STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295023	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carson Nursing and Rehabilitation Center	2898 Highway 50 East Carson City, NV 89701

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34524 Based on interview, clinical record review, and document review, the facility failed to offer a bowel and bladder retraining program for residents assessed to be candidates for retraining for 11 of 49 residents (Resident #13, #47, #22, #24, #34, #18, #23, #41, #20, #28, and #45). This deficient practice had the potential to affect all residents' ability to maintain and achieve their highest continent status and increase the risk of related health issues. Findings include: Resident #13 Resident #13 was admitted to the facility on [DATE], with diagnoses including strain of other muscles and tendons at lower leg level, left leg, and muscle weakness. Resident #13's Minimum Data Set 3.0 (MDS) Section H - Bowel and Bladder dated 12/06/2024, documented Resident #13 was occasionally incontinent of bladder and occasionally incontinent of bowel. A trial of a toileting program had not been attempted and a toileting program was not being used to manage the resident's bowel incontinence. Resident #13's Bowel and Bladder assessment dated [DATE], documented Resident #13 was a potential candidate for retraining. Resident #13's Bowel and Bladder assessment dated [DATE], documented Resident #13 was a potential candidate for schedule toileting. Resident #47 Resident #47 was admitted to the facility on [DATE] and readmitted on [DATE], with a diagnosis of other drug induced secondary parkinsonism. Resident #47's MDS Section H - Bowel and Bladder dated 12/07/2024, documented Resident #47 was frequently incontinent of bladder and always incontinent of bowel. A trial of a toileting program had not been attempted and a toileting program was not being used to manage the resident's bowel incontinence. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #47's Bowel and Bladder assessment dated [DATE], documented Resident #47 was a potential candidate for retraining. Resident #47's Bowel and Bladder assessment dated [DATE], documented Resident #47 was a potential candidate for schedule toileting. Resident #22 Resident #22 was admitted to the facility on [DATE] and readmitted on [DATE], with a diagnosis of [NAME] fascial fibromatosis. Resident #22's MDS Section H - Bowel and Bladder dated 12/11/2024, documented Resident #22 was occasionally incontinent of bladder and always continent of bowel and a trial of a toileting program had not been attempted. Resident #22's Bowel and Bladder assessment dated [DATE], documented Resident #22 was a potential candidate for retraining. Resident #22's Bowel and Bladder assessment dated [DATE], documented Resident #22 was a potential candidate for retraining. Resident #22's Bowel and Bladder assessment dated [DATE], documented Resident #22 was a potential candidate for retraining. Resident #24 Resident #24 was admitted to the facility on [DATE], with a diagnosis of hemiplegia and hemiparesis following cerebral infarction. Resident #24's MDS Section H - Bowel and Bladder dated 10/08/2024, documented Resident #24 was occasionally incontinent of bladder and always continent of bowel and a trial of a toileting program had not been attempted. Resident #24's Bowel and Bladder assessment dated [DATE], documented Resident #24 was a potential candidate for retraining. Resident #24's Bowel and Bladder assessment dated [DATE], documented Resident #24 was a potential candidate for retraining. Resident #24's Bowel and Bladder assessment dated [DATE], documented Resident #24 was a potential candidate for retraining. Resident #24's Bowel and Bladder assessment dated [DATE], documented Resident #24 was a potential candidate for retraining. Resident #34 Resident #34 was admitted to the facility on [DATE], with a diagnosis of torsades de pointes. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #34's MDS Section H - Bowel and Bladder dated 12/09/2024, documented Resident #34 was occasionally incontinent of bladder and always continent of bowel and a trial of a toileting program had not been attempted. Resident #34's Bowel and Bladder assessment dated [DATE], documented Resident #34 was a potential candidate for retraining. Resident #34's Bowel and Bladder assessment dated [DATE], documented Resident #34 was a potential candidate for retraining. Resident #34's Bowel and Bladder assessment dated [DATE], documented Resident #34 was a potential candidate for retraining. Resident #34's Bowel and Bladder assessment dated [DATE], documented Resident #34 was a potential candidate for retraining. Resident #18 Resident #18 was admitted to the facility on [DATE] and readmitted on [DATE], with a diagnosis of Alzheimer's disease. Resident #18's MDS Section H - Bowel and Bladder dated 12/09/2024, documented Resident #18 was frequently incontinent of bladder and always continent of bowel and a trial of a toileting program had not been attempted. Resident #18's Bowel and Bladder assessment dated [DATE], documented Resident #18 was a potential candidate for retraining. Resident #18's Bowel and Bladder assessment dated [DATE], documented Resident #18 was a potential candidate for retraining. Resident #23 Resident #23 was admitted to the facility on [DATE], with a diagnosis of polyneuropathy. Resident #23's MDS Section H - Bowel and Bladder dated 07/29/2024, documented Resident #23 was occasionally incontinent of bladder and always continent of bowel and a trial of a toileting program had not been attempted. Resident #23's Bowel and Bladder assessment dated [DATE], documented Resident #23 was a potential candidate for retraining. Resident #23's Bowel and Bladder assessment dated [DATE], documented Resident #23 was a potential candidate for retraining. Resident #23's Bowel and Bladder assessment dated [DATE], documented Resident #23 was a potential candidate for retraining. