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KINDRED HOSPITAL EAST GREENSBORO	2401 SOUTH SIDE BOULEVARD GREENSBORO, NC 27406

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 9/15/24 through 9/18/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #KTWO11.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite recertification and complaint investigation survey was conducted on 9/15/24 through 9/18/24. Intake NC00220966 was investigated. One of two complaint allegations resulted in a deficiency. Event ID #KTWO11.	F 000		
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record reviews, Pharmacy Nurse Consultant and staff interviews, the facility failed to protect the residents' right to be free from misappropriation of narcotic medications (Hydrocodone and Oxycodone) prescribed to treat pain and an antianxiety medication (Lorazepam) prescribed to treat anxiety. This affected 6 of 6 residents reviewed for misappropriation of resident property (Residents #5, #17, #223, #224, #225 and #226).	F 602	Past noncompliance: no plan of correction required.	

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

Electronically Signed | 10/11/2024

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The findings included:

A. Resident #5 was admitted to the facility on 1/21/20 with diagnoses of spinal stenosis and chronic pain.

A quarterly Minimum Data Set (MDS) assessment dated 7/5/24 indicated Resident #5 was cognitively intact.

A review of Resident #5's physician orders included the following:
- An order dated 12/26/23 through 7/17/24 for Oxycodone 10 milligrams (mg) one tablet by mouth every six hours as needed for pain.
- An order dated 7/17/24 for Oxycodone 10 mg one tablet by G-tube every six hours as needed for pain.

A review of the Controlled Medication Utilization Record revealed Resident #5 was signed out as receiving Oxycodone 10 mg on 6/26/24, 6/28/24, 7/7/24, 7/11/24 and 8/7/24 by Nurse #1.

A review of the Medication Administration Record (MAR) for June 2024, July 2024 and August 2024 did not reveal Resident #5 was signed out as receiving Oxycodone by Nurse #1 on 6/26/24, 6/28/24, 7/7/24, 7/11/24 or 8/7/24.

A review of Resident #5's medical record did not reveal any evidence of uncontrolled pain.

B. Resident #17 was admitted to the facility on 1/15/24 with diagnoses that included spastic hemiplegia affecting the right dominant side and acute and chronic respiratory failure.

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A review of Resident #17's physician orders included an order dated 7/3/24 for Oxycodone 5 mg one tablet by G-tube every eight hours as needed for pain.

A quarterly MDS assessment dated 7/19/24 indicated Resident #17 had severely impaired cognition.

A review of the Controlled Medication Utilization Record revealed Resident #17 was signed out as receiving Oxycodone 5 mg on 8/7/24 at 5:00 AM and 8/7/24 at 12:00 PM by Nurse #1.

A review of the August 2024 MAR did not reveal Resident #17 was signed out as receiving Oxycodone on 8/7/24 at 5:00 AM or 12:00 PM by Nurse #1.

A review of a time punch record for Nurse #1 on 8/7/24 showed she did not clock into work until 7:06 AM.

A review of Resident #17's medical record did not reveal any evidence of uncontrolled pain.

C. Resident #223 was admitted to the facility on 12/18/19 with diagnoses that included acute and chronic respiratory failure and muscle spasm.

A review of Resident #223's physician orders included an order dated 9/30/20 for Oxycodone 5 mg one tablet via G-tube every six hours as needed for moderate pain manifested by grimacing/restlessness.

A quarterly MDS assessment dated 7/8/24 indicated Resident #223 had severe cognitive

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impairment.

A review of the Controlled Medication Utilization Record revealed Resident #223 was signed out as receiving Oxycodone 5 mg on 8/7/24 at 8:40 AM and 8/7/24 at 12:00 PM by Nurse #1.

A review of the August 2024 MAR revealed Resident #223 was signed out as receiving Oxycodone 5 mg on 8/7/24 at 8:40 AM but not 8/7/24 at 12:00 PM by Nurse #1.

A review of Resident #223's medical record did not reveal any evidence of uncontrolled pain.

D. Resident #224 was admitted to the facility on 5/14/24 with diagnoses that included chronic pain and a stage 4 pressure ulcer of the sacral region. He was discharged to the hospital on 9/2/24.

A review of Resident #224's physician orders included an order dated 5/16/24 for Hydrocodone-Acetaminophen 5 mg-325 mg one tablet by G-tube every six hours as needed for pain.

A review of the Controlled Medication Utilization Record revealed the following regarding Resident #224's Hydrocodone:
- The medication was marked as "popped out by accident" by Nurse #1 and wasted on 6/6/24, 7/18/24 and 7/25/24. The witness signature was marked as Nurse #2.
- The medication was signed out as given to Resident #224 on 7/18/24, 7/19/24 at 9:00 AM, 7/23/24 at 2:00 PM, 7/26//24 at 2:00 PM, 7/29/24 at 3:00 PM and 7/30/24 at 2:00 PM by Nurse #1.

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A review of the July 2024 MAR revealed Resident #224 was not signed out as receiving Hydrocodone by Nurse #1 on 7/18/24, 7/19/24 at 9:00 AM, 7/23/24 at 2:00 PM, 7/26//24 at 2:00 PM, 7/29/24 at 3:00 PM and 7/30/24 at 2:00 PM.

A review of the Master Signature Log for staff revealed the initials for Nurse #2 did not match the Controlled Medication Utilization Record for the witnessed wastes on 6/6/24, 7/18/24 and 7/25/24.

A quarterly MDS assessment dated 8/19/24 indicated Resident #224 had severely impaired cognition.

