STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475029	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center for Living & Rehabilitation	160 Hospital Drive Bennington, VT 05201

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 46135 Based on observation, interview, and record review, the facility failed to notify the resident's physician of significant weight loss for 1 of 29 sampled residents (Resident #100). Findings include: Record reveals that Resident #100 has diagnoses that include Alzheimer's disease, hypothyroidism, and dementia. Resident #100's nutrition care plan states that s/he remain at risk for malnutrition in view of need for nutrition supplementation, created on 7/29/23 and has the following goal, My weight will be stable within 125-135 lbs, revised on 12/8/23. Interventions include, Monitor my weights and labs as available, created on 7/29/23, and Notify my MD of any significant weight changes PRN [as needed], created on 7/29/2023. Resident #100's care plan includes interventions for monitoring, documenting, and reporting weight changes in relation to hydration status and thyroid medications. Record review shows that Resident #100 weighed 126.4 pounds on 2/5/2024. The next weight documented for Resident #100 was 105.8 pounds on 3/8/2024. This weight loss of 20.6 pounds, over approximately one month, indicates that s/he lost 16.3% of their body weight, making it a significant weight loss. There is no evidence that Resident #100's physician was notified about this significant weight loss. Per Facility policy titled Weight Assessment Monitoring, last modified on 3/11/2022, licensed nursing staff should report weight loss to the physician. Per interview on 3/20/24 at 2:47 PM, Resident #100's Physician confirmed that s/he has not been made aware of Resident #100's significant weight loss. Per interview on 3/20/24 at 3:54, the Unit Manager confirmed that nursing should have contacted the Physician about Resident #100's weight loss.

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 46135 Based on interview, record review, and policy review, the facility failed to implement policies for screening employees by not completing the required criminal background checks for 4 out of 5 sampled staff. Findings include: Facility policy titled Background Checks, Arrests, and Conviction Notification, last revised on 3/4/2024, indicates that the facility will conduct criminal background checks for all current employees at least annually. Per review of employee human resource files, 4 of 5 sampled direct care staff who have worked at the facility for over a year do not have annual federal background checks completed. Per interview on 3/20/24 at 11:45 AM, the Human Resource Staff explained that there is no system in place for obtaining annual national background checks for staff that have been here over a year but has worked with the Administrator to implement completing annual background checks in starting in June.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44192 Based on observation, interview, and record review the facility failed to ensure that staff implemented a resident's individualized comprehensive care plan related to fall prevention for 1 of 29 residents in the sample (Resident #266). Findings include: Per observation on 3/18/24 at approximately 3:00 PM, Resident #266 had multiple bruises on their face in varying degrees of healing. Per record review, Resident #266 was admitted to the facility on [DATE] after sustaining a significant fall at their Senior Living facility. Resident #266 sustained a fall on 3/12/24 in their bedroom and a second fall on 3/17/24 in the nurse's station after breakfast. Per Resident #266's care plan, it included a focus for [Resident #266] has had an actual fall with minor injury, to [their] face with bruising prior to admission. An intervention was placed on the care plan on 3/19/24 after the second fall in the facility, which states lay resident down after meals. Per observation on 3/20/24 at 12:15 PM, Resident #266 was being fed lunch by staff. At 1:00 PM, Resident #266 was observed sitting outside of the nurse's station in their wheelchair, nodding off to sleep with eyes closed and head hanging downward. Resident #266's assigned Nurse and two LNAs (licensed nursing assistants) were observed walking by Resident #266 multiple times and verbally checking in with Resident #266 between 1:00 PM and 1:15 PM. At 1:15 PM, this surveyor asked Resident #266 if they were tired, and they replied yes. At 1:18 PM, Resident #266 attempted to stand up out of their wheelchair and walk away. An LNA and Resident #266's assigned nurse came over and encouraged Resident #266 to sit back down. At this time, the nurse and the LNA were asked if Resident #266 should be in bed, as they appear tired. The LNA stated that Resident #266 sometimes gets laid down after meals but not all the time. Both the LNA and the Nurse confirmed that they were not aware that Resident #266's care plan includes that they be laid down in bed after meals. Resident #266 continued to stay up out of bed after this interaction and was given coloring materials.