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #23's Bowel and Bladder assessment dated [DATE], documented Resident #23 was a potential candidate for retraining. Resident #23's Bowel and Bladder assessment dated [DATE], documented Resident #23 was a potential candidate for retraining. Resident #41 Resident #41 was admitted to the facility on [DATE], with a diagnosis of acute and chronic respiratory failure with hypoxia. Resident #41's MDS Section H - Bowel and Bladder dated 11/04/2024, documented Resident #41 was occasionally incontinent of bladder and occasionally incontinent of bowel. A trial of a toileting program had not been attempted and a toileting program was not being used to manage the resident's bowel incontinence. Resident #41's Bowel and Bladder assessment dated [DATE], documented Resident #41 was a potential candidate for retraining. Resident #41's Bowel and Bladder assessment dated [DATE], documented Resident #41 was a potential candidate for retraining. Resident #20 Resident #20 was admitted to the facility on [DATE], with a diagnosis of unilateral primary osteoarthritis, right knee. Resident #20's MDS Section H - Bowel and Bladder dated 10/07/2024, documented Resident #20 was occasionally incontinent of bladder and always continent of bowel and a trial of a toileting program had not been attempted. Resident #20's Bowel and Bladder assessment dated [DATE], documented Resident #20 was a potential candidate for retraining. Resident #20's Bowel and Bladder assessment dated [DATE], documented Resident #20 was a potential candidate for retraining. Resident #20's Bowel and Bladder assessment dated [DATE], documented Resident #20 was a potential candidate for retraining. Resident #28 Resident #28 was admitted to the facility on [DATE], with a diagnosis of chronic diastolic congestive heart failure. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #28's MDS Section H - Bowel and Bladder dated 09/24/2024, documented Resident #28 was occasionally incontinent of bladder and always incontinent of bowel. A trial of a toileting program had not been attempted and a toileting program was not being used to manage the resident's bowel incontinence. Resident #28's Bowel and Bladder assessment dated [DATE], documented Resident #28 was a potential candidate for retraining. Resident #28's Bowel and Bladder assessment dated [DATE], documented Resident #28 was a potential candidate for scheduled toileting. Resident #45 Resident #45 was admitted to the facility on [DATE], with a diagnosis of displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing. Resident #45's MDS Section H - Bowel and Bladder dated 11/25/2024, documented Resident #45 was frequently incontinent of bladder and occasionally incontinent of bowel. A trial of a toileting program had not been attempted and a toileting program was not being used to manage the resident's bowel incontinence. Resident #45's Bowel and Bladder assessment dated [DATE], documented Resident #45 was a potential candidate for retraining. Resident #45's Bowel and Bladder assessment dated [DATE], documented Resident #45 was a potential candidate for scheduled toileting. On 12/19/2024 at 10:07 AM, the Director of Nursing (DON) verbalized residents who were incontinent of bladder and/or bowel, able to get to the toilet with or without assistance, and able to feel the need to void and alert the staff, would benefit from a bowel and bladder (BB) toileting program. The DON explained the facility did not have a BB program until the week of 12/16/2024. The program consisted of scheduled toileting on a two-hour schedule. The DON further explained the facility did not have a policy for a BB program, the facility did not assess for the type of incontinence, voiding patterns were not assessed and documented, and all residents were in briefs unless they refused. The DON confirmed residents were only assessed for incontinence and put on a two-hour check and change schedule. The facility policy titled Incontinence, dated 12/2021, documented residents who were incontinent of bladder or bowel would receive appropriate treatment to prevent infections and restore continence to the extent possible.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 34524 Based on observation and interview, the facility failed to ensure current nursing hours were posted for the facility. The deficient practice had the potential to result in a lack of awareness for residents and visitors regarding the type and number of nursing staff on duty. Findings include: On 12/16/2024 at 8:05 AM, the nursing staff posting for the facility, located across from the main nursing station was dated 12/13/2024. On 12/16/2024 at 9:42 AM, the Director of Nursing (DON) verbalized the nursing staff posting for the facility dated 12/13/2024 should have been removed and updated for 12/16/2024. The DON verbalized it was the weekend nurse's responsibility to update and post the nursing staff and hours for the facility on the weekends. On 12/16/2024 at 1:59 PM, the Administrator verbalized the Administrator was usually the one who changed the staff posting in the mornings, however, the Administrator had not arrived when surveyors entered the building and as a result, the staff posting was not current when surveyors arrived.