A review of Resident #224's medical record did not reveal any evidence of uncontrolled pain.

E. Resident #225 was admitted to the facility 10/9/23 with diagnoses that included chronic respiratory failure, ankylosing spondylitis and chronic pain. He expired on 5/6/24.

A quarterly MDS assessment dated 4/11/24 indicated Resident #225 had severe cognitive impairment.

A review of Resident #225's physician orders included the following:
- An order dated 4/26/24 through 4/29/24 for Lorazepam 2 mg per milliliter (ml). Inject 0.25 ml intravenous every three hours as needed for anxiety/agitation/shortness of breath.
- An order dated 4/29/24 for Lorazepam 2 mg per ml. Give 0.25 ml intravenously every two hours as needed for anxiety/agitation/shortness of breath.

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A review of the Controlled Medication Utilization Record revealed the automatic waste of 0.75 ml of Lorazepam was signed out by Nurse #1 on 4/29/24 at 11:00 AM, 4/29/24 at 6:20 PM, 4/30/24 at 10:25 AM and the waste of the 0.75 ml was witnessed by Nurse #2. In addition, Nurse #1 signed out Lorazepam on 5/5/24 at 8:00 AM, 5/5/24 at 2:00 PM, 5/5/24 at 5:30 PM and 5/5/24 at 6:34 PM and the waste of the 0.75 ml was witnessed by Nurse #3.

A review of the Master Signature Log for staff revealed the initials for Nurses #2 and #3, did not match the Controlled Medication Utilization Record for the witnessed wastes of Lorazepam 0.75 ml.

Review of an employee timecard for Nurse #3 indicated she clocked in to work on 5/5/24 at 7:00 PM.

F. Resident #226 was admitted to the facility on 4/12/24 with diagnoses that included acute and chronic respiratory failure and chronic pain. He expired 8/3/24.

A review of Resident #226's physician orders included an order dated 4/13/24 for Hydrocodone-Acetaminophen 5 mg- 325 mg one tablet via G-tube every six hours as needed for pain.

A quarterly MDS assessment dated 7/17/24 indicated Resident #226 had severe cognitive impairment.

A review of the Controlled Medication Utilization Record revealed Nurse #1 had the following

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Hydrocodone-Acetaminophen 5 mg-325 mg marked as wasted by Nurse #1:
- An entry on 4/30/24 as an error and waste witnessed by Nurse #2.
- An entry on 5/2/24 as an error and waste witnessed by Nurse #4.
- An entry on 6/13/24 at 5:37 PM with no reason for waste and witness signature unreadable.
- An entry on 6/17/24 at 10:00 AM with no reason for waste and witness signature unreadable.
- An entry on 6/20/24 with no time and waste witness signature Nurse #2.
- An entry on 7/6/24 at 7:00 PM with no reason for waste and waste witness signature Nurse #5.
- An entry on 7/8/24 at 9:00 PM with reason as "dropped" and no waste witness signature.
- An entry on 7/18/24 at 7:16 AM with no reason for waste and waste witness signature Nurse #2.
- An entry on 7/26/24 at 12:00 PM with reason as "dropped" and waste witness signature Nurse #4
- An entry on 7/29/24 at 1:00 PM with no reason for the waste and waste witness signature Nurse #2.
- An entry on 7/30/24 at 12:00 PM with reason as "dropped" for the waste and waste witness signature #2.

A review of the Master Signature Log for staff revealed the initials for Nurses #2, #4 and #5 did not match the Controlled Medication Utilization Record.

An initial report was submitted to the North Carolina Department of Health Human Services Division of Health Service Regulation on 8/19/24 by the Administrator. The allegation of misappropriation of property was made on 8/9/24 when narcotic discrepancies were found on five residents narcotic records involving Nurse #1.

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A witness statement dated 8/9/24 from Nurse #2 read that the signatures for wastes with Nurse #1 were not hers.

Review of the facility investigation completed by the Director of Nursing on 8/13/24 revealed on 8/9/24 she was informed by the Unit Manager that there was a discrepancy on two Controlled Medication Utilization Records dated 8/7/24 by Nurse #1. Nurse #1 had signed out Oxycodone 5 mg for Resident #17 at 5:00 AM and 12:00 PM. Both administrations were not captured on the MAR and Nurse #1 did not clock into the facility to begin work on 8/7/24 until 7:06 AM. Therefore, she was not present in the facility at 5:00 AM. Nurse #1 also signed out Oxycodone 5 mg for Resident #223 at 12:00 PM on 8/7/24. There was no documentation of this on the MAR. The previous administration was documented as 8:40 AM and the medication was ordered every six hours as needed for pain, thus it would have been too soon for the resident to have received the medication. A more thorough investigation began with all narcotic records being reviewed. It was found during the investigation that Nurse #1 signed out on the narcotic record providing Resident #5 with Oxycodone 10 mg five times with no record of the medication given on the MAR. Resident #226 had Hydrocodone-Acetaminophen 5-325 mg wasted seven times by Nurse #1 from 4/30/24 to 7/8/24 with signatures for witnessed wastes that did not match the Master Signature Log. Resident #225 was ordered Lorazepam 0.25 ml as needed with an automatic waste of 0.75 ml. There were eight witnessed wastes for this medication with questionable witness signatures. One that stood out the most was on 5/5/24 for a signature from

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Nurse #3 witnessed at 8:00 AM, 2:00 PM, 5:30 PM and 6:34 PM. Nurse #3 did not clock in for work on 5/5/24 until 7:00 PM.

