STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345569	A. BUILDING ______ B. WING ______	C 09/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGBROOK NURSING & REHABILITATION CENTER	195 SPRINGBROOK AVENUE CLAYTON, NC 27520

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 09/19/2022 through 09/22/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #775811.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 09/19/2022 through 09/22/2022. Event ID# 775811. 5 of 20 complaint allegations were substantiated resulting in deficiencies. The following intakes were investigated: NC00191883, NC00191872, NC00191878, NC00192395, NC00192404, NC00192851 and NC00193198.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		10/18/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 10/08/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Continued From page 1

severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and resident and staff interviews the facility failed to provide incontinence care causing the resident to feel not good but there was nothing she could do about it for 1 of 6 residents reviewed for activities of daily living care. (Resident #31)

Findings included:

Resident #31 was admitted to the facility on 08/09/2018 with a diagnosis of stroke (damage to the brain from interrupted blood supply).

A review of her quarterly Minimum Data Set (MDS) assessment dated 07/21/2022 revealed

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Springbrook Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.

Springbrook Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor

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F 550	Continued From page 2 she was cognitively intact. It further revealed she had no behaviors or rejection of care. She was always incontinent of bowel and bladder. She required the extensive assistance of two people for toileting and personal hygiene. On 09/19/2022 at 1:46 PM an interview with Resident #31 indicated she had not been offered or provided with incontinence care since the early morning of the night shift around 4:00 AM or 5:00 AM that day. She stated she did not always know if or when she had been incontinent. She went on to say she asked a nurse aide (NA) for incontinence care when they came to her room around lunch time that day. She stated the NA told her they would be back to provide her care after lunch. She further indicated she did not know the NA's name. Resident #31 stated it did not make her feel good to wait this long for incontinence care but she really didn't think there was anything she could do about it. She went on to say it was her understanding the NAs had a system where they started at one end of her hall and worked around. She further indicated she must be at the end. On 09/19/2022 at 2:03 PM Resident #31 was observed to initiate her call light for assistance. A continuous observation revealed at 2:09 PM NA #5 responded to Resident #31's call light. Resident #31 asked NA #5 for incontinence care. An observation of the incontinence care provided by NA #5 at that time revealed Resident #31's incontinence brief was saturated with urine and stool. Her under pad and draw sheet were observed to be soiled with urine. The case on a pillow positioned on Resident #31's left side near her waist was observed to be soiled with urine. A strong odor of urine was present. An interview	F 550	does it constitute an admission that any deficiency is accurate. Further, Springbrook Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F550 Resident Rights/Exercise of Rights On 9/19/22, the nursing assistant (NA) provided incontinent care to resident #31. On 9/23/22, the Director of Nursing verbally educated NA #5 regarding incontinent care and dignity/respect. On 10/7/22, the Unit Managers initiated an audit of all incontinent residents to include resident #31 to ensure residents were provided incontinent care timely. The Unit Managers will address all concerns identified during the audit to include providing incontinent care and education of the staff. Audit will be completed by 10/18/22. On 10/7/22, the Social Worker and/or Activities Director initiated resident questionnaires with all alert and oriented residents regarding incontinent care/toileting assistance to include (1) do you have any concerns related to receiving incontinent care and/or assistance with toileting? The Social Worker and/or Activity staff will address all	

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F 550	Continued From page 3 with NA #5 at that time indicated Resident #31 was not able to reliably tell if or when she was incontinent. NA #5 stated Resident #31's incontinence brief was saturated with urine and stool. She stated her pad, drawsheet and pillowcase were also soiled with urine. She went on to say this was the first time she provided incontinence care to Resident #31 since she started her shift at 7:00 AM. She further indicated she had not offered Resident #31 any incontinence care previously that day. On 09/19/2022 at 2:55 PM an interview with Nurse #4 indicated she was assigned to Resident #31 on the 7AM-3PM shift that day. Nurse #4 went on to say she would help NA's with providing incontinence care or other care to residents when she was asked . She stated NA #5 had not asked her for any assistance with providing incontinence care to Resident #31. On 09/19/2022 at 3:14 PM a follow-up interview with NA #5 indicated she was assigned to provide care to Resident #31 from 7AM until 3PM that day. She went on to say she was responsible for the usual number of residents. She stated she was familiar with Resident #31. NA #5 went on to say she did not keep track of when Resident #31 was last offered or provided with incontinence care. She stated she had a system where she started her shift by providing care to the residents that needed a shower first. She further indicated she just had not gotten around to Resident #31 yet. She stated she should have provided incontinence care to Resident #31 at least 2 to 3 times during her shift. She stated she had not asked the nurse or other NAs for help with providing incontinence care to Resident #31. She further indicated from 7:00 AM until 2:00 PM was	F 550	concerns identified during the questionnaires. Questionnaires will be completed by 10/18/22. On 10/7/22, the Unit Managers initiated an in-service with all nurses and nursing assistants regarding Dignity with Incontinent Care with emphasis on ensuring each resident is treated with respect and dignity and provided care in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life to include providing incontinent care and/or assessing residents not able to verbalize need for incontinent care routinely. In-service will be completed by 10/18/22. After 10/18/22, any nurse or nursing assistant who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses and nursing assistants will be in-serviced during orientation regarding Dignity with Incontinent Care. The Unit Managers will complete 15 Resident Care Audits on residents who are incontinent to include resident #31 weekly x 4 weeks then monthly x 1 month. Audits will include all shifts and all days of the week. This audit is to ensure all residents with incontinence are provided incontinent care timely. The Unit Managers will address all concerns identified during the audit to include providing incontinent care when indicated and re-education of the staff. The Director of Nursing will review the Resident Care Audits weekly x 4 weeks then monthly x 1	

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F 550	Continued From page 4 too long for Resident #31 to go without incontinence care. She stated going that long without incontinence care would put Resident #31 at risk for skin breakdown. On 09/22/2022 at 11:00 AM an interview with the Director of Nursing (DON) indicated incontinent residents should receive incontinence care at least every 2 to 3 hours and more often if they needed it. She stated she would expect NAs to check residents for incontinence at the beginning of their shift and then every 2 to 3 hours or more frequently as needed.	F 550	month to ensure all areas of concern were addressed. The Director of Nursing will present the findings of the Resident Care Audits to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Resident Care Audits to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives	F 578		10/18/22

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F 578	Continued From page 5 and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to ensure the advanced directive code status information maintained in the electronic record and the hard copy chart matched. This was for 1 of 1 resident (Resident #76) reviewed for advanced directives. Findings included: Resident #76 was admitted to the facility on 10/29/2019 with a diagnosis of spinal stenosis (narrowing of the spinal canal). A review of his quarterly Minimum Data Set (MDS) assessment dated 08/19/2022 revealed he was cognitively intact. On 9/19/2022 at 1:12 PM a review of Resident #76's electronic medical record revealed a	F 578	F578 Request/Refuse/Discontinue Treatment; Formulate Adv Directive On 9/22/22, the social worker reviewed resident # 76 desire for advance directive and code status. The physician was notified and the electronic record updated for resident preference. On 9/23/22, the Social Workers initiated an audit of all resident orders for advance directive/code status, chart documentation of advance directives/code status and resident/resident representative preference for advance directive/code status. This audit is to ensure the Social Worker and/or nurse reviewed with the resident and/or resident representative the desired advance directive/code status,	

