to review and analyze the data on the tracking logs of current residents with wounds both non pressure and pressure injuries. If medical director is not available he /she may appoint an designee provider. Pressure Ulcers and other skin issues are to be brought to QAPI for further review with QAA committee.	

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F 841	Continued From page 74 conducting the facility assessment." "The Medical Director responsibilities, additionally, should include, but are not limited to: a. Administrative decisions including recommending, developing and approving facility policies related to resident care. Resident care includes the resident's physical, mental, and psychosocial well-being; b. Ensuring the appropriateness and quality of medical care and medically related care; c. Assisting in the development of education programs for facility staff and other professionals; d. Working with the facility's clinical team to provide surveillance and develop policies to prevent the potential infection of residents..... g. Identifying performance expectations and facilitating feedback to physicians and other health care practitioners regarding their performance and practices..... i. Assisting in developing systems to monitor the performance of the health care practitioners including mechanisms for communicating and resolving issues related to medical care and ensuring that other licensed practitioners (e.g., nurse practitioners) who may perform physician-delegated tasks act within the regulatory requirements and within the scope of practice as defined by State law." 2. A document titled, "MEDICAL DIRECTOR SERVICES AND PREFERRED PROVIDER AGREEMENT (the "Agreement"), effective as of December 1, 2023....." was signed by the hospital's Vice President and the facility's Administrator, this documented is not dated. 3. A document titled "Exhibit A MEDICAL DIRECTOR SERVICES" and states, "The	F 841	5/28/2025 The Administrator provided education on the responsibilities of a medical director to the medical director including involvement and oversight and approval of policies for care being provided in the facility, how to coordinate and oversee other practitioners, the oversight needed of clinical processes and the participation in developing education for the staff and by also participating in the QAPI process addressing care areas through the QAPI committee if concerns should arise. 5/28/2025 A Medical Director Agenda tool that includes but not limited to standards of care, physician orders, adverse events, has been developed to be reviewed with the Medical Director. 5/28/2025 A Medical Director review of Responsibilities tool has been developed to be reviewed with the Medical Director. The Administrator is responsible for overseeing this process. Monthly there will be a follow up review including the Administrator, DNS and Designated Wound Nurse reviewing pressure ulcer and non-pressure ulcer logs. The results of these reviews and discussions will be brought to the QAPI for 6 months for further review and recommendation to ensure substantial compliance has been achieved. Completion Date:5/28/2025 IJ 6/7/2025 **Tag F 841 POC accepted on 7/25/25 by P. Cota**	

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F 841	Continued From page 75 Medical Director shall have responsibility and oversight of medical services at GMNH (facility name) and shall: (a) Provide medical decision input and support to the Administrator and governing body of the GMNH..... (c) Participate in developing resident care policies..... (d) Participate in periodic meetings with the Administrator and/or the governing body, director of nursing or other professional staff to discuss clinical and administrator issues, specific resident care problems, and professional staff needs for education or consultants..... (f) Participate in establishing policies and procedures to enhance and promote the quality of life for residents and include provisions that enhance resident decision making, including regarding options for care and treatment..... (h) communicate on a regular basis with administration and organization leadership regarding actions, recommendations and concerns of the medical director. (i) Remain current regarding federal an state regulatory requirements, as well as professional service and administrative requirements of third party payers..... (k) Monitor compliance with requirement that GMNH immediately inform resident and consult with resident's physician in cases of accidents with injuries that have the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status; a need to alter treatment significantly; or a decision to transfer or discharge the resident from the GMNH. (l) Coordinate, consult and advise GMNH over care and treatment, including physician services and services of other professionals as they relate to patient care.	F 841		

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F 841	Continued From page 76 (m) Participate in evaluating the adequacy of the professional and support staff and the GMNH to meet the medical and physical, psychosocial, cultural, and spiritual needs of residents. (n) Develop a process to review physician and health care practitioner credentials (e.g., licensure and pertinent background) and confirm that residents have primary attending and backup physician coverage. (o) In cooperation with the administration and with the approval of the governing body, represent the medical staff in developing rules, regulations and policies for resident attending physicians. (p) Monitor the clinical practices of attending physicians, and intervene as needed on behalf of the residents or the GMNH's administration..... (r) Assist in the development of and advise GMNH staff concerning appropriate clinical practices and other care policies to help confirm that each resident's medical assessment and regime is incorporated appropriately into the resident's record on a timely basis. (s) Monitor physician participation in assessment and care planning. (t) Monitor provision of physician services to provide services to meet the highest practicable physical, mental, and psychosocial well-being of each resident. (u) Monitor that services provided or arranged by GMNH meet professional standards of quality and are provided by qualified persons. (v) Supervise compliance by attending physicians with requirements for: *admission orders, timely review of residents' total program of care, including medication and treatments; written, signed & dated progress notes at each visit..... (x) Exercise medical and clinical leadership in a multi-disciplinary approach to resident care and	F 841		

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F 841	Continued From page 77 care planning within the long-term care setting, and interact with the attending staff as a colleague and peer..... (bb) Address and resolve issues related to continuity of care and transfer of medical information and GMNH staff. (cc) Facilitate feedback to health care and other service practitioners about their performance and practices. (dd) Discuss and intervene (as appropriate) with a health care practitioner about medical care that is inconsistent with applicable current standards of practice. (ee) Review consultant recommendations that affect GMNH's residents care policies and procedures or the care of an individual resident. (ff) Monitor that all necessary medical services provided to residents are adequate and appropriate..... (ii) Advise and assist in developing mechanisms for communicating and resolving issues related to medical care. (jj) Participate/Consult in the GMNH's quality assurance process. (kk) Participate in GMNH quality assurance activities to identify care issues related to individual residents as well as are throughout the GMNH, and take appropriate and timely action as needed to implement recommendations..... (mm) Participating and consulting in quality assurance includes but is not limited to a continuous quality improvement program, as well as participation on relevant committees, such as the pharmacy and therapeutics committee, the infection control committee, and the safety committee..... (rr) Maintain current knowledge of clinical developments to promote the highest practicable functional level and well-being of residents.....	F 841		

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F 841	Continued From page 78 (tt) Participate in the development and presentation of education programs. (uu) Organize in-service training and other educational programs and materials for the attending physicians and other professional staff within the institution, in cooperation with the director of nursing and the Administrator as needed..... (iii) Medical Director shall at all times render Services in a competent, professional and ethical manner, in accordance with prevailing standards of medical practice in the relevant community, perform professional and supervisory services in accordance with recognized stands of the medical profession, and act in a manner consistent with all applicable statutes, regulations, rules, orders and directives of any and all applicable governmental and regulatory bodies having competent jurisdiction..... Multiple repeat deficiencies were identified during this survey. F686 was cited during an onsite revisit survey dated 6/11/24 at a harm severity. F584 was cited during a recertification survey dated 3/28/24. Deficient practices related to unnecessary psychotropic medications (currently F605) were cited during both the recertification survey dated 3/28/24 and the onsite revisit survey dated 6/11/24. F689 was cited during an onsite revisit survey dated 6/11/24. F880 was cited during a recertification survey dated 3/28/24. F940 was cited during a recertification survey dated 3/28/24. Per offsite phone interview on 5/22/25 at 12:35 PM and 5/23/25 at 9:16 AM with the Medical Director, s/he stated they had been in this role for approximately 2 and 1/2 years. They were aware of the Medical Director contract however, had not	F 841		

