STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265677	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
NAME OF PROVIDER OR SUPPLIER: Campbell Healthcare & Senior Living		STREET ADDRESS, CITY, STATE, ZIP CODE: 17108 US Highway 62 Campbell, MO 63933	

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48532 Based on observation, interview and record review, the facility failed to ensure staff treated residents with dignity and in a respectful manner by leaving two residents (Residents #9 and #11) out of 18 sampled residents exposed during care. The facility census was 72. The facility did not provide a policy regarding maintaining a resident's dignity. 1. Review of Resident #9's medical record showed: - admitted [DATE]; - Diagnoses of cerebral infarction (disrupted blood flow to the brain), dysphagia (difficulty swallowing), apraxia following unspecified cerebrovascular disease (neurological disorder that makes it difficult to perform certain movements), contracture, right hand (a permanent tightening of muscles, tendons, causing the joints to shorten and become stiff); Review of the resident's quarterly Minimum Data Set (MDS, a federally mandated assessment instrument completed by facility staff), dated 08/14/24 showed: - Cognition severely impaired; - Always incontinent of bowel; - Dependent (helper does all the effort) for toileting hygiene;. Observation of the resident on 09/11/24 at 11:24 A.M., showed: - The resident lay in bed; - Certified Nurse Assistant (CNA) D and CNA E entered the room to perform incontinent care; - The CNAs did not close the curtains to the windows; - The residents' bed was closest to the window; (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265677	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A parking lot and yard could be seen through the window; - The resident required his/her clothing to be changed, CNA D and CNA E changed resident shirt and brief; - The resident's breast and genitalia were exposed to the window. 2. Review of Resident #11's medical record showed: - admitted [DATE]; - Diagnoses of dementia with mild agitation (condition that causes loss of cognitive function, such as thinking, remembering, and reasoning that interferes with daily life), mood disorder (disturbance of mood, in the form of depression or euphoria), and metabolic encephalopathy (a brain dysfunction that occurs when a chemical imbalance in the blood affects the brain). Review of the resident's admission MDS, dated , 07/01/24, showed: - Cognition not impaired; - Always incontinent of bowel and bladder; - Dependent for toileting hygiene; Observation of the resident on 09/12/24 at 9:12 A.M., showed: - The resident lay in bed; - CNA I and CNA J assisted LPN F with wound care; - The CNA's closed the door to hallway to provide privacy; - The residents' window curtain remained open to yard; - The resident had wounds to both hips; - The resident did not have a brief covering private areas; - CNA I and CNA J assisted LPN F to turn resident from side to side exposing the resident's genitalia and buttocks to the outside window. During an interview on 09/11/24 at 2:10 P.M. Licensed Practical Nurse (LPN) G said before peri-care is started, staff should always ensure privacy by pulling the curtain within the room, pull the window curtains and close the door. (continued on next page)

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	265677	A. Building B. Wing	09/12/2024

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/12/24 at 12:19 P.M., CNA D said before performing peri-care, staff should provide privacy by closing the door, pull the curtain in front of the door, the curtain on the window. If the resident has a roommate and they are in the room, then staff should pull the curtain to divide the room. During an interview on 09/12/24 at 12:47 P.M., the Director of Nursing (DON) said the curtains on the window and in the room should be pulled closed before providing peri-care to any resident.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45872 Based on observation, interview, and record review, the facility failed to provide a safe, clean and comfortable homelike environment. This deficient practice had the potential to affect all residents in the facility. The facility census was 72. Review of the facility's policy titled, Homelike Environment, revised February 2021, showed: - Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible; - The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting which include a clean, sanitary and orderly environment. 1. Observations made on 09/09/24 at 9:38 A.M. and 09/11/24 at 11:02 A.M., of the 500 hall unit, showed: - A three foot (ft.) piece of base trim peeled off the bottom wall of the closet located in room [ROOM NUMBER]; - A piece of wood trim hung off the bottom of the closet onto the floor located in room [ROOM NUMBER]. - Several areas of exposed sheet rock and peeled paint on the wall above bed 1 located in room [ROOM NUMBER]. 2. Observations made on 09/09/24 at 10:54 A.M., 09/10/24 at 11:06 A.M., and 09/11/24 at 10:54 A.M., of the courtyard, showed two electrical conduits (a pipe or tube designed to enclose and protect cables or wires from moisture and physical damage) with broken zip ties hung low from the top of the wooden awning attached from the side of the building leading to two outside air-conditioner units. 3. Observation made on 09/10/24 at 11:30 A.M., of room [ROOM NUMBER] showed five stuffed animals sat on top of the overbed light fixture of bed 1. 4. Observations made on 09/11/24 at 6:48 A.M., of the shower room on the left side of the 400 hall, showed: - The left side of shower stall with a four ft. cove base trim missing; - The bottom of the floor of the shower stall showed a buildup of brown/grime/stain near the drain; - The toilet with dried fecal matter on the top of lid; - A large shower chair with a dried brown substance on seat and surrounding surfaces. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/12/24 at 9:00 A.M., Housekeeper A said it was the housekeeping department's job to keep the showers and bathrooms clean. He/She said staff had not made it in there yet this morning. During an interview on 09/12/24 at 9:13 A.M., Housekeeper A said there is maintenance request form that can be filled out for any environmental issues such as peeled paint, exposed sheetrock, loose base boards or any other concerns. He/She has not seen any environmental issues to report to maintenance. During an interview on 09/12/24 at 9:16 A.M., Housekeeper B said there is maintenance request form that can be filled out for any environmental issues such as peeled paint, exposed sheetrock, loose base boards or any other concerns. He/She has not seen any environmental issues to report to maintenance. During an interview on 09/12/24 at 9:20 A.M., the Maintenance Supervisor (MS) said he would secure the electrical conduits with new zip ties immediately. He/She would expect staff to write down any needed repairs as well to be addressed in a timely manner. It makes it easier to keep up with repairs instead of staff verbally telling him. During an interview on 09/12/24 09:43 AM, the Administrator said she would expect staff to write down environmental concerns so the MS could address in a timely manner. This will be addressed.