STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475049	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bel Aire Center	35 Bel-Aire Drive Newport, VT 05855

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 46135 Based on interview and record review the facility failed to provide activities of daily living care based on resident preference for 3 of 21 residents sampled (Residents #43, #209, and #15). Findings include: 1. Per record review, Resident #43's care plan reveals the following focus [Resident #43] is at risk for decreased ability to perform ADL(s) [activities of daily living] in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: CVA [stroke], created 3/2/2023. Interventions include Provide resident/patient with extensive assist of 1 for dressing; Provide resident/patient with extensive assist of 2 for transfers using a mechanical lift; Provide resident/patient with extensive assist of 1 for eating. Per observation and interview on 4/23/24 at 8:33 AM, Resident #43 was awake and in bed. S/He stated that s/he would like to be up and in the dining room eating breakfast right now but has to wait until there is enough staff to get him/her up. Per observation at 10:45 AM, staff brought Resident #43 to the dining room for breakfast in his/her wheelchair. Per interview at 11:48 AM, Resident #43 explained that s/he is not able to get out of bed and eat breakfast when s/he wants to because staff are too busy. S/He said that s/he is hungry and by the time s/he eats breakfast, lunch is shortly after. S/He explained this happens almost every day. 2. Per record review, Resident #209's care plan reveals the following focus [Resident #209] is at risk for decreased ability to perform ADL(s) in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting related to: Limited mobility, L hip fx s/p ORIF [left hip fracture status post open reduction and internal fixation], created 4/06/2024. Interventions include: Provide resident/patient with extensive assist of 2 for ambulation using a walker, gait belt, and nonskid footwear. Follow with [wheelchair]; Provide resident/patient with extensive assist of 1 with [bedside commode] over toilet; Provide resident/patient with extensive assist of 1 for bathing. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per observation and interview on 4/23/24 at 8:30 AM, Resident #209 was sitting in his/her chair in his/her room. S/He stated that s/he would like to be up and eating breakfast right now but s/he has to use the bathroom first. S/He explained that the aides know that s/he is waiting to use the bathroom but they are going to come back when they are not as busy. At 9:20 AM, Resident #209 received their breakfast. At 11:57 AM Resident #209 said that s/he never got help using the bathroom this morning. S/He explained that she would like to use the bathroom before s/he eats breakfast in the morning and that never happened because staff did not have enough time. S/He was frustrated that s/he also had to wait so long for breakfast. Per interview on 4/23/24 at 8:40 AM, a Registered Nurse explained that it is typical for residents to be waiting in bed for am care and breakfast at this time of day because there are only 2 aides on. The staff try their best to get the residents up when they want to but with only two aides on, some residents have to wait a long time after they ask to get up. Per interview on 4/24/24 at 3:20 PM the Director of Nursing confirmed that all residents have the right to make their own choices, including when to get out of bed and eat meals. 50336 3. Per record review, Resident # 15's care plan reveals the following focus [Resident #15] is at risk for decreased ability to perform ADL(s) in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting) related to: weakness, acute renal failure, right great toe amputated; created 05/15/2023. Interventions reveal that Resident # 15 needs assistance with ADL's. Another care area focus states: While in the facility, [Resident # 15] states that it is important that [s/he] has the opportunity to engage in daily routines that are meaningful relative to their preferences. Intervention includes I like to get up in the morning between 7am-9am. During an interview with Resident # 15 on 04/22/2024 approximately 11:30 AM, Resident # 15 states I have to be removed from my room when the staff care for my roommate. I then wait for my care in the hall outside of the room. I don't get to eat breakfast until 10:00 or 11:00 am which is too late. I would prefer to eat at 7:00 am when I am awake. I have complained to staff, but no one seems to be doing anything about it. Per observation and interview at approximately 8:45 am on 4/23/2024 Resident # 15 was outside his/her room, in the wheelchair with a night gown on, open back, and blanket on his/her lap. Resident # 15 stated I have been up since 7:00 am ready to be bathed and dressed but nobody would assist me in getting up. Now I have to wait in the hall for my turn to take a bath and get dressed. I won't get to today until 10:00 or 11:00 which happens all the time. Per interview with the Social Service Director on 04/23/2024 at approximately 4:00 pm she/he stated they were aware of Resident # 15 concerns related to being moved out of his/her room. The Social Service Director confirmed Resident # 15 has complained several times to her/him about being left in the hall while they move the roommate around. Social Service Director confirmed that there has been no resolution to this issue.