STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055084	A. Building B. Wing	04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverbank Post-Acute	2649 Topeka Street Riverbank, CA 95367

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a comprehensive, person-centered care plan was developed and implemented to meet the identified needs for one of three sampled residents (Resident 1) when Resident 1 did not have a care plan for bilateral (both sides of the body) nephrostomy tubes (thin, flexible tube placed through the skin of a person's back into the kidney to drain urine into an outside bag) and abdominal accordion drain (a small tube placed into an abscess [pocket of pus/infection] to drain fluid using a collapsible plastic bulb that creates gentle suction) site.This failure had the potential for Resident 1's care needs to go unmet and resulted in a delay in care for dressing changes to the nephrostomy tubes and drain sites, placing the resident at risk for infection and dislodgement of the tubing. (Cross reference F684)During a review of Resident 1's admission Record, undated, the admission record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included psoas muscle (hip flexor muscle) abscess, malignant neoplasm of bladder (bladder cancer), encounter for surgical aftercare following surgery on the genitourinary system (the body's urinary and reproductive system), and artificial openings of urinary tract system (surgical procedure that creates a stoma [artificial opening] to drain urine when the bladder is no longer able to do so).During a review of Residents 1's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 1's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 14 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1 was not cognitively impaired.During a concurrent interview and record review on 4/13/26 at 11:38 a.m. with the Treatment Nurse (TN), the TN stated a CNA had paged her to Resident 1's room on 3/26/26 because the resident's family was requesting her dressings be changed to the nephrostomy tubes and drain site. The TN stated she was unaware Resident 1 had nephrostomy tubes or drain site dressings because they were not identified or documented on admission. The TN stated when she checked Resident 1, she discovered bilateral nephrostomy tubes from the residents back, each had a split gauze over the tube exit site and was secured with tape, and the resident also had an accordion drain in the lower abdomen. Resident 1's admission Assessment, dated 3/21/26 was reviewed and indicated, . Catheter/Ostomy. ileostomy/Urostomy [not checked] . Nephrostomy/urostomy [not checked] . Other Relevant Dx[diagnosis]/Concerns [left blank] . Additional nurses notes . voiding well and using bedpan . Resident 1's Skin Assessment, dated 3/20/26, indicated, . Special Equipment. Other. If other, specify [left blank] . Type of skin problem. Surgical site. Other. If other, specify [left blank] . The TN stated the nephrostomy tubes and drain were not documented on the admission assessment or skin assessment. The TN stated she had reviewed Resident 1's orders and was unable to find any dressing changes or site monitoring orders. The TN stated she contacted Resident 1's physician and received new orders to change the dressings every other day and to monitor the sites for signs and symptoms of infection. The TN stated she performed the wound care and entered the orders into the Electronic Medical Record (EMR). Resident (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1's care plans were reviewed and the TN stated she was unable to locate care plans addressing the nephrostomy tubes or drain site. The TN stated a care plan should have been entered on admission and updated when new orders were received. The TN stated care plans were important to address resident problems, identify the treatment goals and to put interventions in place to meet those goals.During a concurrent interview and record review on 4/13/26 at 1:12 p.m. with the Director of Staff Development (DSD), the DSD stated Resident 1 was admitted to the facility from 3/20/26 to 3/27/36. Resident 1's Order Summary Report (OSR), undated, was reviewed and indicated . Nephrostomy: Assess STOMA site for s/sx [signs and symptoms] of infection (i.e. redness, swelling, tenderness, drainage, warm to touch) QS [every shift] & notify MD if any. 3/26/26. NEPHROSTOMY: Cleanse nephrostomy stoma site with NS and pat dry, apply dry dressing to Left and Right nephrostomy site QOD [every other day] and PRN [as needed]. 3/26/26. TREATMENT: ACOORDION DRAIN-Cleanse stoma site with NS, pat dry, apply dry dressing QOD and as needed if soiled or dislodged. 3/26/26. The DSD stated Resident 1 had bilateral nephrostomy tubes and a drain site on admission 3/20/26, but the care orders were not received until 3/26/26. The DSD stated the admission nurse should have documented the nephrostomy tubes and drain and called the physician for new orders. The DSD reviewed Resident 1's care plans but was unable to locate any care plans addressing the nephrostomy tubes and drain site. The DSD stated care plans were important to identify Resident 1's nephrostomy tubes and drain site, what the goals of treatment were, and care interventions needed to meet those goals. The DSD stated the nurses failed to identify the tubes and drain on admission and did not enter a care plan for their treatment. The DSD stated Resident 1 was placed at risk for drain and tube site infection from the delay in treatment.During an interview on 4/13/26 at 2:01 p.m. with