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F 841	Continued From page 79	F 841		

signed this document or been provided with or signed a job description. The following was reveled during these interviews:

1. Development, revision, and implementation of facility policies
When asked about their role in the development, and revision of facility policy and procedures, they stated they had been asked to review the policies and procedures related to Covid and masking but there were no other policies or procedures that they had reviewed or otherwise been involved with creating, updating, or revising during their tenure as the Medical Director. The Medical Director confirmed that they have not signed off on any policies or procedures since taking the Medical Director role 2 and 1/2 years ago. They stated, "I review what [proper name omitted] [administrator] brings me to review and provide feedback on those items." They stated that prior to their taking the Medical Director position there had been a couple other medical directors in the role and they assumed policies and procedures had been created, updated, and revised by the previous medical director.

During an onsite revisit survey dated 6/11/24 for the recertification survey dated 3/28/24, a harm level deficiency was identified related to the facility failing to provide pressure ulcer treatment consistent with professional standards of practice. The facility submitted a plan of correction that read "to ensure this alleged deficient practice does not occur pressure ulcer policy is reviewed and/or updated as needed, facility to perform self-assessment relating to pressure ulcer as QAPI review, weekly interdisciplinary team meetings to be initiated to review wound status, ensure proper adherence to

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F 841	Continued From page 80 facility policy, care planning and documentation is completed," and committed to be in compliance with regulatory requirements by 6/27/25. There is no evidence to support that the medical director has reviewed, revised, updated, or approved any of the facility's resident care policy and procedures. The Medical Director was asked if they had reviewed any of the facility's policy and procedures other than the Covid and masking policies and they stated they had not. The Medical Director was asked if they had reviewed the skin policies and procedures since becoming the medical director at this facility they stated, "No, I can not say that I have. I review what [proper name omitted] [administrator] brings to me to review." See F865 for additional information. 2. Development and revision of the Facility Assessment The Medical Director was asked to share their part in creating, updating, and/or revising the Facility Assessment tool (a comprehensive evaluation used to determine the resources, including staff, equipment, and services, needed to provide competent care to residents), and s/he was not aware of what this document was and had no part in it's creation, updating, revision, or approval. The Medical Director was asked if they had reviewed the Facility Assessment tool, and they confirmed they had not and again was not aware of what this document is.	F 841		

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F 841	Continued From page 81 3. Pressure ulcer prevention, monitoring, and treatment The Medical Director was asked if they were aware of the pressure ulcer Resident #62 developed in the facility, they stated, "I became aware of it from one of my colleagues when it was a stage 2 (A partial-thickness skin loss involving the epidermis and dermis. A shallow, open ulcer/wound)." The Medical Director confirmed that Resident #62's pressure ulcer should have been identified before it became a stage 2. When asked if there would be obvious skin changes that should have been noticed prior to it becoming a stage 2, the Medical Director stated, "yes, there would have been signs like erythema (redness of the skin), swelling, changes to the skin that would indicate something was not right." The Medical Director was asked what their expectations were specific to notification of pressure ulcers, they stated, "This is something that is important. We do need to make sure that it is part of the QAPI (Quality Assurance Performance Improvement) meeting. We need to be gathering our providers to read up on the policies and procedures. It's hard though because we are not at the facility together to go over the policies and procedures." The Medical Director stated s/he was sure there was a way to have all providers as well as herself/himself to have access to the policies for review. The Medical Director stated s/he was not aware of how to access the policies and procedures or where they are kept. The Medical Director stated s/he would be discussing this with the Administrator and they felt it would be a good idea for themselves and their colleagues to review the policies and procedures.	F 841		

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F 841	Continued From page 82 The Medical Director was asked if they would expect the facility nursing staff to notify them of a new pressure ulcer and the status of existing pressure ulcers, s/he stated, "yes." The Medical Director was asked if they would say it was fair to expect staff to identify changes in resident conditions timely, and notify the Medical Director of these changes timely, s/he stated, "yes." The Medical Director was asked if they would consider Resident #62's pressure ulcer to be a change in condition, s/he stated, "yes." The Medical Director was asked if they felt that Resident #62's pressure ulcer should have been identified prior to it becoming a stage 2 pressure ulcer, s/he stated, "yes." The Medical Director was asked if they were aware of several other pressure ulcers in this facility, s/he stated, they were aware at this time that there were pressure ulcers in the facility. The Medical Director was asked if these pressure ulcers had been discussed with them prior to the recertification survey, s/he stated that they did not recall all the patients off the top of their head that had skin issues, more specifically pressures ulcers, but "yes, I was aware of some." The Medical Director was asked about new treatment orders and what their expectations were and how soon new orders should be started. The Medical Director stated, "It should be implemented per the order and there should be no delay in following the physician or providers order." When ask if s/he was aware of the	F 841		

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F 841	Continued From page 83	F 841		

significant delay in Resident #62 receiving the ordered treatment, the Medical Director stated they were made aware of this by their colleague and the wound nurse who ordered the treatment. The Medical Director stated that they did not have access to the wound nurses notes as they are not always available at the facility. The Medical Director confirmed that they did not have frequent communication with the wound nurse.

See F686 and F865 for additional information.

4. Coordination of Care
The Medical Director was asked how communication occurred between themselves and the other physicians. The Medical Director stated it is either done in person, in EPIC, or by secure email. The Medical Director stated that each physician decides who to see at the facility based on which residents are due for a routine visit, are a new admission, will be discharging in the near future, or has a medical need. The Medical Director explained that communication with the nurses occurs either in person or the nurses have a clip board where the list the residents by name who require a visit for non-urgent needs. The Medical Director stated that communication between nursing, themselves, and their colleagues is "not as good as we would like." The Medical Director stated they did not recall being notified by the staff at the facility that Resident #62's ordered pressure ulcer treatment had been delayed. The Medical Director stated that the wound nurse did contact them to discuss their concerns regarding the delay in this treatment. The Medical Director confirmed that s/he does not oversee the wound nurse as they are from a separate medical practice. The Medical Director stated that the

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F 841	Continued From page 84 wound nurse does not usually keep the physicians apprised of skin issues that the s/he is treating and "we don't discuss the care [pronoun omitted] is providing but if [pronoun omitted] notes are available at the facility I do review them prior to seeing the patient myself and my colleagues do as well." The Medical Director was asked where physicians who provide care to residents at this facility document the care provided. The Medical Director stated that all physician notes are entered in the EPIC system (the computer program used by physicians providing care to residents at this facility from their medical practice). When asked how facility staff access the notes entered in EPIC, the Medical Directed stated each physician copies their notes and adds them to PCC (the computer program used by the facility to document resident medical information). See F686 and F840 for additional information. 5. Medical Director oversight of other health care providers and facility staff The Medical Director was asked how they address or intervene with a health care practitioner regarding medical care that's inconsistent with current professional standards of care. The Medical Director stated, "if I have a concern about the clinical care by a colleague I would address that with them. I have confidence in all their skills and they all come from different backgrounds." The Medical Director stated they have not had to address any concerns with her/his colleagues. The Medical Director was asked how they	F 841		

