STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055685	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Place Spring Valley	9009 Campo Road Spring Valley, CA 91977

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 47914 Based on interview, record review, facility policy review, and the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument (RAI) manual, the facility failed to ensure the annual Minimum Data Set (MDS) assessment was accurate for the preadmission screening and resident review (PASARR) Level II for 1 (Resident #15) of 4 residents reviewed for PASARR. Findings included: A facility policy titled, RAI Process, revised 10/04/2016, indicated the purpose was, To provide resident assessments that accurately depict and identify resident-specific issues and objectives as required, while meeting state and federal guidelines and data submission requirements. The facility will utilize the Resident Assessment Instrument (RAI) process as the basis for the accurate assessment of each resident's functional capacity and health status, as outlined in the CMS [Centers for Medicare and Medicaid Services] RAI MDS 3.0 Manual. A document titled, Centers for Medicare and Medicaid Services, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11, revised 10/2023, indicated The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status. The RAI manual indicated, A1500: Preadmission Screening and Resident Review (PASRR) (cont.) -Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions. An Admission Record revealed the facility admitted Resident #15 on 05/06/2022. According to the Admission Record, the resident had a medical history that included schizophrenia and schizoaffective disorder. An annual MDS, with an Assessment Reference Date (ARD) of 07/29/2023, revealed a Staff Assessment for Mental Status (SAMS) was conducted, which indicated the resident had severe impairment in cognitive skills for daily decision making. Section A1500 Preadmission Screening and Resident Review (PASRR) indicated Resident #15 was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or related condition. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055685	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Department of Health Care Services letter dated 05/06/2022 revealed the Level I Screening for Resident #15 was positive for suspected mental illness and a Level II Mental Health Evaluation Referral was required. A Department of Health Care Services letter dated 08/09/2022 revealed a Level II evaluation had been completed on 06/08/2022 and the determination report was attached. The Preadmission Screening and Resident Review (PASRR) Individualized Determination Report, dated 08/09/2022, revealed specialized services were recommended for Resident #15. During an interview on 05/23/2024 at 11:04 AM, the MDS Coordinator stated that she had only been working at the facility for three months, so was not present for the MDS for Resident #15. She said if a resident had a Level II PASRR, then she would trigger it on the MDS. During an interview on 05/23/2024 at 12:06 PM, the Director of Nursing (DON) stated her expectation was that the MDS for residents be accurate. The DON indicated the MDS should have been marked for Level II because nothing had changed with Resident #15. During an interview on 05/23/2024 at 11:48 AM, the Administrator stated his expectation was the MDS for residents be accurate, timely, and true.

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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	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 35314 Based on observation, interview, record review, and facility document and policy review, the facility failed to implement the comprehensive care plan for 1 (Resident #17) of 2 residents reviewed for accidents. Resident #17's care plan included interventions for smoking and elopement that were not implemented. Findings included: A facility policy titled, Comprehensive Person-Centered Care Planning, revised 11/2018, revealed, It is the policy of this Facility to provide person-centered, comprehensive and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents in order to obtain or maintain the highest physical, mental and psychosocial well-being. An Admission Record revealed the facility admitted Resident#17 on 04/29/2024. According to the Admission Record, the resident had a medical history to include a diagnosis of chronic obstructive pulmonary disease. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/04/2024, revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident used tobacco. Resident #17's care plan, initiated on 05/13/2024, revealed the resident was an elopement risk/wanderer related to a history of attempts to leave the facility unattended. Resident #17's care plan, initiated on 05/13/2024, revealed the resident was a smoker. Interventions revealed the resident required supervision while smoking. During an observation on 05/20/2024 at 11:37 AM, Resident #17 exited the side door of the facility in their wheelchair, while smoking a cigarette. The resident continued down the sidewalk to the end of the street and turned the corner until they could no longer be visualized. On 05/21/2024 at 2:35 PM, the surveyor observed Resident #17 outside smoking in a non-designated smoking area. A facility document titled, Resident Out on Pass Log, revealed Resident #17 signed themself out on 05/03/2024, 05/06/2024, 05/08/2024, and 05/17/2024. There was no evidence to indicate Resident #17 signed themself out of the facility on 05/20/2024. During an interview on 05/21/2024 at 10:09 AM, the Infection Preventionist stated Resident #17 was allowed to be outside alone, if the resident signed out. During an interview on 05/21/2024 at 9:32 AM, the Director of Nursing (DON) stated Resident #17 was independent, knew the rules, and forgot to sign out of the facility on 05/20/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/23/2024 at 10:52 AM, the Administrator stated he expected the care plans for the resident to be correct. The Administrator stated that regarding Resident #17's care plan, he believed the staff were moving too fast and documented in error.