STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265275	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Butler Rehab and Healthcare Center	416 S High Street Butler, MO 64730

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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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. 26996 Based on interview and record review, the facility failed to develop a spend down plan for two sampled residents (Resident #13 and #18) out of two residents sampled for the resident fund review process, who maintained a balance of more than $5,726.00 (the legal Missouri Medicaid limit) in their account for more than one month. The total facility census was 56 residents. Review of the facility's policy titled Resident's Funds Handling and Recording revised 10/24/22 showed: -The facility would notify the resident if his/her Resident Trust Fund (RTF) account was within $200.00 of the Social Security Income (SSI-Medicaid) legal limit. 1. Review of Resident #13's RTF statements showed: -On 9/1/23 the resident's balance was $8049.94. -On 10/3/23 the resident's balance was $8806.38. -On 11/3/23 the resident's balance was $8993.86. -On 12/30/23 the resident's balance was $9303.54. -On 1/3/24 the resident's balance was $9656.71. -On 2/2/24 the resident's balance was $11044.75. -On 3/1/24 the resident's balance was $10800.34. 2. Review of Resident #18's RTF statements showed: -On 9/5/23 the resident's balance was $8965.12. -On 10/3/23 the resident's balance was $8634.71. -On 11/2/23 the resident's balance was $8857.69. (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

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 12/30/23 the resident's balance was $9303.54 -On 1/3/24 the resident's balance was $9656.71. -On 2/7/24 the resident's balance was $10944.75. -On 3/12/24 the resident's balance was $9441.64. 3. During an interview on 4/3/24 at 1:40 P.M. the Business Office Manager (BOM) said: -He/she was responsible for the RTF accounts. -He/she did tell the residents they were over the legal limit. -The legal limit was $5000.00. -He/she did not tell the residents they could lose their Medicaid benefits since they were over the legal limit. -He/she just told the residents to spend their money. -He/she did not assist with a plan to help spend their RTF money to ensure they did not lose Medicaid services.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42955 Based on interview and record review, the facility failed to properly and accurately document a resident's advanced directives (wishes for what procedures, if any, a person would like to have should the heart stop beating and/or they stopped breathing) by reporting full code (giving the resident Cardiopulmonary Resuscitation CPR- An emergency procedure used to restart a person's heartbeat and breathing after one or both have stopped) and Do Not Resuscitate (DNR-do not provide life-saving measures) on the resident's care plan for one sampled resident (Resident #27) out of 15 sampled residents. The facility census was 56 residents. Review of the facility's Advance Directives Policy, dated [DATE], showed: -The facility respected a resident's advance directive and complied with the resident's wishes expressed in the advance directive. -Upon admission the admission staff obtained a copy of a resident's advance directive. -A copy of the resident's advance directive was included the resident's medical record. -Advance directive was a written preference regarding treatment options. -If the resident had an advance directive the facility obtained a copy of the document and put it in the resident's medical record. -The Interdisciplinary Team (IDT) reviewed advance directives with the resident or responsible party on an annual basis, to ensure the directive still reflected the wishes of the resident. -Changes or revocations of the advance directive was communicated to the attending physician. -The resident's care plan was updated to reflect the changes. 1. Review of Resident 27's face sheet, undated, showed: -The resident was diagnosed with Chronic Obstructive Pulmonary Disease (COPD- a condition involving constriction of the airways and difficulty or discomfort in breathing), chronic kidney disease (a gradual loss of kidney function over time) and major depressive disorder (a mood disorder that caused a persistent feeling of sadness and loss of interest). -The resident had a legal guardian (a person who looked after and was legally responsible for someone who was unable to manage their own affairs). -The resident was a full code. Review of the resident's electronic health record (EHR) uploaded documents showed the resident had a DNR dated [DATE]. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Full Code cover sheet, dated [DATE], showed: -The resident wished to have CPR performed. -There was verbal consent obtained from the resident's guardian. Review of the resident's annual Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated [DATE], showed: -The resident scored a 15 on the Brief Interview for Mental Status (BIMS --This showed that the resident was cognitively intact. Review of the resident's care plan, dated [DATE], showed: -DNR at resident's request would be honored. -The resident wished to be a full code. -Paper placed in the chart reflected the wishes for a full code. Review of the resident's physician orders showed: -On [DATE] at 2:27 P.M. the resident was shown as full code. -On [DATE] at 9:43 A.M. the resident was shown as DNR. -On [DATE] at 2:40 P.M. the resident was shown as full code. During an interview on [DATE] at 9:00 A.M., Certified Nurse's Assistant (CNA) A said: -He/She checked the physician orders or the EHR for a resident's code status. -He/She was unaware if the resident was a full code or not. During an interview on [DATE] at 9:12 A.M., Registered Nurse (RN) A said: -He/She was pretty sure the resident had a DNR. -He/She had to look it up in the computer. -He/She went by the physicians order. -Every care plan meeting the team addressed the residents code status. -They also ensured the code status still met the wishes of the guardian or resident. -Code status was in the care plan. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Every resident had a code status. During an interview on [DATE] at 10:55 A.M., the resident said: -He/She was a full code and wanted CPR performed. -He/She clarified he/she wanted CPR and was not to be considered DNR. During an interview on [DATE] at 10:45 A.M., the MDS coordinator said: -When the resident was readmitted after a hospital stay, he/she had to have the code status updated. -The care plan was reviewed and updated as well. -There was a whole care plan meeting when he/she returned to the facility. -The social worker or the Director of Nursing (DON) updated him/her then he/she updated the care plan. -He/She verified code status on the physician orders. -He/She reviewed and agreed the resident's care plan had both full code and DNR during the interview. -He/She called the guardian yesterday and found out the resident was a full code. -He/She was going to revise the care plan immediately. During an interview on [DATE] at 12:04 P.M., the DON said: -He/She found a resident's code status in the top ribbon of the EHR face sheet screen. -It should also be in the care plan. -Code status documents were also to be uploaded under documents in the EHR. -Code status was reviewed quarterly or with care plan meetings. -If a resident was a full code status, they should not have an uploaded DNR. -He/She would expect staff to go by physician orders for code status. -He/She would not expect the care plan to say the resident was a full code and a DNR. -When a DNR was revoked then a document stating the revocation was uploaded in documents. -When uploaded they were titled a revoked DNR. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident had a revoked DNR and now wished to be a full code.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 42955 Based on interview and record review the facility failed to follow their policy to conduct Criminal Background Checks (CBC) for new employees, not having on the policy to check the Nurses Aide (NA) Registry (a data base that provided the list of eligible nursing assistants who can be employed by long-term care facilities as health workers) for all employees prior to hire, and not completing a check of the NA Registry for two sampled employees (Employee B and Employee F) out of ten sampled new employees. The facility census was 56 residents. Review of the facility's Staff Screening policy, dated 10/24/22, showed: -Prior to employment the facility verified and documented or obtained a copy of the following information: --Previous/current employer regarding work history, allegations of abuse against residents, employees, or others. --Criminal Background Checks. --National Sex Offender Public Website. --Office of Inspector General Exclusion Screening. --State exclusion screening, if applicable. --Current licenses and certifications. --References and disclosure of information. -The facility did not employee an individual who was found guilty of abuse, neglect, exploitation or mistreatment or misappropriation of property by a court of law or who had a finding in the state nursing aide registry concerning abuse, neglect or exploitation or mistreatment or misappropriation of property, or had a disciplinary action in effect taken against his/her professional license. 1. Review of the facility's list of employees hired since the facility's last annual survey showed: -Employee B was hired on 12/18/23. -Employee F was hired on 7/17/23. 2. Review of Employee B's Federal Indicator tracking sheet showed he/she did not have a NA registry check completed. 3. Review of Employee F's Federal Indicator tracking sheet showed: -He/She had a NA registry check completed 7/19/23. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--This was two days after his/her hire date. 4. During an interview on 4/5/24 at 9:00 A.M., the Business Office Manager (BOM)/Human Resources (HR) said: -He/She was responsible for completing the NA registry for new hires. -He/She was responsible for completing the background checks for new hires. -He/She started the background checks when he/she received notification of a new employee. -Employees were not supposed to start working until all background screenings including EDL checks and NA Registry checks were completed. -Employee B had interviewed and was available to start work immediately and the facility started Employee B before he/she had the chance to complete the background process. -He/She normally did NA registry checks before new employees started working. -He/She had a checklist to follow to be sure all backgrounds were completed before they started working on the floor. -Sometimes they slipped through the cracks. -Employee F started working on 11/1/23. During an interview on 4/5/24 at 12:01 P.M., the Director of Nursing (DON) said: -The NA registry check should be completed before new employees started working. -The BOM/HR was responsible for completing the NA registry backgrounds. -All staff should have a NA registry screening.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 37576 Based on interview and record review, the facility failed to ensure one sampled resident's (Resident #29) care plan was updated to reflect an unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed); failed to ensure one sampled resident's (Resident #18) care plan was updated to reflect requiring assistance / supervision with smoking; failed to ensure one sampled resident's (Resident #38) care plan was updated to reflect his/her current pain level, frequency, and interventions; failed to ensure one sampled resident's (Resident #46) care plan reflected all pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) were addressed with current status and interventions/treatments out of 15 sampled residents. The facility census was 56 residents. Review of the facility's policy titled Care Planning dated 10/24/22 showed: -The Facility's Interdisciplinary Team (IDT) would develop a Baseline and/or Comprehensive Care Plan for each resident. -The care plan served as a course of action where the resident (resident's family and/or guardian or other legally authorized representative), resident's Attending Physician, and IDT work to help the resident move toward resident-specific goals that address the resident's medical, nursing, mental and psychosocial needs. -Each resident's comprehensive care plan would describe the following: --Services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. --Any services that would be required but are not provided due to the resident's exercise of rights, which includes the right to refuse treatment. --The resident's goals and desired outcomes. Review of the facility's policy titled Pressure Ulcer Prevention dated October 24, 2022, showed: -The facility will identify residents at risk for pressure ulcers and provide care and services to promote the prevention of pressure ulcer development. -The licensed nurse should complete a Braden Scale Assessment (a standard tool for assessing pressure ulcer risk) upon admission, and quarterly to identify residents at risk for skin breakdown. -The licensed nurse will conduct a skin assessment for a resident upon admission, readmission, weekly, and as needed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The results of the weekly skin assessment should to be documented in the medical record and may be documented using the Weekly Skin Inspection form. -The licensed nurse should develop a care plan specific to the resident's risk factors such as moisture control, pressure reduction, positioning, mobility, and nutrition in consultation with the following: --Attending physician. --Interdisciplinary Team (IDT)-Skin committee. --Registered Dietician. --Director of Rehabilitation Services. -Nursing staff should monitor interventions for effectiveness and resident tolerance. -The care plan will be revised as indicated. -Certified Nursing Assistants (CNA) should inspect the resident's skin during Activities of Daily living (ADL) care and report unusual findings to the licensed nurse. -CNA's should complete body checks on resident's shower days and report unusual finding to the licensed nurse -The licensed nurse should document effectiveness of pressure ulcer prevention techniques in the resident's medical record on a weekly basis. Review of the facility's Smoking by Residents policy, dated 10/24/22, showed: -Residents who wanted to smoke were assessed for their ability to smoke safely. -A Licensed Practical Nurse (LPN) provided the Safe Smoking Assessment. -A smoking care plan was created for the resident. -If clothing was observed with burn holes the resident must wear a smoking apron (an apron made from flame retardant material which prevented burns in clothing and kept hot ashes from burning the skin). 