STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215118	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Future Care Old Court	5412 Old Court Road Randallstown, MD 21133

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50573 Based on observation and interview, it was determined that the facility failed to ensure residents were treated with respect and dignity while assisting residents with meals. This was evident for 1 (Resident #283) of 1 resident observed being fed by staff. The findings include: On 12/10/24 at 1:00 PM, the surveyor observed Geriatric Nursing Assistant (GNA, Staff #46) standing over Resident #283 when feeding the resident. On 12/10/24 at 1:06 PM, an interview with agency GNA #46 revealed that she was agency staff and she was not aware that staff should not stand when feeding residents. On 12/11/24 at 8:43 AM, an interview with agency GNA (Staff #45) revealed that she was agency staff and she was not aware that staff should not stand when feeding residents. On 12/11/24 at 12:43 PM, an interview with the Staffing Coordinator (Staff #22) and the Nursing Home Administrator (NHA, Staff #1) revealed that agency GNAs are not educated on maintaining resident dignity pertaining to feeding upon working at the facility. Staff #22 indicated that GNA's are educated on such skills in school to obtain their GNA license and should be using those skills at the facility. On 12/11/24 at 1:51 PM, the surveyor reviewed the concern with the NHA.

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

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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. 49148 Based on record review and interview with residents and staff, it was determined that the facility failed to develop and implement a comprehensive care plan for residents. This was evident for 1 (Resident #103) out of 61 residents reviewed during survey. The findings include: A care plan is used to summarize a person's health conditions, specific care needs, and current treatments and outlines what needs to be done to plan, assess, and manage a resident's care. On 12/9/2024 at 7:00AM, during an interview with Geriatric Nursing Assistant (GNA) #55, the Surveyor was informed that residents are scheduled to have two showers a week and showers are usually given during the 7AM-3PM shift or 3PM-11PM shift. During review of Resident #103's task care report for November 2024 and December 2024 on 12/9/2024 at 1:30PM, the Surveyor discovered a GNA task for showers/tub bath on Mondays and Thursdays during the 3pm-11pm shift. Further review revealed documentation of N, the resident did not receive a shower or RR, the resident refused a shower on Mondays and Thursdays from November through December 2024 On 12/10/2024 at 10:25AM, the Surveyor reviewed the shower sheet binder at the 1st floor nurses station. The Surveyor did not observe any shower sheets for Resident #103 in the binder. The Surveyor requested Resident #103's shower sheets for November 2024 and December 2024. On 12/10/2024 at 2:10PM, a review of Resident #103's shower sheets revealed the resident refused a shower on Wednesday 11/6/2024, Wednesday 11/13/2024, Wednesday 11/20/2024, Wednesday 11/27/2024, and Wednesday 12/4/2024. On 12/10/2024 at 2:30PM, a review of Resident #103's electronic medical record failed to reveal documentation of a care plan for the residents' refusals of showers, any actions taken by the nursing staff to educate the resident, and any alternatives the nursing staff have taken to meet the resident's needs. On 12/12/2024 at 11:40AM, during an interview with Unit Manager #54, the Surveyor confirmed that if a resident was refusing showers, that resident should be care planned for refusal of showers. The Surveyor expressed the concern that documentation had been reviewed in Resident #103's medical record, which indicate they have been refusing showers and there was no care plan nor education developed and implemented for refusal of showers. On 12/12/2024 at 1:00PM, the Surveyor informed Administrator #1 of the concern regarding failure to develop and implement a care plan for a resident refusing showers.