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40258 Based on interview and record review the facility failed to develop and implement a baseline care plan within 48 hours of admission that included the instructions needed to provide effective and person-centered care for 2 of 9 residents in the sample (Resident #49 and Resident #3). Findings include: 1. Per record review Resident #49 was admitted to the facility on [DATE] with skin breakdown that required treatment to sacrum and bilateral feet. Resident #49's baseline care plan that was created on 1/26/24, the day of admission, states Resident at risk for skin breakdown related to CKD (chronic kidney disease], oxygen dependent COPD [Chronic Obstructive Pulmonary Disease] with a goal of The resident will not show signs of skin breakdown through review. The base line care plan does not reflect the actual skin breakdown, nor does it identify interventions needed to care for actual skin breakdown on Resident's sacrum and bilateral feet. On 1/29/2024 Resident #49's care plan was updated to reflect Resident at risk for skin breakdown related to CKD, oxygen dependent COPD, T2DM [Type 2 Diabetes Mellitus] and has breakdown to sacrum, left lateral and medial foot, left great toe, and right lateral foot. During an interview on 4/24/2024 at 11:20 the Registered Nurse confirmed that Resident #49's baseline care plan should have identified actual skin breakdown and provided interventions that addressed the care needs related to actual skin breakdown however, it did not. 46135 2. Per record review, Resident #3 was admitted to the facility on [DATE] with diagnoses that include anxiety and depression. A 4/2/2024 nursing note reveals that Resident #3 was admitted for short term rehabilitation related to management of diabetes and dementia. Review of Resident #3's care plan reveals that the facility did not develop a baseline care plan related to mood and dementia within the first 48 hours of his/her stay. The following care plans were created on 4/23/2024, 21 days after Resident #3 was admitted to the facility: Resident/patient exhibits or is at risk for distressed/fluctuating mood symptoms related to: dementia . Resident/Patient exhibits or is at risk for limited and/or meaningful engagement related to: Cognitive loss/dementia .Resident/patient has impaired/decline in cognitive function or impaired thought processes related to a condition other than delirium: Dementia (other than Alzheimer's disease). Per interview on 4/24/24 at 3:20 PM, the Director of Nursing confirmed that Resident #3 should have had care plans for mood and dementia in his/her baseline care plan and did not.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility failed to review and revise resident Care Plans related to falls for 3 Residents (Res.# 36, #37, and #47) of 28 sampled residents. Findings include: 1). Per record review, Res. #36 was admitted to the facility with diagnoses that include Alzheimer's Disease, repeated falls, lack of coordination, and abnormalities of gait and mobility. Res. #36 was assessed as at risk for falls related to a history of falls, poor safety awareness and unsteady gait, and a Care Plan was developed with interventions to prevent falls upon their admission to the facility in 2022. Review of Res. #36's medical record reveals the resident suffering multiple falls while at the facility, with the most recent falls on 2/17/24 and 3/8/24. Per nursing notes dated 2/17/24, Res. #36 was found on bedroom floor next to the door laying on [h/her] side. A Change in Condition form for the resident was completed regarding the fall, noting that the resident's Primary Care Provider responded with the following feedback: follow fall protocol. Review of the facility's 'Falls Management' policy [revision date 3/15/24] includes Implement and document patient-centered interventions according to individual risk factors in the patient's plan of care. Review of the resident's Care Plan after the fall on 2/17/24 revealed no new interventions added to prevent future falls. Further review of Res.#36's medical record reveals on 3/8/24 Res. #36 suffered another fall, resulting in a contusion and facial bruising. Nursing notes after the fall record the resident 'has a history of mental health disorders, falls, impulsiveness, wandering, anxiety about surroundings, and left and right leg extremity weakness'. Review of the resident's Care Plan after the fall on 3/8/24 revealed no new interventions added to prevent future falls. 2). Per record review, Res. #37 was admitted to the facility with diagnoses that include Alzheimer's Disease, dementia, psychotic disturbances, and fractures of the right arm, right femur [leg], and right pubis [hip]. Res. #37 was assessed as at risk for falls related to a history of falls, impaired mobility, and unsteady gait, and a Care Plan was developed with interventions to prevent falls upon their admission to the facility in 2022. Review of Res. #37's medical record reveals the resident suffering multiple falls while at the facility, including 3 falls in 3 weeks, from 3/13/24 to 4/3/24. Per review of Res.