A witness statement dated 8/14/24 from Nurse #4 read that she had not witnessed the wasting of narcotics with Nurse #1 on 5/2/24 or 6/17/24. The statement further read the initials that were present were not hers.

On 9/16/24 at 8:07 AM, an interview occurred with the Unit Manager who stated that on the morning of 8/9/24 she was approached by Nurse #6 to look at the Controlled Medication Utilization Record for Resident #223, because the administration times for his Hydrocodone didn't look right. The medication was to be given every six hours as needed but the times of administration were to close together and weren't marked out as given on the MAR. It was also noted that Resident #17's Oxycodone 5 mg was signed out on the Controlled Medication Utilization Record as given by Nurse #1 at 5:00 AM and 12:00 PM. This was odd since Nurse #1 worked 7:00 AM to 7:00 PM that day. This was reported to the DON, who began an investigation of all the narcotic records.

An interview occurred with Nurse #4 on 9/16/24 at 2:11 PM. She reviewed the narcotic record for Resident #226's Hydrocodone and stated that the witnessed waste signature for 5/2/24 and 7/26/24 were not hers. "I didn't witness any wastes of medications" with Nurse #1.

Nurse #6 was interviewed on 9/16/24 at 2:13 PM and stated she notified the Unit Manager on 8/9/24 that something didn't look right on Resident #223's Controlled Medication Utilization

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Record. She explained she noticed his medications were signed out by Nurse #1 as being given to close together and weren't captured on the MAR and for Resident #17 the Oxycodone was signed out by Nurse #1 at a time she wasn't at the facility.

A phone interview occurred with Nurse #3 on 9/17/24 at 9:40AM. She had a witness signature for a waste of Lorazepam 0.75 ml for Resident #225 on 5/5/24 at 8:00 AM, 2:00 PM, 5:30 PM and 6:34 PM on the Controlled Medication Utilization Record. Nurse #3 stated she worked 7:00 PM to 7:00 AM shift and wasn't present at the facility during those times on 5/5/24.

An interview occurred with Nurse #2 on 9/17/24 at 11:02 AM. After reviewing the narcotic records, she stated the following:
- For Resident #224's Hydrocodone, that was not her signature for the witnessed wastes on 6/6/24, 7/18/24 and 7/25/24.
- For Resident #225's Lorazepam it was not her signature for the witnessed wastes on 4/29/24 and 4/30/24.
- For Resident #226's Hydrocodone it was not her signature for the witnessed wastes on 4/30/24, 6/20/24, 7/18/24, 7/29/24 or 7/30/24. Nurse #2 further stated that she did not work on 7/30/24.

A phone interview occurred with the Pharmacy Nurse Consultant on 9/17/24 at 11:17 AM. She stated the facility had identified the misappropriation of narcotics by Nurse #1 and asked for her to come and audit narcotic records to ensure they had not missed anything. She stated the facility had captured all the concerns during her review and she provided education to all the nursing staff regarding procedure for

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wasting medications, and misappropriation of narcotics on 9/14/24.

The Director of Nursing (DON) was interviewed on 9/17/24 at 11:27 AM and explained that during a morning meeting on 8/9/24 she was notified by the Unit Manager there was a discrepancy found for two residents controlled medications by Nurse #1 on 8/7/24. It was noted that Nurse #1 had signed the Controlled Medication Utilization Record as giving Resident #17 his Oxycodone on 8/7/24 at 5:00 AM and 12:00 PM. These were not captured on the MAR and Nurse #1 didn't arrive to work until 7:06 AM on 8/7/24, therefore she couldn't have administered the 5:00 AM dose. Resident #223's Oxycodone was signed out on the Controlled Medication Utilization Record by Nurse #1 on 8/7/24 at 12:00 PM but was not captured on the MAR. This prompted the DON to do a more thorough investigation that revealed a lot of wastes with questionable signatures for the nurses that were to witness the wasting of the narcotic or no witness signatures, as well as entries on the Controlled Medication Utilization Record that were not captured on the MAR. The specific narcotic records were reviewed with the DON and revealed the following:
- Resident #5 had Oxycodone signed out on the Controlled Medication Utilization Record by Nurse #1 that was not captured on the MAR.
- Resident #17 had Oxycodone signed out on the Controlled Medication Utilization Record by Nurse #1 on 8/7/24 at 5:00 AM when she didn't clock in for work on that day until 7:06 AM.
- Resident #223 had Oxycodone signed out on the Controlled Medication Utilization Record by Nurse #1 on 8/7/24 at 12:00 PM and was not captured on the MAR.
- Resident #224 had a waste of Hydrocodone on

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6/6/24 where the witness signature did not match the master signature log and nurse denied the handwriting was hers. The July Controlled Medication Utilization Record had multiple times Hydrocodone was signed out by Nurse #1 and not captured on the MAR.
- Resident #225 had multiple wastes of Lorazepam from Nurse #1. The witness signatures did not match the master signature log and nurses denied the handwriting was theirs. Nurse #3 wasn't at work during the times that indicated she witnessed a waste.
- Resident #226 had wastes of Hydrocodone by Nurse #1 where there were no witness or incorrect witness signatures as well as the medication was signed out on the Controlled Medication Utilization Record and not captured on the MAR.