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26904 Based on interview and record review, the facility failed to provide a written copy of the notice of transfer or discharge to the resident and/or the resident's responsible party and to the representative of the Office of Long-Term Care (LTC) Ombudsman (a program that advocates for residents, provides information and help resolve problems) for three residents (Residents #9 and #21) out of four sampled residents. The facility census was 72. Review of the facility's policy titled, Transfer or Discharge Policy, revised March 2021, showed: - Residents and/or representatives are notified in writing, and in a language and format they understand prior to transfer or discharge; - The resident and representative are notified in writing of the specific reason for transfer, the effective date, the location, and the bed-hold policy; - The reasons for the transfer or discharge are documented in the resident ' s medical record; - The policy did not address sending a monthly transfer log to the Office of the State LTC Ombudsman. 1. Review of Resident #9's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 07/18/24, returned to the facility on [DATE]; - No documentation of the written notification with the reason for the hospital transfer provided to the resident and/or the responsible party; - No documentation of the written transfer/discharge notification provided to the representative of the Office of the LTC Ombudsman. 2. Review of Resident #21's medical record showed: - admitted on [DATE]; - The resident transferred to the hospital on 05/07/24, and returned to the facility on [DATE]; - The resident transferred to the hospital on 06/02/24, and returned to the facility on [DATE]; - No documentation of the written notification with the reason for the hospital transfer provided to the resident and/or the responsible party; (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documentation of the written transfer/discharge notification provided to the representative of the Office of the LTC Ombudsman. During an interview 08/22/24 at 1:09 P.M., the Regional LTC Ombudsman said he/she had not received a single transfer log from the home this year. During an interview on 09/12/24 at 10:14 A.M., the Administrator said she did not know a written notice of the discharge/transfer form needed to be given to the resident and/or the responsible party. She was not aware transfer logs had to be sent on a regular basis to the Regional LTC Ombudsman. She said a social service director had been hired to assist with this task to ensure compliance. 45872 48532

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45872 Based on interview and record review, the facility failed to complete a significant change Minimum Data Set (MDS) (a federally mandated assessment tool completed by the facility) assessment within 14 days for one resident (Resident #66) out of three sampled closed resident records. The facility's census was 72. Record review of the facility's policy titled, Comprehensive Assessments, revised October 2023 , showed: - Comprehensive MDS assessments are conducted to assist in developing person-centered plans; - Significant Change in Status Assessment (SCSA) is a comprehensive assessment for a resident that must be completed when the Interdisciplinary Team (ITD, a group of health care professionals from diverse fields who work in a coordinated effort toward a common goal for a resident) has determined that a resident meets the significant change guidelines for either major improvement or decline; - The policy did not address a timeframe to submit a significant change. 1. Record review of Resident #66's medical record showed: - An admitted [DATE]; - admitted to hospice (health care focused on the quality of life of a terminally ill person) care on 06/07/24; - The facility failed to complete a significant change MDS within 14 days after the election of the resident's hospice benefit. During an interview on 09/12/24 at 11:18 A.M., RN C said there should be a significant change within 14 days when a resident goes on hospice services. During an interview on 09/11/24 at 11:31 A.M., the Director of Nursing (DON) said a significant change assessment should have been completed within 14 days upon a resident receiving hospice services due to a change in condition. During an interview on 09/12/24 at 11:34 A.M., the Administrator said a significant change assessment should be completed within 14 days upon a resident receiving hospice services. The facility does not have an in-house MDS Coordinator. Instead, they use a virtual coordinator, who is part of the corporate office.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48532 Based on interview and record review, the facility failed to document an accurate Minimum Data Set (MDS - a federally mandated assessment completed by facility staff) for one resident (Resident #9) out of 18 sampled residents and one resident (Resident #15) outside the sample. The facility's census was 72. The facility did not provide a MDS policy. 1. Review of Resident #9's medical record showed: - admitted [DATE]; - Diagnoses of cerebral infarction (disrupted blood flow to the brain), dysphagia (difficulty swallowing), apraxia following unspecified cerebrovascular disease (neurological disorder that makes it difficult to perform certain movements), - Resident had a fall and sent to hospital on 07/18/24; Review of the resident's admission MDS, dated [DATE], showed no prior falls. Review of the resident's quarterly MDS, dated [DATE], showed: - No falls; - The facility did not code the resident's MDS accurately. 2. Review of Resident #15's medical record showed: - admitted [DATE]; - Diagnoses of chronic atrial fibrillation with defibrillator (an irregular and rapid heart beat that requires an implantable device to treat the irregular rhythm), insomnia (sleep disorder that makes it difficult to fall, stay and get quality sleep) Type 2 diabetes (chronic disease that occurs when the body is unable to use insulin properly, resulting in high blood sugar levels); Review of Physicians Order Sheet (POS), dated April 2024-September 2024 showed no insulin injections prescribed. Review of the resident's annual MDS, dated [DATE], showed: - Resident received one insulin injection weekly; - The facility did not code the resident's MDS accurately. Review of the resident's quarterly MDS, dated , 03/18/24, showed: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident received zero insulin injections weekly; During an interview on 09/12/24 at 10:25 A.M., Licensed Practical Nurse (LPN) G said Resident #9 did have a fall in July. During an interview on 09/12/24 at 10:45 A.M., Registered Nurse (RN) C said if a resident has a change in condition it should be reflected on MDS. During an interview on 09/12/24 at 1:00 P.M., the Administrator and Director of Nursing (DON) said they would expect the MDS to accurately reflect falls and if the resident is receiving insulin.