the Director of Nursing (DON), the DON stated Resident 1 was admitted to the facility with nephrostomy tubes and a drain site, but they were not documented on admission. The DON stated it was her expectation for the admission nurse to note the nephrostomy tubes and drain site in the admission assessment, skin assessment and be communicated to the physician and floor staff. The DON stated the physician should have been notified and asked for orders to care for the nephrostomy tubes and drain site, such as dressing changes and monitoring the site for signs of infection or dislodgement (move out of place or fall out). The DON stated monitoring was very important because any changes in the nephrostomy tube and drain sites would need to be noted and reported to the physician immediately to prevent complications such as an infection. The DON reviewed Resident 1's care plans and stated the nephrostomy tubes and drain site were not documented in the plan of care. The DON stated care plans were important to have all problems addressed because they direct the care provided to the residents. During a review of the facility's policy and procedure (P&P) titled Care Plans-Baseline, dated 3/2022, the P&P indicated, . baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including. Initial goals based on admission orders. Physician orders. baseline care plan is used until the staff can conduct the comprehensive assessment and develop and interdisciplinary person-centered comprehensive care plan. base line care plan is updated as needed to meet the resident's needs until the comprehensive care plan is developed. resident and/or representative are provided a written summary of the baseline care plan. that includes. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.During a review of the facility's documents titled Job Description: Licensed Nurse/Medication/Treatment Nurse, undated, the job description indicated, . primary purpose of your job is to provide direct nursing care to the residents including medication management and skin care treatments. Ensure that the Nursing Services . reflects the day-to-day nursing procedures performed in this facility. Ensure that all nursing service personnel comply with the procedures set forth in the Nursing Service Procedures. Complete and file required (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recordkeeping forms/charts upon the resident's admission. Chart nurses' notes in an informative, descriptive and legible manner that reflects the care provided to the resident. Care Plan and Assessment Functions. Participate in the development of written preliminary and comprehensive assessments of the nursing needs of each resident. Participate in the development of a written care plan. that identifies the problems/needs of the resident, indicates the care to be given, goals to be accomplished . Review resident care plans for appropriate resident goals, problems, approaches, and revisions based on nursing needs. Ensure that all personnel involved in providing care to the resident are aware of the resident/s care plan. Ensure that nursing personnel refer to the resident's care plan prior to administering daily care to the resident. Review nurses' notes to determine if the care plan is being followed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice when Licensed Nurses did not complete an accurate physical assessment upon admission for one of three sampled residents (Resident 1) when Resident 1 was admitted to the facility on [DATE] with bilateral (both sides of the body) nephrostomy tubes (thin, flexible tube placed through the skin of a person's back into the kidney to drain urine into an outside bag) and an abdominal accordion drain (a small tube placed into an abscess [pocket of pus/infection] to drain fluid using a collapsible plastic bulb that creates gentle suction) site that were not documented.This failure had the potential to negatively affect Resident 1's health when her bilateral nephrostomy tubes and the accordion drain were not documented in the resident's medical record causing a delay in treatment, including no site monitoring or dressing changes from 3/20/26 until 3/26/26.During an interview on 4/13/26 at 11:30 a.m. with Certified Nursing Assistant (CNA) 5, CNA 5 stated Resident 1 was at the facility for a short time. CNA 5 stated she remembered taking care of Resident 1, emptying her nephrostomy tubes frequently. CNA 5 stated Resident 1 also had an accordion drain.During a review of Resident 1's admission Record, undated, the admission record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included psoas muscle (hip flexor muscle) abscess, malignant neoplasm of bladder (bladder cancer), encounter for surgical aftercare following surgery on the genitourinary system (the body's urinary and reproductive system), and artificial openings of urinary tract system (surgical procedure that creates a stoma [artificial opening] to drain urine when the bladder is no longer able to do so).During a review of Residents 1's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 1's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 14 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1 was not cognitively impaired.Resident 1's Order Summary Report (OSR), undated, indicated . Nephrostomy: Assess STOMA site for s/sx [signs and symptoms] of infection (i.e. redness, swelling, tenderness, drainage, warm to touch) QS [every shift] & notify MD if any. 3/26/26. NEPHROSTOMY: Cleanse nephrostomy stoma site with NS and pat dry, apply dry dressing to Left and Right nephrostomy site QOD [every other day] and PRN [as needed]. 