1. Review of Resident #29's Admission Record showed he/she was admitted on [DATE] and readmitted on [DATE] with following diagnoses: -Cerebral Infarction (stroke). -Hemiplegia and Hemiparesis (muscle weakness or partial paralysis on one side of the body) following stroke affecting the left non-dominant side. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Muscle wasting and apathy (is characterized by a significant shortening of the muscle fibers and a loss of overall muscle mass). Review of the resident's Quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility staff for care planning) dated 1/2/2024 showed: -Risk for pressure ulcer. -One or more unhealed pressure ulcers. -One unstageable pressure ulcer due to coverage of the wound bed by slough. Review of the resident's care plan dated 3/28/24 showed there was no care plan for wounds or risk for wounds and/or skin breakdown. Review of the resident's Physicians Order Summary (POS) dated April 2024 showed: -Weekly skin assessment every evening shift on Friday. -Refer to an outside wound care company for evaluation and treatment. -Wound care treatment every day shift for wound healing: --Cleanse wound on left heel with hypochlorous acid (helps disinfect and provide treatment for wounds), and pat dry. --Cover wound bed with nickel thick Santyl (an enzyme ointment that helps remove dead skin tissue and aids in wound healing by removing damaged tissue from chronic skin ulcers). --Cover Santyl with Calcium Alginate (CaAlg-a type of dressing that can absorb 20 times its weight in exudate [fluid that leaks out of blood vessels into nearby tissues] and soak up loose debris from a wound bed) cut to the size of wound bed. --Cover with bordered gauze (a type of wound dressing) and change daily and PRN if soiled. During an interview on 4/4/24 at 10:45 A.M., the MDS Coordinator said: -The resident should have a care plan for any type of wound if he/she had one. -Corporate made changes to the care plans when something was found. -They tried to make care plans specific. 42955 2. Review of Resident #18's quarterly MDS dated [DATE], showed: -The resident scored a 15 on the Brief Interview for Mental Status (BIMS). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--This showed that the resident was cognitively intact. -The resident's diagnoses included: Multiple Sclerosis (MS- a potentially disabling disease of the brain and spinal cord causing communication problems between the brain and the rest of the body), lack of coordination and reduced mobility. -NOTE: Section J of the MDS did not indicate the resident smoked. Review of the resident's Smoking assessment dated [DATE], showed the resident required supervision while smoking. Review of the resident's Smoking Assessment, dated 1/2/24, showed the resident required supervision while smoking. Review of the resident's comprehensive care plan, dated 1/4/24, showed: -The resident was a smoker. -The resident required supervision while smoking. -The resident needed assistance with putting out cigarettes. -The resident needed assistance with ashes. Review of the resident's Smoking Assessment, dated 3/28/24, showed the resident was safe to smoke without supervision. Observation on 4/1/24 at 11:12 A.M., showed the resident was in his/her wheelchair with a cigarette in his/her mouth. Another resident took the cigarette out of his/her mouth. A staff person lit a new cigarette and placed it in the resident's mouth. Another resident then took the cigarette out of the resident's mouth again and threw it away. Observation on 4/3/24 at 11:11 A.M., showed: -The resident was smoking on the smoking patio. -A staff person lit a cigarette for the resident. -The resident was in his/her wheelchair with a cigarette hanging out of his/her mouth with approximately an inch long ash on the end. --No ashes observed on the residents sweatshirt. -A staff person came to up to the resident and removed the cigarette butt from the resident's mouth then assisted him/her in lighting a second cigarette. -The resident smoked most of the cigarette without handling it with his/her fingers, using just his/her lips. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Another inch long ash fell on the resident's shirt. --He/She did not brush it off, no staff or residents assisted. -The resident continued to smoke the second cigarette showing no signs of distress, again not handling it with his/her fingers. -Ashes from second cigarette fell on the shirt again. -Another resident came over to the resident and took the cigarette out of his/her mouth. During an interview on 4/3/24 at 9:00 A.M., Certified Nurse's Assistant (CNA) A said: -The resident was a smoker. -He/She was unaware if the resident needed assistance with smoking. -The resident received assistance with eating because his/her hands and arms did not work well enough to feed himself/herself. -Staff supervised the smokers in the smoking area but they were not CNA's. -The resident had MS and received assistance eating. -He/She was unaware of what staff supervised the smokers. During an interview on 4/3/24 at 9:12 A.M., Registered Nurse (RN) A said: -The resident was a smoker. -The resident was his/her own person and chose to smoke on his/her own and was allowed to smoke on his/her own outside of the facility. -He/She told the resident it was not safe to smoke without supervision. -He/She had seen holes on the resident's shirts, and he/she had educated the resident on the safety aspect. -The resident chose to have other residents help him/her while smoking. -The resident refused to wear a smoking apron. -Designated smoke times were all supervised, but the residents were able sign out and go outside and to smoke on their own. During an interview on 4/4/24 at 8:31 A.M., the Medical Records/CNA said: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The resident required assistance with eating because his/her hands and arms did not work well enough to feed himself/herself. During an interview on 4/4/24 at 8:40 A.M., the resident said: -His/Her left arm was dead and he/she had no ability to move it. -His/Her right arm had some mobility, but he/she was unable to move his/her hand and had no gripping strength. -He/She needed assistance smoking and sometimes resident's helped him/her. During an interview on 4/4/24 at 10:17 A.M., the Activities Director said: -There was a smoking schedule and staff were assigned to supervise. -Nursing was assigned in the evening, during the day it was dietary, activities, and housekeeping. -Staff were in-serviced on the smoking procedure, which included monitoring the residents. -Each department also trained their staff who supervised smoking. -There was no list of residents who required additional supervision. -Everyone watched everyone. -There was no list of residents who required a smoking apron. --He/She thought there were two residents who were to wear a smoking apron, the resident was one of the two. -The resident refused the smoking apron 98% of the time but it was offered. -Smoking aprons were kept at the nurses station. During an interview on 4/4/24 at 10:45 A.M., the MDS Coordinator said: -They tried to make care plans specific. -The resident was independent with smoking. -He/She had not done a MDS on the resident yet. -Corporate was aware of discrepancies between care plans and the MDS. -If there was conflicting information on the care plan then staff looked at the physician orders, or asked the Director of Nursing (DON). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	50579 3. Resident #38's Admission MDS dated [DATE] showed he/she: -admitted with an amputation of the left leg above the knee. -Received scheduled and as needed pain medications during the lookback period. -Reported pain almost constantly. -Frequently had pain that effected sleep and day to day activities. Review of the resident's MDS Care Area Assessment (CAA) for pain dated 2/27/23, showed he/she: -Had diseases and conditions that may cause pain including heart conditions, peripheral vascular disease (reduced blood flow in the arms and legs), neurological conditions, musculoskeletal conditions, and gastrointestinal conditions. -Would have pain addressed in the care plan to slow or minimize decline. Review of the resident's POS 4/4/24 showed orders for: -Acetaminophen (a medication for pain) 650 milligrams (mg) by mouth every six hours as needed for pain. -Gabapentin (a medication to treat nerve pain) 100 mg three times daily. -Lidocaine patch (a patch that is applied to the skin for pain) daily to the amputation site. -Hydrocodone (A narcotic pain medication) 5-325 mg three times a day for pain. -Hydrocodone 5-325 mg every six hours as needed for pain. -Voltaren (a gel applied to the skin to relieve pain) apply to the amputation site at bedtime and every 6 hours as needed for pain. Review of the resident's current, undated care plan accessed 4/4/24, showed: -The resident was at risk for pain. -Interventions included administering analgesia per orders and anticipating the resident's need for pain relief. -A lack of documentation related to the resident's current pain status including frequency, type and location of pain, non-pharmacological pain interventions and history of chronic pain. 4. Review of Resident #47's Quarterly MDS 2/28/24 showed he/she: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Had pressure ulcers to the feet. -Was at risk for developing pressure ulcers. -Was being treated with: --A pressure reducing device for chairs. --A pressure reducing device for bed. --A turning/repositioning program --Nutrition/hydration supplementation --Pressure ulcer care including application of dressings and ointments. Review of the resident's Weekly Wound Observation Tool dated 3/25/24, showed he/she had: -A pressure ulcer to the left lateral/medial (outer) 5th toe acquired 2/24/24. -A pressure ulcer to the right heel acquired 2/24/24. -A pressure ulcer to the left heel acquired 1/30/24. -A pressure ulcer to the left great toe acquired 1/30/24. Review of the resident's POS dated 4/4/24 showed orders for: -An air loss mattress for prevention of pressure ulcers. -Nutritional supplementation for prevention/healing of pressure ulcers. -Pressure ulcer skin treatments to both heels, the left great toe, and the left outer foot. Review of the resident's current, undated care plan accessed 4/4/24, showed: -The resident had a potential impairment to skin integrity. -The resident had three unstageable ulcers to the left foot. -A lack of documentation for the pressure ulcer to the right heel. 5. During an interview on 4/5/24 at 12:04 P.M., the DON said: -The IDT was responsible for updating care plans. -Care plans should have been updated quarterly with MDS completion and on an as needed basis. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The MDS Coordinator audited care plans for accuracy. -Regarding Resident #29: --He/She should have had a care plan that indicated the resident had a pressure ulcer and showed the location(s), treatment(s), and been updated to reflect changes as they were made. -Regarding Resident #18: --He/She was his/her own person and checked himself/herself out and left to smoke outside on his/her own. --He/She was supposed to be supervised while on facility grounds. --He/She should not be helped by another resident while smoking. --His/Her care plan should indicate if he/she was educated on safe smoking and if he/she was non-compliant with who assisted him/her. --He/She would expect his/her most recent smoking assessment and the care plan to have the same information. -Regarding Resident #38: --He/She should have had a care plan that addressed his/her pain status, location, frequency, treatment, and response to treatment.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 50579 Based on observation, interview and record review, the facility failed to provide treatment/services, equipment, supplies or assistance to maintain and improve range of motion (ROM) and mobility for one sampled resident (Resident #38) reviewed for ROM out of 15 sampled residents. The facility census was 56 residents. Review of the facility policy titled Range of Motion Exercises dated 10/24/22 indicated: -Staff used a physician order to deliver ROM exercises to residents. -The exercises were used to prevent/decrease contractures and increase ROM for a joint. 1. Review of Resident #38's undated face sheet indicated he/she had the following diagnoses: -Cerebral infarction (stroke). -Dysphasia (impairment in the production of speech resulting from brain disease or damage). -Hemiplegia and hemiparesis following cerebral infarction affecting the left side (paralysis of the left side of the body). -Muscle weakness. Review of the resident's admission orders showed an order for a left arm splint dated 2/1/24 with no end date. Review of the resident's Interdisciplinary Rehabilitation Screening form dated 2/14/24 signed by the Director of Rehabilitation (DOR) lacked documentation of functional joint motion and contractures. Review of the resident's Admission Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff for care planning) 2/21/24 showed the resident had: -A limited range of motion. -Received no physical or occupational therapy during the look back period. -Received no restorative therapies. Review of the resident's Admission MDS Care Area Assessment (CAA) for pain dated 2/27/24 listed the resident as having contractures. Review of the resident's Physician Order Sheet (POS) dated April 2024 indicated a lack of orders for services, equipment, or assistance that would maintain or improve the resident's ROM status. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's current, undated care plan showed a lack of documentation for ROM status or interventions. Observation on 4/1/24 at 10:14 A.M., showed the resident had: -A dependent left hand with fingers contracted toward the wrist. -No devices or equipment in place to maintain a neutral hand position. -An inability to move the left side of his/her body. During an interview on 4/1/24 at 10:14 A.M., the resident said: -He/she did not receive any therapy or exercise by facility staff. -He/she once had a splint to keep the left hand in a neutral position and prevent worsening of contracture, but the splint never came from his/her previous facility. Observation on 4/4/24 at 8:12 A.M., showed the resident had: -A dependent left hand with fingers contracted toward the wrist. -No devices or equipment in place to maintain a neutral hand position. -An inability to move the left side of his/her body. During an interview on 4/4/24 at 11:35 A.M., the DOR said: -The resident was not on therapy services. -A resident with contractures would have benefited from a splinting device or restorative therapies to prevent worsening of contractures. -A resident with hemiplegia should have had therapies for ROM. -A previously ordered medical device should have been continued after admission. During an interview on 4/5/24 at 12:11 P.M., the Director of Nursing (DON) said: -He/she expected orders from the previous facility to be reviewed by a physician and continued if appropriate. -He/she expected the resident would have been evaluated and treated by the therapy department upon admission. -He/she expected a resident with hemiplegia and/or contractures would have received treatment to maintain or improve ROM.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37576 Based on interview and record review, the facility failed to ensure the resident's monthly pharmacy Drug Regimen Review (DRR) recommendations were reviewed and acted upon by the physician, for one sampled resident (Resident #29), out of 15 sampled residents. The facility census was 56 residents. Review of the facility's policy titled Drug Regimen Review dated 10/24/22 showed: -The pharmacist was responsible for reviewing each resident's medication regimen at least once a month to identify irregularities and to identify clinically significant risks and/or actual or potential adverse consequences which may result from or be associated with medications. -The pharmacist was responsible for reporting any irregularities to the Attending Physician, the facility's Medical Director, and the Director of Nursing (DON), and these reports must be acted upon. -The pharmacist performing the Drug DRR will review the residents' medical records to appropriately monitor the medication regimen and verify the medication each resident is taking is clinically indicated. -The pharmacist will note in the residents' medical records that the pharmacy medication review regimen was completed. -If no irregularities were identified during the review, the pharmacist included a signed and dated statement to that effect. -The pharmacist will report any irregularities such as unnecessary drugs (which include but are not limited to excessive dosage, excessive duration, inadequate monitoring, inadequate indications for use or adverse consequences of use) to the facility's Medical Director, Director of Nursing, and the Attending Physician. -Irregularities must be addressed in a separate, written report. The report will include the resident's name, the relevant drug, and the irregularity the pharmacist identified. -The report will be submitted within three business days of review, unless the irregularity is an emergent issue requiring immediate action. If the irregularity is emergent, the Attending Physician will be contacted as soon as practicable from the time the irregularity is identified. -The Attending Physician will respond to any irregularities reported by the pharmacist by reviewing the irregularities and documenting in the resident's medical record that the irregularity has been reviewed, and what, if any, action has been taken to address it. -If no action has been taken, the Attending Physician must document his/her rationale. -Documentation by the Attending Physician must occur within 30 days of issuance of the pharmacist's report, unless the irregularity is an emergent issue requiring immediate action. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Medical Director and DON will also review the pharmacist's report if any irregularities are identified. -The DON was responsible for following up with the Attending Physician, as indicated 1. Review of Resident #29's Admission Record showed he/she was admitted on [DATE] and readmitted on [DATE] with following diagnoses: -Cerebral Infarction (stroke). -Hemiplegia and Hemiparesis (muscle weakness or partial paralysis on one side of the body) following stroke affecting the left non-dominant side. -Bipolar disorder (a form of mental illness associated with episodes of mood swings ranging from depressive lows to manic highs). -Anxiety disorder (anticipation of impending danger and dread accompanied by restlessness, tension, fast heart rate, and breathing difficulty not associated with an apparent stimulus). -Major Depressive Disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Review of the resident's Pharmacist Consultant Note dated 3/22/23 at 5:31 P.M., showed: -See report for any noted irregularities and/or recommendations. -No reports were found in the resident's medical record for this note. -No physician response was found in the resident's medical record. Review of the resident's Pharmacist Consultant Note dated 4/27/23 at 6:53 P.M., showed: -See report for any noted irregularities and/or recommendations. -No reports were found in the resident's medical record for this note. -No physician response was found in the resident's medical record. Review of the resident's Pharmacist Consultant Note dated 9/1/23, no time noted, showed: -The resident was taking both Ticagrelor and Apixaban both are blood thinning medications. -Evaluate if both blood thinning medications were necessary. -Please clarify If both were to be continued. -Please have staff monitor closely for abnormal bleeding/bruising. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Physician discontinued the Ticagrelor. -There was no order, by the Physician, to monitor closely for abnormal bleeding or bruising while on a blood thinner. Review of the resident's Physician's Order Summary (POS) dated April 2024 showed no order to monitor closely for abnormal bleeding or bruising while on a blood thinner. During an interview on for 4/5/24 at 12:03 P.M. the DON said: -The pharmacist reviewed medications monthly. -The pharmacist emailed the recommendations to him/her. -He/She would give the pharmacist recommendations report to the physician to review and sign off on. -The physician gave the report with his/her acceptance or rejection and rational back to him/her. -He/She would make sure any new orders or changes were put into the POS. -The physician should respond to the pharmacist recommendations whether he/she agreed or disagreed and sign that he/she had received it within 30 days of receiving it. -If no response then he/she kept following up with physician until a response was received.