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26904 Based on interview and record review, the facility failed to provide documentation of a Level I Preadmission Screening and Resident Review (PASARR - a federally mandated preliminary assessment to determine whether a resident may have a mental illness or an intellectual disorder to determine the level of care needed) for two residents (Residents #21 and #43) out of 18 sampled residents. The facility's census was 72. The facility did not provide a PASARR policy. 1. Review of Resident #21's medical record showed: - An admitted [DATE]; - Diagnoses of schizophrenia (a disorder that affects one's ability to think, feel and behave clearly) violent behavior and generalized anxiety disorder (an excessive, ongoing anxiety and worry that are difficult to control); - No level I PASARR. 2. Review of Resident #43's medical record showed: - An admitted [DATE]; - Diagnoses of psychotic disorder (a mental disorder characterized by a disconnection from reality), traumatic brain injury (TBI) (an injury to the brain) and dementia (thinking and social symptoms that interfere with daily functioning); - No level I PASARR. During an interview on 09/11/24 at 7:30 A.M., the Administrator said she was unable to find the PASARR on these two residents. She said she had contacted the previous facilities and was not able to obtain the PASARR's and would start the process of completing new ones. Every resident should have a Level I PASARR in their chart. 50260

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26904 Based on observation, interview and record review, the facility failed to ensure the baseline care plan (initial plan for delivering of care and services) included specific interventions and the resident and/or guardian received a written summary of the baseline care plan for one resident (Resident #120) out of two sampled residents. The facility was census was 72. Review of the facility's policy titled, Baseline Care Plan Policy, revised 03/2022, showed: - The baseline care plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission; - The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative; b. Physician orders; c. Dietary orders; d. Therapy services; e. Social services: and f. Preadmission Screening and Resident Review (PASARR) recommendation, if applicable. - The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan. - The resident and/or representative are provided a written summary of the baseline care plan (in language that the resident/representative can understand) that includes, but is not limited to the following: a. The stated goals and objectives of the resident; b. A summary of the resident's medications and dietary instructions; c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and d. Any updated information based on the details of the comprehensive care plan, as necessary. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Provision of the summary to the resident and/or resident representative is documented in the medical record. 1. Review of Resident #120's medical record, showed: - admitted to the facility on [DATE] ; - Diagnoses of coronary artery disease (CAD), renal insufficiency (a condition in which the kidneys lose the ability of remove waste and balance fluids, diabetes mellitus (DM) (a chronic disease that occurs when the body cannot control its blood sugar levels) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest); - No documentation of a written summary of the baseline care plan. During an interview on 09/09/24 at 10:45 A.M., the resident said he/she did not receive any paperwork and is own responsible party. During an interview on 09/09/24 at 3:00 P.M., the Director of Nursing (DON) said the Minimum Data Set (MDS - a federally mandated assessment instrument required to be completed by facility staff) coordinator and care plan coordinator work offsite. She said there is a nurse that works part-time to help with the tasks, however she does not complete the MDS's and care plans. The DON said the MDS coordinator always does a care plan on admission of the residents and is a computer generated care plan. The DON said she was not aware the baseline care plan had to be given to the resident or the resident representative. During an interview on 09/12/24 at 1:45 P.M., the Administrator said the MDS coordinator worked off-site. However, the Administrator said information is shared with the staff member on each resident and she has access to the facility's computer system.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45872 Based on interview and record review, the facility failed to follow physician's order for fall mats (a soft landing surface to help prevent injuries) for one resident (Resident #6) out of two sampled residents. The facility census was 72. Review of the facility's policy titled, Attending Physician Responsibilities, revised August 2014, showed: - The attending physician's shall be the primary practitioners responsibility for providing medical services and coordinating the healthcare of each resident in the facility; - The physician will provide orders to ensure that individuals have appropriate comfort and supportive measures as needed; - The policy did not address facility following physician orders. 1. Review of Resident #6's medical record showed: - admitted on [DATE]; - Diagnoses of abnormal involuntary (cannot control) movements, epilepsy (a disease that causes recurrent seizures), and muscle spasm (involuntary tightening of a muscle or group of muscles). Review of the resident's Physician Order Sheet (POS), dated September 2024, showed an order for fall mats to both sides of the bed dated 01/29/24. Observations made on 09/09/24 at 10:55 A.M., 09/09/24 at 2:43 P.M., 09/10/24 at 08:43 A.M. and 09/11/24 at 8:23 A.M., showed: - Resident laid in bed; - A fall mat placed on the left side of the resident's bed. - No fall mat in place on the right side of the resident's bed. During an interview on 09/12/24 at 1:46 P.M., the Director of Nursing (DON) said if there is an order for fall mats for both sides of the bed she would expect fall mats to be placed on both sides of the resident's bed. During an interview on 09/12/24 at 1:48 P.M. , the Administrator said if there is a physician order for fall mats to be on both sides of the bed she would expect fall mats to be placed on both sides of the resident's bed.

