STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455001	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood of Beaumont	4195 Milam St Beaumont, TX 77707

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460 Based on observations, interviews, and record review, the facility failed to consult with the resident's physician when there was a need to alter treatment for 1 of 24 residents (Resident #92) reviewed for notification of changes. The facility failed to ensure the physician was notified of a missed dose of Oxacillin (used to treat bacterial infections) 1gm IV Q6H x 5 days was to start at 6:00 a.m. on 04/30/24 and unable to start the prescribed Oxacillin for Resident #92. The facility failed to ensure the physician was consulted when the pharmacy indicated the Oxacillin was outside of the recommended dose or frequency. This failure could place residents at risk of not receiving appropriate medical treatments, which could result in severe illness or hospitalization . Findings included: Record review of a face sheet dated 04/30/24 indicated Resident #92 was admitted on [DATE] with diagnoses of urinary tract infection (UTI), altered mental status, and heart disease. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #92 had a BIMS score of 10 (moderate cognition impairment) and required moderate assistance with toileting hygiene and showering. Physician orders dated 04/30/24 indicated Resident #92 had an order for Oxacillin Sodium in dextrose IV solution give 1 gram intravenously every 6 hours x 5 days ordered on 04/29/24 to start 04/30/24. Record review of the MAR dated 04/30/24 indicated Resident #92 had a dose of Oxacillin IV due at 6:00 a.m. and was not initialed to indicated was given. Record review of the care plan dated 04/30/2024 indicated for Resident #92 had a UTI / with Staphylococcus aureus (a major human bacterial pathogen which can cause serious infections) was prescribed: Oxacillin Sodium interventions include check at least every 2 hours for incontinence. Wash, rinse, and dry soiled areas. Encourage adequate fluid intake. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 04/30/24 at 10:45 a.m., Resident #92 had no IV infusing which was ordered on 04/29/24 at 9:56 p.m. He said he did not know about an antibiotic. Record review of Resident #92 nurses' notes from 04/28/24 through 4/29/24 indicated: *04/28/2024 11:29 a.m. Nursing Note- Note Text: Received UA results. Called into Resident #92's physician's answering service. Awaiting call back. *04/29/2024 9:49 p.m. Nursing Note- Note Text: Received C&S results, positive for staph A. Per DON, patient needs to be isolated with contact precautions. Reported results to on call nurse for Resident #92's physician. N/O received: Oxacillin 1gm IV Q6H x 5 days. Left message for Resident #92's daughter. *04/29/2024 9:56 p.m. Order Note- Note Text: This order is outside of the recommended dose or frequency. Oxacillin Sodium in Dextrose Intravenous Solution 1 GM/50ML Use 1 gram intravenously every 6 hours for UTI for 5 Days - The daily dose of 4 grams is below the usual dose of 6 to 12 grams. During an observation and interview on 04/30/24 at 10:45 a.m., LVN P was giving Resident #92's his morning meds and said the IV never came in and she will check the pix cart and call the pharmacy later. She said we have 1 hour before and 1 hour after to give meds. She said she was just running late. She gave no reason. During an interview on 04/30/24 at 1:00 p.m., the DON said she was not sure why Resident #92 's antibiotic was not started or why the physician was not informed of the medication not coming in. She said her expectation was for medications to be given as ordered and in a timely manner or the nurses should notify the physician and herself. She said all nurses knew an hour before and after the medication was due to administer medications. She said no one had reported to her of medications being late this morning. She said when the order was outside of the recommended dose or frequency, the computer system would flag the nurse, who would call the physician, and she said on 04/29/24 the physician was not called and should have been. Record review of Administering Medications dated April 2019 indicated Medications are administered in a safe and timely manner and as prescribed. 4. Medications are adminstered in accordance with prescriber orders, including any required time frame.7. Medications are administered one hour of their prescribed time, .