The Administrator was interviewed on 9/17/24 at 2:01 PM and stated once the suspicion of misappropriation of narcotics was found the nurse was suspended pending the investigation. The police department, corporate, pharmacy, Drug Enforcement Agency and North Carolina Board of Nursing were notified. The investigation began with all the narcotic records being audited. The investigation showed that Nurse #1 was the nurse that marked waste for narcotics the most and most entries weren't reflected on the resident MAR's as being given to them. "We never suspected her of taking medication prior to 8/9/24 as she was never visibly impaired". Once the investigation was completed Nurse #1 was terminated.

Multiple unsuccessful attempts were made to contact Nurse #1.

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F 602	Continued From page 12	F 602		

The facility provided the following corrective action plan:

Corrective action for the involved residents: Resident records were reviewed as well as medications/narcotics for the residents affected. Interviews were conducted with the residents. Resident Council was completed. Pain assessments were completed. Pharmacy performed an audit of the narcotics on 8/14/24. The nurse was suspended pending the investigation. On 8/9/24 the police department was notified. On 8/16/24 the Drug Enforcement Agency was notified. On 8/19/24 a 24 hour report was submitted, and the North Carolina Board of Nursing was notified.

Corrective action for other potentially affected residents: All narcotic records as well as Medication Administration records were reviewed. A pharmacy audit was performed on 8/14/24 with no other concerns identified. Pain assessments were completed by the DON.

Measures that were put in place or systemic changes: The Staff Development Coordinator (SDC) initiated education on 8/9/24 to all nurses on Controlled Substance Diversion Training and Drug Diversion Policy.

How the facility plans to monitor: The DON and Unit Manager will continue their audits of the MAR, Narcotic Sheets and Medications weekly for six months then monthly for one year. The SDC will educate all new and active staff on a continued basis on Abuse, Neglect and Misappropriation. All nurses will continue, on a regular basis, to be educated by the SDC/DON on medication administration and drug diversion.

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F 602	Continued From page 13 The plan alleged compliance on 8/30/24. As part of the validation process, the plan of correction was reviewed and verified through review of audit sheets, education records and staff interviews. Review of the facility plan of correction revealed evidence of 100% auditing of medication concerns or misappropriation, including pain assessments. The facility provided evidence of 100% staff education on Controlled Substance Diversion Training and Drug Diversion Policy completed on 8/9/24. The facility reported Nurse #1 to the North Carolina Board of Nursing on 8/19/24. Reports were presented to the Quality Assurance committee by the DON to ensure corrective action was appropriate. Ongoing audits were reviewed. The validation process verified the facility's date of compliance of 8/30/24.	F 602		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to	F 609		10/12/24

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F 609	Continued From page 14 the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interview, the facility failed to submit an initial report to the state regulatory agency within 24 hours of a discovery of misappropriation of resident property. This was for 6 of 6 residents (Residents #5, #17. #223, #224, #225 and #226) reviewed. The findings included: A review of the facility's Reporting Reasonable Suspicion of Crime policy, last revised 10/2022, revealed the facility would report a 24-hour investigation for a reasonable suspicion of crime no later than 24 hours if the alleged violation does not result in serious bodily injury. An interview with the Director of Nursing (DON) was conducted on 9/17/24 at 11:27 AM and indicated she was notified on 8/9/24 by the Unit Manager that there was a discrepancy on the Controlled Medication Utilization Record for Residents #17 and #223 involving Nurse #1. The DON stated she notified the Administrator and	F 609	1.On 8/19/24, the initial self report was completed by the Administrator and subsequent final report submitted on 8/19/24. 2. Residents #5,#17,#223,#224,#225 and #226 were assessed by the licensed nurse on 8/9/24 for any uncontrolled pain related to the misappropriation of their narcotic pain medication .No negative findings were identified during the assessments. 3. The Staff Development Coordinator conducted an education with the current staff on abuse neglect and the timeliness of reporting alleged violations on 8/14/24. The education concluded on 8/23/24.Any staff that were not educated by 8/23/24 will not be allowed to provide resident care until they have received the required education. Education was conducted by the Vice President of Operations with the Director of Nursing on 8/9/24 on the requirement of reporting alleged abuse,	

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F 609	Continued From page 15 began an audit of all resident Controlled Medication Utilization Records on 8/9/24 , finding the following: - Resident #5 had Oxycodone signed out on the Controlled Medication Utilization Record by Nurse #1 that was not captured on the MAR. - Resident #17 had Oxycodone signed out on the Controlled Medication Utilization Record by Nurse #1 on 8/7/24 at 5:00 AM when she didn't clock in for work on that day until 7:06 AM. - Resident #223 had Oxycodone signed out on the Controlled Medication Utilization Record by Nurse #1 on 8/7/24 at 12:00 PM and was not captured on the MAR. - Resident #224 had a waste of Hydrocodone on 6/6/24 where the witness signature did not match the master signature log and nurse denied the handwriting was hers. The July Controlled Medication Utilization Record had multiple times Hydrocodone was signed out by Nurse #1 and not captured on the MAR. - Resident #225 had multiple wastes of Lorazepam from Nurse #1. The witness signatures did not match the master signature log and nurses denied the handwriting was theirs. Nurse #3 wasn't at work during the times that indicated she witnessed a waste. - Resident #226 had wastes of Hydrocodone by Nurse #1 where there were no witness or incorrect witness signatures as well as the medication was signed out on the Controlled Medication Utilization Record and not captured on the MAR. On 9/17/24 at 2:01 PM, an interview occurred with the Administrator. She explained that she didn't send an initial report to the state regulatory agency within 24 hours because they were not sure if this was a misappropriation of resident	F 609	neglect and misappropriation with in 2 hours of receipt of allegation. 4.An audit will be conducted by the Administrator (or designee) to ensure that any allegation of abuse, neglect ,or misappropriation are reported according to regulation. The audits will begin 10/10/24 and occur daily x7 days ,then 5xweek for 2 weeks,then weekly for 4 weeks,then monthly for 3 months.The results of the audit will be taken to the Quality Assurance and Performance Improvement Committee monthly to ensure compliance,or any needed change to the action plan.	