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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45872 Based on interview and record review, the facility failed to identify, assess and provide supportive interventions for one resident (Resident #52) with a diagnosis of post traumatic stress disorder (PTSD - a mental health condition triggered by a terrifying event - either experiencing it or witnessing it; symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event) out of one sampled resident. The facility's census was 72. Review of the facility's policy titled, Trauma Informed Care, revised March 2019, showed: - To guide staff in appropriate and compassionate care specifics to individuals who have experienced trauma; - All staff are provided in-service training about trauma, its impact on health, and post-traumatic stress disorder in the context of the healthcare setting; - Nursing staff are trained on screening tools, trauma assessment and how to identify triggers associated with re-traumatization; - As part of the comprehensive assessment, identify history of trauma or interpersonal violence when possible. Identifying past trauma or adverse experiences may involve record review or the use of screening tools. 1. Review of Resident #52's medical record showed: - admitted on [DATE]; - Diagnoses of PTSD, major depressive disorder (MDD - long-term loss of pleasure or interest in life), and anxiety disorder (persistent worry and fear about everyday situations); - No documentation of a PTSD assessment. Review of the resident's Physician's Order Sheet (POS), dated September 2024, showed: - An order for donepezil (an anti-depressant medication) 10 milligram (mg) tablet once a day for PTSD dated 09/4/24; - An order for venlafaxine (an anti-anxiety medication) 37.5 mg tablet at bedtime dated 09/04/24. Review of the resident's Preadmission Screening and Resident Review (PASARR - a federal program to prevent inappropriate admission and retention of people with mental disabilities in nursing facilities), dated 03/31/23, showed: - PTSD, major depression, and anxiety; - No behaviors documented. (continued on next page)

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	265677	A. Building B. Wing	09/12/2024

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, last updated 06/09/24, showed: - PTSD not addressed; - No documentation the resident had past trauma or any triggers that would cause the resident to have behaviors. During an interview on 09/12/2024 at 10:53 A.M., the Director of Nursing (DON) said she had never seen a PTSD assessment. A PTSD assessment will be implemented. DON said PTSD should be part of the resident's care plan with triggers and interventions. During an interview on 09/12/2024 at 10:53 AM, the Administrator said she was not aware of an assessment for residents with a PTSD diagnosis. She would expect a resident to be care planned for PTSD with triggers and interventions.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45872 Based on observation, interview and record review, the facility failed to provide sufficient nursing staff to answer call lights in a timely manner to meet each resident's rights, physical, mental and psychosocial (how someone feels and copes with changes in their social environment) well-being. The deficient practice had the potential to affect all residents in the facility. The facility census was 72. Review of the facility's policy titled, Answering the Call Light, undated, showed: - The purpose of this procedure is to respond to the resident's requests and needs; - Explain the call light to the new resident; - Demonstrate the use of the call light; - Ask the resident to return the demonstration so that you will be sure that the resident can operate the system; - Be sure the call light is plugged in and functioning at all times; - When the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident; - Some residents may not be able to use their call light, provide alternative such as bell and check on these residents frequently; - Report all defective call lights to the administration and maintenance; - When answering call light, present to resident room in timely manner; - Call light must be acknowledged on the phone and residents room; - Assist resident at this time and make sure all needs are med before leaving the room; - If assistance is needed from more than one staff member upon entering the room, staff member should press the call light again once both call lights have been acknowledged. Review of the facility layout, dated 11/13/19, showed: - A call light central monitoring unit located at the nurse workstation on the 300 hall; - A call light central monitoring unit located in a nurse office on the 500 hall; - A call light central monitoring unit located in the Director of Nursing (DON) office; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A call light central monitoring unit located in the Administrator's office. Review of the facilities wireless nurse call system report log, dated 09/03/24 through 09/8/24, showed: - 09/03/24 at 12:47 P.M., room [ROOM NUMBER] response time of 7 hours (h)18 minutes (m); - 09/03/24 at 1:52 P.M., room [ROOM NUMBER] response time of 1 h 21 m; - 09/03/24 at 3:17 P.M., room [ROOM NUMBER] response time of 4 h 47 m; - 09/03/24 at 9:20 P.M., room [ROOM NUMBER] response time of 1 h 8 m; - 09/03/24 at 9:38 P.M., room [ROOM NUMBER] response time of 1 h 9 m; - 09/04/24 at 3:02 A.M., room [ROOM NUMBER] response time of 2 h 41 m; - 09/04/24 at 6:59 A.M., room [ROOM NUMBER] response time of 2 h 56 m; - 09/04/24 at 8:54 A.M., room [ROOM NUMBER] response time of 2 h 36 m; - 09/04/24 at 9:59 A.M., room [ROOM NUMBER] response time of 1 h 31 m; - 09/04/24 at 10:39 A.M., room [ROOM NUMBER] bathroom response time of 2 h 59 m; - 09/04/24 at 12:27 P.M., room [ROOM NUMBER] response time of 1 h 30 m; - 09/04/24 at 1:49 P.M., room [ROOM NUMBER] response time 1 h 41 m; - 09/04/24 at 3:48 P.M., room [ROOM NUMBER] response time 2 h 16 m; - 09/04/24 at 4:15 P.M., room [ROOM NUMBER] response time of 3 h 45 m; - 09/06/24 at 7:19 A.M., room [ROOM NUMBER] response time of 1 h 12 m; - 09/06/24 at 5:05 P.M., room [ROOM NUMBER] response time