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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** 33460 Based on observation, interview, and record review, the facility failed to maintain a safe, clean and homelike environment for 1 of 24 residents (Resident #92) reviewed for environment. The facility failed to provide Resident #92 with a thoroughly clean room without other resident's personal belongings in his room. This failure could place residents at risk of unclean, unhomelike environment and a decline in health. The findings included: Record review of face sheet dated 04/30/24 indicated Resident #92 was admitted on [DATE] with diagnoses of urinary tract infection, altered mental status and heart disease. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #92 with a BIMS score of 10 (moderate cognition impairment) and moderate assistance with toileting hygiene and showering. Record review of the care plan dated 04/30/2024 for Resident #92 has UTI / with Staphylococcus aureus was prescribed: Oxacillin Sodium. Interventions included to check at least every 2 hours for incontinence, wash, rinse, and dry soiled areas, and encourage adequate fluid intake. During an observation and interview on 04/30/24 at 9:30 a.m., Resident #92's room had a stack of boxes and bags on the floor, which contained personal belongs for female clothes, stuffed animals and wrapped box with a female name. A plastic chest with personal belongings. He said he moved here last night and was not sure what that stuff was. During an interview on 04/30/24 at 1:00 p.m., the DON said the personal belongings on the floor of Resident #92's room belong to a resident who discharged about 2 weeks ago. She said when a resident discharges all items sent home with the families or disposed of if the family desires the items to be disposed of. The room should had been deep cleaned to prevent spreading germs and then it could be occupied by another person. She said the room was for Resident #92 and no other resident's personal belongings should had been left in the room. During an interview on 05/01/24 at 10:00 a.m., the ADON said all personal belongings of discharged resident should be removed then room should be deep cleaned before another resident could be placed in the room. She said to prevent the spread of germs. During an interview on 05/01/24 at 10:10 a.m., Housekeeping Supervisor said her housekeepers would clean the rooms of discharged residents when personal belongs were removed. They have a place to put donated clothes. She said she would remove personal belongings and deep clean the room. She said she was not sure what happen. She said all rooms should be cleaned prior to someone being placed in the rooms to prevent spread of germs and so he has the space for his belongings.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664 Based on observation, interview, and record review, the facility failed to ensure assessments accurately reflected the status for 2 of 28 residents reviewed for assessments. (Residents #13 and #109)). The facility failed to complete an accurate resident assessment for Resident #13. Resident #13's resident assessment did not reflect she was a tobacco user. The facility failed to complete an accurate resident assessment for Resident #109. Resident #109's resident assessment did not reflect her active diagnosis of anxiety disorder. This failure could place residents at risk of not having individual needs met and a decreased quality of life. Findings included: 1. Record review of a face sheet dated 04/30/24 indicated Resident #13 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included chronic obstructive pulmonary disease (a lung disease that blocks airflow making it difficult to breathe) and respiratory failure (a serious condition that makes it difficult to breathe on your own). Record review of a smoker list provided by the facility on 04/29/24 indicated Resident #13 was listed. Record review of a Smoking assessment dated [DATE] indicated Resident #13 was a smoker. Record review of a care plan revised 02/21/24 indicated Resident #13 was a smoker. During an interview on 05/01/24 at 09:45 a.m., LVN C indicated Resident #13 smoked on occasion but not every day. She indicated the resident had the right to smoke and she would monitor her O2 sats after just to make sure not dropped too low because she had an episode of the O2 level dropping. Record review of a Significant Change MDS dated [DATE] indicated Resident #13 was marked No for smoking. 2. Record review of a face sheet dated 04/30/24 indicated Resident #109 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included depression (mental illness that negatively affects how you feel, the way you think and how you act) and diabetes mellitus type 2 (chronic condition that affects the way the body processes blood sugar). Record review of nurse note with an entry dated 02/21/24 at 07:49 p.m. written by LVN T indicated the NP saw Resident #109 and prescribed Depakote related to diagnosis of anxiety. Record review of physician orders for April 2024 indicated Resident #109 had an order dated 02/21/24 for Depakote 125mg twice daily for anxiety/mood. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the MDS assessment dated [DATE] indicated Resident #109's diagnosis of anxiety disorder was not marked. Record review of the MDS assessment dated [DATE] indicated Resident #109's diagnosis of anxiety disorder was not marked. During an interview on 05/01/24 at 11:16 a.m., the DON indicated she expected the MDS to be filled out correctly. She indicated they discovered the previous MDS nurse who was responsible for the MDS was not filling them out correctly. The DON said they did not have a policy, they followed the MDS RAI manual. During an interview on 05/01/24 at 01:08 p.m., the Administrator indicated she expected the MDS to be filled out correctly or it could affect residents receiving care and mess up the billing.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30664 Based on observation, interview, and record review the facility failed to refer residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change of condition to the State-designated authority for 1 of 12 residents (Resident #109) reviewed for PASRR. The facility did not refer Resident #109 to the LMHA when the NP provided a new mental illness diagnosis of anxiety. This failure could place residents at risk of not receiving the needed PASSAR services to meet their individual needs and could result in a decreased quality of life. Findings included: Record review of a face sheet dated 04/30/24 indicated Resident #109 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included depression (mental illness that negatively affects how you feel, the way you think and how you act) and diabetes mellitus type 2 (chronic condition that affects the way the body processes blood sugar). Record review of a PASRR Level 1 Screen dated 02/15/24 indicated Resident #109 was negative. Record review of nurse notes indicated the NP saw Resident #109 on 02/21/24 and prescribed Depakote related to diagnosis of anxiety. Record review of physician orders for April 2024 indicated Resident #109 had an order dated 02/21/24 for Depakote 125mg twice daily for anxiety/mood. Record review of the EMR for Resident #109 indicated no new PASRR Level 1 or PE was conducted. During an observation and interview on 04/29/24 at 09:14 a.m., Resident #109 was ambulatory. She was sitting in a chair in common area. She indicated she had no issues. During an interview on 05/01/24 at 10:54 a.m., the Corporate MDS/PASRR Nurse said a new P1 should have been done and referral for PE on Resident #109 with the new medication and new diagnosis. During an interview on 05/01/24 at 11:16 a.m., the DON indicated the MDS nurse was responsible for the PASRRs-ensuring they were correct, following up for PE to be done, or when a resident had a new diagnosis a new P1 was to be done. She indicated they had discovered the previous MDS nurse was not checking the PASRRs like they should have been. She indicated they did not have a PASRR policy. During an interview on 05/01/24 at 01:08 p.m., the Administrator indicated she expected PASRRs to be reviewed and done correctly or a new one filled out. She indicated it could affect residents from receiving services they would be entitled to receive.