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F 609	Continued From page 16 medications issue or not on 8/9/24. The Administrator stated once they suspected the misappropriation of narcotic medications, the corporate agency, pharmacy, law enforcement, Drug Enforcement Agency and North Carolina Board of Nursing were notified. She acknowledged the 24 hour report was not sent to the State Agency until 8/19/24, stating "we were doing the investigation and wanted to make sure the problem was corrected".	F 609		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-	F 623		10/12/24

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(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part

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F 623	Continued From page 18 C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on record review, family, and staff interviews, the facility failed to provide the responsible party (RP) written notification of the reason for a hospital transfer for 1 of 1 resident reviewed for hospitalization (Resident #10). The findings included: Resident #10 was originally admitted to the facility	F 623	1. The RP was supplied a written notice of transfer /discharge on 9/17/24. Resident #10 is currently residing in the facility, so a notice of transfer/discharge is not appropriate at the time, however the Director of Nursing did notify the RP of the requirements for the notice of transfer/discharge on 9/17/24 due to the missed notifications on the previous	

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F 623	Continued From page 19 on 12/27/23. A review of Resident #10's medical record revealed the following transfers and discharges to the hospital: - Transferred to the hospital on 1/22/24 for hypotension and fever. He returned to the facility on 1/26/24. - Transferred to the hospital on 2/6/24 for hypotension and returned to the facility on 2/13/24. - Transferred to the hospital on 2/20/24 for altered mental status and returned to the facility on 2/27/24. - Transferred to the hospital on 6/23/24 for altered mental status and returned to the facility on 7/3/24. There was no documentation that a written notice of transfer was provided to the RP for any of the hospital transfers noted above. A quarterly Minimum Data Set (MDS) assessment dated 7/9/24 indicated Resident #10 had severe cognitive impairment. During an interview with Resident #10's RP, he indicated he had not received anything in writing regarding Resident #10's hospital transfers but was notified by phone. The Administrator was interviewed on 9/17/24 at 9:00 AM and stated that when a resident was transferred to the hospital the RP was notified by phone. A transfer/discharge form was sent with the resident to the hospital, but nothing was mailed to the RP. The Administrator further stated it was her expectation for the resident and/or RP to be notified in writing for the reason of the hospital transfer per the regulation.	F 623	transfer/discharge notifications on the previous transfer/discharges as stated in the Statement of Deficiencies. 2. An audit was conducted by the Director of Nursing on 9/20/24 to ensure that any transfer/discharge that took place in the pervious 7 days had the required notification of transfer/discharge issued at the time of transfer. Any issues identified were corrected at that time. The DNS provided education to the licensed nurses on 9/17/24 regarding the the requirement to provide the patient and/or patient representative a written notice of transfer /discharge prior to the transfer or discharge and provide documentation in the residents medical record. The education concluded on 10/10/24 . Any staff that were not educated by 10/11/24 will not be allowed to provide resident care until they have received the required education. 3) The Admissions Coordinator will mail the written notice to the residents' representative . The Unit Coordinator will send a copy of the notice to the Office of the State Long- Term Care Ombudsman. 4) The Medical Records Clerk will conduct an audit verifying the written notice of transfer/ discharge was supplied to the resident and /or resident representative. These audits will begin on 10/11/24 and will occur 3 times a week for 2 weeks, them 1 time a week for 2 weeks , then monthly for 3 months. The audits will be reviewed by the Quality Assurance and Performance Improvement Committee , which meets monthly.	

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F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced	F 732		10/12/24

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F 732	Continued From page 21 by: Based on observations, staff interviews and record review, the facility failed to post daily nurse staffing data at the beginning of two shifts, post accurate daily nurse staffing data for two shifts and maintain records of posted daily nurse staffing data for two shifts. This failure occurred for 6 of 45 days of daily nurse staffing data reviewed. The findings included: 1a. An observation of posted daily nurse staffing data occurred on 9/15/24 at 8:50 AM and 9/15/24 at 11:55 AM. Each observation revealed daily nurse staffing data was posted for the 7AM shift for 9/14/24. The daily nurse staffing data recorded the facility census of 21 residents, two registered nurses (RN) for a total of 24 hours worked, one licensed practical nurse (LPN) for a total of 12 hours worked and three nurse aides (NA) for a total of 36 hours worked. Actual staff observed for the 7AM shift on 9/15/24 included one RN, two LPNs and four NAs. 1b. A review of daily nurse staffing data records occurred with the Staffing Coordinator on 9/17/24 at 2:04 PM and revealed the following: - On Saturday, 8/3/24, there was no record of the daily nurse staffing data posting for the 7AM to 7PM shift. - On Monday, 8/12/24, the daily nurse staffing data posting for the 7AM shift did not record a RN who worked 8 hours. - On Saturday, 8/17/24, there was no record of the daily nurse staffing data posting for the 7AM to 7PM shift. - On Tuesday, 8/20/24 the daily nurse staffing data recorded two LPNs worked 12 hours on the 7PM to 7AM shift. The nursing assignment sheet	F 732	1) No resident was affected. 2) No residents have potential to be affected. 3) The Director of Nursing provided education to licensed nurses on the requirement to post daily nurse staffing data on 9/16/24. The education concluded on 9/30/24. Any licensed nursing staff that were not educated by 10/11/24 will not be allowed to provide resident care until they have recieved the required education. 4) The Director of Nursing Services/Designee will audit daily to ensure the nurse staffing data is posted. The audit will begin on 10/11/24 and will occur daily x 2 weeks , then 3 times a week for 2 weeks , then 1 time weekly for 2 weeks, and then monthly for 3 months. These audits will be reviewed by the Quality Assurance and Performance Improvement Committee , which meets monthly.	