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F 578	Continued From page 6 physician's order dated 7/01/2021 for "Full Code". The profile section of the electronic record indicated "Full Code". In an interview on 09/21/2022 at 2:29 PM Resident #76 stated he had a DNR status. He further indicated he did not want to be resuscitated if his heart or breathing were to stop. On 9/21/2022 at 2:36 PM a review of Resident #76's hard copy chart revealed a physician's order dated 10/30/2019 of "Do Not Resuscitate" (DNR). It further revealed a bright yellow DNR form as the front page signed by Resident #76's attending physician on 1/07/2021. There was no expiration date. On 9/21/2022 at 2:51 PM in an interview Social Worker (SW) #1 stated he had been Resident #76's SW since he was admitted to the facility. He further indicated Resident #76's code status was initially DNR. SW #1 went on to say he had a conversation with Resident #76 in July 2021 where Resident #76 expressed the desire to be a Full Code. SW #1 stated while he periodically did an audit to make sure the code status of residents matched in both the electronic record and the hard chart, he must not have taken Resident #76's DNR form out like he should have after that conversation and the physician's order for Full Code. He went on to say resident's advanced directive code status information should match in the electronic record and hard copy chart or nurses could be confused about code status in the event the electronic record was unavailable. On 09/21/2022 at 3:36 PM an interview with the Director of Nursing (DON) indicated the advanced	F 578	the physician was notified of desired advance directive/code status, an order placed in the electronic record/resident chart and the care plan updated to reflect resident desired advance directive/code status. The Social Worker and/or nurse will address all concerns identified during the audit to include notification of the physician of desired advance directive/code status and updating electronic record when indicated. The audit will be completed by 10/18/22. On 10/7/22, the Director of Nursing initiated an in-service with all social workers, admission director, Administrator and nurses regarding Advance Directives with emphasis on reviewing advance directives with the resident and/or resident representative upon admission, notification of the physician of desired advance directive/code status, obtaining an order for code status and updating the electronic record/care plan. In-service will be completed by 10/18/22. After 10/18/22, any social worker, admission director and/or nurse who has not received the in-service will be in-serviced prior to next scheduled work shift. All newly hired social workers, admission director and/or nurse will be in-serviced during orientation regarding Advance Directives. The Medical Records Director and/or Admission Director review all admissions during Interdisciplinary Team Meeting (IDT) 5 times a week x 4 weeks then monthly x 1 month utilizing the Advance Directive Audit Tool. This audit is to	

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F 578	Continued From page 7 directive code status information for residents should match in both the electronic record and hard copy chart.	F 578	ensure that the Social Worker, Admission Director and/or nurse reviewed advance directive/code status with the resident and/or resident representative upon admission, the physician was notified of desired advance directive/code status, an order was placed in the electronic record and that the care plan was updated to reflect resident desired advance directive/code status. Medical Records Director, and/or Social Worker will address all concerns identified during the audit. The Director of Nursing will review the Advance Directive Audit Tool 5 times a week x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will present the findings of the Advance Directive Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Advance Directive Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		10/18/22

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F 677	Continued From page 8 Based on observations, record review, and resident, staff and physician interviews the facility failed to provide incontinence care (Resident #31) and failed to rinse soap from a resident's skin per manufacturer's directions during a bath (Resident #7) for 2 of 6 residents reviewed for activities of daily living care. Findings included: 1. Resident #31 was admitted to the facility on 08/09/2018 with a diagnosis of stroke (damage to the brain from interrupted blood supply). A review of her quarterly Minimum Data Set (MDS) assessment dated 07/21/2022 revealed she was cognitively intact. It further revealed she had no behaviors or rejection of care. She was always incontinent of bowel and bladder. She required the extensive assistance of two people for toileting and personal hygiene. A review of the current comprehensive care plan for Resident #31 revealed a focus area initiated on 08/10/2018 of urinary and bowel incontinence related to impaired mobility, requires assistance with toileting needs, history of overactive bladder and increased risk for skin breakdown. The goal last revised on 05/12/2022 was for her to be free of skin breakdown related to bowel and bladder incontinence through the next review. An intervention was to provide incontinence care promptly. On 09/19/2022 at 1:46 PM an interview with Resident #31 indicated she had not been offered or provided with incontinence care since the early morning of the night shift around 4:00 AM or 5:00 AM that day. She stated she did not always know	F 677	F677 ADL Care Provided for Dependent Residents On 9/19/22, the nursing assistant (NA) provided incontinent care to resident #31. On 9/21/22, the nursing assistant provided resident # 7 a bath under the supervision of the Director of Nursing to ensure staff appropriately rinsed soap from resident skin per manufacturer□s directions during bath. On 9/23/22, the Director of Nursing verbally educated NA #5 regarding incontinent care and dignity/respect. NA #5 verbalized understanding of education. On 9/20/22, the Director of Nursing verbally educated NA #1 regarding ADL Care with emphasis on ensuring soap is rinsed from resident skin per manufacturer□s directions during baths. NA #1 verbalized understanding of education. On 10/7/22, the Unit Managers and Assistant Director of Nursing initiated an audit of ADL care for all residents to include incontinent care and baths. This audit is to ensure all residents were assisted with ADL care to include but not limited to incontinent care when indicated and/or staff appropriately rinsed soap from resident skin per manufacturer□s directions during bath. The Unit Managers and Assistant Director of Nursing will address all concerns identified during the audit to include	

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if or when she had been incontinent. She went on to say she asked a nurse aide (NA) for incontinence care when they came to her room around lunch time that day. She stated the NA told her they would be back to provide her care after lunch. She further indicated she did not know the NA's name. Resident #31 stated it did not make her feel good to wait this long for incontinence care but she really didn't think there was anything she could do about it. She went on to say it was her understanding the NAs had a system where they started at one end of her hall and worked around. She further indicated she must be at the end.

On 09/19/2022 at 2:03 PM Resident #31 was observed to initiate her call light for assistance. A continuous observation revealed at 2:09 PM NA #5 responded to Resident #31's call light. Resident #31 asked NA #5 for incontinence care. An observation of the incontinence care provided by NA #5 at that time revealed Resident #31's incontinence brief was saturated with urine and stool. Her under pad and draw sheet were observed to be soiled with urine. The case on a pillow positioned on Resident #31's left side near her waist was observed to be soiled with urine. A strong odor of urine was present. Resident #31 was not observed to have any skin breakdown on her bottom or perineal area. Slight skin redness was observed present to Resident #31's bottom. An interview with NA #5 at that time indicated Resident #31 was not able to reliably tell if or when she was incontinent. NA #5 stated Resident #31's incontinence brief was saturated with urine and stool. She stated her pad, drawsheet and pillowcase were also soiled with urine. She went on to say this was the first time she provided incontinence care to Resident #31 since she

F 677

assisting residents with ADL care and education of staff. Audit will be completed by 10/18/22.

On 10/7/22, the Social Worker and/or Activities Director initiated resident questionnaire with all alert and oriented residents regarding activities of daily living (ADL) care to include (1) do you have any concerns related to receiving incontinent care and/or assistance with toileting and (2) During baths, do you have any concerns with staff rinsing soap from skin?. The Social Worker and/or Activity staff will address all concerns identified during the questionnaires. Questionnaires will be completed by 10/18/22

On 10/7/22, the Staff Facilitator initiated an in-service with all nurses and nursing assistants regarding (1) ADL Care with emphasis on ensuring resident is provided incontinent care timely and ensuring soap is rinsed from resident skin per manufacturer□s directions during baths and (2) Dignity with Incontinent Care with emphasis on ensuring each resident is treated with respect and dignity and cared for in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life to include providing incontinent care and/or assessing residents not able to verbalize need for incontinent care routinely. In-services will be completed by 10/18/22. After 10/18/22, any nurse or nursing assistant who has not received the in-service will be in-serviced prior to next scheduled work shift. All newly hired

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SPRINGBROOK NURSING & REHABILITATION CENTER	**195 SPRINGBROOK AVENUE** **CLAYTON, NC 27520**

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F 677 Continued From page 10
started her shift at 7:00 AM. She went on to say she had not offered Resident #31 any incontinence care previously that day.

On 09/19/2022 at 2:55 PM an interview with Nurse #4 indicated she was assigned to Resident #31 on the 7AM-3PM shift that day. Nurse #4 went on to say she would help NA's with providing incontinence care or other care to residents when she was asked . She stated NA #5 had not asked her for any assistance with providing incontinence care to Resident #31.