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 49148 Based on record review and interview with staff, it was determined that the facility failed to facilitate timely care plan meetings after a resident's quarterly assessment to allow the resident and resident representative to participate in the care planning process. This was evident for 1 (Resident #48) out of 2 residents investigated for care planning during the survey. The findings include: Interdisciplinary team (IDT) is a team of medical professionals that provide specific patient centered care to the residents within a facility. The MDS (Minimum Data Set) is a standardized, comprehensive assessment of a resident's functional, medical, psychosocial, and cognitive status to develop a plan of care based on the resident's individualized needs. A care plan is used to summarize a person's health conditions, specific care needs, and current treatments and outlines what needs to be done to plan, assess, and manage care. Care plans are developed, reviewed, and/or revised by the IDT after the completion of a comprehensive MDS assessment (Admission, Annual, Quarterly, Significant Change) to help to evaluate the effectiveness of the resident's care while in the facility. On 12/4/2024 at 11:53AM, during an interview with Resident #48, the Surveyor discovered that the resident had a care plan meeting in November 2024, however, it was the first care plan meeting in about 7 months. On 12/5/2024 at 2:00PM, a review of Resident #48's paper medical record revealed a care plan meeting sign in sheet with attendance logs for meetings on 2/14/2024 and 11/14/2024. On 12/6/2024 at 8:47AM, the Surveyor conducted and interview with Social Services Director #13 and the Director of Nursing (DON) #2. The Surveyor was informed that care plan meetings are held quarterly, usually within days of the MDS assessment. The Surveyor expressed a concern that Resident #48 did not have a care plan meeting following their MDS assessment in May 2024 and August 2024. On 12/6/2024 at 10:48AM, Social Services Director #13 provided the Surveyor with documentation that a care plan meeting was held on 5/16/2024. Social Services Director #13 and the administrative staff failed to provide the Surveyor with documentation of a care plan meeting in August 2024 following the MDS assessment on 8/6/2024.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 51128 Based on record reviews and interviews, it was determined that the facility failed to provide the necessary Range of Motion (ROM) exercises for a resident in the functional maintenance program. This was evident for 1 (Resident #11) out of the 5 residents reviewed for mobility during the survey. The findings include: A functional maintenance program (FMP) is a set of activities designed to help residents maintain or improve their functional abilities, including range of motion (ROM), after therapy. The program aims to maintain the strength, independence, and functionality gained during therapy and prevent or slow further decline in function. On 12/04/24 at 08:09 AM, during an interview with Resident #11, she/he stated that staff did not provide ROM exercises to his/her wrist and hands. The resident had a history of multiple sclerosis with contractures (permanent restriction to the ROM of a joint). On 12/09/24 at 09:15 AM, the restorative aide (staff # 23) was interviewed. She explained that her job as a restorative aide is to carry out the orders written by the Physical Therapist (PT) or Occupational Therapist (OT). Her work contributes to a resident's functional maintenance program (FMP) after therapy has ended, including exercises to maintain or improve ROM. Staff #23 provided a list of residents who are on an FMP. Resident #11 was listed for ROM to right upper joints 2 times a week for 12 weeks and passive ROM to right upper extremities, wrist, and fingers, PRN (as needed) for 7 AM -3 PM and 3 PM -11 PM. Staff #23 stated that the documentation for the tasks should be found in the electronic medical records. A medical record review was conducted on 12/09/24 at 09:34 AM. Daily documentation on the GNA task under the Restorative/Functional Maintenance area indicated that the resident had a Functional Limitation of Range of Motion. On 12/09/2024 at 09:47 AM, an interview with the Director of PT/OT (Staff #20) revealed that residents not getting ongoing therapy by the PT/OT therapists were placed on the functional maintenance program maintained by nursing. When asked about Resident #11's ROM order written for PRN, Staff #20 stated that it was something that the facility had to clarify. A follow-up interview was conducted on 12/09/24 at 11:43 AM with Staff # 23, who stated that Resident #11 had not had ROM for the past several months because she/he would complain about pain. When asked if this was communicated to anyone, Staff #23 stated that she informed Staff #20 but had not informed the nurse or unit manager. Staff #23 also said she could provide documentation of the times ROM was done. On 12/09/24, at 02:39 PM, Staff #23 provided documentation that the PRN ROM was completed for Resident #11 on 10/11/2024, 11/18/2024, and 12/7/2024. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/09/2024 at 2:57 PM, the regional nurse (Staff #3) and Director of Nursing (Staff #2) were interviewed. When asked about the FMP program and the PRN order, they both stated that the program was geared toward residents to help maintain their function, and they had to clarify what constitutes PRN ROM. They both indicated that they were unaware that Resident #11 was not getting ROM due to pain. On 12/12/24 at 08:30 AM, the Administrator was informed of the concern about the lack of communication regarding the resident's ROM not being performed and the clarification and meaning of a PRN ROM order that does not indicate when or under what conditions it should be performed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49148 Based on record review and interview with resident and facility staff, it was determined that the facility failed to offer and provide showers to a dependent resident twice per week. This was evident for 1 (Resident #103) of 2 residents investigated for Activities of Daily Living (ADL) during the annual survey. The findings include: On 12/4/2024 at 11:40AM, the Surveyor conducted an interview with Resident #103, which revealed that the resident would like to have a shower and that he/she had not had a shower in a long while. On 12/9/2024 at 7:00AM, during an interview with Geriatric Nursing Assistant (GNA) #55, the Surveyor was informed that residents are scheduled to have two showers a week and showers are usually given during the 7AM-3PM shift or 3PM-11PM shift. During review of Resident #103's task care report for November 2024 and December 2024 on 12/9/2024 at 1:30PM, the Surveyor reviewed a GNA task for showers/tub bath on Mondays and Thursdays during the 3pm-11pm shift. Further review revealed that the resident did not receive a shower in November 2024 through December 2024. On 12/10/2024 at 7:26AM, the Surveyor reviewed the facility's Skin: Preventative Care Policy and discovered that residents will receive a shower or tub bath twice weekly and PRN. On 12/10/2024 at 10:25AM, a review of the shower sheet binder at the 1st floor nurses station revealed that Resident #103 followed a Wednesday and Saturday 7am-3pm shower schedule. During further review, the Surveyor did not observe any shower sheets for Resident #103 in the binder. The Surveyor requested Resident #103's shower sheets for November 2024 and December 2024. During an interview conducted with Resident #103 on 12/10/2024 at 10:34AM, the Surveyor asked the resident if he/she had a shower recently and the resident shook his/her head no. The Surveyor asked the resident if he wanted a shower, and he/she said yes. The Surveyor asked if he/she ever refused a shower, and the resident said no. The Surveyor asked the resident if he/she was offered a shower, and the resident said no. The MDS (Minimum Data Set) is a standardized, comprehensive assessment of a resident's functional, medical, psychosocial, and cognitive status to develop a plan of care based on the resident's individualized needs. A review of Resident #103's annual MDS assessment dated [DATE], section F, revealed that it was very important to the resident to choose between a tub bath, shower, bed bath, or sponge bath. Additional review revealed that the resident was dependent on staff for ADL care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/2024 at 2:10PM, a review of Resident #103's shower sheets revealed the resident refused a shower on Wednesday 11/6/2024, Wednesday 11/13/2024, Wednesday 11/20/2024, Wednesday 11/27/2024, and Wednesday 12/4/2024. There were no shower sheets for the Saturday shower schedule during November or December 2024. Additional review of the electronic medical record failed to support showers offered or received twice per week. On 12/11/2024 at 10:45AM, the Surveyor conducted an interview with Resident #103. During the interview, the Surveyor discovered that the resident had a shower that morning. The Surveyor was informed that the resident was offered a shower and was happy to receive one. The Surveyor asked the resident if he/she knew what days he/she was scheduled for a shower and the resident stated no. The Surveyor informed the resident that he/she is scheduled to have showers two times a week on Wednesdays and Saturdays. During an interview conducted with Unit Manager #54 on 12/12/2024 at 11:45, the Surveyor confirmed that Resident #103 had not had a shower on Wednesdays and Saturdays as scheduled during the month of November 2024 and December 2024, until 12/11/2024. The Surveyor reviewed the concern that during the survey, Resident #103 stated that it had been a while since he/she was offered showers, he/she has not refused showers, would like to have showers, and was not informed of his/her shower schedule. On 12/12/2024 at 1:00PM, the Surveyor informed Administrator #1 of the concern with Resident #103's showers.