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39469 Based on observation, interview, and record review, the facility failed to ensure two sampled residents (Resident #25 and #51) received dental services for broken teeth out of 15 sampled residents. The facility census was 56 residents. Review of the facility's policy, Dental Services dated October 24, 2022 showed: -It was the responsibility of each staff member within the nursing department to ensure good oral care for each resident. -An assessment of the oral cavity and teeth was to have been preformed upon admission and as necessary. -Observe mouth for any adverse conditions such as bleeding, swelling, unusual mouth odor or any complaint of pain or discomfort. -Note any such condition in the resident's chart. -Report problem to the charge nurse. -Refer and or assist the resident to obtain dental services as indicated for routine and emergency dental care including making appointment for the resident, if needed or requested and arranging transportation to and from the dentist's office. -Routine services include but were not limited to; -Annual inspections. -Dental cleaning, fillings, and x-ray as needed. -Smoothing of broken teeth. -Emergency dental services include but were not limited to; -Broken , damaged teeth, or dentures. 1. Review of Resident #25's face sheet showed he/she was admitted on [DATE] with the following diagnose of moderate protein-calorie malnutrition (the state of inadequate intake of food). Review of the resident's undated care plan showed: -He/She had a self care performance deficit. -He/She required set up assistance to eat. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She was at risk for nutritional problem or potential nutrition problem. -There were no dental related issues noted in any of the resident's care plans. Review of the resident's Dental/Oral Assessment, dated 2/15/24 showed: -He/She had his/her own teeth both upper and lower. -He/She did not have any dentures. -He/She did not have any pain or discomfort. -The form was electronically signed by the physician. Review of the resident's Dental/Oral Assessment, dated 3/8/24 showed: -He/She had his/her own teeth both upper and lower. -He/She did not have any dentures. -He/She did not have any pain or discomfort. -The form was electronically signed by the physician. Review of the resident's Dental/Oral Assessment, dated 3/12/24 showed: -He/She had his/her own teeth both upper and lower. -He/She did not have any dentures. -He/She did not have any pain or discomfort. -He/She did not have any signs of infection. -The form was electronically signed by the physician. Review of the resident's Quarterly Minimum Data Set (MDS- a federally mandated assessment toll completed by the facility for care planning) dated 3/8/24 showed: -His/Her Brief Interview for Mental Status (BIMS) score was 15 out of 15 indicating he/she was cognitively intact. -He/She needed set up help for oral hygiene. -He/She was at risk for malnutrition. -Did not show any dental issues. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Physician's Order Sheet (POS) dated March 2024 showed there was no order to see a dentist. Observation on 4/1/24 at 1:34 P.M. showed: -The resident had most of his/her teeth missing. -He/She had a couple of whole teeth. -The rest of the resident's teeth were broken. During an interview on 4/1/24 at 1:35 P.M. the resident said: -Most of his/her teeth were broken. -His/Her teeth needed to be pulled and he/she needed to be fitted for dentures. -He/She had not seen a dentist since he/she had been admitted to the facility. -He/She had told the nurse he/she would like to be seen by the dentist as it hurt to chew. -No one at the facility had said anything to him/her about seeing a dentist. 2. Review of Resident #51's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnosis need for assistance with personal cares. Review of the resident's Dental/Oral assessment dated [DATE] showed: -He/She had his/her own teeth. -He/She had one tooth on the top. -He/She had two teeth on the bottom. -He/She did not have dentures. -The assessment was electronically signed by the physician. Review of the resident's quarterly MDS dated [DATE] showed: -His/Her BIMS score was 15 out of 15 indicating he/she was cognitively intact. -He/She had no dental issues. -He/She was independent with oral cares. Observation on 4/1/24 at 11:44 A.M. during initial tour showed the resident: (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Was missing most of his/her teeth. -Had many teeth that were broken. During an interview on 4/1/24 at 11:44 A.M. the resident said: -He/She would like to see a dentist. -He/She has been afraid of the dentist in the past but now it was time to do something. -He/She would like to have his/her teeth pulled. -He/She would like to have dentures. Review of the resident's undated care plan showed he/she required supervision/limited assistance with oral cares. During an interview on 4/2/24 at 11:59 A.M. Certified Medication Technician (CMT) A said: -He/She had watched the resident take his/her medications. -He/She did not know if the resident had any problems with his/her teeth. -The Social Service Director (SSD) was responsible for making appointments for residents to see the dentist. -If a resident had broken teeth, they should see a dentist. During an interview on 4/2/24 at 12:01 P.M. the Assistant Director of Nursing (ADON) said: -He/She did not know if the resident had any problems with his/her teeth. -He/She had not looked in the resident's mouth. -The charge nurse would have been responsible to make an appointment for the resident to see the dentist. -The residents should see a dentist every three months. -A dentist was at the facility last month. -The resident had not seen the dentist. -He/She did not know anything about the resident having broken teeth or wanting dentures. During an interview on 4/2/24 at 12:04 P.M. Certified Nursing Assistant (CNA) E said: -There used to be a place on the computer to chart oral cares or any issues with someone's teeth. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If a resident had missing teeth the staff should have charted it. -If staff did oral hygiene with the resident it should have been charted. -Last year in July a new company took over with a new computer system. -The corporate staff was still working on the computer system. -The admission assessment had a place to chart an assessment but it is not there now. -There was no documentation about missing or broken teeth on the resident's chart. -The resident did not have any teeth. -Currently there was no where on the chart to document oral cares or tooth issues. -He/She had spoke to the new company maybe two months ago about charting dental or oral cares. During an interview on 4/2/24 at 1:40 P.M. the SSD said: -He/She had been working on getting a dental visit with a new company for the residents for the last few months. -There was no date for the resident to see a dentist at this time. During an interview on 4/5/24 at 12:00 P.M. the Director of Nursing (DON) said: -He/She would have expected nursing staff to know if a resident had dentures or missing any teeth. -The CNAs when they were doing oral cares should have assessed the resident's teeth daily. -A resident's teeth should have been assessed quarterly for the care plan. -If a resident had broken teeth they should have been seen by a dentist. -If a resident would like to have dentures a referral to a dentist should have been made. -A dentist had been to the facility twice in the last six months. -Social Services would put the resident on a list to see the dentist. -A resident should have been reviewed at least quarterly for cares. -The DON was responsible to audit to ensure the physicians see the residents. -If a resident had dental issues it should have been in the resident's care plan. -The Interdisciplinary Team should have ensured the resident's care plans were updated quarterly.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39469 Based on observation, interview, and record review, the facility failed to ensure residents were screened for Tuberculosis (TB-a communicable disease that affects especially the lungs, that is characterized by fever, cough, difficulty in breathing, abnormal lung tissue and function) for four sampled residents (Resident #29, #38, #47, and #50) out of 15 sampled residents; and failed to properly screen new employees for TB for two sampled employees, (Employee's G and J) out of ten sampled new employees prior to hire. The facility census was 56 residents. Review of the facility's policy (Tuberculosis - Screening) dated October 24, 2022 showed: -The facility screened residents for TB upon admission, readmission, and as indicated thereafter. -Any resident without documentation receives a baseline (two-step test) upon admission. -When the first TB test is negative, a follow-up TB test is administered one to three weeks after the initial test was read. -The Attending Physician screens new admissions for possible signs and symptoms of TB. -Facility staff were given a screening for TB. -NOTE: the policy did not address any TST procedures or details for employees. Review of 19 Code of State Regulations 20-20.100 TB testing for residents and workers in long-term care facilities, paragraph three, showed: -All new long-term care facility employees who work ten or more hours per week should have the first of two TB skin tests (TST) within one month prior to starting employment in the facility. -The results of TST should be read 48-72 hours from administration. -If the initial TST result is zero to nine millimeters (mm) in duration, the second test should be administered as soon as possible within three weeks after employment begins, unless documentation is provided indicating a two-step TST was completed in the past and at least one subsequent annual test within the past year. 1. Review of Resident #29's face sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's TB tests showed: -There was no documentation of a TB test being given before 12/17/19. -Step one of the admission two step TB test was administered on 12/17/19. --There was no documentation the test was read. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--There was no documentation a second test was given. -Step one of the annual two step TB test was administered on 1/6/20. --There was no documentation the test was read. --There was no documentation a second test was given. -Step one of the annual TB test was administered on 12/21/21. --There was no documentation the test was read. -Step one of the annual TB test was administered on 12/9/22. --There was no documentation the test was read. Review of the resident's Physician's Order Sheet (POS) dated April 2024 showed the following order for a TB test or chest x ray annually. 2. Review of Resident #38's face sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's TB tests showed: -Step one of the admission two step TB test was administered on 2/14/24 --There was no documentation the test was read. -The second step was administered on 3/26/24 and read on 3/28/24. -The second step was administered more than three weeks after the first TB test was administered. Review of the resident's POS dated April 2024 showed the following order: -TB testing per community protocol. -Initiate TB testing protocol, dated 2/14/24. 3. Review of Resident #47's face sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's TB tests showed: -Step one of the admission two step TB test was administered on 1/16/24. --There was no documentation the test was read. -The second step was administered on 3/26/24 and read on 3/28/24. -The second step was administered more than three weeks after the first TB test was administered. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the resident's POS dated April 2024 showed the following order: -TB testing per community protocol. -Initiate TB testing protocol, dated 1/16/24. 4. Review of Resident #50's face sheet showed he/she was admitted to the facility on [DATE]. Review of the resident's two step TB tests showed: -Step one of the two step TB test was administered on 3/26/24 and read on 3/28/24. --There were no TB test documented prior to the 3/26/24 test. --There was no documentation that a chest x-ray had been completed at the tie of admission. Review of the resident's POS dated April 2024 showed the following order: -TB testing per community protocol. -Initiate TB testing protocol, dated 6/16/23. 5. During an interview on 4/5/25 at 10:00 A.M. the Infection Preventionalist (IP) said: -He/She had just started in the IP position. -Many of the residents did not have two step TB tests done per protocol. -Newly admitted residents should have had their first TB test done within the first day or so of admission. -72 hours after administration of the first TB test, the test should have been read. -The date and results of the TB test should have been documented on the immunization tag. -A second TB test should have then been administered within three weeks of the first TB test. -The date and results of the second TB test should have been documented on the immunization tag. -The person who was in his/her position previously was not keeping track of the residents' TB tests. -Many of the residents' TB tests were not done timely or documented correctly. During an interview on 4/5/24 at 12:00 P.M. the Director of Nursing (DON) said: -Residents should have their first TB test done as soon as they were admitted . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Residents should have a TB test read within 72 hours of administration. -Residents should have had a second TB test administered one to three weeks after the first test was read. -He/She or the IP were responsible for ensuring the TB tests were given to the residents timely. -The TB test and results should have been documented in the immunization log on the computer. -Many of the TB tests were missed in the past. 42955 6. Review of the facility's list of employees hired since the facility's last annual survey showed: -Employee G was hired on 11/11/23. -Employee J was hired on 11/1/23. Review of Employees G's TB tracking sheet showed: -Employee G had the first step TST administered on 10/30/23 and read on 11/2/23. --Employee G had the second step TST administered on 11/13/23 with no date read dated recorded. Review of Employee J's TB tracking sheet showed: -Employee J had the first step TST administered on 11/4/23 and read on 11/7/23. --Employee J had the second step TST administered on 11/18/23 and read on 11/21/23. 7. During an interview on 4/5/24 9:00 A.M., the Business Office Manger (BOM)/Human Resources (HR) Director said: -The Assistant Director of Nursing (ADON) administered and tracked employee TB. -Employee J started working 11/1/23. -Employee J started working before everything cleared. During an interview on 4/5/24 at 9:41 A.M., the ADON said: -New employees were usually hired directly after the interview. -He/She gave the new employees their first TST directly after the interview. -He/She told them to come back in two to three days to have it read then they could start working. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-All new employees received their TST. -New employees started working the day the first TST was read with a negative result. -Employees were not allowed to start working until the first TST was read. -He/She documented on a form and tracked it in a binder. -If he/she was unavailable another nurse read the results. -He/She remembered giving and reading Employee G's TST but could not find the documentation of the reading. -He/She was not working when Employee J hired. -Employee J started before the TST was administered. During an interview on 4/5/24 at 12:04 P.M., the DON said: -TST's were completed before employees started working. -Once a TST was read with a negative result, the employee was able to start working. -The ADON was responsible for tracking employee TST. -He/She expected staff to have the first TST completed and read prior to working.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 37576 Based on interview and record review, the facility failed to provide 12 hours of training/in-services to include behavior and dementia training, abuse and neglect prevention, and resident rights, for three Certified Nursing Assistants (CNA B, C, & D). The facility census was 56 residents. A policy was requested and not provided by the time of exit. 1. Review of the list of current employees who were CNA's showed three CNA's were chosen for records to be reviewed for the required 12 hour training/in-services. 2. Review of CNA B's training record dated April 2023 to April 2024 showed he/she was hired on 8/27/21 and worked as needed (PRN) and attended the following in-services: -On 4/28/23 nurses meeting (did not say what the topic was). -On 5/19/23 COVID changes, Transmission Based Precautions (TBP), New owner. -On 7/31/23 abuse prevention and prohibition program, interact-stop and watch early warning tool. -He/She did not receive training/in-services for the following: --Abuse and Neglect. --Behavior and dementia training. --Resident rights. --Care of the cognitively impaired resident. -CNA B did not receive the required 12 hours of training/in-services from April 2023 through April 2024. 3. Review of CNA C's training record dated April 2023 to April 2024 showed he/she was hired on 5/4/20 and attended the following in-services: -On 5/19/23 COVID changes, Transmission Based Precautions (TBP), New owner. -On 6/16/23 accessing kardex (name brand of an informational system used as a quick reference for nursing staff, resident transfer method. -On 6/17/23 care for a specific resident (the in-service sheet did not list what the cares for the resident were). -On 6/18/23 notification processes of grievances, complaints, and events. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 7/31/23 abuse prevention and prohibition program, interact-stop and watch early warning tool. -September meeting (did not show a date) agenda showed the following areas that were covered: --Skin and Pressure Ulcers, reporting, care and prevention. --Bedbound- turn every two hours, low air loss mattress, bunny boots, rashes, red areas, skin tears. -On 9/5/23 the in-service sheet showed bed hold policy, hydration, skin pressure ulcers, reporting, care and prevention. -In October 2023 (no day listed) transfer of residents. -On 12/26/23 stop and watch (acronym for observing and reporting changes in a resident's condition). -February 2024 meeting agenda had dates of 1/6/24, 1/7/24, and 1/8/24 on it included: --Toileting residents between meals. --Call lights. --Skin issues- let the wound nurse know immediately. -On 2/2/24 monthly nursing meetings (no specific topics listed). -On 3/20/24 abuse and neglect, infection prevention ad control program, hand hygiene -On 4/1/24 enhanced barrier precautions. -CNA C did not receive training/in-services for the following: --Behavior and dementia training. --Resident rights. --Care of the cognitively impaired resident. 4. Review of CNA D's training record dated April 2023 to April 2024 showed he/she was hired on 10/21/19 and attended the following in-services: -On 4/28/23 -nurses meeting (did not say what the topic was). -On 5/19/23 COVID changes, Transmission Based Precautions (TBP), new owner. -On 6/17/23 care for a specific resident (the in-service sheet did not list what the cares for the resident were). (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 6/18/23 notification processes of grievances, complaints, and events. -September meeting (did not show date) agenda showed the following areas that were covered: --Skin and Pressure Ulcers, reporting, care and prevention. --Bedbound- turn every two hours, low air loss mattress, bunny boots, rashes, red areas, skin tears. -On 9/5/23 bed hold policy, hydration, skin pressure ulcers, reporting, care and prevention. -CNA D did not receive training/in-services for the following: --Abuse and Neglect. --Behavior and dementia training. --Resident rights. --Care of the cognitively impaired resident. -CNA D did not receive the required 12 hours of training/in-services from April 2023 through April 2024 when he/she was terminated. 5. During an interview on 4/5/24 at 12:03 P.M., the Director of Nursing (DON) said: -CNA's should receive 12 hours of in-service/training a year. -In-services are held monthly at a minimum. -He/She had a calendar of what topics were covered for each month. -Topics that should be covered at least once a year were: --Abuse and neglect safety. --Dementia and Alzheimer's safety. --Fire safety. --Resident falls. --Any other resident needs that would come up. --In-services were taught by the DON, the Assistant Director of Nursing (ADON) or other department heads depending on the topic presented. --Staff should sign the in-service attendance sheet. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--In-services were about an hour each. --Human Resource staff should be monitoring the in-service hours for the CNA's. --PRN staff should attend each month's in-service.