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35314 Based on observation, interview, record review, document review, and facility policy review, the facility failed to 1 (Resident #17) of 2 sampled residents reviewed for accidents, did not leave the facility without staff knowledge, and did not smoke in a non-designated smoking area. Findings included: A facility policy titled, Wandering and Elopement, with an effective date of 02/10/2023, revealed, Definition: Elopement - A behavior that may lead to the resident leaving the facility unsupervised and/or without permission. A facility policy titled Smoking Residents, with an effective date of 08/18/2023, revealed, Procedures: 2. Smoking by residents is allowed outside the facility in designated, marked smoking areas with the following safety measures readily available: a. Ashtrays made of noncombustible material and safe design; b. Metal containers with self-closing covers into which ashtrays can be emptied, c. Portable fire extinguisher; and d. Fire-retardant blanket (smoking blanket). An Admission Record revealed the facility admitted Resident#17 on 04/29/2024. According to the Admission Record, the resident had a medical history to include a diagnosis of chronic obstructive pulmonary disease. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/04/2024, revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident used tobacco. Resident #17's care plan, initiated on 05/13/2024, revealed the resident was an elopement risk/wanderer related to a history of attempts to leave the facility unattended. Resident #17's care plan, initiated on 05/13/2024, revealed the resident was a smoker. Interventions revealed the resident required supervision while smoking. During an observation on 05/20/2024 at 11:37 AM, Resident #17 exited the side door of the facility in their wheelchair, while smoking a cigarette. The resident continued down the sidewalk to the end of the street and turned the corner until they could no longer be visualized. On 05/21/2024 at 2:35 PM, the surveyor observed Resident #17 outside smoking in a non-designated smoking area. During an interview on 05/20/2024 at 2:09 PM, Resident #17 stated they went to the store and came back. Resident #17 acknowledged they did not sign themself out of the facility. According to Resident #17, they did not tell the nurse, but stated they knew where they went to the store. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility document titled, Resident Out on Pass Log, revealed Resident #17 signed themself out on 05/03/2024, 05/06/2024, 05/08/2024, and 05/17/2024. There was no evidence to indicate Resident #17 signed themself out of the facility on 05/20/2024. During an interview on 05/21/2024 at 9:01 AM, Licensed Vocational Nurse (LVN) #8 stated she dd not know Resident #17 left the faciity on [DATE]. LVN #8 stated the resident was safe to be outside alone and had never left the facility alone before. Per LVN #8, the resident needed to sign the book (Resident Out on Pass Log). During an interview on 05/21/2024 at 9:32 AM, the Director of Nursing (DON) stated if staff did not know the resident left the facility, the resident would be identified as a missing person. The DON reported that Resident #17 was independent, knew the rules, and forgot to sign out of the facility on 05/20/2024. During an interview on 05/21/2024 at 10:09 AM, the Infection Preventionist stated Resident #17 was allowed to be outside alone, if the resident signed out. During an interview on 05/21/2024 at 2:57 PM, the Director of Staff Development (DSD) stated there were no residents in the facility who were allowed to smoke in a non-designed smoking area. The DSD stated she never saw Resident #17 smoke in a non-designated smoking area. During an interview on 05/21/2024 at 3:43 PM, the Administrator stated he was not aware of any incidents when Resident #17 smoked in a non-designated smoking area. According to the Administrator, the resident was allowed to go outside alone, but they were not allowed to go down the street.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 35314 Based on interview, record review, and facility policy review, the facility failed to ensure an as needed psychotropic medication had a stop date and was limited to 14 days for 2 (Resident #16 and Resident #42) of 5 sampled residents reviewed for unnecessary medications. Findings included: A facility policy titled, Behavior/Psychoactive Drug Management, revised in 11/2018 revealed, Any Psychoactive Medication ordered on a prn [pro re nata, as needed] basis, must be ordered not to exceed 14 days. If the physician feels the medication needs to be continued, he/she must document the reason(s) for the continued usage, and write the order for the medication; not to exceed the 14-day time frame. 1. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/24/2024, revealed Resident #16 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS indicated the facility admitted Resident #16 on 04/17/2024. The MDS indicated the resident had active diagnoses that included anxiety disorder, depression, and schizophrenia. Resident #16's care plan, initiated on 04/19/2024, revealed the resident had a behavior problem related to anxiety, depression, and psychosis. Interventions directed staff to administer medications as ordered and monitor/document for side effects and effectiveness. Resident #16's Order Summary Report with active orders as of 05/22/2024, revealed an order dated 05/02/2024, for lorazepam (an antianxiety medication) 0.5 milligrams one tablet by mouth every eight hours as needed for anxiety. There was no end or stop date listed for the medication. 2. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/26/2024, revealed Resident #42 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the facility admitted Resident #42 on 02/19/2024. The MDS indicated the resident had active diagnoses that included anxiety disorder and depression. Resident #42's care plan, initiated on 02/19/2024, revealed the resident had a mood problem. Interventions directed staff to administer medications as ordered and to monitor/document for side effects and effectiveness. Resident #42's Order Summary Report with active orders as of 05/22/2024, revealed an order dated 05/07/2024, for alprazolam (an antianxiety medication) 0.25 milligrams, one tablet by mouth every eight hours as needed for restlessness and agitation. There was no end or stop date listed. During an interview on 05/22/2024 at 10:59 AM, Registered Nurse #1 stated as needed psychotropic medication was usually ordered for 14 days and the order should include a stop date. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/23/2024 at 8:15 AM, the Director of Nursing stated as needed psychotropic medication was usually ordered for 14 days and then the resident was re-evaluated by the physician to determine if the medication should extend past the 14 days. During an interview on 05/23/2024 at 10:44 AM, the Administrator stated his expectation was to minimize the use of psychotropic medications as much as possible.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41493 Based on observation, interview, record review, and facility policy review, the facility failed to ensure expired medications were discarded in 1 of 1 medication storage room and medications were properly stored for 3 (Residents #7, #12, and #116) of 18 sampled residents. Findings included: A facility policy titled, Medication Storage in the Facility, with an effective date of April 2008, revealed, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized. The policy revealed, G. Medications labeled for individual residents are stored separately from floor stock medications when not in the medication cart. Per the policy, M. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. 1. During a concurrent observation and interview on 05/22/2024 at 3:31 PM, Licensed Practical Nurse (LVN) #7 stated she did not know who the expired liquid medication belonged to. LVN #7 acknowledged the medication was lorazepam, it had an opened date of 02/19/2024, and it should have been discarded after 90 days, but still remained in the refrigerator. During a concurrent observation of the medication room and interview on 05/22/2024 at 3:34 PM, the Director of Nursing (DON) was shown a bottle of pantoprazole with an expiration date of 05/17/2024 and a bottle of lorazepam, with an opened date of 02/19/2024. The DON stated expired medication should not be in the refrigerator. During an interview on 05/23/2024 at 10:06 AM, the DON stated all medications should be checked for expiration dates. Per the DON, expired medications should be removed from storage. During an interview on 05/23/2024 at 11:22 AM, the Administrator stated expired medications should be disposed of in an appropriate manner. 2. An Admission Record revealed the facility admitted Resident #7 on 05/31/2022. According to the Admission Record, the resident had a medical history that included multiple sclerosis and pain. An quarterly Minimum Data Set (MDS), with an Assessment Review Date (ARD) of 03/01/2024, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. Resident #7's comprehensive care plan, with an admitted [DATE], revealed no evidence to indicate the resident was care planned to self-administer or store their medication(s). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #7's Order Summary Report, with active orders as of 05/20/2024, revealed there was no physician's order to indicate the resident was able to self-administer or store their medication(s). During an observation on 05/20/2024 at 1:28 PM, the surveyor noted Resident #7 had joint food (a dietary supplement), BenGay (a topical analgesic heat rub), and heal-n-soothe (a supplement for the relief of achy, inflamed joint) at their bedside. Resident #7 stated they took the joint food by themselves, but was not able to reach the BenGay as it was on their bedside table. During an observation on 05/21/2024 at 1:00 PM the surveyor noted the BenGay was still located on Resident #7's bedside. During an interview on 05/22/2024 at 11:22 AM, Registered Nurse (RN) #4 stated Resident #7 could not self-administer their medications. RN #4 stated medication should not be at a resident's bedside. Per RN #4, if staff fond a medication at a resident's bedside, they would talk with the resident, remove the medication, and notify the physician for further orders. Oon 05/22/2024 at 11:24 AM, RN #4 entered Resident #7's room and visualized the BenGay at the resident's bedside. RN #4 informed the resident they were not to have the medication. 