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29776 Based upon interview and record review, the facility failed to review and revise Care Plans regarding prevention of future falls for 1 of 29 residents sampled (Res.#62). The facility also failed to ensure that the Resident's comprehensive care plan was reviewed and revised by the interdisciplinary team for one of 79 sampled residents (Resident #79). Findings include: 1.) Per review of Res.#62's medical record, the resident was admitted to the facility with diagnoses that include Parkinsonism, dementia, muscle weakness and a history of falling. Review of the facility's 'Fall Prevention and Protocol' policy [last modified 3/11/22] reads Every resident admitted to [the facility] will have the Fall Risk Evaluation done for the first 24 hours of admission or readmission . and after each fall. Upon admission, Res. #62 scored a '21', with the facility policy listing If the score is 10 or greater, the resident/patient is considered to be at HIGH risk for falls and should be evaluated by the interdisciplinary care team for identification and implementation of individualized fall prevention interventions. Review of Res.#62's medical record reveals the resident fell on : 1/5/24, 1/11/24, 1/14/24, 1/24/24, 2/19/24, 3/4/24, and 3/9/24. Nursing description of Res.#62's falls include Resident found face down on floor diagonal to bed with face toward bed and feet toward the door, found to be on the floor in the doorway . feet were sticking partially out into the hallway, sitting next to the bed on the right side and hanging onto the 1/4 side rail. Results of the resident's falls included complained of pain to right side of face near eye, bright red drainage from left Nare and from abrasion to right posterior wrist, Skin tear to right hand and right knee, and knee was sore; exposed knee to find previous skin tear had abraded [a skin injury caused by rubbing or scraping against a rough surface] with this fall. Per the interview on 3/20/24, the DON stated that after each resident fall the resident's Care Plan is reviewed and revised to include new interventions to prevent future falls. Review of the facility's 'Fall Prevention and Protocol' includes 'Care Planning', which notes ensure that all interventions related to prevention of falls remains appropriate. Review of Nursing Progress Notes dated 1/5/24, 2 days after the resident's admission, record This unit manager was notified by staff that resident had an unwitnessed fall in [h/her] room. Review of Res.#62's Care Plan reveals no new interventions added to the Care Plan after the resident's first fall on 1/5/24, with the resident then falling again 6 days later, on 1/11/24. Review of Physician Notes for Res.#62 reveal on 1/11/24, the Physician reported I saw [Res.#62] at CLR [Center for Living and Rehab] today, one week after [his/her] initial admission for long-term placement due to gait instability with multiple falls in the setting of Parkinson's disease and dementia. In fact, I was called to see [h/her] urgently because they fell . It looks like [s/he] scraped [his/her] hand on the grip strips on the floor next to [his/her] bed (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Res.#62's Care Plan reveals no new interventions added after the fall on 1/11/24 to prevent future falls. 3 days later, the resident suffered another fall on 1/14/24. Per review of Physician notes dated 1/11/24, grip strips were already in place on the floor next to [his/her] bed prior to the fall on 1/11/24. Nursing Notes from the fall on 1/14 record there was a couple of grip strips in front of [h/her] recliner chair. After falls on 1/11/24 and 1/14/24, the Care Plan lists as a 'new' intervention grip strips to the left side and right side of bed, dated 1/15/24. After grip strips failed to prevent falls on 1/11/24 and 1/14/24, 'new' interventions added after falls on 1/24/24 and 3/4/24 included more grip strips, in front of the closet and in front of bedside stand: both of which were followed by other falls. Further review of Res.#62's fall Care Plan reveals the intervention PT [Physical Therapy] to evaluate and treat as ordered or PRN [as needed]. The intervention first appears in the Care Plan on 1/3/24 upon admission, then is repeated and marked as 'initiated' and 'created' on 1/4/24. After falls on 1/5, 1/11, & 1/14/24, the identical wording of the intervention is repeated and marked as a 'revision' to the Care Plan and dated 1/18/24. Per interview with the Director of Nursing [DON] on 3/20/24 at 10:47 AM, the DON confirmed that the facility failed to evaluate the effectiveness of fall prevention interventions regarding the grip strips and failed to revise the Care Plan after each fall with new interventions in order to prevent future falls, some of which resulted in injury. 