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49557 Based on observation, interview, clinical record review, and document review the facility failed to ensure medications were administered with an error rate of less than 5 percent (%). There were 25 opportunities and two medication errors. The error rate was 8%. This deficient practice resulted in a resident receiving a medication at a different concentration than ordered in the electronic Medication Administration Record (eMAR) and had the potential for medication errors and adverse effects. Findings include: Resident #24 Resident #24 was admitted to the facility on [DATE], and readmitted to the facility on [DATE], with a diagnosis of unspecified intracapsular fracture of left femur, subsequent encounter for closed fracture with routine healing. On 12/18/2024 at 2:56 PM, a Licensed Practical Nurse (LPN) began preparing medications for Resident #24. The LPN verbalized the physician ordered Diclofenac Sodium gel was not available in the facility. Resident #24's December 2024 Medication Administration Record (MAR) documented Diclofenac Sodium external gel 1 percent (%), apply to right wrist topically three times a day for osteoarthritis. The scheduled administration times were 8:00 AM, 2:00 PM, and 8:00 PM. The 2:00 PM administration on 12/18/2024, was documented as MN. The MAR legend documented MN equated to Medication Not available. Resident #205 Resident #205 was admitted to the facility on [DATE], with a diagnosis of malignant neoplasm of prostate. On 12/18/2024 at 3:26 PM, the LPN administered 1 milliliter (ml) of Morphine Sulfate to Resident #205. The label on the bottle documented the bottle contained Morphine Sulfate 20 milligrams (mg) per ml. Resident #205's December 2024 MAR documented Morphine Sulfate oral solution 20 mg/5 ml, give 1 ml by mouth every four hours as needed for severe pain. The order date was 12/11/2024 and no discontinue date was documented. On 12/18/2024 at 4:58 PM, the LPN reviewed the Morphine Sulfate bottle and compared the bottle to the physician's order in Resident #205's eMAR. The LPN confirmed the strength of the Morphine Sulfate administered to Resident #205 did not match the eMAR. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The LPN located a physician order from Resident #205's hospice provider in the resident's hospice communication binder. The order documented Morphine concentration 100 mg/5 ml, 0.5 ml by mouth every four hours as needed for moderate pain and 1 ml by mouth every four hours as needed for severe pain. The order date was 12/10/2024, had no discontinue date documented and the order was not entered in the resident's eMAR. The LPN verbalized medications were to be given according the orders in the resident's eMAR. The LPN verbalized the strength of Morphine Sulfate administered to Resident #205 matched the order from the hospice provider however it did not match the order in the eMAR. The physician was not contacted for clarification of the orders prior to administration of the medication on 12/18/2024. On 12/19/2024 at 4:29 PM, the Director of Nursing (DON) explained the DON's expectation of nursing staff when administering medications was to review the resident's eMAR and compare the medication to the eMAR. If a discrepancy was noted between the medication available in the facility and the physician's order in the eMAR, the nurse was to contact the physician immediately to clarify the order or to notify the physician of a medication being unavailable. The DON verbalized a medication error was any medication not given as ordered by the physician. Medication errors included omission of an ordered medication and a medication administered at a dose or strength different than what was documented in the resident's eMAR. The facility policy titled Medication-Related Errors, revised 05/01/2010, documented medication administration errors included dose errors and omission errors. A dose error was defined as the administration of a dose greater or less than the amount ordered by the physician. An omission error was defined as the failure to administer an ordered dose to a resident. The facility policy titled Medication Administration, reviewed 10/22/2023, documented staff were to review the resident's MAR to identify the medication to be administered and compare the medication to the MAR to verify the dose. If any discrepancies were found, the discrepancy was to be corrected and reported to the nurse manager.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49557 Based on observation, interview, and document review the facility failed to ensure expired medications were removed from 1 of 2 inspected medication carts and from 1 of 1 inspected medication storage rooms. This deficient practice had the potential to place residents at risk of receiving expired/outdated medications. Findings include: On 12/17/2024 at 11:54 AM, during a review of the B hall medication cart and in the presence of the Assistant Director of Nursing (ADON), a box of Aspercreme four percent (%) Lidocaine patches was found. Three patches remained in the box. The expiration date printed on the patches was 10/2024. The ADON confirmed the expiration date printed on the Lidocaine patches was 10/2024, and the patches should have been removed from the cart and discarded by 10/31/2024. On 12/17/2024 at 12:15 PM, during a review of the B hall medication storage