On 09/19/2022 at 3:14 PM a follow-up interview with NA #5 indicated she was assigned to provide care to Resident #31 from 7AM until 3PM that day. She went on to say she was responsible for the usual number of residents. She stated she was familiar with Resident #31. NA #5 went on to say she did not keep track of when Resident #31 was last offered or provided with incontinence care. She stated she had a system where she started her shift by providing care to the residents that needed a shower first. She further indicated she just had not gotten around to Resident #31 yet. She stated she should have provided incontinence care to Resident #31 at least 2 to 3 times during her shift. She stated she had not asked the nurse or other NAs for help with providing incontinence care to Resident #31. She further indicated from 7:00 AM until 2:00 PM was too long for Resident #31 to go without incontinence care. She stated going that long without incontinence care would put Resident #31 at risk for skin breakdown.

On 09/21/2022 at 2:42 PM an interview with Resident #31's physician (MD #2) indicated from 7:00 AM until 2:00 PM was too long for Resident

F 677
nurses and nursing assistants will be in-serviced during orientation regarding ADL Care and Dignity with Incontinent Care

The Unit Managers and Assistant Director of Nursing will complete 15 Resident Care Audits on residents to include resident #31 and resident #7 weekly x 4 weeks then monthly x 1 month and will include all shifts and all days of the week. This audit is to ensure all residents were assisted with ADL care to include but not limited to incontinent care when indicated and/or staff appropriately rinsed soap from resident skin per manufacturer□s directions during bath. The Unit Managers and Assistant Director of Nursing will address all concerns identified during the audit to include providing incontinent care and/or skin care when indicated, and re-education of the staff. The Director of Nursing will review the Resident Care Audits weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed.

The Director of Nursing will present the findings of the Resident Care Audits to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Resident Care Audits to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.

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#31 to go without being provided incontinence care. He stated going that long would put Resident #31 at risk for skin breakdown from friction.

On 09/22/2022 at 11:00 AM an interview with the Director of Nursing (DON) indicated incontinent residents should receive incontinence care at least every 2 to 3 hours and more often if they needed it. She stated she would expect NAs to check residents for incontinence at the beginning of their shift and then every 2 to 3 hours or more frequently as needed. She went on to say Resident #31 had a history of skin issues. She further indicated going from 7:00 AM until 2:00 PM without receiving any incontinence care would put Resident #31 at increased risk for skin breakdown.
2. Resident #7 was admitted to the facility on 5/1/22. His active diagnoses included chronic systolic (congestive) heart failure, cerebrovascular accident (CVA, TIA, or stroke), and hemiplegia or hemiparesis.

Resident #7's care plan dated 8/8/2022 revealed he was care planned activities of daily living care. The interventions included to assist the resident with bathing, personal hygiene, dressing, set up assistance with eating, transfers, bed mobility, and toileting.

Resident #7's minimum data set assessment dated 9/2/22 revealed he was assessed as severely cognitively impaired. He was assessed to have no moods or behaviors. He required extensive assistance with bed mobility, dressing, eating, and personal hygiene. He was totally dependent on staff for transfers, locomotion off unit, and toilet use.

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Review of the manufacturer's directions on the bottle for the soap used for Resident #7 indicated to, "Moisten scalp, skin or washcloth. Apply gel, lather, and rinse thoroughly."

During observation on 9/20/22 at 10:48 AM Nurse Aide #1 was observed providing a bath for Resident #7. Nurse Aide #1 added warm water and soap to a wash bin. Soap suds were visible in the soap bin water. Nurse Aide #1 then placed a washcloth in the soap water and used this to clean the resident's arms and upper body with soap suds visible on the skin. Nurse Aide #1 then put the washcloth back in the soap water, wrung out the washcloth, and used this to then go over the areas of Resident #7's skin he just washed and then patted the resident dry. Nurse Aide #1 proceeded to complete Resident #7's bath in this manner.

During an interview on 9/20/22 at 11:22 AM Nurse Aide #1 stated in hindsight he should have had a system to rinse the soap from the resident's skin, but because he only had one wash bin, he only had the water with soap in it which was why he did not rinse the soap from the resident's skin prior to drying it.

During an interview on 9/20/22 at 1:45 PM the Director of Nursing stated Nurse Aide #1 should have rinsed the soap from the skin prior to drying the skin to avoid skin irritation.

F 693 SS=D Tube Feeding Mgmt/Restore Eating Skills F 693 10/18/22
CFR(s): 483.25(g)(4)(5)

§483.25(g)(4)-(5) Enteral Nutrition
(Includes naso-gastric and gastrostomy tubes,

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both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-

§483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and

§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interviews, Physician interview and family interview, the facility failed to provide the resident's tube feeding according to the Physician's orders for 1 of 1 resident (Resident #249) reviewed for tube feeding.

Findings included:

Resident #249 was admitted to the facility on 9-13-22 with multiple diagnoses that included unspecified protein-calorie malnutrition.

Upon admission, Resident #249 was documented as alert and oriented to place.

The hospital discharge summary dated 9-13-22

F 693

F693 Tube Feeding Management/Restore Eating Skills

On 9/16/22, the assigned nurse clarified the orders for resident #249 feeding tube. The electronic record was updated, and tube feedings initiated per physician orders.

On 10/7/22, the Unit Managers, Assistant Director of Nursing and Director of Nursing initiated an audit of all physician□s orders for the past 30 days to include admission orders and orders for tube feedings. This audit is to ensure orders were completed per physician recommendation. The Unit Managers,

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F 693	Continued From page 14 revealed an order for Resident #249 to receive "one can" (can of fortified nutritional supplement), every 4 hours, 4 times a day and a heart healthy puree diet. Review of the facility's Physician orders from 9-13-22 to 9-15-22 revealed Resident #249's tube feeding order was not written until 6:58pm on 9-14-22. Resident #249's care plan dated 9-14-22 revealed a goal that she would be free from complications of tube feeding. The interventions for the goal were in part observe for signs and symptoms of tube feeding complications, elevate the head of the bed, care for tube feeding site per facility protocol. Review of a Physician order dated 9-14-22 revealed Resident #249 was to receive 240ml (milliliters) of tube feeding followed by 240ml of water every 4 hours. A Physician order dated 9-15-22 revealed Resident #249 was to have nothing by mouth (NPO). Resident #249's Medication Administration Record (MAR) for the month of September 2022 revealed no documentation that Resident #249 received her tube feedings until 9-15-22 at 8:30am. During a family interview on 9-19-22 at 2:31pm, the family member voiced concern that she did not think Resident #249 received her tube feedings for several days. The family member explained she had brought several cans of the tube feeding the resident received in the hospital	F 693	Assistant Director of Nursing and Director of Nursing will address all concerns identified during the audit to include but not limited to assessment of the resident, notification of the physician for all concerns identified for clarification of orders and/or further recommendations and education of staff. Audit will be completed by 10/18/22. On 10/7/22, the Unit Managers initiated an in-service with all nurses regarding Transcribing/Following Physician Orders. Emphasis is on (1) ensuring all orders to include but not limited to admission orders, treatments, consult orders, diet orders, orders for labs, x-rays and/or tube feedings are transcribed accurately to the eMAR/eTAR and are completed per physician order (2) all orders must be verified by 2 nurses to ensure orders are transcribed accurately and (3) notification of the physician for any order not clearly defined or that cannot be completed as ordered for further instruction. In-service will be completed by 10/18/22. After 10/18/22, any nurse who has not worked or completed the in-service will be in-serviced prior to next scheduled work shift. All newly hired nurses will be in-serviced during orientation regarding Transcribing/Following Physician Orders. The Unit Managers, Assistant Director of Nursing and Minimum Data Set Nurses will review all newly written physician orders to include but not limited to admission orders, treatments, consult orders, diet orders, orders for labs, x-rays	

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and placed it on the resident's countertop. She stated each day she had come to visit Resident #249; the same number of cans would be on the resident's countertop. The family member said she had spoken with staff about the resident's tube feeding and stated the staff would tell her the facility was trying to obtain an order to provide the tube feeding.