40258 2. Per record review Resident #79 was admitted to the facility on [DATE]. Review of progress notes and care plan sign in sheets indicate that the interdisciplinary team (IDT) met to review and revise Resident #79's care plan on the following dates: 3/12/2023, 7/13/2023, and 1/4/2024. There is no documented evidence that the IDT met to review and revise Resident #79's care plan in October of 2023 between the 7/13/23 and 1/4/2024 review. Per interview with the Long Term Care Manager on 3/20/2024 at 5:13 PM there were no progress notes or care plan meeting sign in sheets in Resident #79's medical record that indicate that the IDT held a quarterly care plan meeting, or reviewed and revised Resident #79's care plan in October of 2023 as required. The Long Term Care Manager confirmed that there should be evidence that Resident #79's care plan was reviewed and revised as indicated by the IDT in October of 2023.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 46135 Based on resident/representative interview, staff interview, and record review, the facility failed to ensure that a resident who is unable to carry out activities of daily living without assistance receives the proper level of assistance for one of 29 sampled residents (Resident #100). Findings include: Per record review, Resident #100's care plan states that s/he has potential for impairment to skin integrity [related to] dementia, incontinence, with the intervention to Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short, created on 10/20/23. Per observation on 3/18/24 at 3:44 PM, Resident #100 is in bed, wearing just a brief on his/her lower body. His/her nails are very long nails and appear to have a dark brown substance underneath most of the nails. S/He is tugging at his/her brief and groin area. Per observation and interview on 3/20/24 at 1:40 PM, a Licensed Nursing Assistant (LNA) confirmed that Resident #100's nails were very long and dirty and explained that they should be shorter because s/he scratches himself/herself. S/he stated s/he does not cut his/her nails because s/he thinks that the Nurse Practitioner cuts them. While the surveyor and the LNA were looking at Resident #100's fingernails, Resident #100 stated that s/he doesn't like scratching but s/he does. Per observation and interview on 3/20/24 at approximately 3:45 PM, the Unit Manager explained that the nursing staff are able to cut Resident #100's nails and confirmed that Resident #100's nails were very long and should have been cut.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135 Based on interview and record review, the facility failed to assist residents in making audiology appointments for 1 of 29 sampled residents (Resident #71). Findings include: Record reveals that Resident #71 was admitted to the facility on [DATE]. Per his/her care plan, initiated on 9/2/2021, Resident #71 has a communication problem related to a hearing deficit. Per interview on 3/18/2024 at 1:32 PM, Resident #71 requested that this surveyor speak loudly because they are hard of hearing and needs hearing aids. Resident #71 explained that s/he was frustrated because s/he has been trying to get new hearing aids for a while. S/He had an audiology appointment on Friday that was canceled by the provider and s/he hasn't heard any follow up on when it is rescheduled for. Record review reveals a care plan meeting note dated 1/31/2024 indicating that Resident #71 needs an appointment to get new hearing aids. A 3/15/24 progress note confirms that Resident #71 did have an appointment with audiology early that morning but did miss his/her appointment due to transportation reasons. The note indicates that the facility will reschedule. Per interview on 3/20/2024 at 4:18 PM, the Scheduler explained that s/he would be responsible for rescheduling the audiology appointment and confirmed that it has not been rescheduled. Per interview on 3/20/24 at approximately 4:30 PM, the Director of Nursing stated that it would be the expectation that if a resident missed an appointment, it should be rescheduled as soon as possible, and indicated that Resident #71's audiology appointment should have been rescheduled already.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29776 Based upon interview and record review, the facility failed to ensure an environment free of Accident hazards regarding implementing interventions to reduce hazards and risks and monitoring for effectiveness related to falls for Res.#62, and regarding falls with a possible brain bleed for Res.#266, 2 of of 29 sampled residents. Findings include: 1.) Per review of Res.#62's medical record, the resident was admitted to the facility with diagnoses that include Parkinsonism, dementia, muscle weakness and a history of falling. Review of the facility's 'Fall Prevention and Protocol' policy [last modified 3/11/22] reads Every resident admitted to [the facility] will have the Fall Risk Evaluation done for the first 24 hours of admission or readmission . and after each fall. Upon admission, Res. #62 scored a '21', with the facility policy listing If the score is 10 or greater, the resident/patient is considered to be at HIGH risk for falls and should be evaluated by the interdisciplinary care team for identification and implementation of individualized fall prevention interventions. Review of Res.