#37's medical record, a Change in Condition note dated 3/13/24 records Resident found on floor on [h/her] right side between [h/her] bed and [h/her] recliner chair .Resident hoyered [mechanical lift] off the floor onto [h/her] bed. On 3/25/24, a Change in Condition note for Res.#37 records Resident found to be sitting upright on floor at bedside. States [s/he] was trying to get into bed and slid down to floor. On 4/3/24, Nursing notes document Res.#37 was laying on right side of body, on the floor, directly by bed .Assisted from floor to wheelchair with 2 person assist. Review of the resident's Care Plan after 3 consecutive falls on 3/13, 3/25, & 4/3/24 revealed no new interventions added to prevent future falls. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the facility's Director of Nursing [DON] and the Corporate Compliance Director on 4/24/24 at 10:56 AM. The DON and the Corporate Compliance Director confirmed that after multiple falls, the care plans for both Res.#36 and #37 were not updated with new interventions to prevent future falls, resulting in both residents suffering additional falls, including Res. #36 who suffered a contusion and facial bruising. 50336 3. Per record review, Resident # 47 was admitted to the facility on [DATE] and has diagnoses that include history of falls, lumbar spine fracture and orthostatic hypotension (low blood pressure drops when standing). Resident # 47 has the following care plan initiated on 08/11/2023 which states resident at risk for falls related to impaired mobility, lumber fracture, stroke with left sided weakness. Interventions include toilet after meals, offer resident to go to the bathroom every 2-3 hours, obtain resident input and anticipate needs to prevent future falls, provide verbal cues for safety, place walking device within reach to enable use of walker, and place the call bell within reach. Per record review from 08/11/2023 through 4/22/2024, Resident # 47 had 22 documented falls. Resident # 47's care plan was revised only 4 of the 22 times after a fall. Per facility policy Falls Management last revised 03/24/2024 states patients experiencing a fall will receive appropriate care and post fall interventions will be implemented. The purpose is to identify risk for falls, minimize the risk of recurrence of falls, and to ensure patient centered care plan is reviewed and revised. Per interview with a Licensed Nursing Assistant (LNA) familiar with Resident # 47's care on 4/23/2024 at approximately 2:30 pm, he/she stated that they were concerned that there isn't enough staff to keep Resident # 47 from falling. The LNA stated that often Resident # 47 has falls multiple times a day, and there are not enough interventions including adequate supervision to prevent falls and keep Resident # 47 safe.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48017 Based on record review and interview, the facility failed to provide treatment and care to an existing non-pressure-related injury in accordance with professional standards of practice and the person-centered care plan consistent with the facility policy for 1 of 6 residents (Resident # 11). Findings Include: Per record review, Resident #11 was admitted to the facility on [DATE] with the following diagnoses: Acute osteomyelitis (infection in the bone) of left ankle and foot, acquired absence of left great toe (amputation), Type 2 Diabetes, and peripheral artery disease (PAD), (the narrowing or blockage of the vessels that carry blood from the heart to the legs.) Per record review, a care plan entry was dated 3/28/24 with an intervention of weekly wound assessment to include measurements and description of wound status. Per record review, a skin assessment dated [DATE] and 4/12/2024 states, Left foot, surgical toe amputation. Dressing C/D/I [clean/dry/intact]. Per record review, a skin assessment dated [DATE] has a note entry: Left foot, surgical toe amputation. Great toe sutures have dehisced [partial or total separation of previously approximated wound edges due to failure of proper wound healing], and great toe is currently open. Per record review, a clinical office note from the attending surgeon dated 4/23/24 indicates dead tissue was removed from the wound to expose the bone, given [his/her] diabetes and PAD, [s/he] will have difficulty healing this wound and may ultimately need a BKA [below the knee amputation]. Facility policy titled NSG236 Skin Integrity and Wound Management, last reviewed 2/1/23, states: A comprehensive initial and ongoing nursing assessment of intrinsic and extrinsic factors that influence skin health, skin/wound impairment, and the ability of a wound to heal will be performed. The plan of care for the patient will be reflective of assessment findings from the comprehensive patient assessment and wound evaluation. Staff will continually observe and monitor patients for changes and implement revisions to the plan of care as needed. Practice Standards include: 6 A licensed nurse will: 6.4 Perform and document skin inspection on all newly admitted /readmitted patients weekly thereafter and with any change in condition. 6.5 complete wound evaluation upon admission /readmission, new in-house acquired weekly and with unanticipated decline in wounds. 