of 2 h 48 m; - 09/06/24 at 10:22 P.M., room [ROOM NUMBER] response time of 1 h 22 m; - 09/07/24 at 7:45 A.M., room [ROOM NUMBER] response time of 6 h 2 m; - 09/07/24 at 11:02 A.M., room [ROOM NUMBER] response time of 2 h 35 m; - 09/07/24 at 12:33 P.M., room [ROOM NUMBER] response time of 1 h 24 m; - 09/07/24 at 3:03 P.M., room [ROOM NUMBER] response time of 5 h 36 m; - 09/08/24 at 5:59 A.M., room [ROOM NUMBER] response time of 1 h 22 m; (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 09/08/24 at 6:39 A.M., room [ROOM NUMBER] response time of 4 h 44 m; - 09/08/24 at 7:04 A.M., room [ROOM NUMBER] response time of 4 h 19 m; - 09/08/24 at 5:52 P.M., room [ROOM NUMBER] response time of 2 h 14 m. During an interview on 09/09/24 at 9:08 A M, Resident #69 said he/she had been lying in bed with his/her call light on for over an hour. Resident said he/she had a bowel movement and had not been changed all night. The resident said call lights do not get answered during the night. Observation made on 09/09/24 at 9:13 A.M. showed a strong, foul odor coming from resident #69's room. During an interview on 09/09/24 at 10:22 A.M., Resident #219 said the call lights take a long time to be answered. During an interview on 09/09/24 at 10:45 A.M., Resident #120 said the call lights take a long time to get answered. The resident said the call light was on from 7:45 A.M. until noon when the staff brought his/her lunch tray to the room. During an interview on 09/09/24 at 11:04 A.M., Resident #15 said call lights do not get answered, especially at night. During an interview on 9/09/24 at 12:33 P.M., Resident #29 said that call lights are a constant issue and are not answered. The resident said he/she does not even push the call light anymore. He/She will use wheelchair, leave room, go find staff for help themselves and/or ask roommate for assistance. During an interview on 09/10/24 at 1:57 P.M., Resident #18 said it takes a long time for staff to answer the call lights. He/she said night time was the worse usually. During an interview on 09/09/24 at 2:47 P.M., Resident #27 said it took a long time for the call lights to be answered. The resident said he/she just kept pushing the button, hoping someone would answer it. During an interview on 09/09/24 at 2:53 P.M., Resident #13 said sometimes the call lights are not answered in a timely manner. The resident said sometimes it takes up to 1-2 hours before someone comes in to check on him/her. During an interview on 09/09/24 at 3:06 P.M., Resident #26 said it takes awhile for staff to answer his/her call light. During an interview on 09/09/24 at 3:24 P.M., Resident #35 said the day shift answers call lights for the most part, but the night shift is terrible about answering call lights. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/10/24 at 9:03 A.M., Resident #69 said he/she pushed the call light over an hour ago and still had not been changed. The resident said staff came to his/her room, turned off his/her call light and said they would be back, but never did. The resident said he/she pushed the call light again and was still waiting to be changed. Observations made on 09/10/24 at 9:05 A.M. showed: - CNA P walked toward Resident #69's room; - CNA P's facility-issued iPhone (mobile device) with an alert notification and resident's room number identified; - A response time of 42 minutes. During an interview on 09/11/24 at 3:11 A.M., CNA T said the call light notification on the iPhone has a two-step process. When a resident presses the call light, the iPhone will show an alert notification with the time and room number listed. The first step is to tap the button on the iPhone to clear the call light time. The second step is for staff to turn off the call light by pressing the button on the wall in the resident's room before leaving. He/She clears the alert on the iPhone, but does not always press the call light button on the wall before leaving. CNA T said by clearing the alert notification on the iPhone should take care of the call light notification. Observation on 09/11/24 at 3:15 A.M., showed CNA T with a facility-issued iPhone in his/her possession at the time of interview. During an interview on 09/12/24 at 10:25 AM, CNA N said he/she was headed to a resident's room to turn a call light off. CNA N was asked if he/she would be taking care of residents needs when the call light was turned off. CNA N said no and the resident's aides were currently busy. CNA N said he/she would turn off the resident's call light and the resident's aides would get to the resident when they were done. CNA N said he/she did not think staff should wait to turn call lights off until care is provided and he/she tries to turn call lights off as soon as possible regardless if care is provided at that time. During an interview on 09/12/24 at 12:43 P.M., the Administrator said she does not expect staff to go in and turn off call lights without providing resident care. The call light system is a two-step process. She would expect staff to complete both steps upon receiving the alert notification on their facility-issued iPhone and providing care before leaving the resident's room.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45872 Based on observation, interview, and record review, the facility failed to store and distribute food under sanitary conditions, increasing the risk of cross-contamination and food-borne illness. These deficient practices had the potential to affect all residents. The facility census was 72. Review of the facility's policy titled, Sanitation, revised [DATE], showed: - The food service area is maintained in a clean and sanitary manner; - All kitchen areas and dining areas are kept clean; - All utensils, counters, shelves and equipment are kept clean, maintained in good repair and free of breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Review of the facility's policy titled, Food Receiving and Storage, revised [DATE], showed: - Foods shall be received and stored in a manner that complies with safe food handling practices; - All foods stored in the refrigerator or freezer are covered, labeled and dated; - Functioning of the refrigerators and food temperatures are monitored daily and at designated intervals throughout the day by the food and nutrition services manager or designee and documented according to state-specific requirements; - Refrigerated foods are labeled, dated and monitored so they are used by their use by date, frozen or discarded. 