3/26/26. TREATMENT: ACOORDION DRAIN-Cleanse stoma site with NS, pat dry, apply dry dressing QOD and as needed if soiled or dislodged. 3/26/26.During a concurrent interview and record review on 4/13/26 at 11:38 a.m. with the Treatment Nurse (TN), the TN stated a CNA had paged her to Resident 1's room on 3/26/26 because the resident's family was requesting her dressings be changed to the nephrostomy tubes and drain site. The TN stated she was unaware Resident 1 had nephrostomy tubes or drain site dressings because they were not identified or documented on admission. The TN stated when she checked Resident 1, she discovered bilateral nephrostomy tubes from the residents back, each had a split gauze over the tube exit site and was secured with tape, and the resident also had an accordion drain in the lower abdomen. Resident 1's admission Assessment, dated 3/21/26 was reviewed and indicated, . Catheter/Ostomy. ileostomy/Urostomy [not checked] . Nephrostomy/urostomy [not checked] . Other Relevant Dx[diagnosis]/Concerns [left blank] . Additional nurses notes . voiding well and using bedpan . Resident 1's Skin Assessment, dated 3/20/26, indicated, . Special Equipment. Other. If other, specify [left blank] . Type of skin problem. Surgical site. Other. If other, specify [left blank] . Resident 1's Skin Assessment, dated 3/20/26, indicated, . Special Equipment. Other. If other, specify [left blank] . Type of skin problem. Surgical site. Other. If other, specify [left blank]. The TN stated the nephrostomy tubes and drain were not documented on the admission assessment or skin assessment. The TN stated when she saw Resident 1 on 3/26/26, she had reviewed the physician orders and was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unable to find any dressing changes or site monitoring orders. The TN stated she contacted Resident 1's physician and received new orders to change the dressings every other day and to monitor the sites for signs and symptoms of infection. Resident 1's Skin Assessment, dated 3/26/26, written by the TN, indicated, . Special Equipment. Other [box checked]. If other, specify. accordion drain and nephrostomy tubes. Type of skin problem. Surgical site. Present on admission. patient noted with left and right nephrostomy tubes, sites are clean, normal skin color, no redness, no s/sx [signs or symptoms] of infection. cleansed with NS [normal saline] and applied dry dressing for protection, accordion drain noted to left lower abdominal quadrant. no s/sx of infection. The TN stated she performed the wound care and entered the orders into the Electronic Medical Record (EMR). Resident 1's care plans were reviewed and the TN stated she was unable to locate care plans addressing the nephrostomy tubes or drain site. The TN stated a care plan should have been entered on admission and updated when new orders were received. The TN stated care plans were important to address resident problems, identify the treatment goals and to put interventions in place to meet those goals. The TN stated that when a new resident was admitted with dressings, the admission nurse should assess the resident, check the transfer orders for wound care and contact the physician to review the information and receive new orders. The TN stated there was no wound care, site care or drain care ordered from admission on [DATE] until saw Resident 1 on 3/26/26. The TN stated Resident 1's dressings should have been changed at least twice since admission if the orders had been received sooner. The TN stated Resident 1's accordion drain was from an abscess site, making her at high risk of infection. The TN stated it was very important to have orders to monitor the drain and nephrostomy sites to assess changes to catch any issues quickly.During a concurrent interview and record review on 4/13/26 at 1:12 p.m. with the Director of Staff Development (DSD), the DSD stated Resident 1 was admitted to the facility from 3/20/26 to 3/27/36. Resident 1's Order Summary Report (OSR), undated, was reviewed and indicated . Nephrostomy: Assess STOMA site for s/sx [signs and symptoms] of infection (i.e. redness, swelling, tenderness, drainage, warm to touch) QS [every shift] & notify MD if any. 3/26/26. NEPHROSTOMY: Cleanse nephrostomy stoma site with NS and pat dry, apply dry dressing to Left and Right nephrostomy site QOD [every other day] and PRN [as needed]. 3/26/26. TREATMENT: ACOORDION DRAIN-Cleanse stoma site with NS, pat dry, apply dry dressing QOD and as needed if soiled or dislodged. 3/26/26. The DSD stated Resident 1 had bilateral nephrostomy tubes and a drain site on admission 3/20/26, but the care orders were not received until 3/26/26. The DSD stated the admission nurse should have documented the nephrostomy tubes and drain and called the physician for new orders. The DSD reviewed Resident 1's care plans but was unable to locate any care plans addressing the nephrostomy tubes and drain site. The DSD stated care plans were important to identify Resident 1's nephrostomy tubes and drain site, what the goals of treatment were, and care interventions needed to meet those goals. The DSD stated the nurses failed to identify the tubes and drain on admission and did not enter a care plan for their treatment. The DSD stated Resident 1 was placed at risk for drain and tube site infection from the delay in treatment. During an interview on 4/13/26 at 2:01 p.m. with the Director of Nursing (DON), the DON stated Resident 1 was admitted to the facility