#62's medical record reveals the resident fell on : 1/5/24, 1/11/24, 1/14/24, 1/24/24, 2/19/24, 3/4/24 and 3/9/24. Review of Fall Risk Evaluations for Res.#62 demonstrated that after scoring '21' on admission [>10 = HIGH risk], before their first fall in the facility on 1/5/24, Res.#62 was re-evaluated by the facility as only a moderate risk for falls, scoring a '9' after their 7th fall [on 3/9/24] in 3 months. Per interview with the Director of Nursing [DON] on 3/20/24 at 10:47 AM, the DON confirmed that the Fall Risk Evaluations for Res.#62, part of the facility's Fall Prevention and Protocol, were inaccurate and reported facility staff did not have consistent documentation when it came to assessing risks. The DON also confirmed that implementing Fall Risk Evaluations after each fall was part of the facility's program to prevent future falls, and the facility failed to conduct Fall Risk Evaluations after falls on 1/14/24 and 2/19/24. During the interview on 3/20/24, the DON reported that falls were identified as incidents, and an incident reporting and tracking system was used to develop fall prevention measures for individuals and the facility overall. Per record review and confirmed by the DON, 2 of Res.#62's 7 falls [1/5/24 & 3/4/24] were not listed as incidents, with no incident report filed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing description of Res.#62's falls include Resident found face down on floor diagonal to bed with face toward bed and feet toward the door, found to be on the floor in the doorway . feet were sticking partially out into the hallway, sitting next to the bed on the right side and hanging onto the 1/4 side rail. Results of the resident's falls included complained of pain to right side of face near eye, bright red drainage from left Nare and from abrasion to right posterior wrist, Skin tear to right hand and right knee, and knee was sore; exposed knee to find previous skin tear had abraded [a skin injury caused by rubbing or scraping against a rough surface] with this fall. Per the interview on 3/20/24, the DON stated that after each resident fall the resident's Care Plan is reviewed and revised to include new interventions to prevent future falls. Review of the facility's 'Fall Prevention and Protocol' includes 'Care Planning', which notes ensure that all interventions related to prevention of falls remains appropriate. Review of Nursing Progress Notes dated 1/5/24, 2 days after the resident's admission, record This unit manager was notified by staff that resident had an unwitnessed fall in [h/her] room. Review of Res.#62's Care Plan reveals no new interventions added to the Care Plan after the resident's first fall on 1/5/24, with the resident then falling again 6 days later, on 1/11/24. Review of Physician Notes for Res.#62 reveal on 1/11/24, the Physician reported I saw [Res.#62] at CLR today, one week after [his/her] initial admission for long-term placement due to gait instability with multiple falls in the setting of Parkinson's disease and dementia. In fact, I was called to see [h/her] urgently because they fell . It looks like he scraped [his/her] hand on the grip strips on the floor next to [his/her] bed. Review of Res.#62's Care Plan reveals no new interventions added after the fall on 1/11/24 to prevent falls. 3 days later, the resident suffered another fall on 1/14/24. Per review of Physician notes dated 1/11/24, grip strips were already in place on the floor next to [his/her] bed prior to the fall on 1/11/24. Nursing Notes from the fall on 1/14 record there was a couple of grip strips in front of [h/her] recliner chair. After falls on 1/11/24 and 1/14/24, the Care Plan lists as a 'new' intervention grip strips to the left side and right side of bed, dated 1/15/24. After grip strips failed to prevent falls on 1/11/24 and 1/14/24, 'new' interventions added after falls on 1/24/24 and 3/4/24 included more grip strips, in front of the closet and in front of bedside stand: both of which were followed by other falls. Further review of Res.#62's fall Care Plan reveals the intervention PT [Physical Therapy] to evaluate and treat as ordered or PRN [as needed]. The intervention first appears in the Care Plan on 1/3/24 upon admission, then is repeated and marked as 'initiated' and 'created' on 1/4/24. After falls on 1/5, 1/11, & 1/14/24, the identical wording of the intervention is repeated and marked as a 'revision' to the Care Plan and dated 1/18/24. Per interview with the Director of Nursing [DON] on 3/20/24 at 10:47 AM, the DON confirmed that the facility failed to address accident hazards by failing to evaluate the effectiveness of the interventions regarding the grip strips and failed to attempt new interventions after each fall with in order to prevent future falls, some of which resulted in injury. 