6.6 Perform daily monitoring of wounds or dressings for the presence of complications or declines. 6.6.1.4 Signs of decline in wound status. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6.6.1.4.1 If unanticipated decline in the wound, surrounding tissue, or new or increased wound-associated pain, complete a wound re-evaluation, change in condition. Per an interview on 4/23/24 at approximately 1:30 PM with the facility's wound care nurse, s/he stated that the facility does not assess surgical wounds on admission, and the responsibility of documenting the condition of the wound falls to the nurse changing the dressings. S/he stated s/he did not assess the wound until the skin check dated 4/19/2024 when the wound was assessed to have necrotic (dead tissue) in it. S/he had not assessed the wound since 4/19/2023 and has not followed facility policy 6.6, perform daily monitoring of wounds or dressings for the presence of complications or declines. Per record review, Resident # 11's care plan has no documentation of revisions to reflect the 4/19/24 assessment of necrotic tissue in the wound. Per an interview on 4/24/24 at approximately 11:15 AM with the Director of Nursing, s/he confirmed that the facility failed to perform an initial wound assessment after the resident was admitted to the facility as per the facility's policy. Additionally, the facility failed to assess and document the status of the wound weekly, as the resident's care plan indicated. There is no evidence that the wound was assessed during dressing changes in the medical record until 4/19/2024; s/he confirmed that there was no evidence of documentation of the condition of the wound from 4/19/2024 until 4/23/2024 when the surgeon removed the dead tissue from the wound. S/he also confirmed that the facility failed to revise Resident #11's care plan after the assessment on 4/19/2024. [NAME], R. D. 2023, (November 3). National Library of Medicine (NLM). National Institute of Health. https://www.nih.gov/about-nih/what-we-do/nih-almanac/national-library-medicine-nlm Accessed 30 April 2024 [NAME],J.(2023,July 5).PAD: The other arterial disease-mayo clinic news network. Mayo Clinic. https://newsnetwork.mayoclinic.org/discussion/pad-the-other-arterial-disease/ Accessed 30 April 2024 Momodu, I. I. (2023, May 31). Osteomyelitis. StatPearls [Internet]. https://www.ncbi.nlm.nih.gov/books/NBK532250/#:~:text=Osteomyelitis%20is%20a%20serious%20infection,bloodstream%2C%20fractures%2C%20or%20surgery. Accessed 30 April 2024

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135 Based on interview and record review, the facility failed to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, and the comprehensive person-centered care plan for 1 of 21 sampled residents (Resident #3). Findings include: Per record review, Resident #3 was admitted to the facility on [DATE] for rehabilitation services following repeated falls at home. Resident #3's care plan reveals Resident exhibits or is at risk for alterations in comfort related to advanced age, [history] of falls, created 4/02/2024 with interventions that include Evaluate pain characteristics: quality, severity, location, precipitating/relieving Factors, created on 4/2/24 and Monitor for pain. Attempt non-pharmacologic interventions to alleviate pain and document effectiveness, created on 4/16/24. Review of Resident #3's Medication Administration Record (MAR) reveals that following physician orders for as needed (PRN) pain medications were administered: Acetaminophen Oral Tablet 500 MG (Acetaminophen) Give 2 tablet by mouth every 8 hours as needed for pain TID as needed -Start Date- 04/02/2024, administered on 4/16/24, 4/18/24, 4/19/24, and 4/23/24; and Lidoderm Patch 5 % (Lidocaine) Apply to back topically as needed for back pain daily as needed -Start Date- 04/10/2024, administered on 4/17/24. In addition to the above medications, Resident #3's MAR reveals the following order Non-Pharmacological Intervention(s) used before PRN Pain Medication. Record Non-Pharm intervention in Supplementary Documentation. Document Effectiveness. If pain continues follow providers direction which may include pain medication. as needed -Start Date- 04/02/2024. The MAR does not show documentation that non-pharmacological interventions were used prior to the administration of the above PRN medications. A review of pain assessments in both the MAR and under vitals, Resident #3's pain is documented as being 0 for the entirety of their stay. There is no pain assessment indicating the use of the above PRN pain medications. Per interview on 4/24/24 at 3:58 PM, the Director of Nursing confirmed that if Resident #3 was receiving PRN medications, there would need to be both an indication for the need based on a pain assessment and documentation that non-pharmacological interventions were attempted before and there was not.