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recorded five LPNs, and one RN worked on 8/20/24, 7PM shift.

An interview with the Staffing Coordinator occurred on 9/17/24 at 9:58 AM. The Staffing Coordinator stated she normally worked 9AM to 5:30PM Monday through Friday and weekends as needed. She stated that the nurse on each shift was responsible to post the daily nurse staffing data at the beginning of the shift, but that she checked when she arrived to work and if the correct daily nurse staffing data was not posted, she would post it. The Staffing Coordinator stated that she worked 9/14/24 7PM to 7AM and completed and posted the daily nurse staffing data for that shift but that she may have recorded the wrong shift on the posting. She stated she recorded that the data was for the 7AM to 7PM shift on 9/14/24, but that she meant to record that it was for 9/14/24, 7PM to 7AM shift. She stated that she always reminded the nurses that daily nurse staffing data should be posted at shift change, and currently the charge nurse was responsible to post daily nurse staffing data at the beginning of each shift. She stated she could not locate the daily nurse staffing postings for 8/3/24 or 8/17/24 and that the daily nurse staffing data postings on 8/12/24 and 8/20/24 did not include all the RNs or LPNs that worked in the facility on those dates.

An interview with the charge nurse (Nurse #4) occurred on 9/18/24 at 9:32 AM. Nurse #4 stated that she worked the 7AM shift on 9/15/24 and that she trained a new nurse on that shift. Nurse #4 stated that when she arrived for work at 7AM on 9/15/24, she just forgot to post the daily nurse staffing data for the 9/15/24 7AM shift, but that she was aware of that responsibility. She stated,

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F 732	Continued From page 23 "It was just an oversight." An interview with the Administrator occurred on 9/16/24 at 4:51 PM. The Administrator stated that she expected the nursing staff to work together to post the daily nurse staffing data at the beginning of each shift, ensure the records were accurate and that staffing data records should be maintained for 15 months.	F 732		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.	F 803		10/12/24

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F 803	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with the Registered Dietitian (RD) and staff, the facility failed to provide a four-ounce portion of pureed beef taco meat per the approved menu and prepare pureed foods per the recipe (beef taco meat, bean and corn salsa and cilantro lime rice). This failure occurred for 1 of 1 resident with a diet order for pureed textured foods (Resident #4). The findings included: A continuous observation of the lunch meal tray line occurred on 9/17/24 from 11:40 AM to 11:50 AM. Review of the tray card revealed Resident #4 had a diet order for pureed textured foods. During the observation, the following foods were plated for Resident #4: -Cook #1 used a #10 scoop to plate a 3 1/5-ounce portion of pureed beef taco meat that had an applesauce consistency instead of a four-ounce portion, per the menu. -Cook #1 used a #8 scoop to plate a four-ounce portion of pureed bean and corn salsa with a thick consistency. -Cook #1 used a #8 scoop to plate a four-ounce portion of pureed cilantro lime rice with an applesauce consistency. Review of the approved menus and recipes revealed the following instructions: -Bean and Corn Salsa, Pureed, serve a 1/2 cup or four-ounce portion. For texture modification, remove the number of portions required from the regular recipe, process bean and corn salsa and 3 tablespoons of thickener per 10 servings, to	F 803	1) Resident # 4 was assessed by the license nurse on 10/11/24 for any affects of not receiving the four-ounce portion of pureed beef taco meat per approved menu no concerns were identified during the assessment. 2) An observation audit was conducted on 10/11/24 by the Director of Nursing and/or the Registered Dietician to ensure that residents with orders for pureed food were served the appropriate food/texture per their menu. No issues were identified during the audit. 3) The Dietary Manager educated the dietary staff on 10/11/24 regarding providing required pureed serving portions and the appropriate scoop to use. 4) The Dietary Manager and /or Designee will audit pureed portion sizes to ensure the appropriate scoop is used and that that the preparation of pureed foods are per the recipe/menu.The audits will begin 10/11/24 and will occur 3 x daily for 2 weeks , then 1 time daily for 2 weeks , then 2 times weekly for 2 weeks , and then weekly for 2 weeks, then monthly for 3 months. These audits will be reviewed by the Quality Assurance and Performance Improvement Committee which meets monthly.	

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achieve a smooth textured product, final product should be smooth, pudding like consistency but not runny.

-Cilantro Lime Rice, Pureed, serve a 1/2 cup or four-ounce portion. For texture modification, remove the number of portions required from the regular recipe, blend until smooth adding 1 teaspoon margarine, melted, plus 1 tablespoon hot water or hot low sodium vegetable broth per serving to achieve a smooth textured product. Final product should be smooth pudding like but not runny.

-Beef Taco Bowl, Pureed. Serve a four-ounce portion. Prepare beef taco meat and puree according to the recipe. There was no recipe available for review for the beef taco meat, pureed.