A telephone interview occurred with Nurse #1 on 9-20-22 at 10:14am. Nurse #1 confirmed she was the admitting nurse for Resident #249 on 9-13-22 around 3:00pm. She stated she had reviewed the hospitals discharge orders with the facility Physician on 9-13-22 around 3:30pm but said she could not remember verifying any tube feeding orders for resident #249. Nurse #1 also stated she did not provide tube feedings to Resident #249 but clarified the resident should have received a feeding at 4:00pm on 9-13-22.

An interview with Nurse #2 occurred on 9-20-22 at 10:52am. Nurse #2 discussed being assigned to Resident #249 on 9-14-22 from 7:00am to 7:00pm. She explained she did not review the resident's orders because when she arrived to work the previous nurse had informed her all the orders were in the computer system. Nurse #2 said she was aware Resident #249 had a percutaneous endoscopic gastrostomy (PEG) tube for tube feedings but did not see any feedings were scheduled on her shift. The nurse explained when Resident #249's family member arrived for a visit late in the afternoon of 9-14-22, the family member had questioned her about the resident's tube feedings. She said it was then she realized there had not been an order obtained for Resident #249's tube feedings so she called the Physician and obtained an order at 6:58pm on

F 693

and/or tube feedings 5 times a week x 4 weeks then monthly x 1 month utilizing the Orders Listing Report to ensure orders were transcribed accurately to the eMAR/eTAR and completed per physician orders. The Unit Managers, Assistant Director of Nursing and Minimum Data Set Nurses will address all concerns identified during the audit to include but not limited to assessment of the resident, notification of the physician for all concerns identified for clarification of orders and/or further recommendations and re-education of staff. The Director of Nursing will review the Orders Listing Report 5 days a week x 4 weeks then monthly x 1 month to ensure all concerns were addressed.

The Director of Nursing will present the findings of the Orders Listing Report to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Orders Listing Report to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.

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9-14-22. Nurse #2 stated she could not remember if she provided a tube feeding to the resident but thought she may have and just forgot to document the tube feeding.

During a telephone interview with Nurse #3 on 9-20-22 at 12:21pm, the nurse confirmed she had worked 7:00pm to 7:00am on 9-14-22 and was assigned to Resident #249. Nurse #3 stated upon her arrival to work, she assisted Nurse #2 to place Resident #249's tube feeding order into the computer system. She said Resident #249 could have a tube feeding at 8:00pm but she did not provide the feeding. She explained the resident's family member was present and thought the family member would provide the tube feeding. Nurse #3 stated she did not know if the family member had provided the tube feeding.

Physician #1 was interviewed by telephone on 9-20-22 at 2:27pm. The Physician stated he had received a call to review Resident #249's hospital discharge orders but said he could not remember if the resident's tube feedings were discussed at that time. The Physician discussed the possibility of Resident #249 declining if she had not received her tube feedings for 2 days but clarified the labs he had obtained on 9-15-22 did not reflect Resident #249 had gone 2 days without tube feedings.

The Director of Nursing (DON) was interviewed on 9-20-22 at 4:09pm. The DON stated the admitting nurse should have clarified Resident #249's tube feeding orders and placed the order into the facility's computer system.

During an interview with the Administrator on 9-22-22 at 11:45am, the Administrator stated she

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F 693	Continued From page 17 expected all orders to be clarified upon admission and entered in the computer system. She also said she expected the staff following the admission to also review, clarify and ensure all orders are entered into the computer.	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to notify the Physician of the Pulmonologist consult recommendations for Resident #11. This was for 1 of 2 residents reviewed for respiratory. Findings included: Resident #11 was admitted to the facility on 10/04/21 with a diagnosis which included chronic obstructive pulmonary disease. The annual Minimum Data Set dated 9/02/22 revealed Resident #11 was cognitively intact, and he was coded for oxygen usage. Review of Resident #11's Pulmonary consult dated 3/10/22 revealed the Pulmonologist recommended the following:	F 695	F695 Respiratory/Tracheostomy Care and Suctioning On 9/21/21, resident # 11 was seen by the pulmonologist. All recommendations were forward to the attending physician and initiated per physician orders. On 10/7/22, the Director of Nursing and Assistant Director of Nursing initiated an audit of all consult appointments from 6/1/22 to 10/7/22 to include resident # 11 to ensure all recommendations were reviewed by the physician and the electronic record updated per physician orders and follow up appointments scheduled as recommended. The Director of Nursing and Assistant Director of Nursing will address all concerns	10/18/22

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- a follow up appointment in about 3 months
- Budesonide (anti inflammatory for lungs) one vial twice daily
- Performist (relaxes the lung muscles) twice daily
- Duonebs (respiratory inhalant) four times a day while awake
- Auto bipap (bilevel positive airway pressure which is a breathing machine that delivers 2 levels of air pressure) at night with oxygen

Review of Resident #11's electronic medical record (EMR) for March 2022 revealed the resident had orders Budesonide twice daily (ordered 10/26/21), Cpap (continuous positive airway pressure which is a breathing machine that delivers a continuous level of air pressure) at night with oxygen (ordered 10/26/21), and duoneb (ipratropium and albuterol ordered 11/08/21) and no orders were discovered for Performist, bipap, or the Pulmonary follow up appointment.

An interview on 9/20/22 at 2:42 PM with the Transportation Director revealed she was not employed at the facility until the end of June. She was unable to locate any information related to a follow up Pulmonary appointment for Resident #11 since his Pulmonary consult on 3/10/22.

An interview, conducted in conjunction with a record review, on 9/20/22 at 3:37 PM with the Director of Nursing (DON) confirmed that Resident #11 had no orders for Performist or bipap and had not been scheduled for a follow up Pulmonary appointment since his 3/10/22 consult.

An interview on 9/21/22 at 11:19 AM with Physician #1 revealed he was not aware that Resident #11 had a Pulmonary consult in March

F 695

identified during the audit to include notification of the physician for further recommendations, initiating orders per physician orders, scheduling follow up appointments when indicated and/or education of staff. The Audit will be completed by 10/18/22.

On 10/7/22, the Unit Managers initiated an in-service with all nurses regarding Transcribing/Following Physician Orders. Emphasis is on (1) immediately notifying the physician of all consult recommendations for approval (2) ensuring all orders to include but not limited to consult orders/recommendations are transcribed accurately to the eMAR/eTAR and are completed per physician order () ensuring all follow up appointments are scheduled per orders and/or physician notified if follow up appointments cannot be completed timely for further recommendations. In-service will be completed by 10/18/22. After 10/18/22, any nurse who has not worked or completed the in-service will be in-serviced prior to next scheduled work shift. All newly hired nurses will be in-serviced during orientation regarding Transcribing/Following Physician Orders.

The Medical Records Director and Unit Managers will review all consult recommendations to include new orders and/or recommendations for follow up appointments 5 times a week x 4 weeks then monthly x 1 month utilizing the Consult Audit Tool to ensure the physician

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F 695	Continued From page 19 and had not seen the Pulmonologist's notes or recommendations. He stated Resident #11 was very stable on his current respiratory medications and treatments so he would not have changed them at that time. He further stated the resident should have had his recommended follow up Pulmonary appointment. An interview on 9/21/22 at 12:09 PM with the Administrator confirmed that Physician #1 should have been provided the Pulmonary consult recommendations and she did not know why it was not done.	F 695	was notified of all consult recommendations, orders were transcribed accurately to the eMAR/eTAR and completed per physician order and follow up appointments were scheduled per recommendations and/or the physician notified if follow up appointments cannot be completed timely for further recommendations. The Medical Records Director will address all concerns identified during the audit to include but not limited to assessment of the resident, notification of the physician for all concerns identified for clarification of orders and/or further recommendations, scheduling follow up appointments when indicated and re-education of staff. The Director of Nursing will review the Consult Audit Tool 5 days a week x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will present the findings of the Consult Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Consult Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or	F 745		10/18/22