room and in the presence of the ADON, the following items were found: -Two intravenous (IV) solution bags containing 50 milliliters (ml) of Normal Saline 0.9 percent. The expiration date printed on the bag was 10/2024. -One IV solution bag containing 100 ml of 5 percent Dextrose. The expiration date printed on the bag was 11/2024. On 12/17/2024 at 12:19 PM, the ADON confirmed the three IV solution bags had expired and should have been discarded. On 12/17/2024 at 4:41 PM, the Director of Nursing (DON) verbalized expired drugs were to be destroyed. The DON confirmed expired medications should be removed from medication carts. Medicated patches were to be cut up and placed in drug buster (a drug disposal system). Expired IV solution bags were to be cut open and the contents poured into drug buster. The DON verbalized the DON was made aware of the expired Lidocaine patches found in the medication cart and the expired IV solution bags found in the medication storage room. The DON verbalized the medications should have been removed and destroyed. The facility policy titled Storage and Expiration of Medications, Biologicals, Syringes, and Needles, revised 01/01/2013, documented the facility was to ensure medications and biologicals had an expiration date on the label and were not retained longer than recommended by the manufacturer. The facility was to destroy or return all outdated/expired medications or biologicals.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34524 Based on observation, interview, clinical record review and document review, the facility failed to ensure resident information was not visible on an unattended computer screen and hospice medication orders were entered timely into the electronic medical record (EMR) for 1 of 13 sampled residents (Resident #205). This deficient practice had the potential to expose a resident's private and protected health information and for records to be incomplete, placing a resident at risk of not receiving physician ordered medications. Findings include: On 12/18/2024 at 11:18 AM, a computer screen on an unattended medication cart in the B wing dining area displayed resident information. On 12/18/2024 at 11:19 AM, a Registered Nurse (RN) returned to the medication cart and verbalized the computer screen should not display resident information. The RN confirmed the computer screen was unlocked and unattended with resident information on display. On 12/18/2024 at 11:28 AM, the Director of Nursing verbalized the expectation was computer screens would be locked when not in use. The facility policy titled Medication Administration Operating Standard Guideline, undated, documented to cover the Medication Administration Record or to close the computer screen when leaving the cart to protect resident privacy. 49557 Incomplete Records Resident #205 Resident #205 was admitted to the facility on [DATE], with a diagnosis of malignant neoplasm of prostate. On 12/17/2024 at 3:29 PM, during a review of Resident #205's hospice communication binder, a physician order dated 12/13/2024, was found and included the following: -Fleet enema per rectum, one time, now. -Increase Milk of Magnesia to 30 milliliters (ml) by mouth every 12 hours as needed for constipation. -Dulcolax suppository, one suppository per rectum as needed for no bowel movement in three days. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #205's Order Summary Report, from the facility's EMR system, documented Milk of Magnesia oral suspension 400 milligrams (mg)/5 ml. Give 15 ml by mouth every 24 hours as needed for constipation. The order date was 12/11/2024. The Order Summary Report did not include orders for a Fleet enema or Dulcolax suppository. On 12/17/2024 at 4:29 PM, a Licensed Practical Nurse (LPN) explained when the facility received new orders from hospice the nurse would enter the orders in the facility's EMR system so the facility's orders matched the hospice provider's orders. The LPN reviewed Resident #205's hospice communication binder and EMR and confirmed the resident's Milk of Magnesia order had not been updated and an order for the Dulcolax suppository had not been entered. On 12/17/2024 at 4:45 PM, the Director of Nursing (DON) explained when the facility received orders from hospice, the nurse was expected to review the orders and enter the orders into the facility's EMR system. The DON verbalized hospice orders were to be entered into the EMR the same day the orders were received. On 12/17/2024 at 4:53 PM, in the presence of the DON and the LPN, the DON reviewed Resident #205's hospice communication binder. The LPN verbalized the LPN had been aware of the orders for the Fleet Enema, increased dose of Milk of Magnesia, and the Dulcolax suppository and had forgotten to enter the orders into the facility's EMR system. The facility policy titled Consulting Physician/Practitioner Orders, reviewed 10/22/2022, documented if the facility received orders from a consulting physician in writing or via fax, the nurse in a timely manner would call the attending physician to verify the order and transcribe the order to the medication or treatment administration record. The facility policy titled Coordination of Hospice Services, dated 12/2022, documented the facility would communicate with hospice and identify, communicate, follow and document all interventions put into place by hospice and the facility. All residents receiving hospice would continue to receive the same facility services as residents who had not elected hospice including medication administration.