with nephrostomy tubes and a drain site, but they were not documented on admission. The DON stated the normal process for a new admission was for the Interdisciplinary Team (IDT- team from different healthcare disciplines who work together to provide comprehensive patient care) to meet, review the residents Electronic Medical Record (EMR) for the history and physical, hospital records, admission assessment for any needed treatments, consents or wound care to ensure the residents needs had been addressed in the plan of care. The DON stated Resident 1's IDT meeting was delayed, so the LN's failure to document the nephrostomy tubes and drain site and request physician orders was not found timely and resulted in the resident not receiving site care for 6 days. The DON stated normally the IDT would have met and followed up with the physician for new orders. The DON stated it was her expectation for the admission nurse to note the nephrostomy tubes and drain site in the admission assessment, skin assessment and be communicated to the floor staff. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON stated the physician should have been notified and asked for orders to care for the sites such as dressing, monitoring the site for signs of infection or dislodgement. The DON stated monitoring was very important because any changes in the nephrostomy tubes and drain sites would need to be noted and reported to the physician immediately to prevent complications such as an infection. The DON stated care plans were important to have all problems addressed because they direct the care provided to the residents. During a review of the facility's policy and procedure (P&P) titled admission Assessment and Follow Up: Role of the Nurse, dated 9/2012, the P&P indicated, . purpose of this procedure is to gather information about the resident's physical, emotional, cognitive, and psychosocial condition upon admission for the purposes of managing the resident, initiating the care plan, and completing required assessment. Conduct an admission assessment (history and physical), including. summary of the individual's recent medical history, including hospitalizations, acute illnesses and overall status. Relevant medical, social, and family history. A list of active medical diagnoses and patient problems. especially those most related to reasons for admission to the facility. Conduct a physical assessment, including the following systems. genitourinary. skin. Contact the Attending Physician to communicate and review the findings of the initial assessment and any other pertinent information. Documentation. following information should be recorded in the resident's medical record. All relevant assessment data. Orders obtained from the physician. Report other information in accordance with facility policy and professional standards of practice.During a review of the facility's policy and procedures (P&P) titled Nephrostomy Tube, Care of, dated 10/2010, the P&P indicated, . purpose of this procedure is to provide guidelines for the care of the resident with a percutaneous nephrostomy tube. Assess the resident for indications of bleeding in the flank area . every 8 hours. Check placement of the tubing and integrity of the tape during assessments. Drainage should be below the level of the kidneys. no kinks in the tubing. if the tubing is dislodged, cover stoma with sterile 4X4 and notify the Attending Physician immediately. Empty drainage bag once per shift and as needed. Change drainage bag monthly, or as needed. Measure output as follows. Every 8 hours. Measure output from the right and left kidneys separately. Change dressings every 1-3 days, or as ordered. Reporting. Report any of the following signs or symptoms to the physician. Redness, inflammation, reports of pain, or other signs of infection at the insertion stie. Reduced output or output below established parameters. Inability to irrigate tube or signs of obstruction of the tube. Signs of skin breakdown. or If the tube becomes dislodged. During a review of the facility's documents titled Job Description: Licensed Nurse/Medication/Treatment Nurse, undated, the job description indicated, .Complete and file required recordkeeping forms/charts upon the resident's admission. Chart nurses' notes in an informative, descriptive and legible manner that reflects the care provided to the resident. Nursing Care Functions. Provide direct nursing care as necessary. Care Plan and Assessment Functions. Participate in the development of written preliminary and comprehensive assessments of the nursing needs of each resident. Participate in the development of a written care plan. that identifies the problems/needs of the resident, indicates the care to be given, goals to be accomplished . Review resident care plans for appropriate resident goals, problems, approaches, and revisions based on nursing needs. Ensure that all personnel involved in providing care to the resident are aware of the resident/s care plan. Ensure that nursing personnel refer to the resident's care plan prior to administering daily care to the resident. Review nurses' notes to determine if the care plan is being followed.During a review of a professional reference retrieved from https://www.ncbi.nlm.nih.gov/books/NBK242385/ titled Nephrostomy and Biliary Tube Management: A Review of the Clinical Evidence and Guidelines, dated 2014, the reference indicated, . General recommendations for patients and health care providers caring for nephrostomy tubes include routinely checking nephrostomy tube patency and monitoring for pain, leakage or bleeding, as well as fever. Patient instruction to inspect their nephrostomy tube daily, looking for skin breakdown, soiled dressings, kinks in the tubing, and evidence of blockage. An absence of urine, presence of blood in the collection bag, or flank pain may indicate that the tube is blocked. Recommendation for the frequency (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of changing drainage bags ranged from three times weekly to every 7 days. recommended frequency of dressing changes also varied from every other day to twice weekly; however, there was generally agreement across references that the dressing should be changed if it becomes visibly soiled.