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135 Based on interview and record review, the facility failed to identify a resident's past history of trauma, and/or triggers which may cause re-traumatization for 2 applicable residents (Residents #26 and #11). Findings include: 1. Record review reveals that Resident #26 was admitted to the facility on [DATE] and has diagnoses that include mood disorder, major depressive disorder, and delusional disorder. Per review of Resident #26's physician orders, Resident #26 is taking Olanzapine, an antipsychotic medication, for post traumatic stress disorder (PTSD). Nurse Practitioner notes from 3/28/24, 4/3/24, and 4/11/24 reveal in the list of medications reviewed and updated that Resident #26 is taking OLANZapine Oral Tablet 5 MG (Olanzapine) Give 5 mg by mouth two times a day for PTSD. Per review of Resident #26's care plan, neither PTSD or trauma is addressed as a care plan focus or within care plan interventions. Per interview on 4/24/24 at 9:55 AM, a Licensed Nursing Assistant (LNA) explained that Resident #26 sometimes has flashbacks from being in the service. The LNA said s/he didn't think s/he was care planned for this. Per interview on 4/24/24 at 1:38 PM, the Nurse Practitioner explained s/he recently attempted a gradual dose reduction for Resident #26's Olanzapine but was not successful because s/he received reports that Resident #26 was having aggressive behaviors and flashbacks. A social service assessment used to screen for PTSD was completed 7/19/23. The assessment coded Resident #26 as negative for trauma. The screening tool used is a two question assessment that asks the resident if they have experienced any consequences from trauma in the past month. It does not ask the resident if they have experienced trauma at any point in their past. Per interview on 4/23/24 4:02 PM, the Social Service Director explained that s/he was not aware that Resident #26 had a history of PTSD. S/He confirmed that the only screening that s/he did for trauma was to ask the two questions above. S/He explained that there are no other screening tools that s/he uses to assess for trauma. 48017 2.) Per interview on 4/22/24 at approximately 1:40 PM, Resident #11 revealed that s/he has post-traumatic stress disorder PTSD. S/he is a [NAME] with a history of live combat. S/he states sudden loud noises and loud male voices all trigger him/her causing panic and a need to hide. Per record review, Resident #11 was admitted to the facility on [DATE] with diagnoses of Major Depressive Disorder and Traumatic Stress Disorder. A care plan with a date of 4/10/24 indicates an entry: Resident /Patient reports past experience of trauma as evidenced by PTSD, with an intervention of Encourage Resident/Patient to identify personal trauma and triggers and take steps to eliminate/minimize. Resident #11 has no triggers identified in his/her medical record or care plan. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per the record review, a social service assessment used to screen for PTSD was completed on 4/3/24; the assessment coded Resident #11 as positive for trauma. The screening tool used is a two-question assessment that asks the residents if they have experienced any consequences from trauma in the past month. It does not ask the resident if they have experienced trauma at any point in their past. Per interview on 4/24/24 at approximately 2:30 PM, the Director of Social Services confirmed that the only screening that s/he used for trauma was to ask the two questions above. S/he confirmed there are no other screening tools s/he uses. S/he reveals that she/he learns of a resident's PTSD by their medical record or the two-question assessment.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bel Aire Center	35 Bel-Aire Drive Newport, VT 05855

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 29776 Based upon interview and record review, the facility failed to provide sufficient nursing staff related to resident care and treatment for Res.#20, #36, #8, #51and #209 of 28 sampled residents. Findings include: 1.) Review of Res.#20's Care Plan reveals the resident is assessed as at risk for decreased ability to perform Activities of Daily Living [ADLs] in bed mobility, transfer, and toileting related to impaired mobility and generalized weakness. Interventions to be provided by staff include Provide resident with extensive assist of 1 for toileting. Ambulate into bathroom with rolling walker and extensive assist of 1 with gait belt. The Care Plan also assessed the resident as at risk for falls and at risk for skin breakdown related to incontinence. An interview was conducted with Res.#20 on 4/22/24 at 4:53 PM. Res.#20 stated that staff have been 'wonderful' but sometimes I have to wait and wait. Once in a while I couldn't wait any longer, and I was embarrassed [wet myself]. I was told I have to wait for staff for assistance- with transfers to the bedside commode. Per observation, a notice next to Res.#20's bedside instructs the resident to wait for staff before toileting. 2.) Review of Res.#36's Care Plan reveals the resident is assessed as at risk for decreased ability to perform Activities of Daily Living [ADLs] in bed mobility, transfer, and toileting related to altered mental status. Interventions to be provided by staff include Provide resident with extensive assist of 2 for toileting. The Care Plan also assessed the resident as at risk for falls related to a history of falls, poor safety awareness and unsteady gait, and at risk for skin breakdown related to incontinence. An interview was conducted with Res. #20 on 4/22/24 at 1:26 PM. Res.