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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. 49557 Based on observation, interview, and document review the facility failed to ensure a Registered Nurse (RN) performed hand hygiene between administering medications to different residents. This deficient practice had the potential to affect all residents receiving medication from the RN and placed residents at risk for spread of infection. Findings include: On 12/18/2024, during the medication pass from 8:44 AM through 9:12 AM, an RN administered medications to two residents, readjusted a resident's nasal cannula, touched a resident's shoulder, and donned and doffed a glove. The RN did not perform hand hygiene prior to preparing medication for each resident, prior to administering medication to each resident, after contact with the residents and the residents' environment, or after administering medication to each resident. On 12/18/2024 at 9:14 AM, the RN confirmed the RN did not perform hand hygiene prior to medication preparation and administration, after contact with the residents and the residents' environment, or after medication administration. The RN verbalized hand hygiene was required to be performed before and after care of each resident, after medication administration, and after touching a resident. On 12/19/2024 at 4:29 PM, the Director of Nursing (DON) explained hand hygiene was required to be performed by staff between care of different residents. The DON confirmed hand hygiene would be required to be performed after adjusting a resident's nasal cannula, after touching a resident, and after removing gloves. The DON verbalized failure to perform hand hygiene after contact with or providing care to a resident had the potential to spread infection. The facility policy title Medication Administration, revised 10/22/2023, documented staff were to wash hands prior to and after administering medications. The facility policy titled Hand Hygiene, revised 11/2024, documented hand hygiene was considered the most important procedure for preventing healthcare associated infections. Staff were to perform hand hygiene before and after contact with a resident, after contact with an object in the resident's room, and after removing personal protective equipment including gloves.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295023	A. Building B. Wing	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carson Nursing and Rehabilitation Center	2898 Highway 50 East Carson City, NV 89701

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 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 30748 Based on employee record review, document review and interview, the facility failed to ensure timely completion for initial and annual training on preventing, identifying, and reporting abuse, neglect, misappropriation of property, and exploitation (abuse training) for 3 of 20 sampled employees (Employee #2, #9, and #13). The deficient practice had the potential to place residents at risk for abuse and neglect. Findings include: Employee #2 Employee #2 was hired as the Director of Nursing on 03/28/2024. Employee #2's personnel record documented abuse training completed on 04/12/2024, one month late. Employee #9 Employee #9 was hired as a Licensed Practical Nurse on 09/07/2021. Employee #9's personnel record documented abuse training completed on 04/17/2023 and annual training completed on 12/17/2024, eight months late. Employee #13 Employee #13 was hired as a Registered Nurse on 11/06/2024. Employee #13's personnel record documented abuse training completed on 11/20/2024, 14 days late. On 12/18/2024 at 9:58 AM, the Payroll Human Resources employee explained abuse training was required to be completed by all employees by the employees hire date with the facility and annually thereafter. The Payroll Human Resources employee confirmed Employees #2, #9, and #13 had not completed timely abuse training. The facility policy titled, Alleged or Suspected Abuse and Crime Reporting, revised 10/2022, documented all new employees were required to be trained in abuse in orientation with the facility and existing staff were provided planned education on abuse.