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure Licensed Nurses received competency skills on the assessment and care of nephrostomies when three of three sampled Licensed Nursing staff (Registered Nurse [RN] 1, Licensed Vocational Nurse (LVN) 2 and the Treatment Nurse [TN]) did not receive competency training and skill set evaluate in assessing and providing nephrostomy (thin, flexible tube placed through the skin of a person's back into the kidney to drain urine into an outside bag) care.This failure had the potential to place residents with nephrostomies at risk for care to not be provided in a safe and competent manner.During an interview on 4/13/26 at 10:17 a.m. with LVN 2, LVN 2 stated there were residents at the facility with nephrostomy tubes. LVN 2 stated the facility tested skill competencies annually but could not remember if nephrostomy tubes were covered.During an interview on 4/13/26 at 11:38 a.m. with the Treatment Nurse (TN), the TN stated the facility held annual competencies for the nursing staff, which included genitourinary system (organs involved in producing urine and reproduction) such as catheters (thin, flexible tube inserted through the urethra into the bladder to drain urine into a collection bag) and suprapubic catheters (tube inserted through a small, permeant opening in the lower abdomen to drain urine), but was unsure if she had received training and competency regarding nephrostomy tubes.During a concurrent interview and record review on 4/13/26 at 1:12 p.m. with the Director of Staff Development (DSD), the DSD stated the facility provided the nurses with an annual training and competency skills check. The facility's document titled Licensed Nurse Competency Checklist, updated 7/5/2023, was reviewed and indicated, . Catheters. Urethral Catheterization. Female. Male. Insertion. Removal. Supra Pubic Catheter Daily Care. Insertion. Removal. Genitourinary Assessment. The DSD stated the template did not include competency for nephrostomy care, so the nurses had not been evaluated for their skill competency during the annual check. The DSD stated if it was not on the template, it was not done. The DSD stated there were residents in the facility with nephrostomy tubes, and it was important for all the nurses to be competent in providing care. The DSD stated he would reach out to the facility consultant to train the nursing staff for nephrostomies.During an interview on 4/13/26 at 1:53 p.m. with Registered Nurse (RN) 1, RN 1 stated the facility held in-services and annual competency checks, including the urinary system but was unsure if nephrostomies were covered.During an interview on 4/13/26 at 2:01 p.m. with the Director of Nursing (DON), the DON stated the annual competency skills check should cover procedures performed in the facility and nephrostomy care should be added to the checklist. The DON stated it was important to make sure the nurses were competent prior to providing nephrostomy care to ensure the care was adequate and would not bring harm to the resident. The DON stated ideally all nurses should have competencies checked before accepting a resident with an issue not covered by the competency check list. The DON stated there were residents in the building with nephrostomies and staff providing care needed to be competent.During a review of the facility's policy and procedures (P&P) titled Staffing, Sufficient and Competent Nursing, dated 8/2022, the P&P indicated, . Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. Licensed nurses. provide competent resident care services including. attaining or maintaining the highest practicable physical, mental and psychosocial well-being of each resident. assessing, evaluating, planning and implementing resident care plans. Competency is a measurable pattern of knowledge, skills, abilities, behaviors and other characteristics that an individual needs to perform work roles. All nursing staff must meet the specific competency requirements of their respective licensure and certification. Staff must demonstrate the skills and techniques necessary to care of resident needs including. Person centered care. Basic nursing skills. Skin and wound care. Infection control. Licensed nurses . are trained and must demonstrate (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	competency in identifying, documenting and reporting resident changes of condition consistent with their scope of practice and responsibilities. Competency requirements and training for nursing staff are established and monitored by nursing leadership. programming for staff training results in nursing competency. gaps in education are identified and addressed. education topics and skills needed are determined based on the resident population. training includes critical thinking skills and managing care in a complex environment.