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 49148 Based on record review and interview with staff, it was determined that the facility failed to ensure a physician's order for a STAT (without delay) x-ray was performed timely, preventing a delay in treatment. This was evident for 1 (Resident #34) out of 3 residents investigated for accidents during the survey. The findings include: On 12/4/2024 at 11:36AM, during an interview with Resident #34, the Surveyor was informed that the resident sustained an injury to his/her left ankle in June 2024 while attempting to be weighed using a wheelchair scale. On 12/6/2024 at 10:00AM, a review of Resident #34's electronic medical record revealed a change in condition note written on 6/14/2024 at stating the resident complained of left ankle pain and the resident stated that he/she got his/her left leg caught on the scale while he/she was being weighed on 6/13/2024. Further review of Resident #34's electronic medical record revealed an physician order for a STAT(without delay) x-ray placed on 6/14/2024 at 1:31PM and confirmed by Registered Nurse (RN) #56. The left x-ray exam was completed on 6/14/2024 at 10:23PM. The findings were reviewed on 6/15/2024 at 7:09AM and confirmed a left ankle fracture. The results were reviewed by the physician and the resident was transferred to the hospital on 6/15/2024 at 1:59PM. During an interview with Regional Nurse #3 on 12/9/2024 at 7:20AM, the Surveyor was informed that STAT orders should be performed within 4-6 hours after the order was placed and called in to the radiology company by the nurse. On 12/9/2024 at 10:07AM, the Surveyor reviewed the provider application for the x-ray for Resident #34 which revealed that the order was called in to the company on 6/14/2024 at 2:09PM by RN #56 and the priority was labeled Routine, a same day request, and was assigned to a technologist at on 6/14/2024 at 2:10PM. During an interview conducted with RN #56 on 12/9/2024 at 2:35PM, the Surveyor reviewed the provider application and the priority stating Routine. RN #56 stated she called in a STAT order for the x-ray and informed the Surveyor that the nurses have to call the company to follow up on orders placed because there is often a delay in services provided. On 12/9/2024 at 2:55PM, Regional Nurse #3 and the Surveyor confirmed the a physician order for a STAT x-ray was called in to the diagnostic company as a Routine x-ray. The Surveyor reviewed the concern for a delay in treatment with Regional Nurse #3.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 50457 Based on interviews, and administrative record reviews, it was determined that the facility staff failed to complete annual nursing aide performance reviews. This was evident for 3 out 7 (GNA #28, GNA #31, and GNA #53) nursing aide performance appraisals, reviewed during the survey. The findings include: On 12/09/2024 at 8:59 AM, the review of employee records for Geriatric Nursing Assistant (GNA) #28 revealed the last performance review was conducted on 8/29/18, and GNA #31 showed no evidence of a performance review. On 12/11/24 at 8:16 AM, the surveyor requested annual performance reviews for GNA #23, GNA #28, GNA #31, GNA #52, and GNA #53. On 12/11/24 at 9:44 AM, the surveyor received employee performance appraisal for GNA #23, and GNA #52. On 12/11/24 at 1:12 PM, the Administrator #1 informed the surveyor that Human Resource personnel were having difficulty locating the performance appraisals for GNA #28, GNA #31, and GNA #53. On 12/12/2024 at 7:08am, during an interview with the Human Resource Director (HR) #47 regarding the process for employee annual reviews, she explained that she tracks all employees' annual performance reviews and completes her portion of the appraisal. One month prior to the review due date, she submits the documentation to the employee's manager with a deadline date. One week before the due date, she follows up verbally with the manager, and if the review is still not received, she follows up via email. When asked about the annual employee appraisals for GNA #28, GNA #31, and GNA #53, the HR Director #47 stated that two of the three performance appraisals were completed on 12/11/24. She explained that the remaining employee works the weekends and plans to complete their review upon their return to work. On 12/12/24 at 9:56AM, during an interview with Unit Manager #26, regarding GNA annual reviews she explained that employees are evaluated, and the HR Director #47 provides notification one month prior to the review due date. She further explained that the HR Director #47 follows up a few days before the deadline. The Unit Manager #26 reported that she is behind on several employee performance reviews due to being assigned multiple job responsibilities.