44192 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Per observation on 3/18/24 at approximately 3:00 PM, Resident #266 had multiple bruises on their face in varying degrees of healing. Per record review, Resident #266 was admitted to the facility on [DATE] after sustaining a significant fall at their Senior Living facility. Resident #266 sustained a fall on 3/12/24. As a result, the plan of care was updated to toilet Resident #266 every 2-3 hours. Resident #266 sustained a second fall on 3/17/24 in the nurse's station after breakfast. As a result of this fall, the plan of care was updated to lay Resident #266 down for a nap after meals. This intervention was added to the care plan on 3/19/24. Per observation on 3/20/24 at 12:15 PM, Resident #266 was being fed lunch by staff. At 1:00 PM, Resident #266 was observed sitting outside of the nurses station in their wheelchair, nodding off to sleep with eyes closed and head hanging downward. Resident #266's assigned Nurse and two LNAs (licensed nursing assistants) were observed walking by Resident #266 multiple times and verbally checking in with Resident #266 between 1:00 PM and 1:15 PM. At 1:15 PM, this surveyor asked Resident #266 if they were tired, and they replied yes. At 1:18 PM, Resident #266 attempted to stand up out of their wheelchair and walk away. Resident #266 still had eyes half closed and their head down as if they were very sleepy. An LNA and Resident #266's assigned nurse came over and encouraged Resident #266 to sit back down. They did not attempt to determine Resident #266's reason for wanting to stand up unassisted. After this observation, the nurse and the LNA were asked if Resident #266 should be in bed, as they appear tired. The LNA stated that Resident #266 sometimes gets laid down after meals but not all the time. Both the LNA and the Nurse confirmed that they were not aware that Resident #266's care plan includes that they be laid down in bed after meals. Resident #266 continued to stay up out of bed after this interaction and was given coloring materials. The Nurse and LNA were not observed to move Resident #266.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135 Based on interview and record review, the facility failed to ensure that residents maintain acceptable parameters of nutritional status as evidenced by the facility failing to obtain weights as care planned and identify weight loss for 1 of 29 sampled residents (Resident #100). Findings include: Facility policy titled Weight Assessment Monitoring, last modified on 3/11/2022 states, Nursing staff weighs resident/patient per nursing protocol weekly, or as ordered for the first 4 weeks after admission. If resident/patient is identified to be at risk for weight loss/gain, weights may be continued weekly and reviewed by Interdisciplinary Care Team for appropriate intervention. 1. Record reveals that Resident #100 was admitted to the facility on [DATE] and has diagnoses that include Alzheimer's disease, hypothyroidism, and dementia. Resident #100's nutrition care plan states that s/he remain at risk for malnutrition in view of need for nutrition supplementation, created on 7/29/23 and has the following goal, My weight will be stable within 125-135 lbs [pounds], revised on 12/8/23. Interventions include, Monitor my weights and labs as available, created on 7/29/23, and Notify my MD of any significant weight changes PRN [as needed], created on 7/29/2023. Resident #100's care plan includes interventions for monitoring, documenting, and reporting weight changes in relation to hydration status and thyroid medications. Record review reveals that Resident #100 was weighed on 1/1/2024, 2/3/2024, 2/5/2024, 3/8/2024, 3/11/2024, and 3/18/2024. There is no evidence in Resident #100's record that s/he had weekly weights taken between 1/1/24 through 2/3/204 and 2/5/2024 through 3/8/2023. Per Resident #100's documented weights, s/he weighed 126.4 pounds on 2/5/2024 and 105.8 pounds on 3/8/2024, five weeks after his/her last weight. This weight loss of 20.6 pounds indicates that s/he lost 16.3% of their body weight, making it a significant weight loss. Per interview on 3/20/24 at 3:54 PM, the Unit Manager confirmed that Resident #100 should have been weighed weekly and was not.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 46135 Based on observation, interview, and record review, the facility failed to create an individualized person-centered plan to render trauma informed care to a resident with a personal history of trauma for 1 of 29 residents (Resident #30). Findings include: Per observation on 3/18/2024 at 4:18 PM, Resident #30 was seen lying in his/her bed, awake, with the covers pulled to his/her chin. S/He was crying in his/her bed; when asked if s/he was okay, Resident #30 appeared afraid and was weeping while s/he tried to explain concerns s/he had about his/her mother and father and their skin. S/He repeated incoherent phrases about the skin of her father and the skin of her mother and how s/he needed to get it to them and they would not be happy. When asked if s/he would be eating dinner in the dining room, s/he explained that s/he would very much like to