1. Observations made on [DATE] at 9:44 A.M. and [DATE] 2:04 P.M., of the temperature check logs, showed: - A two-door standup refrigerator with no temperature checks from [DATE] through [DATE]; - A three-door standup refrigerator with no temperature checks from [DATE] through [DATE]. 2. Observations made on [DATE] at 9:47 A.M. and [DATE] at 2:09 P.M., of the standup freezers, showed: - A plastic container of yellow shredded cheese undated; - A bag of tortilla shells with an expiration date of [DATE]; - A bag of dinner rolls undated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. Observations made on [DATE] at 10:01 A.M. and [DATE] at 2:12 P.M., of the kitchen, showed: - No lid on the trash can by the stove; - No lid on the trash can by the food disposal; - A build up of grease and grime on the bottom surface leg supports and wheels of the deep fryer; - A build up of grease on the area of the cracked and missing floor tile under the deep fryer; - Several broken floor tiles under the deep fryer. 4. Observations made on [DATE] at 10:10 A.M., [DATE] at 2:18 P.M. and [DATE] at 1:14 P.M. , of the canned goods area, showed: - Two bags of flour tortillas with an expiration date of [DATE]; - A bag of flour tortillas with an expiration date of [DATE]. 5. Observations made on [DATE] at 10:16 P.M. and [DATE] at 2:25 P.M., of the dish machine, showed: - A buildup of dirt and debris on the floor underneath; - A black and gray bristle brush with a buildup of dirt laid on the floor underneath; - A panel unattached and/or unglued from the wall laid on the floor underneath; - A buildup of dirt and grime on the trash disposal. During an interview on [DATE] at 2:31 P.M., the Dietary Manager (DM) said the kitchen floors should be free of dirt, debris and kitchen equipment should be cleaned daily. Daily refrigerator temperatures should be checked by staff and initialed when completed. There should be dates on all food and expired foods should be thrown away. The DM said these areas of concern will need to be monitored more closely. During an interview [DATE] at 4:01 P.M., the Administrator said the kitchen floors should be free of dirt and debris. Kitchen equipment should be cleaned daily. Refrigerator temperatures should be checked by staff daily and initialed when completed. There should be dates on all food and expired foods should be thrown away accordingly. The DM should ensure areas of the kitchen are checked and monitored on a regularly to meet compliance.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48532 Based on observation, interview and record review, the facility failed to maintain proper infection control practices during incontinent care for one resident (Resident #9) out of four sampled residents and during wound care for one resident (Resident #24) out of two sampled residents. The facility failed to follow enhanced barrier precautions (EBP) for four residents (Residents #7, #9, #11 and #31) out of six sampled residents during care. The facility also failed to implement a risk management process specific to Legionella disease (a serious type of pneumonia caused by legionella bacteria) which had the potential to affect all residents, staff and the public. The kitchen staff failed to perform hand hygiene between the residents during a meal pass. The facility census was 72. Review of the facility's policy titled, Wound Care, revised, October 2019, showed: - Put on gloves, loosen tape and remove dressing; - Pull glove over dressing and discard into appropriate receptacle. Wash and dry hands thoroughly; - Put on gloves; - Use a no-touch technique to apply creams and ointments. Review of the facility's policy titled, Perineal Care, revised, February 2019, showed: -Did not address when during the procedure of perineal care to change gloves. Review of the facility's policy titled, Legionella Water Management Program, revised July 2017, showed: - The water management program includes the following elements: - A detailed description and diagram of the water system in the facility, including the following: a) receiving b) cold water distribution c) heating d) hot water distribution e) waste; - The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including the following: a) storage tanks b) water heaters c) filters d) aerators e) showerheads and hoses f) misters, atomizers, air washers and humidifiers g) hot tubs h) fountains i) medical devices such as continued positive airway pressure (CPAP), hydrotherapy equipment, etc.; - Specific measures used to control the introduction and/or spread of Legionella (temperature, disinfectants): - The control limits or parameters that are acceptable and that are monitored; - A diagram of where control measures are applied; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A system to monitor control limits and the effectiveness of control measures; -Documentation of the program. Review of the facility's policy titled, Enhanced Barrier Precautions, revised March 2024, showed: - An order for enhanced barrier precautions will be obtained for residents with any of the following: wounds (e. g. chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters (a tube inserted into the bladder to drain urine), feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with multi-drug resistant organism (MDRO); - High-contact resident care activities include: dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, wound care: any skin opening requiring a dressing. Review of the facility's policy titled, Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices, revised October 2017, showed: - Food and nutrition services employees will follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness; - All employees who handle, prepare or serve food will be trained in the practices for safe food handling and preventing foodborne illness; - Employees must wash their hands: - whenever entering or re-entering the kitchen; - after handling soiled equipment or utensils; - Antimicrobial hand gel cannot be used in place of handwashing in food service areas; - Gloves are considered single-use items and must be discarded after completing the task for which they were used. The use of disposable gloves does not substitute for proper handwashing. 