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F 745	Continued From page 20 maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interviews, the facility failed to arrange a follow-up pulmonary appointment for 1 of 1 resident reviewed for respiratory care (Resident #11). Findings included: Resident #11 was admitted to the facility on 10/04/21 with diagnoses which included chronic obstructive pulmonary disease. The annual Minimum Data Set dated 9/02/22 revealed Resident #11 was cognitively intact and he was coded for receiving oxygen. Review of Resident #11's pulmonary consult dated 3/10/22 revealed the Pulmonologist recommendation for a return appointment 'in about 3 months or around 6/10/22.' Review of Resident #11's electronic medical record revealed no pulmonary follow up appointment. An interview on 9/20/22 at 2:42 PM with the Transportation Director confirmed her position was responsible for scheduling resident follow up appointments but she was not employed at the facility until the end of June. She was unable to locate any information related to a follow up pulmonary appointment for Resident #11 since his pulmonary consult on 3/10/22. She stated she was supposed to receive a copy of the consult paperwork to review for follow up appointment recommendations and schedule the appointment.	F 745	F745 Provision of Medically Related Social Services On 9/21/21, resident # 11 was seen by the pulmonologist. All recommendations were forward to the attending physician and initiated per physician orders On 10/7/22, the Director of Nursing and Assistant Director of Nursing initiated an audit of all consult appointments from 6/1/22 to 10/7/22 to ensure all recommendations were reviewed by the physician and the electronic record updated per physician orders and follow up appointments scheduled as recommended. The Director of Nursing and Assistant Director of Nursing will address all concerns identified during the audit to include notification of the physician for further recommendations, initiating orders per physician orders, scheduling follow up appointments when indicated and/or education of staff. The Audit will be completed by 10/18/22 On 10/7/22, the Unit Managers initiated an in-service with all nurses regarding Transcribing/Following Physician Orders. Emphasis is on (1) immediately notifying the physician of all consult recommendations for approval (2) ensuring all orders to include but not limited to consult orders/recommendations are transcribed	

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F 745	Continued From page 21 An interview on 9/20/22 at 2:45 PM with the Medical Records Director and the Transportation Director revealed she was unable to locate any information related to a follow up pulmonary appointment for Resident #11. An interview on 9/20/22 at 3:37 PM with the Director of Nursing (DON) confirmed that Resident #11 had not been scheduled for a follow up pulmonary appointment since his 3/10/22 consult. An interview on 9/21/22 at 11:19 AM with Physician #1 confirmed that Resident #11 should have had a pulmonary follow up appointment as recommended by the Pulmonologist. An interview on 9/21/22 at 12:09 PM with the Administrator confirmed that Resident #11 should have had a follow up appointment and she did not know why it was not done.	F 745	accurately to the eMAR/eTAR and are completed per physician order () ensuring all follow up appointments are scheduled per orders and/or physician notified if follow up appointments cannot be completed timely for further recommendations. In-service will be completed by 10/18/22. After 10/18/22, any nurse who has not worked or completed the in-service will be in-serviced prior to next scheduled work shift. All newly hired nurses will be in-serviced during orientation regarding Transcribing/Following Physician Orders. The Medical Records Director and Unit Managers will review all consult recommendations to include new orders and/or recommendations for follow up appointments 5 times a week x 4 weeks then monthly x 1 month utilizing the Consult Audit Tool to ensure the physician was notified of all consult recommendations, orders were transcribed accurately to the eMAR/eTAR and completed per physician order and follow up appointments were scheduled per recommendations and/or the physician notified if follow up appointments cannot be completed timely for further recommendations. The Medical Records Director and Unit Managers will address all concerns identified during the audit to include but not limited to assessment of the resident, notification of the physician for all concerns identified for clarification of orders and/or further recommendations, scheduling follow up appointments when indicated and	

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F 745	Continued From page 22	F 745	re-education of staff. The Director of Nursing will review the Consult Audit Tool 5 days a week x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Director of Nursing will present the findings of the Consult Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Consult Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented	F 758		10/18/22

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F 758	Continued From page 23 in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Pharmacy consultant, and Physician interviews, the facility failed to ensure Physician's orders for an as needed (PRN) psychotropic medication (drug that effects the mental state) were time limited in duration for 2 of 5 residents (Resident #1 and Resident #24) reviewed for unnecessary medications.	F 758	F758 Free of Unnecessary Psychotropic Meds/PRN use On 9/21/22, the Director of Nursing clarified desired stop date for resident #1 order for PRN Ativan. A new order was written, and the medication administration record updated to include a stop date for use.	

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F 758	Continued From page 24 Findings included: 1.Resident #1 was admitted to the facility on 9-13-22 with multiple diagnoses that included anxiety. Upon admission on 9-13-22 Resident #1 was documented as moderately cognitively impaired. Resident #1's care plan dated 9-14-22 revealed a goal that she will tolerate the lowest therapeutic dose of psychotropic medications. The interventions for the goal were in part administer psychotropic medications per the Physician orders. Review of the Physician orders for 9-13-22 revealed an order for Resident #1 to have Lorazepam (antianxiety medication) 2mg (milligrams) every 6 hours as needed for anxiety. The order was observed to not have a stop date. Nurse #1 was interviewed on 9-21-22 at 10:35am. Nurse #1 stated PRN psychotropic medication should have a stop date within 14 days of when the order was written. She explained if the PRN medication did not have a stop date, she would contact the Physician and obtain a stop date. Nurse #1 said she was unaware Resident #1's PRN Lorazepam did not have a stop date because she had not provided Resident #1 the PRN medication. The Pharmacy Consultant was interviewed by telephone on 9-21-22 at 11:51am. The Consultant stated she had not seen Resident #1 yet because she was a new admission, so she was unaware the resident had a PRN Lorazepam order without a stop date. She said a PRN Lorazepam order	F 758	On 10/7/22, the PRN Ativan order for resident #24 was discontinued per pharmacy recommendation and physician order. On 10/7/22, the Director of Nursing initiated an audit of all PRN psychotropic medications to ensure PRN psychotropic medications for all residents to include resident # 1 and resident #24 were limited to a duration of 14 days unless the attending physician or prescribing practitioner documented the rational for the extended time period in the medical record and indicated the specific duration. There were no additional concerns identified. On 10/7/22, the Unit Managers initiated an in-service will all nurses and providers regarding PRN Psychoactive Medication Monitoring with emphasis on limiting the duration of PRN psychotropic medication use to a duration of 14 days unless the attending physician or prescribing practitioner documents the rational for the extended time period in the medical record and indicates the specific duration. In-service will be completed by 10/18/22. After 10/18/22, any nurse or provider who has not received the in-service will be in-serviced prior to next scheduled work shift. All newly hired nurses and/or providers will be in-serviced during orientation regarding PRN Psychoactive Medication Monitoring. 10% audit of all residents to include	

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F 758	Continued From page 25 should have a stop date within 14 days from when the order was written. Physician #2 was interviewed by telephone on 9-21-22 at 2:36pm. Physician #2 stated Resident #1's 9-13-22 order for Lorazepam 2mg every 6 hours as needed should have had a stop date written. He stated the order had slipped through the cracks and was missed. During an interview with the Director of Nursing (DON) on 9-22-22 at 10:45am, the DON stated the process for PRN stop dates was the Pharmacy Consultant would review the medications, send the recommendation for a stop date to the facility and the facility would give the recommendation to the Physician. She explained since Resident #1 was a new admission, the nurse liaison was responsible for reviewing the medications and checking for PRN stop dates. The DON stated the nurse liaison was also new and may not have known to check for the stop dates on PRN's. The Administrator was interviewed on 9-22-22 at 11:45am. The Administrator stated she expected staff to have approved documentation that included what the medication was for and a stop date if needed. 2. Resident #24 was initially admitted to the facility on 7/06/22, was hospitalized on 8/15/22 and readmitted to the facility on 8/29/22 on with diagnoses which included anxiety and depression. The 5-day Minimum Data Set dated 9/04/22 revealed Resident #24 was cognitively intact. During the look back period, she was coded for rejection of care for 1 - 3 days and had received	F 758	resident # 1 and #24 physician orders for PRN psychotropic medications will be reviewed by the Unit Managers and Assistant Director of Nursing weekly x 4 weeks then monthly x 1 month utilizing the Psychoactive Medication Audit Tool. This audit is to ensure that the duration of the psychotropic medication is limited to 14 days unless the attending physician or prescribing practitioner documented the rational for the extended time period in the medical records. The Unit Managers and Assistant Director of Nursing will obtain a clarification order from the physician and retrain the nurse for any identified areas of concerns during the audit. The DON will present the findings of the Psychoactive Medication Audit Tool to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Psychoactive Medication Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 758

Continued From page 26
no antianxiety medications.