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F 841	Continued From page 85 oversee the other providers practicing in this facility. They stated that currently there are 3 other MD's (Medical Doctors) providing services at this facility and two of the three are per diem. The Medical Director stated that they do meet with other providers, the other providers do not report to her/him and s/he does not have a formal evaluation process, as they are the medical directors colleagues that s/he works with in a local medical office. The Medical Director stated that the formal evaluation process of their colleagues is done in that medical office by another entity. The Medical Director stated that there is a need for more providers so more time can be spent providing care to the residents. See F710 and F711 for additional information. 6. Sufficient staffing and timely medication administration The Medical Director was asked if s/he believes there are medications that need to be administered timely and if so, which ones. The Medical Director stated that there was a patient s/he sees at this facility that had told her/him that they were not getting their scheduled 6 AM dose of Sinemet for Parkinson's and this was causing the patient much distress. The Medical Director stated they spoke with nursing about this and they felt that the issue was addressed. The Medical Director was asked if s/he was aware that a 293 page report was provided by the facility of late or missed medications for a 30 day period of 4/16/25 through 5/16/25 affecting approximately 50 residents and approximately 2,900 medications. The Medical Director stated they were not aware that the issue of missed or late med's was this significant.	F 841		

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F 841	Continued From page 86 See F725 and F760 for additional information. 7. Participation in QAPI The Medical Director was asked what role they performed in the QAPI Program. The Medical Director stated they attend the monthly meetings. The Medical Director was asked how they are involved in issues that arise related to coordination of care and implementation of resident care policies that are identified in QAPI or the QAA (Quality Assessment and Assurance) process. The Medical Director stated, "if issues come up that need my input I can certainly talk with our folks at the facility. [Proper name omitted] [administrator] comes to me generally if [pronoun omitted] needs something reviewed." The Medical Director was asked if the QAPI meetings are helpful to them as the Medical Director in the process of care coordination they stated, "yes, I do think it is helpful. There are topics that come up from nursing and therapies regarding things that we might need to be addressed. As well as dietary and the environment." The Medical Director was asked if they recalled when the last time was that skin issues were discussed in QAPI. The Medical Director stated they could not provide a date "but it has been a long time since pressure ulcers have been discussed in QAPI", s/he could not explain why this has not been happening. See F865 for additional information. 8. Assisting in the development of educational programs for facility staff The Medical Director was asked how they assist	F 841		

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F 841	Continued From page 87 in the developing, updating, and revision of educational training's for the facility staff or other health care providers working in the facility. The Medical Director stated they do not participate in that specifically unless they have an interaction with a staff member practicing "who is not practicing the way they should". S/he stated they would speak to that staff in the moment to correct the issue. The Medical Director confirmed that s/he has not been part of the development of any of the education or training's and is not aware of what training's any of the staff have had, whether mandatory or not.	F 841	F 843 It is the facilities policy to make a good faith attempt to obtain an transfer agreement with a hospital sufficiently close to the facility to make transfer feasible. The administrator has made multiple documented attempts in 8 years to obtain a transfer agreement with the closest hospital. Most recently multiple documented request starting 6/4/2025. No residents were affected by this alleged deficient practice, all transfers to the local hospital resulted in needed care and services. The administrator obtained a signature on a transfer agreement on 7/15/2025.	
F 843 SS=F	Transfer Agreement CFR(s): 483.70(i)(1)(2) §483.70(i) Transfer agreement. §483.70(i)(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that- (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and (ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will	F 843	The Administrator or designee will review all agreements annually. The QAPI Committee will review the status of transfer agreements quarterly for the next 12 months. The Administrator will report any lapses in agreements or transfer issues to the committee. The results of this monitoring will be documented in QAPI meeting minutes and used to ensure ongoing compliance. Completion Date: 6/7/2025 based on good faith attempt to secure a signature. **Tag F 843 POC accepted on 7/25/25 by P. Cota**	

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F 843	Continued From page 88 be exchanged between the providers, including but not limited to the information required under §483.15(c)(2)(iii). §483.70(i)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: REVIEWED AND NO EDITS NEEDED Based on staff interview and record review, the facility failed to have a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that meets requirements of the regulation. Findings include: During entrance conference on 5/12/25 at approximately 11:30 AM, the facility's written transfer agreement with a local hospital was requested. Per interview on 5/16/25 at approximately 2:50 PM, the Administrator stated that the facility has never had a written transfer agreement with a hospital.	F 843		
F 865 SS=L	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven	F 865		

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F 865	Continued From page 89 QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and	F 865	**F 865** It is the policy of the facility to address systems of care in a comprehensive manner by identifying problems and opportunities for improvement in the areas of treatment/services to include but not limited to prevent/heal pressure ulcers. The facility conducts QAPI meetings monthly with IDT to include but not limited to Medical Director, Pharmacist. The following sub QAPI meetings occur on a regular basis weight review weekly meeting is done on Mondays with dietitian,ADON, Dietary Supervisor, Unit nurse and MDS nurse, falls and incident meeting is done on a monthly basis with the Rehab Manager. The facility has implemented a comprehensive systems-of-care approach by identifying problems and opportunities for improvement in the following areas: Residents are properly assessed and cared for to prevent pressure ulcers QAPI training was completed by an outside consultant on 5/29/2025. The Medical Director fulfills regulatory responsibilities related to resident care policies, coordination of medical services, and QAPI participation. The Administrator effectively oversees corrective actions for deficiencies, ensuring optimal use of resources to support residents' overall well-being, The Administrator and/or designee is collecting and analyzing weekly the audits / observations / tracking tools that each department is using for monitoring the area identified for improvement and having discussions with the person directly involved with working through the process. Administrator implemented an audit company to perform daily audits to be utilized in QAPI program.	