Cook #1 was interviewed on 9/17/24 at 11:50 AM and stated that he did not have a recipe to refer to when he prepared the pureed foods, so he used 2 servings of a #10 scoop (3 1/5 ounce) of each food item, beef taco meat, cilantro lime rice and bean and corn salsa, added "some water and thickener", but that he did not measure how much water or thickener he added to puree these foods. He stated that this was his routine practice when he prepared pureed foods.

The Patient Ambassador, Dietary Aide #1 (DA #1) was interviewed on 9/18/24 at 11:18 AM and stated that she worked in the kitchen as a DA since April 2024. DA #1 stated that she put together the recipe binder when she started, sometime in April 2024 or May 2024. DA #1 stated that when she put together the recipe binder, she printed the recipes for regular

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textured foods and some of those recipes included instructions to modify the texture to prepare pureed foods, but not all of recipes for regular textured foods included instruction for texture modifications. She stated that she did not print or include recipes for pureed foods in the recipe binder, but that she would do so going forward.

The Kitchen Supervisor was interviewed on 9/17/24 at 11:55 AM and stated that he provided oversight of the lunch meal tray line three days per week. During the interview he reviewed the recipe binder and stated that the binder included recipe instructions for preparing foods for a regular textured diet and some of the recipes included instructions for modifying textures. After reviewing the recipe binder, he stated that the recipe binder did not have a recipe in the binder for pureed beef taco meat that was served for lunch on 9/17/24. He stated that the pureed taco meat should be served in a four-ounce portion.

The Food Service Director was interviewed on 9/17/24 at 12:02 PM and stated that he provided tray line and food production oversight to the dietary staff. The Food Service Director stated that he was relatively new to his role in the dietary department and that he had not observed Cook #1 prepare pureed foods, but that he expected recipes to be followed.

The RD was interviewed on 9/18/24 at 10:23 AM and stated that she reviewed/approved the recipes in the recipe binder. The RD stated that when she reviewed the recipe binder, she usually looked for the recipes for regular textured foods, and that she did not always review the recipe binder to ensure there were recipes included for

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F 803	Continued From page 27 all texture modifications. The RD stated that she expected recipes to be followed for texture modified foods and for foods to be served to residents in portions per the menu. During the interview, the RD provided recipes for pureed textured cilantro lime rice, pureed bean and corn salsa and pureed beef taco bowl. A recipe for pureed beef taco meat was requested, but not provided. The RD stated DA #1 was responsible to ensure the recipe binder was kept up to date. The Administrator was interviewed on 9/18/24 at 11:00 AM. She stated that menus and recipes should be available and followed to serve residents the correct portions and texture modifications.	F 803		
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 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.	F 812		10/12/24

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F 812	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with the Registered Dietitian (RD) and staff, the facility failed to remove expired foods from refrigerated storage, store dented canned goods separate from foods available for use, store potentially hazardous foods in sealed containers with a label that recorded the date of storage and the use by date. This failure had the potential to affect food served to 7 of 21 residents. The findings included: 1a. An observation on 9/17/24 at 11:17 AM of the walk-in refrigerator occurred with the Kitchen Supervisor and revealed a sign posted on the exterior that recorded "Food Storage Chart - Refrigerated Foods, Label when product is opened, the time listed is added to today's date. Deli Meats, + (plus) 3 days." Inside the walk-in refrigerator, a plastic bag of sliced turkey meat was observed open to air with a use by date recorded as "9/17/24." During the observation, the Kitchen Supervisor stated that all foods stored in refrigeration should be stored in sealed containers and discarded by the use by date. 1b. An observation on 9/17/24 at 11:20 AM of the walk-in freezer revealed the following opened foods were stored on a rack in plastic bins, not in the original packaging, and open to air with no label to record the date opened or a use by date: - Diced potatoes were stored in a plastic bag that was open to air, with no label to record the date opened or the use by date.	F 812	1) The diced potatoes that were observed on 9/17/24 to be stored in a plastic bag and open to air with no label on record the date opened or use by the date were discarded by the Dietary Manager on 9/17/24. The hashbrowns that were observed on 9/17/24 to be stored in a plastic bag that was open to air , with no label to record date opened or used by date were discarded by the Dietary Manager on 9/17/24. The breakfast sauasage that was observed on 9/17/24 to be stored in a plastic bag that was open to air, with no label to record the date opened or the use by date were discarded by the Dietary Manager on 9/17/24. The diced chicken that was observed on 9/17/24 to be stored in a plastic bag that was open to air, with no label to record the date opened or use by date were discarded by the Dietary Manager on 9/17/24. The tater tots that were observed on 9/17/24 to be stored in a plastic bag that was open to air, with no label to record the date opened or the use by date were discarded by the Dietary Manager on 9/17/24. The Dietary Manager discarded the the deli meat (bag of sliced turkey) on 9/17/24 that was observed in the refrigerator opened to air and use by date recorded as 9/17/24. 2) An observation audit was conducted on 9/19/24 by the Dietary Manager on all	