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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** 41057 Based on observation, interview and record review, the facility failed to ensure preadmission screening for individuals identified with MI, DD, or ID were evaluated for services for 1 of 24 residents reviewed for resident assessments (Resident #415). The facility did not have an accurate PASRR level 1 screening (PL1) for Resident #415 upon admission. This failure could place residents at risk for a diminished quality of life and not receiving necessary care and services in accordance with individually assessed needs. Findings included: Record review of a face sheet dated 04/29/24 indicated Resident #415 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included psychosis (a mental disorder characterized by a disconnection from reality), dementia (a group of thinking and social symptoms that interfere with daily functioning), and anxiety disorder (persistent and excessive worry that interferes with daily activities) on 04/11/24. Record review of a PASRR level 1 screening completed by the transferring facility dated 04/11/24 indicated Resident #415 was negative for mental illness, intellectual disability, and developmental disability and negative for dementia as the primary diagnosis. There was no PASRR Level II Screening or Form 1012 (Mental Illness/Dementia Resident Review) found in the clinical record from the resident's admission on 04/11/24 to 04/29/24. Record review of physician orders dated April 2024 indicated Resident #415 was prescribed quetiapine fumarate 75 mg (antipsychotic medication) at bedtime for psychosis with a start date of 04/17/24 and buspirone hcl 5 mg (used to treat anxiety) three times a day with a start date of 04/11/24. Record review of a care plan dated 04/17/24 indicated Resident #415 had a care plan indicating she received the anti-anxiety medication buspirone and psychotropic medication quetiapine for psychosis. Record review of an admission MDS dated [DATE] indicated Resident #415 was PASSR positive for MI and had a BIMS score of 13 indicating intact cognition. The MDS indicated Resident #415 had diagnoses of psychotic disorder, dementia, and anxiety. During an observation and interview on 04/29/24 at 08:53 a.m., Resident #415 was sitting up in a recliner, she said she was treated great and received needed care. During an interview on 04/30/24 at 2:21 p.m., MDS Nurse A said she was now responsible for PASRR forms. She said the previous MDS nurse left and had been doing the PASRR forms up until 2 weeks ago. MDS Nurse A said she was educated on PASRR forms on 04/29/24. She said she did a new PL1 form on 4/30/24 for Resident #415 after surveyor intervention. MDS Nurse A said Resident #415's PL1 should have been corrected sooner. She said the risk of an incorrect PL1 was a resident could miss out on deserved services. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/30/24 at 2:39 p.m., the DON said the previous MDS nurse was terminated within the last two weeks for not doing all required duties and incorrect documentation. She said the MDS nurse A was now responsible for all PASRR forms. The DON said Resident #415's PL1 form should have been corrected sooner. She said the risk of an incorrect PL1 form was a resident missing out on qualifying services. The DON said her expectation was for all PASRR forms to be completed timely and correctly. During an interview on 04/30/24 at 3:41 p.m., the Administrator said the MDS nurse was responsible for PASRR forms. She said her expectation was for all PASRR forms to be completed correctly and timely. The Administrator said the risk of a PL1 completed incorrectly was a resident may miss out on deserved services. During an interview on 05/01/24 at 2:30 p.m., the DON said they did not have a facility PASRR policy, they followed the RAI. Record review of the October 2023 Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual titled, A1500: Preadmission Screening and Resident Review (PASRR) Item Rationale Health-related Quality of Life indicated . o All individuals who are admitted to a Medicaid certified nursing facility, regardless of the individual's payment source, must have a Level I PASRR completed to screen for possible mental illness (MI), intellectual disability (ID), developmental disability (DD), or related conditions o Individuals who have or are suspected to have MI or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination. Those residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/or specialized services provided by the State.