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F 865	Continued From page 90 management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.	F 865	Administrator has set calendar event reminders for weekly and/or monthly submission of required audits. The Administrator supports each department's QAPI (Quality Assurance and Performance Improvement) efforts by guiding them to evaluate whether to continue current practices—if they are effective—or revise their plans if they are not, based on weekly audit results. The facility has implemented a directed plan of correction. A QAPI specialist has been hired at the request of the directed plan of correction to monitor the QAPI of Pressure Ulcers. Contract signed 7/14/2025. 1st meeting occurred 7/15/2025. QAPI specialist to attend 7/16/2025 QAPI meeting. The Nursing Home Administrator (NHA), with the assistance of the Quality Improvement Specialist (QIS) consultant, will track and trend the effectiveness of all Quality Assurance and Performance Improvement (QAPI) activities. This data will be reported to the QAPI Committee on a monthly basis for a minimum of six months, or until all performance plan objectives related to maintaining an effective QAPI program are consistently met. Completion Date: 5/29/2025 IJ- Notified of DPOC 7/7/2025- 7/14/2025 **Tag F 865 POC accepted on 7/25/25 by P. Cota**	

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F 865	Continued From page 91 §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and interview of the facility's Quality Assurance and Performance Improvement Program (QAPI), the facility failed to address all systems of care in a comprehensive manner by identifying problems and opportunities for improvement in the areas of treatment/services to prevent/heal pressure ulcers (cited at immediate jeopardy level); residents care supervised by a physician (cited at harm level); administration (cited at immediate jeopardy level); and Medical Director (cited at immediate jeopardy level). As a result, a resident developed an in-house pressure ulcers requiring 2 surgical interventions due to delay in identification and treatment and put all residents at risk for serious harm and/or death. The identified failure to have an by the failure that have an effective Quality Assurance and Performance Improvement Program to identify	F 865		

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F 865	Continued From page 92 problems and provide system oversight put all residents at risk for serious harm, injury, or death. On 5/28/25 the facility was notified of non-compliance at the immediate jeopardy level for QAPI. On 5/29/25 the facility's IJ plan of correction was accepted. An unannounced onsite assessment of the IJ removal was conducted on 6/6/25 and the IJ was removed. Findings include: During a recertification survey with 2 complaints the facility was found to have deficient practices that resulted in 4 citations at immediate jeopardy level, 1 harm level citations, and 27 potential for more than minimal harm at citations. Multiple repeat deficiencies were identified during this survey. F686 was cited during an onsite revisit survey dated 6/11/24 at a harm severity. F584 was cited during a recertification survey dated 3/28/24. Deficient practices related to unnecessary psychotropic medications (currently F605) were cited during both the recertification survey dated 3/28/24 and the onsite revisit survey dated 6/11/24. F689 was cited during an onsite revisit survey dated 6/11/24. F880 was cited during a recertification survey dated 3/28/24. F940 was cited during a recertification survey dated 3/28/24. The facility's plans of correction for all repeat deficiencies above identified that either the nursing leadership team (Director of Nursing/Assistant Director of Nursing) and/or the Administrator were responsible for both auditing to ensure that regulatory requirements were met and reporting the audit results to the Quality Assurance Committee.	F 865		

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F 865	Continued From page 93 Per review of Resident #62's medical record, it was revealed that the resident had a stage II (partial-thickness skin loss involving the epidermis and dermis represented by a shallow open ulcer/wound) facility acquired pressure ulcer that worsened and required two surgical inventions. The facility has other facility acquired pressure ulcers. The facility's QAPI plan states pressure ulcers are monitored, however the facility has no tracking system for skin issues/pressure ulcers to monitor improvement/worsening condition(s). The facility had prior knowledge of the deficient practice related to pressure ulcers as this is a repeat deficiency for the facility. Per review of the facility's QAPI plan, subtitle, "QAPI Leadership" under section ii, states "This group of people works together to communicate and coordinate QAPI activities. Currently QAPI Council meets at least quarterly, sometimes monthly. On a weekly basis sub QAPI committees meet relating to resident care items such as weight loss, wounds, falls and incidents." Per interview on 5/16/25 at approximately 2:21 PM, the Administrator confirmed pressure ulcers are not discussed during the monthly QAPI meetings and have not been discussed since the September 2024 QAPI meeting. The Administrator stated that the interdisciplinary team (IDT) meets weekly to talk about facility and resident issues. S/he was not able to provide evidence that sub QAPI committees are occurring or when they were last conducted. An offsite phone interview on 5/22/25 at 12:35 PM and on 5/23/25 at 9:16 AM, the Medical Director confirmed that wounds have not been discussed	F 865		

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F 865	Continued From page 94 in the monthly QAPI meetings and he stated that skin issues used to be discussed in QAPI but haven't been for some time. An email on 5/21/25 at 5:33 PM from the surveyor to the Administrator stated, "To confirm, there have been no skin issues/pressure ulcers discussed in QAPI/QAA since last September?" The Administrator responded to this email question for confirmation on 5/21/25 at 5:38 PM that stated, "I do not have further information that it was." See F686, F835, and F841 for more information. Per review of a 293 page report provided by the facility on 5/16/25 titled, "Medication Audit Report" which captured all late and missed medications for the period of 4/16/25 to 5/16/25. The Medication Audit Report revealed approximately 50 residents who received either missed medications, late medications, or both. Approximately 2,900 medications were administered late or were not administered at all, of which, approximately 15 medications were significant medication errors. See F725 and F841 for more information. Per review of employee personnel files, and the facility "Education Tracking Sheet" provided by the facility via email on 5/22/25 revealed the lack of mandatory training regarding areas of Communication; Resident Rights, Abuse, Neglect, and Exploitation; QAPI; Infection Control; Compliance and Ethics; required in-service trainings; and Behavioral Health. Review of the facility's QAPI plan states the facility monitors employee trainings, however the	F 865		

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F 865	Continued From page 95 monitoring and tracking system has not been completed to include all required trainings. See F940, F941, F942, F943, F944, F945, F946, F947, and F949 for more information.	F 865		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880	**F880** It is the policy of the facility to provide a safe and sanitary environment to prevent the development and transmission of communicable diseases and infections related to water system lines monitoring, hand washing, and cleaning of resident shared equipment. A schematic of the facility water system was on file evaluation and risk assessment was completed in 2024 that included low points. The maintenance department implemented weekly flushes of low points effective May 16th 2025. A water management team has been developed, qtrly meetings will be completed. First meeting was done on May 29th 2025 to include a tour of the facility to educate team members of water flow and low point flushes. Staff education on hand washing has been provided in accordance of random audits are being completed. Toilet risers have been audited to identify need for cleaning , replacement or maintenance. A validation of the condition of toilet risers will be completed on weekly rounds by the administrator. Audits assigned will continue weekly for 4 weeks, then monthly X's 3 months Results of audits will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting. Trends or repeat issues will trigger additional interventions or training. **Completion Date: 6/7/2025**	

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F 880	Continued From page 96 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: READY Based on observation, record review, and interview, it was determined that the facility failed to provide a safe and sanitary environment to	F 880	**Tag F 880 POC accepted on 7/25/25 by P. Cota**	

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F 880	Continued From page 97	F 880		

help prevent the development and transmission of communicable diseases and infections related to water system lines monitoring, handwashing, and cleaning of resident shared equipment. This has the potential to impact all residents. This is a repeat deficiency for this facility, with the violation cited during the previous recertification survey, dated 3/38/24. Findings include:

1. Per record review of the facility's water management program, It did not contain a risk assessment to identify areas in the building where Legionella could grow and spread in the facility's water system.