#26 stated sometimes s/he have to wait and wait and wait and sometimes you can't wait any longer [soil him/herself]. Res.#36 said, then you need even more help and you are still waiting. 3.) Review of Res.#8's Care Plan reveals the resident is assessed as at risk for decreased ability to perform Activities of Daily Living [ADLs] in bed mobility, transfer, and toileting related to a history of a left leg fracture and altered mental status. Interventions to be provided by staff include Provide resident with supervision of 1 for toileting. The Care Plan also assessed the resident as at risk for falls related to a impaired mobility and impaired cognition and to monitor and assist with toileting. An interview was conducted with Res.#8 on 4/22/24 at 11:55 AM. Res.#8 stated they have to wait a long time for staff to respond to the call bell at night. Two times no one came. I ended up peeing in my pants. It's degrading. 46135 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4.) The following observations were made during dinner service on 4/22/24. At 4:11 PM, there were 13 residents in the dining room waiting for dinner. Dinner started to be plated at 4:30 PM and a few more residents were brought into the dining area. At 4:39 PM, Resident #51 was sitting at the dining table with food in from of him/her. A Licensed Practical Nurse (LPN) approached him/her and said that they need him/her for a minute because s/he hadn't had his/her sugars done yet. The nurse brought Resident #51 back to the unit. Staff approached Resident #35 at 4:43 PM, Resident #25 at 4:45 PM, and Resident #36 at 4:56 PM, all during dinner service because they had not had their blood sugars checked before eating the meal. Per interview on 4/22/24 at 5:01 PM, this LPN explained that s/he has at least 7 blood sugars to check before dinner and was unable to check the above residents because s/he was busy with another resident. S/He explained that staffing is low and there are resident safety concerns because of it, like not being able to get to all the residents in time to do their blood sugars as one example. 5.) Per observation on B hall on 4/23/24 from 8:30 AM through 8:45 AM, most residents are in their rooms in their beds or in their chairs. Most residents are not dressed. Per observation on 4/23/24 at 8:30 AM, Resident #209 was sitting in his/her chair in his/her room. S/He stated that s/he would like to be up and eating breakfast right now but s/he has to use the bathroom first. S/He explained that the aides know that s/he is waiting to use the bathroom but they are going to come back when they are not as busy. At 8:36 AM, Resident #15, who is in the hall in a johnny, stated that s/he will probably have to wait until 10:00 AM now to get dressed because of how busy staff are. Per interview on 4/23/24 at 8:40 AM, a Registered Nurse explained that it is typical for residents to be waiting in bed for am care and breakfast at this time of day because there are only 2 aides on. The staff try their best to get the residents up when they want to but with only two aides on, some residents have to wait a long time after they ask to get up. Per interview on 4/23/24 at 2:23 PM with two Licensed Nursing Assistants (LNAs), one LNA stated that there are not enough staff to meet the needs of the residents. This LNA explained that there are not enough staff to get residents up in the morning and to the dining room at the time they want to eat, monitor residents that are at risk for falls, get to residents to help them to the bathroom before they soil themselves, and help residents with eating. The second LNA confirmed the above information.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 40258 Based on interview and record review the facility failed to ensure that 4 of 5 sampled licensed nursing assistants (LNAs) and 4 of 5 nurses were assessed for competency in the skills required to care for the resident needs based on resident care plans. Findings include: Review of 5 LNA training and competency files revealed the following: * 2 LNA files had no evidence of competency evaluation. * 1 LNA file had no evidence of competency since 2022. * 1 LNA file had only hand hygiene and personal protective equipment (PPE) competencies completed on 5/9/2024. There was no evidence in their file of any other resident care competency evaluations. Review of 4 staff nurse's training and competency file revealed the following: * 2 nurse files had no evidence of competency evaluation since 2022. * 1 nurse file had evidence of a Medication Pass and an IV (intra venous) therapy competency dates 7/10/23 only. There was no evidence that the nurse had been assessed for competencies related to other skills since 3/28/22. Per review of the designated wound care nurse's training and competency file there is no evidence that wound care competency evaluations have been completed since 2020. During an interview on 4/24/24 at 9:35 AM the Market Clinical Lead confirmed that nursing competencies have not been completed per regulation. During an interview on 4/24/24 at 11:30 AM the Market Operations Advisor confirmed that nursing staff have not been assessed for competency as required by regulation. The Market Operations Advisor also confirmed that the designated wound care nurse has not been assessed for competency since 2020.