Resident #24's care plan, created on 7/26/22 and last revised on 9/07/22, revealed a focus for psychotropic drugs with the potential for side effects related to antidepressant and antianxiety. The interventions included monitoring for tremors and for the Physician to evaluate the effectiveness and side effects.

A Physician's order dated 7/17/22 read in part for Lorazepam (antianxiety medication) 0.5 milligrams (mg) by mouth every 12 hours as needed (PRN) for anxiety/anxiousness. There was no stop date.

On her readmission to the facility, a Physician's order dated 8/30/22 read in part for Lorazepam 0.5 mg by mouth every 12 hours PRN for anxiety. There was no stop date.

Review of Resident #24's Medication Administration Records (MAR) for July, August, and September revealed she received Lorazepam 6 times in July (July 20, 26, 27, 29, 30, and 31), 2 times in August (August 3 & 9); and 2 times in September (September 5 & 6).

Reviews of the monthly drug regimen review dated July 21, 2022, completed by the Consultant Pharmacist for Resident #24 included a recommendation to the physician that read in part that Centers for Medicaid and Medicare Services (CMS) guidelines limit the duration of PRN psychotropic orders to 14 days with an area for the Physician to discontinue or add for a stop date for the Lorazepam.

Review of the Consultant Pharmacist drug review

F 758

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F 758	Continued From page 27 recommendation revealed it was signed by Physician #2 with no discontinuation or stop date noted. An interview on 9/21/22 at 11:38 AM with Consultant Pharmacist confirmed she was aware of the need for a stop date for PRN psychotropic medications. She stated that on the monthly regimen review she had made a recommendation to the physician for a stop date or discontinuation of Resident #24's Lorazepam. She stated she had not completed the August review due to the resident's hospitalization and had not yet completed the September monthly review. An interview on 9/21/22 at 2:36 PM with Physician #2 revealed he was aware of the need for a stop date for PRN psychotropic medications and did not know why Resident #24's Lorazepam did not have a stop date. He stated it was "Just missed and must have slipped through the cracks. " An interview on 9/21/22 at 12:06 PM with the Administrator revealed she was aware of the need for a stop date for as needed psychotropic medications and did not know why there was no stop date.	F 758		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		10/18/22

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F 812	Continued From page 28 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to serve food in sanitary conditions by a staff not covering their hair while preparing and serving food in 1 of 4 kitchenettes observed (Hall 300/400 Kitchenette) and failed to dry plate covers individually for 1 of 1 dishwashing observations in the main kitchen. Findings included: 1. During observation on 9/20/22 at 8:30 AM Dietary Aide #1 did not have a hairnet on while she was plating food for breakfast at the Hall 300/400 Kitchenette. During observation on 9/20/22 at 12:23 PM Dietary Aide #1 was again observed plating food at the Hall 300/400 Kitchenette. Dietary Aide #1 did not have a hairnet on while she was plating food for lunch. During an interview on 9/20/22 at 12:27 PM Dietary Aide #1 stated she did not realize she was not wearing a hair net and should have been for infection control.	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) On 9/20/22, the Dietary Manager immediately educated dietary staff #1 on use of hair net when in the kitchen and/or kitchenettes preparing food to maintain sanitary conditions. The dietary staff obtained and applied a hair net while in kitchenette area per facility protocol. On 9/21/22, the Dietary Manager removed all plate covers found to be stacked wet, re-washed the plate covers and air dried per facility protocol. On 9/20/22, the Dietary Manager completed an audit of all dietary staff to ensure staff were wearing appropriate hair net when working in the kitchen or kitchenette areas per facility protocol. There were no additional concerns identified. On 9/21/22, the Dietary Manager under	

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F 812	Continued From page 29 During an interview on 9/20/22 at 12:28 PM the Dietary Manager stated staff should wear a hairnet when preparing and serving food at the kitchenettes and Dietary Aide #1 did not have one on and should have. During an interview on 9/20/22 at 2:13 PM the Administrator stated staff should wear hair nets when preparing and serving food. 2. During observation on 9/21/22 at 8:28 AM plate covers were observed in the kitchen on the drying rack next to the dishwasher. There were 15 plate covers and they were stacked or nested in each other where they were placed on the drying rack. When the Dietary Manager removed the 15 plate covers from the nested stack, water was observed on the surfaces of each plate cover. During an interview on 9/21/22 at 8:28 AM the Dietary Manager stated the plates should have been stored separately to dry to prevent bacterial and other growth. He concluded he would separate the lids for drying immediately. During an interview on 9/21/22 at 11:34 AM the Administrator stated when dishes were drying including plate covers, they should not be nested when drying.	F 812	the oversight of the Administrator completed an audit of all kitchenware. This audit is to ensure all kitchenware was dried per facility protocol and not stored wet. There were no additional identified concerns during audit. On 9/21/22 the Dietary Manager initiated an in-service with all dietary staff regarding (1) Wet Nesting with emphasis on not stacking kitchenware wet to prevent bacteria growth and (2) Hair Nets with emphasis on use of hair nets when in the kitchen and/or kitchenette areas to maintain a sanitary environment for meal prep All in-services will be completed by 10/18/22. After 10/18/22, any dietary staff who has not worked or completed the in-service will be in-serviced prior to next scheduled work shift. All newly hired dietary staff will be in-serviced during orientation regarding Wet Nesting and Hair Nets. 100% audit of kitchenware will be observed by the Environmental Service Director and/or Dietary Consultant to ensure all kitchenware was dried per facility protocol and not stored wet and that staff donn appropriate hair net when in food prep areas 3 times a week x 4 weeks then monthly x 1 month utilizing the Kitchen Audit Tool. The Environmental Service Director and/or Dietary Consultant will address all concerns identified during the audit to include re-washing any kitchenware not dried per facility protocol and/or re-education of staff when indicated. The Administrator will review	

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F 812	Continued From page 30	F 812	the Kitchen Audit Tool 3 times a week x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The DON will present the findings of the Kitchen Audit Tool to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Kitchen Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with resident, physician, Pharmacy Consultant, and staff, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the 10/19/2019 complaint survey, 12/19/2019 recertification/complaint survey, 3/9/2021 complaint survey, and 8/20/2021 recertification/complaint survey. This was for 7 deficiencies cited on the current recertification/complaint survey of 9/22/22: 3 deficiencies were cited on 12/19/2019 and	F 867	F867 QAPI/QAA Improvement Activities On 10/7/22, The Facility Consultant initiated an audit of previous citations and action plans within the past two years to include F550 Dignity and Respect, F582 Notice of Medicare Non-Coverage (NOMNC), F677 ADL Care Provided to Dependent Residents, F745 Medically Related Social Services, F758 Free from Unnecessary Psychotropic Meds/PRN Use, F812 Dietary Services and F883	10/18/22