Per review of the facility policy with a reviewed/revised date of 1/15/2025 states, "Control measures will be applied to address potential hazards at each control point. A variety of measures may be used, including physical controls, temperature management, disinfectant level control, visual inspections, or environmental testing for pathogens. Testing protocols and control limits will be established for each control measure. The water management team shall regularly verify that the water management program is implemented as designed. The effectiveness of the water management program shall be evaluated no less than annually."

An interview was conducted with the Infection Preventionist and the Director of Maintenance on 5/16/2024 at 11:30 AM. The Director of Maintenance and Infection Preventionist confirmed that the facility did not complete a formal risk assessment, including identifying areas in the building where Legionella could grow or reside. The facility lacked a process to prevent the growth and transmission of communicable

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F 880	Continued From page 98	F 880		

diseases and infections related to Legionella prevention.

2. Observation on 5/13/25 at 4:37 PM with an LPN revealed s/he did not clean their hands before preparing and administering medications or between residents for Residents #56 and #6. S/he did not clean their hands before donning or doffing gloves to perform a finger-stick for blood glucose monitoring. After completing the finger stick, s/he put the lancet and gauze into the palm of one glove and threw it the trash in the residents room. S/he did not clean their hands during any part of the administration of medications for these residents. After s/he completed the administration of the medications and the finger-stick, s/he commented that s/he forgot to clean his hands.

Per interview on 5/13/25 at 4:52 PM, the LPN confirmed that s/he forgot to perform hand hygiene.

3. Per observation on 5/12/25 at approximately 10:45 AM on the Cabot Cove Unit, it was noted that a toilet riser (an assistive device that increases the height of a toilet) was in place over the toilet. A dried brown substance was noted on the front and back of the toilet riser seat. A soft square foam backrest covered in soft plastic, approximately 18" high x 18" wide which was in front of the toilet tank and was noted to have rips in the plastic at the top and bottom corners and a 4 1/2 inch jagged tear down the center of the backrest. There were other places on the backrest where the soft plastic was missing and a yellow/tan foam was exposed.

Observation on 5/12/25 at approximately 4:45 PM

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F 880	Continued From page 99 of the Cabot Cove Unit Spa room toilet revealed there had been no change to the condition of the toilet riser seat or the cushioned backrest. The riser toilet seat still had the dried brown substance on the front of the toilet riser. Per interview on 5/12/25 at approximately 5:05 PM, an RN (Registered Nurse) confirmed the above observations. S/he stated, "we always clean the toilet between residents." This writer stated to the RN that this was observed at 10:45 AM on 5/12/25 and has not been cleaned. At the time of this conversation, a resident entered with their walker stating they needed to use the toilet. The RN used a wipe to clean the front of the toilet and stated "this is probably BM [bowel movement]." The RN stated s/he would have the cushioned backrest addressed and s/he applied paper surgical tape to the cracked areas on the cushion and confirmed that neither the tape nor the backrest could not be adequately cleaned between residents in their current state of disrepair.	F 880		
F 940 SS=F	Training Requirements CFR(s): 483.95 §483. 95Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.71. Training topics must include but are not limited to- This REQUIREMENT is not met as evidenced by:	F 940		

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F 940	Continued From page 100 READY Based on interviews, employee record review, facility assessment, and facility onboarding/ training records, the facility failed to implement an effective training program for new and existing staff by failing to ensure multiple mandatory training requirements were complete for 10 of 10 sampled employees. This is a repeat deficiency for this facility, with the violation cited during the previous recertification survey, dated 3/38/24. Findings include: Per review of the Facility Assessment under Staffing Plan, Staff training/education and competencies "staff are educated upon new employee orientation under the following format: Disaster preparedness; and EP (emergency preparedness). Dementia training. Infection control practices, Residents Rights. Included in the ongoing education process, the following are provided (not an all-inclusive list): Communication, Residents Rights, Abuse, neglect and exploitation. Care Management for 'persons' with dementia. Infection Control, Identification of resident with changes in condition, wound care dressing, skin assessment, pressure injury assessment." Per review of the 2024-2025 Education tracking spreadsheet provided by the facility, on 5/22/25, the facility tracks training for/on the following categories: Teamwork, Customer Service, Communication, Bloodborne Pathogens, Professionalism, Ethics, social media, Emergency Preparedness, Dementia, Abuse, Residents Rights, QAPI (Quality Assurance and Performance Improvement) and HIPPA, a federal law /national standard to protect medical records and other personal health information.	F 940	F 940 It is the policy of the facility to develop and implement an effective training program for new and existing staff. On 5/28/2025 the facility reviewed the current schedule of providing trainings to new staff as well as annual education as part of the IJ Allegation for compliance for F 865 citation. Employees identified as missing training are in the process of completing it. The facility is actively working with nursing staff to bring all education requirements up to date. Due to the essential care needs of residents, the facility is unable to implement a full suspension of all staff needing training but is enforcing completion as feasible therefore any employee who has not completed the required training between 5/28/2025 and 7/17/2025 will be removed immediately removed from the work schedule until all training is completed. Going forward: New employees may not start position until education is complete. Any current employee needing annual education will be notified that they must complete the trainings and will be scheduled to do so. Employees who do not complete their training in accordance with their annual performance evaluation will not receive a performance increase nor will the retro go retro once training is complete.	

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F 940	Continued From page 101 A review of 10 direct care staff education records and the education tracking sheet revealed that many of the 10 employees did not have their required trainings completed. See F 941, F942, F943, F044, F945, F946, F947, and F949 for more information. An email received on 5/22/25 from the Administrator stated, "Regarding the education- many staff had issues logging in, don't have a home computer, we did offer them to use facility chrome books, so the option of paper based was offered which should be in files, I do not know if [proper name omitted] kept a spreadsheet or list of what was completed outside of the evidence of the actual education." Per interview on 5/20/25 at approximately 5:35 PM, the Administrator was unable to provide evidence that the above staff completed their required communication training and confirmed that the employee files reviewed contained the only documentation the facility has for staff training and competencies.	F 940	Employees will receive 2 warnings prior to do date/ evaluation date 30 days prior and 10 days prior, any employee who does not have trainings completed on their performance evaluation due date will be removed from the schedule until trainings are complete. The facility continues to offer staff both an on-line training option and in-person, paper-based options. Staff are frequently reminded of the need to complete trainings through multiple communication channels to include postings, call em all text system and verbally. The facility has signed a contract and waiting an implementation date on a new training software health care academy. The facility is taking measures to validate staff are completing the required trainings by logging them on a spreadsheet. Once Health Care Academy is implemented trainings will be documented in the software. The human resources director is responsible for overseeing this process.	
F 941 SS=F	Communication Training CFR(s): 483.95(a) §483.95(a) Communication. A facility must include effective communications as mandatory training for direct care staff. This REQUIREMENT is not met as evidenced by: READY Based on interview and record review, the facility failed to ensure all staff completed mandatory training that outlines and informs staff of the elements of effective communication, including	F 941	The Human Resources director will update Administrator of any refusals by staff to complete trainings. Audits of training completion will continue weekly for 4 weeks, then monthly X's 3 months Results of audits will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting. Trends or repeat issues will trigger additional interventions or training. Completion Date of plan 5/28/25, IJ, 6/7/25 Survey **Tag F 940 POC accepted on 7/25/25 by P. Cota**	