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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 are accurately monitored for behaviors and/or side effects for 5 of 5 sampled residents (Residents #3, #26, #36, #6 and #47). Findings include: [NAME]-Aire policy titled Psychotropic Medication Use, last revised 10/24/2022, states all medications used to treat behaviors must have a clinical indication and be used in the lowest possible dose to achieve the desired therapeutic effect. All medications used to treat behaviors should be monitored for efficacy, risks, benefits and harm or adverse consequences. Facility policy also states staff should monitor the resident's behavior triggers, episodes and symptoms and document in the medical record. 1. Per record review, Resident #26 on 7/29/22 and has diagnoses that include mood disorder, major depressive disorder, and delusional disorder. Resident #26 has the following care plan focus [Resident #26] is at risk for complications related to the use of psychotropic drugs, revised 4/21/24. Interventions include Complete behavior monitoring flow sheet. Monitor for continued need of medication as related to behavior and mood. Resident #26's Medication Administration Record (MAR) reveals the following physician orders for psychotropic medications: OLANZapine Oral Tablet 5 MG (Olanzapine) Give 5 mg by mouth in the afternoon for PTSD [post traumatic stress disorder], psychosis GDR [gradual dose reduction] on 3/5/24 -Start Date- 03/06/2024 through- 04/11/2024 . OLANZapine Oral Tablet 5 MG (Olanzapine) Give 5 mg by mouth two times a day for PTSD, psychosis GDR on 3/5/24 failed -Start Date- 04/11/2024. There is no documentation of behavior monitoring in the MAR. Per interview on 4/24/24 at 11:30 AM, a Licensed Practical Nurse explained that Resident #26 has behaviors daily and s/he is typically angry, yelling, refusing care, and aggressive with staff. While Resident #26's behaviors are monitored by the licensed nursing assistants (LNAs), they are not accurately monitored by the LNAs. Per review of the behavior flow sheets for March 2024 and April 2024, Resident #26 is documented to have behaviors only 3 times from March 1, 2024 through April 23, 2024. This behavior monitoring sheet does not reflect actual behaviors as per the LPN above. Per interview on 4/24/24 at 9:57 AM, the Market Clinical Lead confirmed that behavior monitoring for Resident #26 was not being completed by the licensed nursing staff, rather it was being done by the LNAs. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Per record review, Resident #3 was admitted to the facility on [DATE] and has diagnoses that include anxiety and depression. Resident #3 has the following care plan focus Resident is at risk for complications related to the use of psychotropic drugs Medication: antidepressant, antianxiety, created 4/2/24. Interventions include Monitor for side effects and consult physician and/or pharmacist as needed. Resident #3's MAR reveals the following physician orders for psychotropic medications: clonazePAM Oral Tablet 0.5 MG(Clonazepam) Give 1 tablet by mouth at bedtime for anxiety -Start Date- 04/03/2024. Sertraline HCl Tablet 50 MG Give 1 tablet by mouth one time a day for Depression -Start Date- 04/03/2024. Monitoring for psychotropic medication side effects was not added to the MAR until 4/24/24. Per interview on 4/24/24 at 9:57 AM, the Market Clinical Lead confirmed that side effect monitoring was added to Resident #3's MAR today (4/24/24). 3. Per record review, Resident #36 was admitted to the facility on [DATE] and has diagnoses that include major depressive disorder. Resident #36 has the following care plan focus [Resident #36] is at risk for complications related to the use of psychotropic drugs antidepressant, created 2/10/2022. Interventions include Monitor for side effects and consult physician and/or pharmacist as needed. Resident #3's MAR reveals the following physician orders for psychotropic medications: DULoxetine HCl Capsule Delayed Release Particles 60 MG Give 1 capsule by mouth one time a day for depression -Start Date- 12/15/2022. Monitoring for psychotropic medication side effects was not added to the MAR until 4/24/24. Per interview on 4/24/24 at 9:57 AM, the Market Clinical Lead confirmed that side effect monitoring was added to Resident #36's MAR today (4/24/24). 