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25779 Based on observation, interview, and record review, the facility failed to ensure a resident with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for 1 of 24 resident reviewed for range of motion. (Resident #7) The facility did not ensure Resident #7's splint was placed in her contracted right hand. This failure could place the residents at risk of not receiving the care and services to maintain their highest level of well-being. Findings included: Record review of physician orders dated April 2024 and May 2024 indicated Resident #7, admitted [DATE], was [AGE] years old with diagnoses of right sided hemiplegia (paralysis) and cerebrovascular disease (stroke). The order did not indicate the resident had a splint. Record review of the most recent quarterly MDS dated [DATE] indicated Resident #7 was a BIMs score of 8 (moderate cognitive impairment) and did not have onset of acute mental status changes with inattention, disorganized thinking or altered level of consciousness. The resident had a functional limitation in ROM to one side of the upper extremities. A care plan dated 09/07/21 indicated Resident #7 had a stroke with long term effects of hemiplegia. One of the interventions indicated to assist the resident with mobility as needed. A care plan initiated 04/15/24 indicated the resident was on restorative services. One of the interventions indicated to apply right hand splint daily for 2 hours. Record review of a Task sheet dated April 2024 did not indicate Resident #7 received the Splint Brace Assistance Program on Sunday 4/28/24, Monday 04/29/24 or Tuesday 04/30/24. The columns for those dates did not contain signatures to indicate the task was completed. Record review of a Restorative Plan dated 04/11/24 indicated Resident #7 was to receive splint/brace assistance to the right hand. Apply right hand splint daily for 2 hours. During observation and interview on 04/29/24 at 9:29 a.m., Resident #7 was lying in bed. The fingers to her right hand were contracted upward to the bottom of hand. The resident said she could not move her fingers. The resident pointed to the top of the small refrigerator sitting on the bedside table where a splint was lying on top of the refrigerator. The splint was not in reach of the resident. The resident said she wanted the splint in her hand. She shook her head yes, when asked if staff had placed the splint in her hand the day before. During the following observations, the splint was lying on the refrigerator in the same place as previously seen and Resident #7 did not have the splint in her hand: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*04/29/24 at 2:12 p.m., *04/30/24 at 10:20 a.m., *04/30/24 at 3:01 p.m.; and *05/01/24 at 8:42 a.m. During an interview on 04/30/24 at 10:20 a.m., Resident #7 said the staff had not put the splint in her hand on 04/29/24 or today 04/30/24. During an interview on 05/01/24 at 8:42 a.m., Resident #7 said the staff had not put the splint in her hand on 4/30/24 or today 05/01/24 and she wanted the splint placed in her hand. She said she had not refused to have the splint placed in her right hand. During observation and interview on 05/01/24 at 8:54 a.m., CNA B said Resident #7 did not have the splint on her right hand and he did not place it on her today 05/01/24 or yesterday 04/30/24. He said he was working the day shift today 6:00 a.m. to 2:00 p.m. and he did not usually work Hall 100. He said he worked on 04/30/24, but not on Hall 100. He went to the closet and retrieved a knee brace and said he tried to put the knee brace on her but it would not fit. When asked if he saw the hand splint lying on the refrigerator, he said no and retrieved it. He said the possible negative outcome of not placing the splint in the resident's hand would be the contracture could worsen and possibly the nails could cut the skin. He slightly pulled the resident's finger's away from the palm of her hand. The fingers moved approximately 1/4 inch and would not move any further. There were no open areas to the resident's hand. Resident #7 said she did not want her fingernails cut. The restorative aide told CNA B to leave the splint off until after the resident had her bath. CNA B then placed the splint back on top of the refrigerator. During an interview on 05/01/24 at 9:04 a.m., the restorative aide said she was responsible for ensuring the residents with contractures had the splints placed in their hands and said she had been off for 2 days on Sunday 04/28/24 and Monday 04/29/24 and returned yesterday on 04/30/24. She said she did not put the splint on Resident #7 on 04/30/24 because she was busy on Unit 2 and 3 trying toget the monthly weights completed. She said she had not placed the splint on the resident's hand today 05/01/24. She said the transportation driver had been trained in ROM and was her back-up when she was not available. She said she did not tell the transportation driver she was off or needed help and she was not sure who let the transportation driver know when she had to perform restorative duties. She said the possible negative outcome of not placing the splint in Resident #7's contracted hand would be an increase in the resident's contractures. The restorative aide said the resident received the splint about a month ago. During an interview on 05/01/24 at 9:16 a.m., the DON said the restorative aide was responsible for ensuring the splints were in place. She said the nurses would be the person who would be responsible if the restorative aide was not available because the CNAs had not been trained on restorative care. She said her expectations were for the splint to be placed in Resident #7's hand to prevent further contractures. She said the possible negative outcome would be an increase in the contractures. She said the restorative schedule was Tuesdays through Saturdays. She said Resident #7's splint would be on the restorative aide's task sheet, so the resident's splint placement would not be on the nurses' MAR and would not be the nurses' responsibility. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation and interview on 05/01/24 at 9:29 a.m., RN N grabbed the splint from off the top of the refrigerator and began placing it in Resident #7's contracted right hand. She said Resident #7's right hand was contracted and should have the splint. She said the orders to put the splint on the resident's right hand were not on the nurses' MAR. She said the order was on the restorative aide's task sheet. She said the splint should have been applied as ordered. She said she was unaware she was supposed to place the splint on the resident's hand. During an interview on 05/01/24 02:09 p.m., Transportation Attendant R said she had not been trained in restorative care and was not responsible for ensuring residents with contractures had splints placed in their hands. During an interview on 05/01/24 at 2:13 p.m., Transportation Attendant S said she was trained in restorative care, so if the restorative aide called and let her know she needed help in restorative, then she would help her, if she could. She said the restorative aide never called her to assist with restorative care on Monday 04/29/24 or Tuesday 04/30/24. She said she did not assist with restorative care when the restorative aide was off Monday 04/29/24 or Tuesday 04/30/24 and said she did not see Resident #7 Monday for restorative care on 04/30/24 through today 05/01/24. She said she did not put the splint in Resident #7's hand. She said no one let her know she needed to. She said on the days she was busy transporting residents; she would not be able to help the restorative aide. She said it all depended on how busy she was. During an interview on 05/06/24 at 9:00 a.m., the Administrator said the facility did not have a policy on contracture management or splint management. Record review of a Range of Motion Exercises policy dated October 2010 indicated: Purpose- The purpose of this procedure it to exercise the resident's joints and muscles.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33460 Based on interview and record review, the facility failed to ensure pharmaceutical services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required for 1 of 24 residents reviewed for physician orders. (Resident #92) The facility failed to follow physician orders related to ferrous gluconate (used to treat or prevent low blood levels of iron) for Resident #92. This failure could place the residents at risk of not receiving care and services as ordered by the physician. Findings included: Record review of face sheet dated 4/30/24 indicated Resident #92 was admitted on [DATE] with diagnoses of urinary tract infection, altered mental status and heart disease. Record review of the physician's orders for Resident #92 dated 04/30/24 indicated ferrous gluconate tablet 324 mg, Give 1 tablet by mouth one time a day with start date of 04/18/2024. Record review of the MAR for Resident #92 indicated from 4/18/24 to 4/29/24 the ferrous gluconate was not given and not initialed as being given. Record review of the quarterly MDS assessment dated [DATE] indicated Resident #92 with a BIMS score of 10 (moderate cognition impairment) and moderate assistance with toileting hygiene and showering. Record review of the care plan dated 12/06/23 for Resident #92 has diagnoses of anemia was prescribed iron supplement. Interventions included: Educate the resident/family/caregivers to expect change in color of stools. (Dark green to black) and give medications as ordered. Monitor for side effects, effectiveness. Monitor/document/report PRN following s/sx of anemia: Pallor, Fatigue, Dizziness. During an interview on 4/30/24 at 1:00 p.m., the DON said Resident #92 was not given his iron as ordered, and she was going to call his physician. She said his ferrous gluconate tablet was not given because when the order was changed on 04/17/24 the order was placed on the MA MARS not the nurse MARS. She said the facility had not used medication aides. She said she was responsible for monitoring and ensuring medications were placed correctly on the MARs. Record review of the policy titled Administering Medication dated April 2019 indicated Medications are administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with the prescribers orders, including any required tie frame.