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F 867	Continued From page 31 8/20/2021 in the areas of F582 Medicaid/Medicare Coverage Liability Notice, F758 Free From Unnecessary Psychotropic Medication, and F812 Food Storage; 1 deficiency was cited on 10/19/2019 and 8/20/2021 in the area of F550 Dignity; 1 deficiency was cited on 8/20/2021 and 3/9/2021 in the area of F677 Activities of Daily Living Care Provided for Dependent Residents; and 2 deficiencies were cited on 8/20/2021 in the areas of F745 Provision of Medically Related Social Services and F883 Influenza and Pneumococcal Vaccinations. The continued failure of the facility during 2 or more federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA. Findings included: This tag is cross referenced to: 1. F550: Based on observations, record review, and resident and staff interviews the facility failed to provide incontinence care causing the resident to feel not good but there was nothing she could do about it for 1 of 6 residents reviewed for activities of daily living care. (Resident #31) During the recertification/complaint survey of 8/20/2021 the facility was cited for failing to maintain a dignified dining experience. During the 10/19/2019 complaint survey the facility was cited for failure to ensure a resident was able to use a bedside commode without urine spilling onto the floor causing embarrassment. 2. F582: Based on record review and staff interviews the facility failed to provide a Notice of	F 867	Influenza and Pneumococcal Immunizations to ensure the QA committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QA Committee by the Administrator for any concerns identified. The Facility Consultant will address all concerns identified during the audit to include but not limited to education of staff. Audit will be completed by 10/18/22. On 10/7/22, the Facility Consultant initiated an in-service with the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON) regarding the Quality Assurance (QA) process to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QA process, and modification and correction if needed to prevent the reoccurrence of deficient practice to include professional standards. In-service also included identifying issues that warrant development and establishing a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA process. In-service will be completed by 10/18/22. All newly hired Administrator, DON and QA nurse will be educated during orientation regarding the QA Process. All data collected for identified areas of concerns to include dignity and respect, NOMNC, ADL care, medically related social services, psychotropic medications,	

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F 867	Continued From page 32 Medicare Non-Coverage (NOMNC) and Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) for 1 of 3 residents reviewed for beneficiary notices (Resident #71). During the recertification/complaint survey of 8/20/2021 the facility was cited for failing to provide a Notice of Medicare Non-Coverage (NOMNC) and Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN). During the recertification/complaint survey of 12/19/2019 the facility was cited for failing to provide a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN). 3. F677: Based on observations, record review, and resident, staff and physician interviews the facility failed to provide incontinence care (Resident #31) and failed to rinse soap from a resident's skin per manufactures directions during a bath (Resident #7) for 2 of 6 residents reviewed for activities of daily living care. During the recertification/complaint survey of 8/20/2021 the facility was cited for failing to provide showers or bed baths to dependent residents. During the 3/9/2021 complaint survey the facility was cited for failing to maintain dependent resident's fingernails trimmed. 4. F745: Based on record review, staff and physician interviews, the facility failed to arrange a follow-up pulmonary appointment for 1 of 1 resident reviewed for respiratory (Resident #11). During the recertification/complaint survey of	F 867	dietary services, and immunizations will be taken to the Quality Assurance committee for review monthly x 6 months by the Administrator. The Quality Assurance committee will review the data and determine if plan of corrections are being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the QA Nurse. The Facility Nurse Consultant will ensure the facility is maintaining an effect QA program by reviewing and initialing the Executive committee Quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include interventions to ensure residents are treated with dignity and respect, completion of NOMNC, ADL care, medically related social services, psychotropic medications, dietary services, and immunizations and all current citations and QA plans are followed and maintained Quarterly x2. The Facility Consultant will immediately retrain the Administrator, DON and QA nurse for any identified areas of concern. The results of the Monthly Quality Assurance meeting minutes will be presented by the Quality Assurance Nurse to the Executive Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated	

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F 867	Continued From page 33 8/20/2021 the facility was cited for failure to arrange a follow-up appointment. 5. F758: Based on record review, staff, Pharmacy consultant, and Physician interviews, the facility failed to ensure Physician's orders for an as needed (PRN) psychotropic medication (drug that effects the mental state) were time limited in duration for 2 of 5 residents (Resident #1 and Resident #24) reviewed for unnecessary medications. During the recertification/complaint survey of 8/20/2021 the facility was cited for failure to obtain a stop date for prn psychotropic medication and for not completing a Dyskinesia Identification System Condensed User Scale (DISCUS). During the recertification/complaint survey of 12/19/2019 the facility was cited for failure to obtain a stop date for prn psychotropic medication. 6. F812: Based on observations and interviews the facility failed to serve food in sanitary conditions by a staff not covering their hair while preparing and serving food in 1 of 4 kitchenettes observed (Hall 300/400 Kitchenette) and failed to dry plate covers individually for 1 of 1 dishwashing observations in the main kitchen. During the recertification/complaint survey of 8/20/2021 the facility was cited for failing to label opened foods with a use by date. During the recertification/complaint survey of 12/19/2019 the facility was cited for failing to change gloves.	F 867	to determine the need and/or frequency of continued monitoring.	

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F 867 Continued From page 34 F 867

7. F883: Based on record review and staff interviews the facility failed to include documentation in the resident's medical record to reflect education was provided regarding the benefits and potential side effects of receiving the pneumococcal vaccine and failed to include why vaccines were not administered for 3 of 5 residents reviewed for immunizations (Residents #11, #70, and #88).

During the recertification/complaint survey of 12/19/2019 the facility was cited for failing to assess residents for eligibility and offer pneumococcal vaccinations upon admission to the facility and for failing to offer annual influenza vaccine.

In an interview on 9/22/2022 at 11:25 AM the Administrator stated she felt the facility's failure to maintain the corrective actions put in place by their QAA Committee was due to the frequent changeover in management staff and the facility's being overwhelmed during the COVID pandemic. She went on to say there had been changeover in Director of Nursing, Transportation, and Kitchen management staff. She further indicated she felt the facility now had stable staff in these positions and was working hard to phase out agency staff with permanent staff. The Administrator stated with the consistency of staff and ongoing training the issues would get better.

F 883 SS=D Influenza and Pneumococcal Immunizations
CFR(s): 483.80(d)(1)(2) F 883 10/18/22

§483.80(d) Influenza and pneumococcal immunizations
§483.80(d)(1) Influenza. The facility must develop

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F 883	Continued From page 35 policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883		

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F 883	Continued From page 36 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to include documentation in the resident's medical record to reflect education was provided regarding the benefits and potential side effects of receiving the pneumococcal vaccine and failed to include why vaccines were not administered for 3 of 5 residents reviewed for immunizations (Residents #11, #70, and #88). Findings included: The facility policy for New Admission Vaccination Screening dated 2/23/22 read in part "Regarding Pneumococcal immunizations, facilities are expected to follow Centers for Disease Control (CDC) and ACIP (Advisory Committee on Immunization Practices) recommendations. This means facilities need to have a protocol in place for the administration of pneumococcal vaccine(s)." 1. Resident #11 was admitted to the facility on 10/04/21. His annual Minimum Data Set dated 9/02/22 revealed diagnoses which included chronic obstructive pulmonary disease and heart failure and he was coded to be cognitively intact.	F 883	F883 Influenza and Pneumococcal Immunizations The Director of Nursing (DON) and/or Infection preventionist will clarify immunization history to include but not limited to influenza and pneumococcal, and COVID for residents #11 and resident #70. The resident or resident representative will be education on the risk and benefits of receiving/declining vaccine, consent obtained when indicated, and MD notified to obtain order per resident preference. Vaccines will be provided per physician□s order and/or documentation of resident refusal following education of risk/benefits of the vaccine by 10/18/22. Resident #88 no longer resides in the facility. On 9/23/22, the DON and/or Infection Control Preventionist initiated an audit of immunizations/ vaccines to include but not limited to Influenza, Pneumococcal and	