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51128 Based on the kitchen tour and staff interview, it was determined that the facility failed to ensure that stored food items were properly labeled and dated. This deficient practice has the potential to affect all residents in the facility. The Findings Include: On 12/04/24 at 07:45 AM, during the initial kitchen tour with the Certified Dietary Manager (Staff#10), the following deficiencies were observed: 1. The walk-in refrigerator revealed a stand-alone plastic bag of chicken breast, approximately 20 frozen pieces, and a plastic bag of link sausages that did not have labels and were not dated. 2. A bottle of honey was found in the dry storage area with a prep date of 11/26/2024 and a used date of 12/03/2024. Staff #10 stated, honey is good for 3 years. 3. The dry food section had a container of graham crackers in individual packets that were not dated. An original box of graham crackers had a date. However, there was no way to identify which box the individual crackers came from. 4. Two of one gallon bottles of Cattlemen's BBQ Sauce: one had a sticker label with prep on 11/30/2024 and used by 12/05/2024. The other had a sticker label with prep on 11/16/2024 and used by 11/23/2024. 5. A one gallon of Soy Sauce had a label with a prep date of 11/16/2024 and used by 11/22/2024. 6. A gallon bottle of Worcestershire Sauce had a label with a prep date of 10/29/2024 and used by 11/29/2024. During the tour, Staff #10 was interviewed about the findings. Staff #10 acknowledged that staff were inconsistent in labeling and dating food items, which warrants further staff training. On 12/12/2024 at 09:13 AM, the facility provided the surveyor with the food storage policy. There was no mention of dating or labeling of food written in this policy. The surveyor was not provided a copy of the facility policy that guides the labeling and dating of food items. On 12/12/24 at 08:35 AM, the surveyor discussed these concerns with the Nursing Home Administrator.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49148 Based on record review and interview with staff, it was determined that the facility failed to maintain accurate medical records. This was evident for 2 (Resident #51 and #129) out of 61 resident records reviewed during the survey. The findings include: Maryland Medical Orders for Life-Sustaining Treatment (MOLST) is a form which includes medical orders for emergency medical services or other medical personnel regarding CPR (cardiopulmonary resuscitation) and other life-sustaining treatment options. Cardiopulmonary resuscitation (CPR) is a lifesaving technique used in emergencies in which someone's breathing or heartbeat has stopped. 1) On [DATE] at 12:26PM, a review of Resident #51's paper medical record revealed a MOLST form dated [DATE] and elected a full code status to attempt CPR. An additional review of Resident #51's electronic medical record revealed an Advanced Directive Note which indicated the resident was to remain a Full Code and that an updated MOLST form was completed to reflect that on [DATE]. Do Not Resuscitate (DNR) is an order placed in a person's medical record by a doctor informs the medical staff that CPR should not be attempted. 6 Do Not Intubate (DNI) is an order placed in a person's medical record by a doctor informs the medical staff that chest compressions and cardiac drugs may be used, but no breathing tube will be placed. During a review of Resident #51's electronic medical record on [DATE] at 9:45AM, the Surveyor discovered progress notes written by Physician #51 on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE] which stated the resident is currently DNR/DNI in the unfortunate event of a cardiopulmonary arrest. On [DATE] at 1:00PM, the Surveyor and the Nursing Home Administrator (NHA) #1 reviewed the concern that Resident #51's current MOLST form code status was Full Code and the documentation within Physician #51's progress notes from [DATE] through [DATE] indicated that the resident was DNR/DNI. 43096 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) On [DATE] at 2:32 PM, the surveyor reviewed three residents' medical records for closed records. The review revealed that Resident #129 was found unresponsive in bed on [DATE] at 1:30 AM, and no code was called per Advanced Directive. Further review of progress notes revealed that the licensed practical nurse (LPN #41) wrote, Patient (Resident #129) was presently on hospice; hospice nurse notified of the situation. A review of Resident #129's medical records on [DATE] at 9:06 AM revealed that the resident's hospice care consent was signed on [DATE]. The change in condition form dated [DATE] documented that the resident enrolled in hospice care. However, MDS (Minimum Data Set: a part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes) dated [DATE] was not coded the resident's hospice status. On [DATE] at 9:52 AM, Staff #8 (Regional Nurse) and Staff #42 (MDS coordinator) insisted that Resident #129 did not receive hospice since the court order of care guardian, who signed the resident's hospice care consent, had not been adequately documented: on page 2, option A or option B was not selected, remained blank. Staff #8 said, Since number 2 under option B (the court order) was checked, we believed the order meant option B. However, to avoid making a hasty judgment, we requested and waited for confirmation from the court. That's why even though Resident #129's hospice consent was signed, his/her hospice care was not started till the resident passed away. The surveyor reviewed Resident #129's medical records on [DATE] at 10: 00 AM. The review revealed that the hospice nurses documented notes from [DATE] to [DATE]. Also, progress notes from [DATE] to [DATE] were reported by nurses about being informed/discussed with hospice nurses about Resident #129's condition. In an interview with Staff #8 on [DATE] at 11:11 AM, Staff #8 confirmed that Resident #129 received palliative care under [contracted Hospice care group]. The surveyor asked to provide any documentation to support the resident receiving palliative care, not hospice care. Staff #8 stated that the facility did not have it. On [DATE] at 3:03 PM, the surveyor informed the above concern in an interview with the Director of Nursing (DON). The DON validated it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215118	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Future Care Old Court	5412 Old Court Road Randallstown, MD 21133

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 50457 Based on interviews and administrative record review, it was determined that the facility failed to provide all geriatric nursing assistants (GNA) with the required annual dementia training. This deficient practice was evident for 32 out of 43 GNA's reviewed during the survey. The findings include: On 12/09/2024 at 8:59 AM, review of employee records for GNA #27, GNA #28, GNA #29, and GNA #31 failed to show evidence of required annual dementia training. During an interview with the Director of Nursing (DON) #2 on 12/09/24 at 10:43 AM she explained that annual competency for GNA includes a skills fair. The fair covers education on dementia care, abuse prevention and reporting, resident rights, infection control, and additional in-services to address any concerns that may have arisen during the year. The DON #2 reported that the most recent skills fair was held on 6/27/24. On 12/9/24 at 11:48 AM, a review of the in-service dementia training provided during the GNA annual skills fair, compared to the facility's current list of active GNA's, revealed that only 11 out of 43 employees received dementia training in 2024. Both the Administrator #1 and DON #2 were informed of the findings and the Administrator #1 explained that the facility recently transitioned from Relias to HealthStream training and would attempt to obtain the GNA dementia training records from Health Stream. On 12/10/24 at 7:38 AM, during a follow-up with the Administrator #1 regarding GNA Dementia training, the Administrator stated that a staff member was working on obtaining online dementia training for 2024. The Administrator #1 also acknowledged that the facility was not fully compliant with GNA training requirements for 2024. On 12/11/24 at 7:56 AM, the Corporate Regional Nurse #8 provided the surveyor with evidence that dementia in-service training was conducted on 12/10/24. On 12/12/24 at 7:29 AM, the Administrator #1 provided the surveyor with evidence that dementia in-service training was conducted on 12/11/24