go into the dining room. His/her voice was shaky when speaking and continued to weep while she spoke. Per observation on 3/19/2024 at 2:25 PM, Resident #30 was in bed crying. On approach, s/he appeared distressed and was sobbing about his/her father and his skin. S/He was alone in his/her room. Per interview on 3/19/2024 at 3:34 PM, the Unit Manager (UM) and this surveyor observed Resident #30 in his/her bed crying about his/her father, his skin, and taking the skin to give to his/her mother. The Unit Manger explained that Resident #30 does have a history of trauma but is unsure about the specifics. The UM explained that the observed behavior for Resident #30 is typical. Record review reveals a behavioral health note dated 3/12/2024 states that Resident #30 screened positive for trauma. Resident #30 does have care plan interventions that address behavior but does not have a care plan focus, goals, or interventions that focus on his/her trauma or identifying, mitigating, or eliminating his/her triggers. Facility policy titled Trauma Informed Care, last modified on 3/4/2024, states Social Service personnel, in coordination with the interdisciplinary team, will work to develop a plan of care aimed at mitigating/ eliminating triggers. Resident specific interventions for a resident will be placed in the care plan upon admission and assessment. Care plans and interventions will be reviewed quarterly and more often as necessary. Per interview on 3/20/24 at 2:47 PM, Resident #30's Physician stated that the team, including the family, are not completely sure about the specifics of Resident #30's past trauma and the team has been talking about it for a while. The Physician explained that being alone was a trigger identified for Resident #30. S/He indicated that there used to be interventions in his/her care plan related to trauma informed care plan but they might have been accidentally removed due to other care areas becoming resolved. S/He confirmed that s/he should have interventions in her care plan about his/her trauma and identified triggers.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135 Based on interview and record review, the facility failed to ensure that residents who use psychotropic drugs receive gradual dose reductions (GDR), unless clinically contraindicated, in an effort to discontinue the drugs for 1 of 5 sampled residents (Resident #13); failed to ensure that there was a specific diagnosis/condition documented in the medical record for psychotropic medications for 1 of 5 sampled residents (Resident #100); and failed to ensure that residents who use psychotropic drugs are accurately monitored for behaviors and medication side effects (Residents # 13, #100, and #30). Findings include: Facility policy titled, Psychotropic Medication Use, last modified on 10/2/2022, states, Psychotropic medications should only be given when necessary to treat a specific diagnoses and documented condition. GDR will be attempted using the following guidelines and limits (unless clinically contraindicated): 1. For all psychotropic medications: within the first year following admission or initiation of medication; attempt taper in 2 separate quarters with at least one month between attempts, Reevaluation should occur at least annually. 1. Record reveals that Resident #13 was admitted to the facility on [DATE] and has diagnoses that include major depressive disorder, schizophrenia, and drug induced subacute dyskinesia (movement disorder). Resident #13 has physician orders for Escitalopram Oxalate [psychotropic; antidepressant] Tablet 20 MG Give 30 mg by mouth in the morning for Depression, with a start date of 05/05/2022, fluphenazine Decanoate [antipsychotic] Solution Inject 50 mg intramuscularly at bedtime every 14 day(s) for schizophrenia, with a start date of 10/03/2022, fluPHENAZine HCl [antipsychotic] Tablet 10 MG Give 1 tablet by mouth at bedtime for schizophrenia, with a start date of 10/27/2021, fluPHENAZine HCl Tablet 10 MG Give 1 tablet by mouth in the afternoon for schizophrenia, with a start date of 10/27/2021, fluPHENAZine HCl Tablet 10 MG Give 1 tablet by mouth in the morning for schizophrenia, with a start date of 10/28/2021, and OLANZapine [antipsychotic] Tablet 2.5 MG Give 1 tablet by mouth at bedtime related to UNDIFFERENTIATED SCHIZOPHRENIA, with a start date of 7/11/2023. a.) Review of Resident #13's pharmacist medication regimen review for the past year show that no recommendations were made by the pharmacist, including recommendations for a GDR. There is no evidence that a GDR was attempted in the past year in the medical record for any of the above medications, as required per regulations and facility policy. Per interview on 3/20/24 at 2:47 PM, Resident #13's Physician confirmed that there should have been a GDR attempt made in the past year and was not. b.) Per observation on 3/18/24 at 4:47 PM, Resident #13 was sitting in was wheelchair in the dining room. S/He was fidgeting, had repetitive right foot movements, tongue rolling, and a tremor in his/her left hand. Resident #13 was observed again during breakfast and lunch on 3/19/2024 and 3/20/2024 with similar tremors and repetitive movements. After breakfast on 3/20/2024 at approximately 9:30 AM, the Unit Manager was bringing Resident #13 from the dining room to the bathroom and explained that Resident #13 was feeling anxious. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per interview on 3/19/2024 at 8:52 AM, Resident #13's Representative explained that s/he visits Resident #13 frequently and has observed Resident #13's tremors are happening regularly and have been getting worse. Record reveals that Resident #13 has the following care plan focuses and interventions related psychotropic medications: [Resident #13] is at risk for a mood problem r/t [related to] Disease Process secondary to Schizophrenia and depression, revised on 2/27/2024 with an intervention to, Administer medications as ordered. Monitor/document for side effects and effectiveness, created 8/15/2018. [Resident #13] has an alteration in neurological status (movement disorder/chronic tremors) r/t chronic use of psychoactive medications and PTSD [post-traumatic stress disorder]. Tremors worsen when [s/he] feels that others are watching [him/her], revised on 2/27/2024 with an intervention to Give medications as ordered. Monitor/document for side effects and effectiveness, created 3/3/2022. [Resident #13] uses antidepressant and psychotropic medications r/t behavior management, depression, and schizophrenia, revised on 6/29/2020 with an intervention to, Monitor/record occurrence of behavior symptoms and document per facility protocol, revised on 6/15/2023. Per review of progress notes from January 1, 2024, through March 20, 2024, staff documented about potential side effects from medications 3 times (twice possible medication side effects, once that s/he had no medication side effects) and documented about behaviors 1 time (that s/he did not have behaviors). This does not reflect the observations or interviews made during the recertification survey about Resident #13's behaviors or medication side effects. 2. Record reveals that Resident #100 was admitted to the facility on [DATE] and has diagnoses that include Alzheimer's disease and dementia. Resident #100 has a physician order for Risperidone 0.25 MG Give 1 tablet by mouth in the morning for psychosis history, with a start date of 10/20/2023. a.) A pharmacist medication regimen review dated 10/16/2023 states that Resident #100 is Recently admitted on Risperidone with no clear diagnosis to support current use. Please consider obtaining a psychological workup along with performing a medical workup as soon as possible to assess for underlying causes of behaviors, Should the workups and nursing behavioral monitoring reveal no significant behaviors or identification of a chronic psychiatric condition, please consider implementing a tapering schedule and/or discontinue Risperidone. A box next to this recommendation is checked Disagree, and a handwritten response states psychosis history. A pharmacist medication regimen review dated 1/7/2024 states that Resident #100 is Currently receiving allow dose of Risperidone (Risperdal) for a diagnosis other than an approved chronic psychiatric condition. Please evaluate continued need and efficiency. Consider discontinue, if appropriate. A box next to this recommendation is checked Agree, will do, and a handwritten response states diagnosis psychosis. No changes were made to Resident #100's diagnoses or changes to the physician order for Risperidone after either of the medication evaluations above. As of 3/20/24, Resident #100 did not have a documented diagnosis that Risperidone would be necessary to treat. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per interview on 3/20/2024 at approximately 4:30 PM, the Director of Nursing confirmed that there was no evidence that the physician followed the recommendations in the medication regime reviews listed above. b.) Per observation and interview on 3/18/24 at 3:44 PM, Resident #100 is in bed. S/He is talking about people that are not in the room and is describing things hanging from the ceiling by the door that do not exist. Shortly after, at 4:24 PM, Resident #100 is seen in his/her wheelchair in the common area. S/He is swearing at the surveyors and appears to be significantly agitated. Record reveals that Resident #100 has the following care plan focuses and interventions related psychotropic medications: [Resident #100] uses psychotropic medications r/t disease process secondary to delusional disorder, dementia and CVA [stroke]. Noted to sundown and have hallucinations at times, revised on 10/23/2023, with interventions that include, Monitor/document/report PRN [as needed] any adverse reactions of PSYCHOTROPIC medications, created on 7/28/2023, and Monitor/record occurrence of for target behavior symptoms, revised on 9/11/2023. [Resident #100] is at risk for depression, revised on 10/20/2023, with interventions that include, Monitor/document/report PRN any s/sx [signs/symtoms] of depression, created on 8/16/2023. Per review of progress notes from January 1, 2024, through March 20, 2024, staff documented about potential side effects from medications 1 time (once that s/he had possible medication side effects) and documented about behaviors 15 times (that s/he did not have behaviors). This does not reflect the observations or interviews made during the recertification survey about Resident #100's behaviors. 