3. An Admission Record revealed the facility admitted Resident #12 on 11/21/2023. According to the Admission Record, the resident had a medical history to include diagnoses of chronic obstructive pulmonary disease and dyspnea. An quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/28/2024, revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. Resident #12's comprehensive care plan, with an admitted [DATE], revealed no evidence to indicate the resident was care planned to self-administer or store their medication(s). Resident #12's Order Recap [recapitulation] Report, for the timeframe 11/21/2023 to 05/31/2024, revealed there was no physician's order to indicate the resident was able to self-administer or store their medication(s). Per the Order Recap Report, there was order dated 03/21/2024, for budesonide-formoterol fumarate inhalation aerosol two puffs inhale orally two times a day for COPD. During medication administration observation on 05/21/2024 at 9:46 AM, Resident #12's budesonide-formoterol fumarate inhalation aerosol was observed at the bedside of the resident. Licensed Practical Nurse (LVN) #2 stated the inhaler should not have been left at Resident #12's bedside. Resident #12 stated the medication nurse from the previous night shift left the inhaler at their bedside. During an interview on 05/22/2024 at 12:04 PM, Registered Nurse (RN) #4 acknowledged she administered the inhaler to Resident #12 and forgot and left the inhaler at the resident's bedside. RN #4 stated the inhaler should not have been left at the resident's bedside. 4. An Admission Record revealed the facility admitted Resident #116 on 05/10/2024. According to the Admission Record, the resident had a medical history to include diagnoses of cellulitis of the left lower leg. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #116's comprehensive care plan, with an admitted [DATE], revealed no evidence to indicate the resident was care planned to self-administer or store their medication(s). Resident #116's Order Summary Report, with active orders as of 05/20/2024, revealed there was no physician's order to indicate the resident was able to self-administer or store their medication(s). During a concurrent observation and interview on 05/20/2024 at 9:59 AM, the surveyor observed turmeric curcumin (a supplement) and Orajel (a topical numbing agent) at the bedside of Resident #116. Resident #116 stated they used the Orajel as they had dental pain from a cracked tooth. Resident #116 stated they were not aware they were not supposed to have medications at the bedside. During an interview on 05/23/2024 at 9:21 AM, Licensed Practical Nurse (LVN) #5 stated she was not aware Resident #116 had medications at their bedside. LVN #5 stated Resident #116 was not able to self-administer their medication(s). During an interview on 05/23/2024 at 11:22 AM, the Administrator stated no medications were to be left at a resident's bedside.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 35314 Based on observation, interview, record review, and facility policy review, the facility failed to ensure the water management program included a risk assessment to identify legionella and other waterborne pathogens that could grow in the facility water system. This deficient practice had the potential to affect all residents who currently resided in the facility. The facility also failed to ensure staff wore sterile gloves when they set up equipment to perform an indwelling catheter insertion for 1 (Resident #60) of 2 sampled residents reviewed for urinary catheters. Findings included: 1. A facility policy titled, Water Management, with a revision date of 05/25/2023, revealed, The facility will develop and utilize water management strategies, using the Core Elements of a Water Management Plan, to reduce the risk of growth and spread of Legionella and other opportunistic water-borne pathogens in facility water systems. During an interview on 05/22/2024 at 1:34 PM, the Maintenance Supervisor stated there has not been a completed risk assessment to identify risk areas that could have the potential for legionella. Per the Maintenance Supervisor, he did not know how the water flowed through the facility. The Maintenance Supervisor acknowledged he had not completed a risk assessment. During an interview on 05/22/2024 at 1:43 PM, the Infection Preventionist (IP) she had nothing to do a risk assessment regarding legionella. According to the IP, the Maintenance Supervisor was responsible for the completion of the risk assessment. During an interview on 05/22/2024 at 2:18 PM, the Administrator stated the facility had not identified the risk area regarding the potential for legionella. The Administrator stated the facility's water management plan had not been customized for the facility and a risk assessment had not been completed. During an interview on 05/23/2024 at 8:50 AM, stated the Maintenance Supervisor was responsible for completing the risk assessment to determine the potential for legionella. 