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41057 Based on observation, interview and record review, the facility failed to ensure each resident's drug regimen was free from unnecessary drugs when used without adequate monitoring for 2 of 24 residents reviewed for unnecessary medication. (Residents #58 and #415) The facility failed to hold Resident #58's midodrine hcl (used to treat low blood pressure) when the resident's blood pressure was outside parameters set by the physician from 04/01/24 to 04/29/24. The facility failed to monitor Resident #415 for side effects from 04/12/24 to 04/29/24 of the anticoagulant medication Eliquis (a blood thinning medication). This failure could place residents at risk of complications and not receiving the intended therapeutic effects of their medications. Findings included: 1. Record review of a face sheet dated 04/30/24 indicated Resident #58 was an [AGE] year-old male admitted on [DATE]. His diagnoses included hypertension (high blood pressure), hypotension (low blood pressure), atherosclerotic heart disease (a buildup of substances inside the walls of the arteries that can cause clots and put blood flow at risk from your heart to your body) and coronary angioplasty implant and graft (a procedure to open clogged blood vessels of the heart with a tiny balloon to improved blood flow to the heart. Record review of physician orders dated April 2024 indicated Resident #58 was prescribed midodrine hcl 5 mg three times a day for hypotension, with prescribed parameters to hold for SBP (systolic blood pressure) greater than 100. Record review of a care plan with a target date of 05/29/24 indicated Resident #58 had a care plan indicating he had hypotension and received midodrine. The care plan indicated interventions including hold midodrine if SBP greater than 100 initiated on 03/01/23. Record review of an admission MDS dated [DATE] indicated Resident #58 had a BIMS score of 13 indicating intact cognition. The MDS indicated Resident #58 had diagnoses of hypertension, hypotension, atherosclerotic heart disease and coronary angioplasty implant and graft. Record review of a MAR dated 04/30/24, indicated Resident #58 received midodrine hcl 5 mg three times a day for hypotension with a start date of 02/28/24 and prescribed parameter to hold for SBP greater than 100. On the following dates the midodrine hcl 5 mg was administered to Resident #58 and should have been held at 7:00 a.m., 7 of 30 times, 1:00 p.m., 5 of 30 times and 7:00 p.m., 19 of 30 times. *04/01/24 at 7:00 p.m., SBP 118; *04/03/24 at 7:00 a.m., SBP 114; (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*04/03/24 at 1:00 p.m., SBP 112; *04/03/24 at 7:00 p.m., SBP 110; *04/04/24 at 7:00 p.m., SBP 118; *04/05/24 at 7:00 p.m., SBP 110; *04/09/24 at 7:00 p.m., SBP 118; *04/10/24 at 7:00 a.m., SBP 125 *04/10/24 at 7:00 p.m., SBP 102; *04/11/24 at 7:00 p.m., SBP 105; *04/13/24 at 7:00 p.m., SBP 112; *04/14/24 at 7:00 p.m., SBP 108; *04/15/24 at 7:00 a.m., SBP 140; *04/15/24 at 7:00 p.m., SBP 118; *04/16/24 at 7:00 p.m., SBP 118; *04/19/24 at 7:00 a.m., SBP 127; *04/19/24 at 7:00 p.m., SBP 112; *04/20/24 at 7:00 p.m., SBP 114; *04/22/24 at 7:00 p.m., SBP 110; *04/23/24 at 1:00 p.m., SBP 104; *04/24/24 at 7:00 p.m., SBP 102; *04/25/24 at 7:00 p.m., SBP 118; *04/26/24 at 7:00 a.m., SBP 111; *04/26/24 at 7:00 p.m., SBP 118; *04/27/24 at 1:00 p.m., SBP 118; *04/27/24 at 7:00 p.m., SBP 112; (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*04/28/24 at 7:00 p.m., SBP 112; *04/29/24 at 7:00 a.m., SBP 112; *04/29/24 at 1:00 p.m., SBP 124; *04/30/24 at 7:00 a.m., SBP 127; and *04/30/24 at 1:00 p.m., SBP 139. During an observation on 04/30/24 at 07:48 a.m., Resident #58 was sitting on his bedside and said I feel good today,.he said he gets a pill for his blood pressure. During an interview and record review on 04/30/24 at 1:54 p.m., LVN O said she was providing care for Resident #58 today. She said on review of Resident #58's medication record she should have held the midodrine hcl at 7:00 a.m., and 1:00 p.m. She said she misread the parameter and thought it was diastolic greater than 100 to be held instead of systolic. LVN O said she was educated in medication administration and was aware to follow parameters. She said she was responsible for giving the medication incorrectly. LVN O said the risk for Resident #58 was hypertension. During an interview and record review on 04/30/24 at 3:02 p.m., LVN Q said she provided care for Resident # 58, 04/29/24 and previously this month. She said she was educated in medication administration and was aware to follow parameters. She said she misread the parameter she thought it said 110 or greater instead of 100. She said the risk for Resident #58 was his blood pressure being raised or too high. LVN O said she gave the midodrine hcl out of parameters and should have held it after review, on; *04/01/24 at 7:00 p.m.; *04/03/24 at 7:00 p.m.; *04/04/24 at 7:00 p.m.; *04/05/24 at 7:00 p.m.; *04/09/24 at 7:00 p.m.; *04/10/24 at 7:00 p.m.; *04/11/24 at 7:00 p.m.; *04/13/24 at 7:00 p.m.; *04/14/24 at 7:00 p.m.; *04/15/24 at 7:00 p.m.; (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*04/16/24 at 7:00 p.m.; *04/19/24 at 7:00 p.m.; *04/20/24 at 7:00 p.m.; *04/22/24 at 7:00 p.m.; *04/24/24 at 7:00 p.m.; *04/25/24 at 7:00 p.m.; *04/26/24 at 7:00 p.m.; *04/27/24 at 7:00 p.m.; *04/28/24 at 7:00 p.m.; *04/29/24 at 7:00 a.m.; and *04/29/24 at 1:00 p.m. 2. Record review of a face sheet dated 04/29/24 indicated Resident #415 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included atrial fibrillation (an irregular and often rapid heart rhythm that can lead to blood clots in the heart and increases the risk of a stroke). Record