3. Record reveals that Resident #30 was admitted to the facility on [DATE] and has diagnoses that include dementia, anxiety, and major depressive disorder. S/He has a physician order for Mirtazapine (psychotropic, antidepressant) 22.5 mg once daily at bedtime for depression. Per observation on 3/18/2024 at 4:18 PM, Resident #30 was seen lying in his/her bed, awake, with the covers pulled to his/her chin. S/He was crying in his/her bed; when asked if s/he was okay, Resident #30 appeared afraid and was weeping while s/he tried to explain concerns s/he had about his/her mother and father and their skin. S/He repeated incoherent phrases about the skin of her father and the skin of her mother and how s/he needed to get it to them and they would not be happy. Per observation on 3/19/2024 at 2:25 PM, Resident #30 was in bed crying. On approach, s/he appeared distressed and was sobbing about his/her father and his skin. Per interview on 3/19/2024 at 3:34 PM, the Unit Manager (UM) and this surveyor observed Resident #30 in his/her bed crying about his/her father, his skin, and taking the skin to give to his/her mother. The UM explained that the observed behavior for Resident #30 is typical. Per review of progress notes from January 1, 2024, through March 20, 2024, staff documented potential side effects from medications 0 times and documented behaviors 4 times (once that s/he did not have behaviors, and three times that she did). This does not reflect the observations or interviews made during the recertification survey about Resident #30's behaviors. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per interview on 3/20/24 at 2:14 PM, the Unit Manager demonstrated how nursing staff do not have a place to document what medication side effects or behaviors a resident might be having in the medication administration record or treatment administration record, and explained that nursing staff should be putting in a progress note every time a resident has a behavior or a possible medication side effect. She explained that documenting behaviors used to be easier because there was a form in the electronic medical record that would give structure to documenting behaviors. The Unit Manager reviewed Resident #13, #100, and #30's progress notes and confirmed that behaviors were not accurately documented for all three and medication side effects were not accurately documented for Resident #30. (We start talking about 2 more residents here with no information about those - this may need to be copied to the end?) Per phone interview on 3/26/2024 at 11:30 AM, the Administrator and the Director of Nursing confirmed that they were unable to provide any additional evidence to show that staff were documenting medication side effects or behaviors for Residents #30, #13, and #100.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 44192 Based on staff interview and record review, the facility failed to ensure that residents are free from significant medication errors for one of 29 sampled residents (Resident #266) as evidenced by administration of an anticoagulant for a resident with a brain bleed. Findings include: Per resident #266's record, Resident #266 sustained a fall on 3/12/24 at approximately 5:40 PM. The fall was unwitnessed, and Resident #266 was sent to the emergency room for evaluation. Per a nursing progress note from 3/13/24 at 7:32 AM, the emergency room nurse called to report that the Resident has a brain bleed that was 3mm in diameter, and that they were unable to determine if it was a result of the fall or not. Per a documented secure conversation note on 3/13/24 at 11:52 AM, Resident #266's physician sent a message at 7:14 AM stating [Resident #266] has a small intracranial hemorrhage (brain bleed), stable on second CT (cat scan) 6 hours later. We'll be holding anticoagulation . In the same documented secure conversation note there is an additional message from the facility NP sent at 11:52 AM that states, unfortunately it looks like [Resident #266] did receive [their] apixaban (an anticoagulant medication that makes bleeding easier) dose this morning. I have placed it on hold moving forward. Per Resident #266's orders, the anticoagulant medication apixaban 5 mg - give 1 tablet by mouth every morning and at bedtime was ordered on 3/11/24 and was not placed on hold until 3/13/24 at 11:43 AM. The scheduled AM dose on 3/13/24 is marked as administered. Per interview on 3/13/24 at approximately 1:00 PM, the Director of nursing confirmed that Resident #266 was given a dose of anticoagulant medication against MD recommendations despite Resident #266 having a diagnosed brain bleed.