1. Observation of Resident #7's incontinent care on 09/11/24 at 5:35 A.M., showed: - EBP sign on the resident room door; personal protective equipment (PPE) stored outside the resident door; - Certified Nurse Aid (CNA) O and CNA Q entered the resident room without gowns; - The resident with a gastrostomy (G-tube - a tube inserted into the stomach to deliver nutrition); - CNA O and CNA Q performed incontinent care for the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Observation of Resident #9's incontinent care on 09/11/24 at 6:07 A.M., showed: - EBP sign on the resident room door; - PPE stored in clear drawers outside the resident room; - CNA O and CNA Q entered the resident room without gowns; - The resident with a G-tube; - CNA O and CNA Q performed incontinent care for the resident. Observation of the resident's incontinent care on 09/11/24 at 11:24 A.M., showed: - EBP sign on the resident door; - CNA D and CNA E put on gowns and gloves outside the resident room and entered the room; - CNA D and CNA E removed the resident's dirty pants and brief soiled with urine; - CNA D cleaned the front peri-area, did not change gloves and did not perform hand hygiene; - CNA D placed a clean brief on the resident. 3. Observation of Resident #11's incontinent care on 09/11/24 at 6:58 A.M., showed: - EBP sign on the resident room door; - PPE stored in clear drawers outside the resident room; - CNA O and CNA Q entered the resident room without gowns; - The resident with a Foley catheter (a type of urinary catheter); - CNA O and CNA Q performed incontinent care for the resident. 4. Observation of Resident #24's wound care on 09/12/24 at 12:46 P.M., showed: - LPN G put on an isolation gown and a N95 mask; - LPN G performed hand hygiene, removed the soiled dressing, used a 4x4 gauze and wound cleaner to clean the wound, patted the wound dry with a new 4x4, and applied skin prep and a border dressing; - LPN G did not perform hand hygiene and change gloves between removing the soiled dressing and applying the clean dressing. 5. Observation of Resident #31's wound care on 09/12/24 at 10:38 A.M., showed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- EBP signage on the resident room door; - LPN G performed hand hygiene and put on gloves; - LPN G failed to put on an isolation gown - LPN G removed the dressing from the resident's right second toe, removed the gloves, performed hand hygiene and put on clean gloves; - LPN G cleaned the wound with wound cleanser and gauze, applied a non-adherent pad and a toe guard, applied a clean sock, removed the gloves and performed hand hygiene. 6. Observations on 09/09/24 at 12:14 P.M. showed: - Dietary Staff (DS) K served residents' meal plates in the dining room; - DS K re-entered the kitchen, received residents' plates, exited the kitchen and served the residents' plates, touched the table, and the residents; - DS K did not perform hand hygiene between serving the residents. 7. Observations on 09/09/24 at 12:16 P.M. showed: - Dietary Manager (DM) served residents' meal plates in the dining room; - The DM entered the kitchen, picked up a scoop, placed au gratin potatoes onto the resident's plate, replaced the scoop in the potatoes, picked up another scoop, placed green beans onto the resident's plate, then replaced the scoop into the green beans, exited the kitchen and served the resident's plate; - The DM did not perform hand hygiene before entering the kitchen after serving residents' plates and before exiting the kitchen and serving another resident's plate. 8. Observations made on 09/10/24 at 8:30 A.M. showed: - Dietary staff L wore disposable gloves and served the meal plates to the residents' in the dining room; - Dietary staff L did not change gloves or perform hand hygiene between the residents. 9. The facility did not provide a water flow diagram. During an interview on 09/11/24 at 12:23 P.M., the Maintenance Supervisor (MS) said he/she did not have a waterflow diagram with areas that were potentially at risk for the growth of Legionella. He/she said water temperatures were monitored weekly. During an interview on 09/11/24 at 11:44 A.M., Certified Nurse Aid (CNA) D said during incontinent care, the only time gloves were changed was if they were visibly dirty. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265677	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Campbell Healthcare & Senior Living	17108 US Highway 62 Campbell, MO 63933

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/12/24 at 1:26 P.M., Licensed Practical Nurse (LPN) G said gloves were changed after removing a soiled dressing and before applying a clean dressing during wound care. During an interview on 09/12/24 at 12:34 P.M., Dietary Staff M said the residents were served by the dietary staff. He/She was new to this position, but the staff should wash their hands before serving a resident's plate and staff should wash their hands in the kitchen before getting another resident's plate. During an interview on 09/12/24 at 12:50 P.M., the DM said the dietary staff pass the residents' plates, they do not clean their hands between each resident unless they touch the resident, chair, table or anything else. The DM said, I did not know you had to clean between each resident. During an interview on 09/12/24 at 1:00 P.M., the Administrator said she thought there was a hand sanitizer dispenser in the dining room or kitchen and staff should be using it between each resident. During an interview on 09/12/24 at 1:05 P.M., the Corporate Nurse said staff should cleanse their hands between serving each resident. During an interview on 09/12/24 at 2:17 P.M., the Director of Nursing said when staff were providing care to residents with EBP, gowns and gloves should be worn. During incontinent and wound care, gloves should be changed when going from dirty to clean care.