review of physician orders dated April 2024 indicated Resident #415 was prescribed Eliquis 2.5 mg daily for atrial fibrillation with a start date of 04/12/24. The orders did not address monitoring the anticoagulant medication. Record review of a care plan dated 04/17/24 indicated Resident #415 had a care plan indicating she received the anti-coagulant medication Eliquis for Atrial fibrillation. Record review of an admission MDS dated [DATE] indicated Resident #415 had a BIMS score of 13 indicating intact cognition. The MDS indicated Resident #415 had a diagnosis of atrial fibrillation and received an anticoagulant medication during the look back period. Record review of a MAR dated 04/29/24, indicated Resident #415 received Eliquis 2.5 mg two times a day from 04/11/24 to 04/29/24, and once a day on 04/12/24 the start date. Record review of the electronic record for Resident #415 from 04/11/24 to 04/29/24 indicated the nurses did not document monitoring of side effects of the anticoagulant medication daily with medication administration. During an observation on 04/29/24 at 08:53 a.m., Resident #415 was sitting up in a recliner. She said she was treated great here and received needed care. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/30/24 at 02:07 p.m., LVN R said she provided care for Resident #415 today. LVN F said she proved care for Resident #415 on 04/26/24 and was currently taking over care for Resident #415 for today. LVN R and F said were educated on monitoring for side effects of anticoagulant medication. They said Resident #415 should have been monitored for side effects but was not. LVN F said as nurses they were aware and monitored anticoagulant medication for side effects it was just not documented correctly. They said the nurse admitting the resident was responsible for adding monitoring into the computer system and the DON and ADON double checked for monitoring. LVN F said she admitted Resident #415 and was responsible and started the orders but did not complete them. She said she was aware as a nurse to monitor the meds for side effects but if you did not document it, you did not do it. LVN F said the risk was the potential side effects were not being documented properly but no risk to residents. LVN R said the medication should have been documented in the system but was missed. During an interview on 04/30/24 at 02:39 p.m., the DON said the admission nurse started the orders and monitoring of medication in the computer system and the IDT double checked medication for monitoring. She said Resident #415 should have been monitored for the anticoagulant Eliquis and was not. She said the nurses were educated with an annual check off on medication administration on 04/12/24. The DON said the monitoring was overlooked. She said the risk of an anticoagulant medication not monitored was potential adverse reactions and side effects. She said her expectation was all medication to be given as ordered by the physician and monitored for side effects as required. The DON said Resident #58's Midodrine should have been held when out of parameters. She said the nurse giving medication was responsible for holding a medication that was out of prescribed parameters. The DON said the risk of a medication given out of prescribed parameters was an increase in side effects and adverse reactions caused by the medication. During an interview on 04/30/24 at 03:41 p.m., the Administrator said her expectation was all physician orders followed as ordered and all anticoagulant medication be monitored for side effects as required. She said her expectation was for all medication with prescribed parameters be given within parameters. The Administrator said the charge nurse was responsible for following physician orders, administrating medication to the residents. She said the risk of anticoagulant medication not monitored was potential side effects. She said the risk of a medication given out of parameters was the resident's blood pressure could be lowered. Record review of a facility policy revised November 2018, titled, Anticoagulant -Clinical Protocol indicated, . 5. The staff and physician will monitor for possible complications in individuals who are being anticoagulated and will manage related problems. a. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant. Record review of a facility policy revised April 2019, titled, Administering Medications, indicated, . Medications administered in a safe and timely manner, and as prescribed. 4. Medications are administered in accordance with prescriber orders. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Reference obtained from the internet on 10/12/23 from, How Rx ELIQUIS(R) (apixaban) Can Help | Safety Info (bmscustomerconnect.com) indicated, . ELIQUIS can cause bleeding, which can be serious, and rarely may lead to death. This is because ELIQUIS is a blood thinner medicine that reduces blood clotting. While taking ELIQUIS, you may bruise more easily and it may take longer than usual for any bleeding to stop. Call your doctor or get medical help right away if you have any of these signs or symptoms of bleeding when taking ELIQUIS: *unexpected bleeding or bleeding that lasts a long time, such as unusual bleeding from the gums, nosebleeds that happen often, or menstrual or vaginal bleeding that is heavier than normal *bleeding that is severe or you cannot control *red, pink, or brown urine; red or black stools (looks like tar) *coughing up or vomiting blood or vomit that looks like coffee grounds *unexpected pain, swelling, or joint pain *headaches, or feeling dizzy or weak