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F 883	Continued From page 37 Review of Resident #11's immunization record revealed no pneumococcal vaccinations had been administered or refused. An interview on 9/21/22 at 8:35 AM with the Director of Nursing (DON) who was also the Acting Infection Control Nurse confirmed Resident #11 had not received the pneumococcal vaccine and she did not know why it had not been given. She stated the previous Infection Control Nurse should have monitored newly admitted residents to ensure they were offered or given the pneumococcal vaccine and she had not done so. An interview on 9/21/22 at 12:14 PM with the Administrator confirmed that Resident #11 should have received the pneumococcal vaccine and she did not know why it had not been done. 2. Resident #70 was admitted to the facility on 5/10/22. His quarterly Minimum Data Set dated 8/22/22 revealed diagnoses which included obstructive hypertrophic cardiomyopathy and stroke and he was coded to have severe cognitive impairment. Review of Resident #70's immunization record revealed no pneumococcal vaccinations had been administered or refused. An interview on 9/21/22 at 8:35 AM with the Director of Nursing (DON) who was also the Acting Infection Control Nurse confirmed Resident #70 was eligible for the pneumococcal vaccine due to his medical conditions but had not received the pneumococcal vaccine and she did not know why it had not been given. She stated the previous Infection Control Nurse should have	F 883	Covid vaccines for all current residents. This audit was to identify any resident who had not been provided the Influenza, Pneumococcal or Covid vaccine or have a documented refusal of immunization per facility protocol and to ensure residents/resident representative was educated on the risk/benefits of receiving/refusing vaccine with documentation in the electronic record. The DON and Infection Preventionist will address all concerns identified during the audit to include education of the resident/resident representative of risks/benefits of receiving/refusing vaccine with documentation in the electronic record, providing vaccine per resident preference and/or education of staff. Audit will be completed by 10/18/22. On 10/7/22, the Unit Managers initiated an in-service with all nurses regarding Immunizations. Emphasis is on educating resident/resident representative on the risks/benefits or receiving/refusing vaccines, obtaining consent and physician order for vaccine per resident preference, administering vaccine per physician order with documentation in the electronic record and/or documentation of resident refusal if vaccine declined. In-service will be completed by 10/18/22. After 10/18/22, any nurse who has not worked or received the in-service will complete in-service prior to next scheduled work shift. All newly hired nurses will be in-serviced during orientation regarding Immunizations.	

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F 883	Continued From page 38 monitored newly admitted residents to ensure they were offered or given the pneumococcal vaccine and she had not done so. An interview on 9/21/22 at 12:14 PM with the Administrator confirmed that Resident #70 should have received the pneumococcal vaccine and she did not know why it had not been done. 3. Resident #88 was admitted to the facility on 8/29/22. Her admission Minimum Data Set dated 9/04/22 revealed diagnoses which included coronary artery disease and hypertension and she was coded to be cognitively intact. Review of Resident #88's immunization record revealed no pneumococcal vaccinations had been administered or refused. An interview on 9/21/22 at 8:35 AM with the Director of Nursing (DON) who was also the Acting Infection Control Nurse revealed she did not know if Resident #88 had received the pneumococcal vaccine prior to admission or not. She stated she did not know why it had not been documented as given prior to admission or the resident had not received the vaccine since admission to the facility. She stated the previous Infection Control Nurse should have monitored newly admitted residents to ensure they were offered or given the pneumococcal vaccine and she had not done so. An interview on 9/21/22 at 12:14 PM with the Administrator confirmed that Resident #88 should have received the pneumococcal vaccine and she did not know why it had not been done.	F 883	The DON and/or Infection Control Preventionist will audit 10% of resident immunization record weekly x4 weeks then monthly x 1 month utilizing the Immunization Audit Tool. This audit is to ensure residents were educated on risks/benefits of receiving/refusing Influenza and Pneumococcal and/or Covid vaccines, obtaining consent and physician order for vaccine per resident preference, administering vaccine per physician order with documentation in the electronic record and/or documentation of resident refusal if vaccine declined following education. The DON and Infection Control Preventionist will address all concerns identified during the audit. The Administrator will review the Immunization Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will forward the results of the Immunization Audit Tool to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the Immunization Audit Tool to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	
F 947 SS=E	Required In-Service Training for Nurse Aides	F 947		10/18/22

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F 947	Continued From page 39 CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews the facility failed to provide required dementia management and/or abuse prevention training for 3 of 3 current nursing staff (Nurse Aide (NA) #2, NA #3, NA #4) reviewed for education requirements. Findings included: 1.NA #2 was hired on 2-3-22. The facility provided NA #2's new hire education and education completed since her hire date. Upon review of the education, NA #2 had not received education on dementia management training.	F 947	F947 Required In-serve Training for Nurse Aides On 10/7/22, the facility notified nursing assistant (NA) #2, NA #3 and NA #4 on the need to complete training regarding dementia management and/or abuse prevention to meet education requirements. Training will be completed by 10/18/22. On 10/7/22, the Director of Nursing and Assistant Director of Nursing initiated an audit of all nursing assistant training records. This audit is to ensure continuing	

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F 947	Continued From page 40 2. The hire date for NA #3 was 5-25-21. The facility provided NA #3's new hire education and education completed since her hire date. The review revealed NA #3 had not completed the annual dementia management training or the abuse prevention training. 3. NA #4 was hired on 12-1-20. The facility provided NA #4's new hire education and education completed since her hire date. Upon review, NA #4 had not completed the annual dementia management training. The Human Resource Coordinator (HRC) was interviewed on 9-22-22 at 9:50am. The HRC clarified the facility did not have a staff development coordinator and she was responsible for the staff education. She explained she was not a nurse but was still responsible for teaching nurse topics. She stated she teaches through videos and then the new hire is paired with a long-term employee of the same discipline for their check off requirements. The HRC discussed starting her position in April 2022 and was unaware of the education issues and that employees were to complete their training in the facility's computer system until a survey was conducted in May 2022. She said in July 2022 she had begun educating all the staff on the facility's educational computer system and the need to complete yearly training through the computer system. The HRC discussed prior to the week of 9-19-22, no employee had completed the required dementia management training and explained NA #3 had been mailed the abuse prevention training but stated she had not received confirmation that NA #3 had completed the training.	F 947	competence training of no less than 12 hours of training per year. Education should include but is not limited to dementia management and/or abuse prevention. The Director of Nursing and Assistant Director of Nursing will address all concerns identified during the audit to include education of staff to meet minimum requirements and to ensure training includes dementia management and abuse prevention. Audit will be completed by 10/18/22 On 10/7/22, the Administrator initiated an in-serviced the Human Resource Coordinator and Director of Nursing regarding Required In-service Training for Nurse Assistants and responsibility to ensure nurse assistant training is no less than 12 hours per year and include dementia management and abuse prevention. In-service will be completed by 10/18/22. On 10/7/22, the Human Resource Coordinator initiated an in-serviced all nursing assistants regarding Required In-service Training for Nurse Assistants with emphasis on staff requirement to complete online/on-site training to meet required training hours per facility guidelines. In-service will be completed by 10/18/22. After 10/18/22, any nursing assistant who has not worked or received the in-service will be educated upon next scheduled work shift. All newly hire nursing assistants will be educated during orientation regarding Required In-service Training for Nurse Assistants.	

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F 947	Continued From page 41 During an interview with the Director of Nursing (DON) on 9-22-22 at 10:45am, the DON discussed starting her position in May 2022 and was unaware who was responsible for staff education prior to May 2022. She also discussed becoming aware of the lack of staff education in May 2022 during a survey, so the facility began completing education on abuse and other topics but had not included the dementia management training. The DON stated the lack of staff education was also due to staff turn over and the use of agency staff. The Administrator was interviewed on 9-22-22 at 11:45am. The Administrator discussed staff being educated on the facility's education computer system and she expected staff to complete their annual training as assigned.	F 947	The Director of Nursing and/or Assistant Director of Nursing will review training hours for 10 nursing assistants weekly x 4 weeks then monthly x 1 month utilizing Relias Training Log. This audit is to ensure continuing competence training of no less than 12 hours of training per year. Education should include but is not limited to dementia management and/or abuse prevention. The Director of Nursing and/or Assistant Director of Nursing will address all concerns identified during the audit to include education of staff to meet minimum requirements and to ensure training includes dementia management and abuse prevention. The Administrator will review the Relias Training Log weekly x 4 weeks then monthly x 1 month to ensure all concerns were addressed. The Administrator will forward the results of the Relias Training Log to the Executive Quality Assurance Committee monthly x 2 months. The Executive Quality Assurance Committee will meet monthly x 2 months and review the Relias Training Log to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency of monitoring.	