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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) COMPLETION DATE
F 941	Continued From page 102 speaking to others in a way they can understand, active listening and observing verbal and nonverbal cues for 9 of 10 sampled staff. Findings include: Per review of employee Human Resources files for permanent and contracted direct care staff, in conjunction with review of the Education Tracking spreadsheet provided by the facility via email on 5/22/25, the facility did not have evidence for training in communication for LNA #1 [Licensed Nursing Assistant], hired 5/6/25; LNA # 2, hired 9/13/24; LNA #3, hired 6/26/24; LNA #4, hired 5/22/23; LNA #5, hired 8/17/24; LPN #4, [Licensed Practical Nurse], hired 2/3/25; LPN #5 hired 4/18/25; LPN #7, hired 9/4/21; and LPN #8, hired 3/30/24. Per interview on 5/20/25 at approximately 5:35 PM, the Administrator was unable to provide evidence that the above staff completed their required communication training and confirmed that the employee files reviewed contained the only documentation the facility has for staff training and competencies.	F 941	F 941 It is the policy of the facility to provide effective communication training. Employees identified as missing training are in the process of completing it. The facility is actively working with nursing staff to bring all education requirements up to date. Due to the essential care needs of residents, the facility is unable to implement a full suspension of all staff needing training but is enforcing completion as feasible therefore any employee who has not completed the required training between 5/28/2025 and 7/17/2025 will be removed immediately removed from the work schedule until all training is completed. Going forward: New employees may not start a position until education is complete. Any current employee needing an annual education will be notified that they must complete the trainings and will be scheduled to do so. Employees who do not complete their training in accordance with their annual performance evaluation will not receive a performance increase nor will the retro go retro once training is complete.	
F 942 SS=F	Resident Rights Training CFR(s): 483.95(b) §483.95(b) Resident's rights and facility responsibilities. A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at §483.10, respectively. This REQUIREMENT is not met as evidenced by: READY Based on interview and record review the facility	F 942	Employees will receive 2 warnings prior to do date/ evaluation date 30 days prior and 10 days prior, any employee who does not have training completed on their performance evaluation due date will be removed from the schedule until training is complete.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475040	A. BUILDING _____ B. WING _____	C 06/06/2025

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GREEN MOUNTAIN NURSING AND REHABILITATION	475 ETHAN ALLEN AVENUE COLCHESTER, VT 05446

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 942	Continued From page 103 failed to ensure all staff completed mandatory training that outlines and promotes an understanding of the rights of every nursing home resident for 8 of 10 sampled staff. Findings include: Per review of employee Human Resources files for permanent and contracted direct care staff, in conjunction with review of the Education Tracking spreadsheet provided by the facility via email on 5/22/25, the facility did not have evidence for training in resident rights for LNA #1 [Licensed Nursing Assistant] hired, on 5/6/25; LNA #2, hired on 9/13/24; LNA #3, hired on 6/26/24; LNA #5, hired on 8/17/24; LPN # 4, [Licensed Practical Nurse] hired on 2/3/25; LPN #5, hired on 4/18/25; LPN #7, hired on 9/4/21; and LPN #8, hired on 3/30/24. Per interview on 5/20/25 at approximately 5:35 PM, the Administrator was unable to provide evidence that the above staff completed their required resident rights training and confirmed that the employee files reviewed contained the only documentation the facility has for staff training and competencies.	F 942	The facility continues to offer staff both an on-line training option and in-person, paper-based options. Staff are frequently reminded of the need to complete training through multiple communication channels to include postings, call em all text system and verbally. The facility has signed a contract and is waiting for an implementation date on a new training software health care academy. The facility is taking measures to validate staff are completing the required training by logging them on a spreadsheet. Once Health Care Academy is implemented training will be documented in the software. The human resources director is responsible for overseeing this process. The Human Resources director will update the Administrator of any refusals by staff to complete training. Audits for training completion will continue weekly for 4 weeks, then monthly X's 3 months Results of audits will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting. Trends or repeat issues will trigger additional interventions or training.	
F 943 SS=F	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.	F 943	Completion Date of plan, 6/7/25 **Tag F 941 POC accepted on 7/25/25 by P. Cota**	

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F 943	Continued From page 104 §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure all staff completed mandatory training on abuse, neglect and exploitation for 7 of 10 sampled staff. Findings include: Per review of employee Human Resources files for permanent and contracted direct care staff, in conjunction with review of the Education Tracking spreadsheet provided by the facility via email on 5/22/25, the facility did not have evidence for training in communication for LNA [Licensed Nursing Assistant], #2 hired on 9/13/24; LNA #3, hired on 6/26/24; LNA #5, hired on 8/17/24; LPN #4, hired on 2/3/25; LPN #5, hired on 4/18/25; LPN #7, hired on 9/4/21; and LPN #8, hired on 3/30/24. Per interview on 5/20/25 at approximately 5:35 PM, the Administrator was unable to provide evidence that the above staff completed their required abuse training and confirmed that the employee files reviewed contained the only documentation the facility has for staff training and competencies.	F 943	F 942 It is the policy of the facility to provide Resident Rights training. Employees identified as missing training are in the process of completing it. The facility is actively working with nursing staff to bring all education requirements up to date. Due to the essential care needs of residents, the facility is unable to implement a full suspension of all staff needing training but is enforcing completion as feasible therefore any employee who has not completed the required training between 5/28/2025 and 7/17/2025 will be removed immediately removed from the work schedule until all training is completed. Going forward: New employees may not start a position until education is complete. Any current employee needing an annual education will be notified that they must complete the trainings and will be scheduled to do so. Employees who do not complete their training in accordance with their annual performance evaluation will not receive a performance increase nor will the retro go retro once training is complete. Employees will receive 2 warnings prior to do date/ evaluation date 30 days prior and 10 days prior, any employee who does not have training completed on their performance evaluation due date will be removed from the schedule until training is complete.	
F 944 SS=F	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement.	F 944		

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F 944	Continued From page 105 A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure all staff have completed mandatory QAPI (quality assurance and performance improvement) training for 9 of 10 sampled staff. Findings include: Per review of employee Human Resources files for permanent and contracted direct care staff, in conjunction with review of the Education Tracking spreadsheet provided by the facility via email on 5/22/25, the facility did not have evidence for training on facility's QAPI program for LNA [Licensed Nursing Assistant] #1, hired on 5/6/25; LNA #2, hired on 9/13/24; LNA #3, hired on 6/26/24; LNA #4, hired on 5/22/23; LNA #5, hired on 8/17/24; LPN [Licensed Practical Nurse], #4 hired on 2/3/25; LPN #5, hired on 4/18/25; LPN #7, hired on 9/4/21; and LPN #8, hired on 3/30/24. Per interview on 5/20/25 at approximately 5:35 PM, the Administrator was unable to provide evidence that the above staff completed their required QAPI training and confirmed that the employee files reviewed contained the only documentation the facility has for staff training and competencies.	F 944	The facility continues to offer staff both an on-line training option and in-person, paper-based options. Staff are frequently reminded of the need to complete training through multiple communication channels to include postings, call em all text system and verbally. The facility has signed a contract and is waiting for an implementation date on a new training software health care academy. The facility is taking measures to validate staff are completing the required training by logging them on a spreadsheet. Once Health Care Academy is implemented training will be documented in the software. The human resources director is responsible for overseeing this process. The Human Resources director will update the Administrator of any refusals by staff to complete training. Audits for training completion will continue weekly for 4 weeks, then monthly X's 3 months Results of audits will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting. Trends or repeat issues will trigger additional interventions or training. Completion Date of plan, 6/7/25 **Tag F 942 POC accepted on 7/25/25 by P. Cota**	
F 945 SS=F	Infection Control Training CFR(s): 483.95(e) §483.95(e) Infection control. A facility must include as part of its infection	F 945		