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48532 Based on interview and record review, the facility failed to document pertinent education provided to the residents or the resident's representative regarding benefits, side effects or warnings of the influenza (a viral respiratory infection) and/or the pneumococcal (an infectious lung disease) vaccine for five residents (Residents #2, #6, #21, #24, and #31) out of five sampled residents. The facility's census was 72. Review of the facility's policy, titled, Influenza Vaccine, revised March 2022, showed: - Prior to the vaccination, the resident (or resident's legal representative) will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of such education shall be documented in the resident's medical record. - A resident's refusal of the vaccine shall be documented on the informed consent for the influenza vaccine and placed in the resident's medical record. Review of the facility's policy, titled, Pneumococcal Vaccine, revised March 2022, showed: - Before receiving a pneumococcal vaccine, the resident or legal representative receives information and education regarding benefits and potential side effects of the pneumococcal vaccine. Provision of such education is documented in the resident's medical record. - Resident/representatives have the right to refuse vaccination. If refused, appropriate information is documented in the resident's medical record indicating the date of the refusal of the pneumococcal vaccination. 1. Review of Resident #2's medical record showed: - admitted [DATE]; - Influenza vaccine administered on 10/20/23; - Pneumococcal vaccine administered on 10/20/23; - No documentation the facility provided information and education to the resident or the resident's representative of the influenza vaccine. - No documentation the facility provided information and education to the resident or the resident's representative of the pneumococcal vaccine. 2. Review of Resident #6's medical record showed: - admitted [DATE]; - Influenza vaccine refused on 09/25/23; (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documentation the facility provided information and education to the resident or the resident's representative of the influenza vaccine; 3. Review of Resident #21's medical record showed: - admitted [DATE]; - Influenza vaccine administered on 10/20/23; - No documentation the facility provided information and education to the resident or the resident's representative of the influenza vaccine. 4. Review of Resident #24's medical record showed: - admitted [DATE]; - Influenza vaccine administered on 10/20/23; - No documentation the facility provided information and education to the resident or the resident's representative of the influenza vaccine; 5. Review of Resident #31's medical record showed: - admitted [DATE]; - Influenza vaccine refused on 06/13/24; - Pneumococcal vaccine refused on 06/13/24; - No documentation the facility provided information and education to the resident of the influenza vaccine; - No documentation the facility provided information and education to the resident of the pneumococcal vaccine. During an interview on 09/12/24 at 2:30 P.M., the Director of Nursing (DON) said education should be provided prior to any vaccine being administered. The education should be documented when provided. During an interview on 09/12/24 at 2:32 P.M., the Administrator said Social Services Designee (SSD) usually handles obtaining the consents and providing residents and representatives with information and education. There was no SSD during annual survey.

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 26904 Based on interview an record review, the facility failed to conduct at least twelve hours of nurse aide in-service education per year for two out of two Certified Nurse Aides (CNA) out of two sampled CNAs. The facility census was 72. Review of the policy titled, In-Service Training, All Staff, revised August 2022 showed: - All staff must participate in initial orientation and annual in-service training. - The primary objective of the in-service training is to ensure that staff are able to interact in a manner that enhances the resident's quality of life and quality of care and can demonstrate competency in the topic areas of the training. - Completed training is documented by the staff development coordinator, or his or her designee and includes: a. the date and time of the training; b. topic of the training; c. the method used for training' d. a summary of the competency assessment; and e. the hours of training completed. 1. Review of CNA N's April 2023 through April 2024 in-service records showed: - Hire date of 04/07/23; - No documentation of annual in-service trainings provided; - The facility failed to provide CNA N with at least twelve hours of in-service education for April 2023 through April 2024. 2. Review of CNA O's July 2023 through July 2024 in-service records showed: - Hire date on 07/27/23; - No documentation of annual in-service trainings provided; - The facility failed to provide CNA O with at least twelve hours of in-service education for July 2023 through July 2024. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 09/12/24 at 2:05 P.M., the Administrator said CNAs should have at least 12 hours of training annually. She said she thought the trainings had documented times on the sheets, however would get this done from this point on.