50336 4. Per record review, Resident #6 was admitted to the facility on [DATE] and has diagnoses of delusions and agoraphobia. Per record review Resident #6 has the following care plan initiated 09/11/2020 which states Resident at risk for complications related to the use of psychotropic drugs. Interventions include complete behavior monitoring, monitor for continued need of medication as related to behavior and mood, monitor for side effects, and consult physician and or pharmacist as needed. Resident #6's MAR reveals the following physician orders for psychotropic medications Risperidone 1 milligram by mouth two times a day. There is no documentation of behavior monitoring in the MAR. Per interview on 4/24/24 at 11:16 AM, a Licensed Practical Nurse (LPN) explained that Resident #6 has behaviors almost daily as s/he is typically having hallucinations. While Resident #6's behaviors are monitored by the licensed nursing assistants (LNAs), they are not accurately monitored by the LNAs. Per record review, behavior flow sheets, completed by the LNAs, did not start until 3/5/24 and in March 2024 and April 2024, Resident #6 is documented to have behaviors only 10 times from March 5, 2024, through April 23, 2024. This behavior monitoring sheet does not reflect actual behaviors as per the LPN above. Per interview on 4/24/24 at 9:57 AM, the Market Clinical Lead confirmed that behavior monitoring for Resident #6 was not being completed by the licensed nursing staff, rather it was being done by the LNAs. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Per record review Resident #47 was admitted to the facility on [DATE] with a diagnosis of depression. Per record review Resident #47 has the following care plan initiated 8/11/2023 which states Resident at risk for complications related to the use of psychotropic drugs. Interventions include complete behavior monitoring, gradual dose reduction, monitor for continued need of medication as related to behavior and mood, monitor for side effects, and consult physician and or pharmacist as needed. Resident #47's MAR reveals the following physician orders for psychotropic medications Paroxetine 30 mg by mouth twice a day for depression, start date 03/24/2024. There is no documentation of behavior monitoring in the MAR and monitoring for psychotropic medication side effects was not added to the MAR until 4/24/24. Per interview on 4/24/24 at 11:16 AM, a Licensed Practical Nurse (LPN) explained that Resident #47 is typically sad daily and s/he is frequently having hallucinations. While Resident #47's behaviors are monitored by the licensed nursing assistants (LNAs), they are not accurately monitored by the LNAs. Per record review, behavior flow sheets, completed by the LNAs, did not start until 4/6/24 and in April 2024, Resident #47 is documented to have behaviors only 9 times from April 6, 2024, through April 23, 2024. This behavior monitoring sheet does not reflect actual behaviors as per the LPN above. Per interview on 4/24/24 at 9:57 AM, the Market Clinical Lead confirmed that behavior monitoring for Resident #47 was not being completed by the licensed nursing staff, rather it was being done by the LNAs and confirmed that side effect monitoring was added to Resident #47's MAR today (4/24/24).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 29776 Based upon observation, interview, and record review, the facility failed to implement an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections related to Enhanced Barrier Precautions (EBP) and residents identified as at risk. Findings include: 1.) Per the Centers for Disease Control and Prevention: Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated for residents with . wounds or indwelling medical devices and Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care. (https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html.) Per observation on 4/22/24 at 11:30 AM, there were no residents on Enhanced Barrier Precautions (EBP) on any of the facility's resident units. Per observation, interview, and record review, it was revealed that Residents #26, #51, #17, #37, #36, #19, all were identified as having either wounds or indwelling medical devices which indicated that EBP should be implemented. Per interview on 4/22/24, staff were unaware of any requirement for Enhanced Barrier Precautions for the above listed residents and were not observed using PPE during direct care on the residents. Per observation on 4/23/24 at 8:00 AM, resident rooms #12, #13, #15, #17, #18, and #21 had EBP signs on the doors that were not on the doors the previous day. Per interview on 4/23/24 at approximately 8:10 AM, a Licensed Nursing Assistant explained that the signs were on doors of residents with wounds or catheters and they were just put there last night. Per interview on 4/23/24 at 9:05 AM, the Infection Preventionist confirmed that the signs were not up yesterday; the facility had put up the signs and started education with the staff regarding the precautions last night. Per interview with the facility's Infection Preventionist on 4/23/24 at 2:30 PM, Enhanced Barrier Precautions [EBP] including signage, staff education, placement of PPE, and resident notification were conducted after the survey team arrived on-site on the morning of 4/22/24. The Infection Preventionist confirmed that EBP should have been in place for any residents having either wounds or indwelling medical devices but was not. The Infection Preventionist stated signage, education, and notification was conducted in the afternoon of 4/22/24. 46135