41493 2. A facility policy titled Catheter-Care of, with a revised date of 06/10/2021, revealed IV. Catheter Insertion A. Catheters are to be inserted using aseptic techniques and sterile equipment, including gloves, drape, sponges, appropriate antiseptic solution for periurethral cleaning, and single-use packet of lubricant jelly for insertions. An Admission Record, revealed the facility admitted Resident #60e resident on 04/10/2024 with diagnoses that included obstructive and reflux uropathy, benign prostatic hyperplasia without lower urinary tract symptoms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055685	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PROVIDER OR SUPPLIER Brighton Place Spring Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 9009 Campo Road Spring Valley, CA 91977	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/17/2024, revealed Resident #60 had a Brief Interview for Mental Status (BIMS) of 11, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident had an indwelling catheter. Resident #60's care plan, initiated on 04/11/2024, revealed the resident had an indwelling catheter. Resident #60's Order Summary Report, with active orders as of 05/23/2024, revealed an order dated 04/10/2024 that directed staff to change the urinary catheter as needed. During an observation on 05/21/2024 at 3:47 PM, Licensed Vocational Nurse (LVN) #7 removed sterile gloves from the indwelling catheter package and laid them to the side, while she set up the indwelling catheter supplies with the non-sterile gloves she had on. After LVN #7 set up the supplies, she placed a drape over Resident #60's perineal area, then removed the non-sterile gloves, washed her hands, and put on a pair of sterile gloves. During an interview on 05/22/2024 at 11:01 AM, LVN #7 stated she thought this was first indwelling urinary catheter that she had inserted in a long time. LVN #7 stated she realized she messed up and acknowledged she needed more training. During an interview on 05/23/2024 at 10:14 AM, the Director of Nursing (DON) stated if sterile technique was broken, staff should stop and start over with all new supplies. The DON stated she expected if staff did not know how to complete a procedure, that they would review the policy first before they began or ask for assistance from another staff person. During an interview on 05/23/2024 at 11:37 AM, the Administrator stated there was a process in place the staff should follow, but he did not know the actual process.

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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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 41493 Based on interview, facility policy review, and review of employee records, the facility failed to maintain an effective training program for 2 (Licensed Vocational Nurse [LVN] #3 and LVN #7) of 5 staff members reviewed for training and competencies. Findings included: A facility policy titled, Staff Competency Assessment, revised 03/17/2022, revealed, The purpose of completing competency assessments is to determine knowledge and/or performance of assigned responsibilities based on standard of practice, policy and procedure and regulatory requirement. The policy also indicated, Competency assessments will be performed upon hire during the employee's 90-day employment period, annually, or anytime new equipment or a procedure is introduced and as needed. The policy also indicated, II. All staff are required to have competency assessments by the Director of Staff Development or department manager based on their job description or assigned duties within the first 90 days of employment. The policy further indicated, IX. Competency assessments will be through written testing and/or observation, whichever is appropriate. X. The competency assessment will be retained in the employee file or a 3-ring binder, indefinitely for current employees and seven (7) years from the last date of employment for former employees. A document titled, Employee Information Sheet, for LVN #7 revealed a hire date of 09/16/2021. There was no competency documentation located in the employee file. During an interview on 05/22/2024 at 10:14 AM, the Director of Staff Development (DSD) stated she was unable to locate a completed orientation check off for LVN #7 and had no documentation for LVN #7 regarding skills training. During an interview on 05/22/2024 at 11:01 AM, LVN #7 stated she had not completed a competency checklist during orientation. LVN #7 said the last time that she had any hands-on training was in nursing school. During an interview on 05/22/2024 at 2:08 PM, the DSD stated newly hired staff were asked what tasks they could perform and were then required to shadow a staff member on the floor, but that training was not documented. 35314 2. An untitled document for Licensed Vocational Nurse (LVN) #3 revealed a hire date of 09/03/2023. LVN #3's personnel file revealed a document titled In-Service Training for the facility's blood glucose monitoring system dated 02/13/2024. No additional competencies or skill checks were in the file. During an interview on 05/23/2024 at 9:12 AM, LVN #3 said she did not recall having received any training from the nursing facility. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/23/2024 at 12:45 PM, the Director of Staff Development (DSD) stated the nursing staff shadowed other nurses on the floor upon hire; however, she had no evidence of the shadowing. The DSD said there was no evidence LVN #3 had completed competency and skills training beyond what was in LVN #3's personnel file. During an interview on 05/23/2024 at 10:21 AM, the Director of Nursing (DON) stated that according to facility policy, newly hired staff should have a competency form completed within the first 90 days, and then have annual competencies. The DON said the facility was not in compliance with their policy regarding nursing competency. During an interview on 05/23/2024 at 10:44 AM, the Administrator stated his expectation was for competencies to be completed upon hire, annually, and as needed.