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F 945	Continued From page 106 prevention and control program mandatory training that includes the written standards, policies, and procedures for the program as described at §483.80(a)(2). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure all staff completed mandatory training on infection control for 7 of 10 sampled staff. Findings include: Per review of employee Human Resources files for permanent and contracted direct care staff, in conjunction with review of the Education Tracking spreadsheet provided by the facility via email on 5/22/25, the facility did not have evidence for training in infection control for LNA [Licensed Nursing Assistant] #2, hired on 9/13/24; LNA #3, hired on 6/26/24; LNA #5, hired on 8/17/24; LPN [Licensed Practical Nurse] #4, hired on 2/3/25; LPN #5, hired on 4/18/25; LPN #7, hired on 9/4/21; and LPN #8, hired on 3/30/24. Per interview on 5/20/25 at approximately 5:35 PM, the Administrator was unable to provide evidence that the above staff completed their required infection control training and confirmed that the employee files reviewed contained the only documentation the facility has for staff training and competencies.	F 945	F 943 It is the policy of the facility to provide Abuse, Neglect, and Exploitation Training Employees identified as missing training are in the process of completing it. The facility is actively working with nursing staff to bring all education requirements up to date. Due to the essential care needs of residents, the facility is unable to implement a full suspension of all staff needing training but is enforcing completion as feasible therefore any employee who has not completed the required training between 5/28/2025 and 7/17/2025 will be removed immediately removed from the work schedule until all training is completed. Going forward: New employees may not start a position until education is complete. Any current employee needing an annual education will be notified that they must complete the trainings and will be scheduled to do so. Employees who do not complete their training in accordance with their annual performance evaluation will not receive a performance increase nor will the retro go retro once training is complete. Employees will receive 2 warnings prior to do date/ evaluation date 30 days prior and 10 days prior, any employee who does not have training	
F 946 SS=F	Compliance and Ethics Training CFR(s): 483.95(f)(1)(2) §483.95(f) Compliance and ethics. The operating organization for each facility must include as part of its compliance and ethics program, as set forth at §483.85-	F 946	completed on their performance evaluation due date will be removed from the schedule until training is complete.	

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F 946	Continued From page 107 §483.95(f)(1) An effective way to communicate the program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program. §483.95(f)(2) Annual training if the operating organization operates five or more facilities. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure all staff completed mandatory training on compliance and ethics for 8 of 10 sampled staff. Findings include: Per review of employee Human Resources files for permanent and contracted direct care staff, in conjunction with review of the Education Tracking spreadsheet provided by the facility via email on 5/22/25, the facility did not have evidence for training in compliance and ethics for LNA [Licensed Nursing Assistant] #1, hired on 5/6/25; LNA #2, hired on 9/13/24; LNA #3, hired on 6/26/24; LNA #5, hired on 8/17/24; LPN [Licensed Practical Nurse] #4, hired on 2/3/25; LPN #5, hired on 4/18/25; LPN #7, hired on 9/4/21; and LPN #8, hired on 3/30/24. Per interview on 5/20/25 at approximately 5:35 PM, the Administrator was unable to provide evidence that the above staff completed their required compliance and ethics training and confirmed that the employee files reviewed contained the only documentation the facility has for staff training and competencies.	F 946	The facility continues to offer staff both an on-line training option and in-person, paper-based options. Staff are frequently reminded of the need to complete training through multiple communication channels to include postings, call em all text system and verbally. The facility has signed a contract and is waiting for an implementation date on a new training software health care academy. The facility is taking measures to validate staff are completing the required training by logging them on a spreadsheet. Once Health Care Academy is implemented training will be documented in the software. The human resources director is responsible for overseeing this process. The Human Resources director will update the Administrator of any refusals by staff to complete training. Audits for training completion will continue weekly for 4 weeks, then monthly X's 3 months Results of audits will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting. Trends or repeat issues will trigger additional interventions or training. Completion Date of plan, 6/7/25 **Tag F 943 POC accepted on 7/25/25 by P. Cota**	
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4)	F 947		

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F 947	Continued From page 108 §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure all Licensed Nursing Assistants [LNA] had completed the mandatory 12 hours of annual training for 1 applicable LNA sampled. Findings include: Per review of the facility policy titled "Orientation Program for newly hired employees, Transfers and Volunteers" last reviewed on 1/15/25 states "The Orientation program is separate from the required state-approved Nurse Aide Training." Per review of employee Human Resources files for permanent and contracted staff, the facility had no evidence of the required 12 hours of annual training for LNA #4, hired on 5/22/23.	F 947	F 944 It is the policy of the facility to provide QAPI Training Employees identified as missing training are in the process of completing it. The facility is actively working with nursing staff to bring all education requirements up to date. Due to the essential care needs of residents, the facility is unable to implement a full suspension of all staff needing training but is enforcing completion as feasible therefore any employee who has not completed the required training between 5/28/2025 and 7/17/2025 will be removed immediately removed from the work schedule until all training is completed. Going forward: New employees may not start a position until education is complete. Any current employee needing an annual education will be notified that they must complete the trainings and will be scheduled to do so. Employees who do not complete their training in accordance with their annual performance evaluation will not receive a performance increase nor will the retro go retro once training is complete. Employees will receive 2 warnings prior to do date/ evaluation date 30 days prior and 10 days prior, any employee who does not have training completed on their performance evaluation due date will be removed from the schedule until training is complete.	