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F 812	Continued From page 29 - Hash browns were stored in a plastic bag that was open to air, with no label to record the date opened or the use by date. The hash browns were covered with ice and had a dried, white appearance. During the observation, the Kitchen Supervisor discarded the hash browns and stated the hash browns appeared freezer burned. - Breakfast sausage was stored in a plastic bag that was open to air with no label to record the date opened or the use by date. - Diced chicken was stored in a plastic bag that was open to air, with no label to record the date opened or the use by date. The diced chicken was covered with ice and had a dried white appearance. During the observation, the Kitchen Supervisor discarded the diced chicken and stated the diced chicken appeared freezer burned. - Tater tots were stored in a plastic bag that was open to air with no label to record the date opened or the use by date. 1c. An observation of the dry storage room occurred with the Kitchen Supervisor on 9/17/24 at 11:30 AM. A canned product was observed with a dent along the seal and was stored with canned foods that were available for use. The Kitchen supervisor stated that "I usually put the dented cans on the first row of the rack, but since that row is not labeled, for the storage of dented cans, that's why a dented can was stored with cans available for use." An interview on 9/17/24 at 11:24 AM with the Kitchen Supervisor revealed the facility received food delivery twice per week and on those days,	F 812	stored food to ensure it is stored appropriately. No issues were were identified in the audit. 3) The Dietary Manager provided education to the Dietary Staff on 9/18/24 regarding the removal of expired foods from the refrigerated storage, storing of dented canned goods sperate from the foods available for use, and storing potentionally hazardous foods in sealed containers with a label that that records the date of the storage and the use by date. 4) The Dietary Manager /Designee will conduct an audit daily for expired foods in refrigerated storage ,dented canned goods stored seperatly from the foods available for use, and the storage of potentally hazourous foods in sealed containers with labels of the date of storage and by use dates. These audits will begin on 10/11/24 and will occur daily x 2 weeks, and then bi-weekly for 2 weeks, and then monthly x 3 months. These audits will be reviewee by the Quality Assurance Committee , which meets monthly.	

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F 812	Continued From page 30 staff monitored the storage of foods for proper packaging and labeling. He stated that foods should be stored in sealed containers to prevent freezer burn and include a label that recorded date opened/received and the use by or expiration date. The RD was interviewed on 9/17/24 at 3:23 PM. The RD stated that she conducted monthly sanitation rounds that included an observation of the dish room and cold, frozen and dry storage. The RD stated that when she identified concerns with food storage, she re-educated staff immediately. The RD stated that foods should be stored in sealed containers, with labels and discarded by the use by date. The Food Service Director stated in an interview on 9/17/24 at 12:02 PM that dietary services should be provided per regulatory requirements. The Administrator was interviewed on 9/18/24 at 11:00 AM. She stated that the dietary department should store foods per regulatory requirements.	F 812		
F 947 SS=E	Required In-Service Training for Nurse Aides 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.	F 947		10/12/24

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F 947	Continued From page 31 §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to include dementia management training and care for cognitively impaired residents as part of the required annual training for 3 of 6 nurse aide (NA)s reviewed for annual staff training (NA #4, NA #5 and NA #6). The findings included: 1a. NA #4 was hired on 9/14/20. Review of nursing assignment records revealed NA #4 worked the 7PM to 7AM shift on August 5, 6, 15, 22, and 29, 2024 and September 16, and 17, 2024. Attempts to interview NA #4 were unsuccessful. 1b. NA #5 was hired on 8/23/10. Review of nursing assignment records revealed NA #5 worked the 7PM to 7AM shift on August 10, 13, 19, and 23, 2024 and September 18, 2024. Attempts to interview NA #5 were unsuccessful. 1c. NA #6 was hired on 2/11/08. Review of nursing assignment records revealed NA #5 worked the 7PM to 7AM shift on August 2, 4, 9, 14, 24 and 31, 2024 and September 15, 2024. Attempts to interview NA #6 were unsuccessful.	F 947	1) NA #4, #5, and #6 received the dementia training for the cognitively impaired. On 9/20/24 NA # 4 received received dementia training for the cognitively impaired. On 9/20/24 NA # 5 received dementia training for the cognitive impaired. On 9/21/24 NA #6 received dementia training for the cognitive impaired. 2) Residents with a diagnosis of Dementia were assessed on 10/10/24 by the licensed nurse and/or Social Services to ensure that they had no negative effects of the above mentioned staff not having the required annual Dementia Training. No concerns were identified during the audit. 3) The Staff Development Coordinator educated Nursing Assistants on Dementia management and care for the cognitively impaired impaired on 9/18/24 and was completed on 10/2/24 for all Nursing Assistants. The Staff Development Coordinator will conduct dementia management and care of the cognitively impaired training during new hired orientation for the nursing assistants. Annually, the Staff Development	

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F 947	Continued From page 32 An interview with the Staff Development Coordinator (SDC) occurred on 9/17/24 at 2:00 PM. During the interview, a review of annual NA training revealed there was no documentation of annual dementia management training and care for cognitively impaired residents for NA #4, NA #5 or NA #6. The SDC stated that she was not aware that annual dementia management training and training to care for cognitively impaired residents was required. The SDC stated that the electronic training management system used by the facility allowed her to populate specific training for each NA to complete each month but stated "I just have not populated the training yet, there is no specific reason why." The SDC further stated that NA #4, NA #5 and NA #6 each worked at the facility in the last 12 months. An interview with the Administrator occurred on 9/16/24 at 4:51 PM. The Administrator stated that she expected each NA to receive the required annual training. The Administrator stated she felt certain the required annual training for dementia management and care for cognitively impaired residents had been provided, but that she could not locate any documentation.	F 947	Coordinator will provide dementa management and care of the cognitivley impaired training. 4) The Staff Development Coordinator will conduct an audit ensuring nursing assistants have completed the provided dementia management and care of the cognitively imparired training. These audits will begin 10/10/24 and continue monthly for 3 months , then every 3 months for 12 months. These audits will be reviewed by the Quality Assurance and Performance Committee which meets monthly.	