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F 947	Continued From page 109 Per interview on 5/20/25 at approximately 5:35 PM, the Administrator was unable to provide evidence that the above staff completed their required 12 hour annual training and confirmed that the employee files reviewed contained the only documentation the facility has for staff training and competencies.	F 947	The facility continues to offer staff both an on-line training option and in-person, paper-based options. Staff are frequently reminded of the need to complete training through multiple communication channels to include postings, call em all text system and verbally. The facility has signed a contract and is waiting for an implementation date on a new training software health care academy.	
F 949 SS=F	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.71. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide training on Behavioral Health for 10 of 10 sampled staff. Findings include: Per review of the Facility Assessment dated 2024-2025, Part 1 revealed that resident profile common diagnoses include: "Psychosis (Hallucinations, Delusions, etc.), Impaired Cognition, Mental Disorder, Depression, Schizophrenic Disorder, Behavior that Needs interventions, Alzheimer's Disease, Non-Alzheimer's Dementia." Per review of employee Human Resources files for permanent and contracted direct care staff, in conjunction with review of the Education Tracking spreadsheet provided by the facility via email on 5/22/25, the facility did not have evidence for training in behavioral health for Licensed Nursing Assistant [LNA] #1, hired on 5/6/25; LNA #2, hired on 9/13/24; LNA #3, hired on 6/26/24; LNA #4,	F 949	The facility is taking measures to validate staff are completing the required training by logging them on a spreadsheet. Once Health Care Academy is implemented training will be documented in the software. The human resources director is responsible for overseeing this process. The Human Resources director will update the Administrator of any refusals by staff to complete training. Audits for training completion will continue weekly for 4 weeks, then monthly X's 3 months Results of audits will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting. Trends or repeat issues will trigger additional interventions or training. Completion Date of plan, 6/7/25 **Tag F 944 POC accepted on 7/25/25 by P. Cota**	

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F 949	Continued From page 110 hired on 5/22/23; LNA #5, hired on 8/17/24; Licensed Practical Nurse [LPN] #4, hired on 2/3/25; LPN #5, hired on 4/18/25; LPN #6, hired on 9/18/24; LPN #7, hired on 9/4/21; and LPN #8 hired on 3/30/24. Per interview on 5/20/25 at approximately 5:35 PM, the Administrator was unable to provide evidence that the above staff completed their required behavioral health training and confirmed that the employee files reviewed contained the only documentation the facility has for staff training and competencies.	F 949		

GMNR POC F 945- F949

F 945

It is the policy of the facility to provide effective Infection Control Training.

Employees identified as missing training are in the process of completing it.

The facility is actively working with nursing staff to bring all education requirements up to date.

Due to the essential care needs of residents, the facility is unable to implement a full suspension of all staff needing training but is enforcing completion as feasible therefore any employee who has not completed the required training between 5/28/2025 and 7/17/2025 will be removed immediately removed from the work schedule until all training is completed.

Going forward:

New employees may not start a position until education is complete.

Any current employee needing an annual education will be notified that they must complete the training and will be scheduled to do so.

Employees who do not complete their training in accordance with their annual performance evaluation will not receive a performance increase nor will the retro go retro once training is complete.

Employees will receive 2 warnings prior to do date/ evaluation date 30 days prior and 10 days prior, and any employee who does not have training completed on their performance evaluation due date will be removed from the schedule until training is complete.

The facility continues to offer staff both an on-line training option and in-person, paper-based options. Staff are frequently reminded of the need to complete training through multiple communication channels to include postings, call em all text system and verbally.

The facility has signed a contract and is waiting for an implementation date on a new training software health care academy.

The facility is taking measures to validate staff are completing the required training by logging them on a spreadsheet. Once Health Care Academy is implemented training will be documented in the software.

The human resources director is responsible for overseeing this process.

The Human Resources director will update the Administrator of any refusals by staff to complete training.

Audits for training completion will continue weekly for 4 weeks, then monthly X's 3 months Results of audits will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting.

Trends or repeat issues will trigger additional interventions or training.

Completion Date of plan, 6/7/25

Tag F 945 POC accepted on 7/25/25 by
P. Cota

F 946

It is the policy of the facility to provide effective Compliance and Ethics Training.

GMNR POC F 945- F949

Employees identified as missing training are in the process of completing it.

The facility is actively working with nursing staff to bring all education requirements up to date.

Due to the essential care needs of residents, the facility is unable to implement a full suspension of all staff needing training but is enforcing completion as feasible therefore any employee who has not completed the required training between 5/28/2025 and 7/17/2025 will be removed immediately removed from the work schedule until all training is completed.

Going forward:

New employees may not start a position until education is complete.

Any current employee needing an annual education will be notified that they must complete the training and will be scheduled to do so.

Employees who do not complete their training in accordance with their annual performance evaluation will not receive a performance increase nor will the retro go retro once training is complete.

Employees will receive 2 warnings prior to do date/ evaluation date 30 days prior and 10 days prior, and any employee who does not have training completed on their performance evaluation due date will be removed from the schedule until training is complete.

The facility continues to offer staff both an on-line training option and in-based paper-based options. Staff are frequently reminded of the need to complete training through multiple communication channels to include postings, call em all text system and verbally.

The facility has signed a contract and is waiting for an implementation date on a new training software health care academy.

The facility is taking measures to validate staff are completing the required training by logging them on a spreadsheet. Once Health Care Academy is implemented training will be documented in the software.

The human resources director is responsible for overseeing this process.

The Human Resources director will update the Administrator of any refusals by staff to complete training.

Audits for training completion will continue weekly for 4 weeks, then monthly X's 3 months Results of audits will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting.

Trends or repeat issues will trigger additional interventions or training.

Completion Date of plan, 6/7/25

Tag F 946 POC accepted on 7/25/25 by
P. Cota
F 947

It is the policy of the facility to provide Required In-Service Training for Nurse Aides

Employees identified as missing training are in the process of completing it.

The facility is actively working with nursing staff to bring all education requirements up to date.

GMNR POC F 945- F949

Due to the essential care needs of residents, the facility is unable to implement a full suspension of all staff needing training but is enforcing completion as feasible therefore any employee who has not completed the required training between 5/28/2025 and 7/17/2025 will be removed immediately removed from the work schedule until all training is completed.

Going forward:

New employees may not start a position until education is complete.

Any current employee needing an annual education will be notified that they must complete the training and will be scheduled to do so.

Employees who do not complete their training in accordance with their annual performance evaluation will not receive a performance increase nor will the retro go retro once training is complete.

Employees will receive 2 warnings prior to do date/ evaluation date 30 days prior and 10 days prior, and any employee who does not have training completed on their performance evaluation due date will be removed from the schedule until training is complete.

The facility continues to offer staff both an on-line training option and in-person, paper-based options. Staff are frequently reminded of the need to complete training through multiple communication channels to include postings, call em all text system and verbally.

The facility has signed a contract and is waiting for an implementation date on a new training software health care academy.

The facility is taking measures to validate staff are completing the required training by logging them on a spreadsheet. Once Health Care Academy is implemented training will be documented in the software.

The human resources director is responsible for overseeing this process.

The Human Resources director will update the Administrator of any refusals by staff to complete training.

Audits for training completion will continue weekly for 4 weeks, then monthly X's 3 months Results of audits will be reviewed monthly during the Quality Assurance and Performance Improvement (QAPI) meeting.

Trends or repeat issues will trigger additional interventions or training.

Completion Date of plan, 6/7/25

Tag F 947 POC accepted on 7/25/25 by P. Cota

GMNR POC F 945- F949

F 949

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Completion Date of plan, 6/7/25

Tag F 949 POC accepted on 7/25/25 by P. Cota