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41057 Based on observation, interview and record review, the facility failed to ensure based on the comprehensive assessment of a resident, residents who use psychotropic drugs received gradual dose reduction and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs for 1 of 24 residents (Resident #415) reviewed for unnecessary medications. The facility failed to monitor Resident #415 for side effects of the antipsychotic medication quetiapine fumarate and Abilify and the antianxiety medication buspirone hcl. This failure could place residents at risk for adverse consequences such as dizziness, drowsiness, oversedation, agitation, restlessness, and suicidal thoughts related to the use of psychotropic medications. Findings include: Record review of a face sheet dated 04/29/24 indicated Resident #415 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included psychosis (a mental disorder characterized by a disconnection from reality) and anxiety (a mental disorder characterized by feelings of worry or fear that are strong enough to interfere with one's daily activities). Record review of physician orders dated April 2024 indicated Resident #415 was prescribed Abilify 10 mg daily for depression (a group of conditions associated with the elevation or lowering of a person's) with a start dated of 04/12/24, buspirone hcl 5 mg three times a day for anxiety with a start date of 04/12/24 and quetiapine fumarate 75 mg at bedtime for psychosis with a start date of 04/17/24. Record review of a care plan dated 04/17/24 indicated Resident #415 had a care plan indicating she received the antianxiety medication buspirone for anxiety with an intervention of monitor for side effects and effectiveness every shift. The care plan indicated Resident #415 received Ability for depression with an intervention to monitor for side effects and effectiveness every shift and quetiapine for psychosis with an intervention to monitor for side effects and effective every shift. Record review of an admission MDS dated [DATE] indicated Resident #415 had a BIMS score of 13 indicating intact cognition. The MDS indicated Resident #415 had a diagnosis of anxiety, psychotic disorder and received antipsychotic medication and antianxiety medication during the look back period. Record review of a MAR dated 04/29/24, indicated Resident #415 received Abilify 10 mg daily for depression from 04/13/24 to 04/29/24 with a start date if 04/13/24. The MAR indicated Resident #415 received quetiapine fumarate 75 mg at bedtime for psychosis 04/17/24 to 04/28/24 with a start date of 04/17/24. The MAR indicated Resident #415 received buspirone hcl 5 mg three times a day for anxiety from 04/13/24 to 04/28/24 and one time a day on 04/12/24 with a start date of 04/12/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the electronic record for Resident #415 from 04/11/24 to 04/29/24 indicated the nurses did not document monitoring of side effects of the antianxiety medication or antipsychotic medication daily with medication administration. During an observation on 04/29/24 at 08:53 a.m., Resident #415 was sitting up in a recliner. She said she was treated great and received needed care. During an interview on 04/30/24 at 02:07 p.m., LVN R said she provided care for Resident #415 today. LVN F said she proved care for Resident #415 on 04/26/24 and was currently taking over care for Resident #415 for today. LVN R and F said were educated on monitoring for side effects of antipsychotic medication. They said Resident #415 should have been monitored for side effects but was not. LVN F said as nurses they were aware and monitored antipsychotic medication for side effects it was just not documented correctly. They said the nurse admitting the resident was responsible for adding monitoring into the computer system and the DON and ADON double checked for monitoring. LVN F said she admitted Resident #415 and was responsible and started the orders but did not complete them. She said she was aware as a nurse to monitor the meds for side effects but if you did not document it, you did not do it. LVN F said the risk was the potential side effects were not being documented properly but no risk to residents. LVN R said the medication should have been documented in the system but was missed. During an interview on 04/30/24 at 02:39 p.m., the DON said the admission nurse started the medication orders and monitoring of medication in the computer system and the IDT double checked medication for monitoring. She said Resident #415 should have been monitored for the antipsychotic medications Abilify, buspirone and quetiapine fumarate but was not. The DON said the nurses were educated through annual check offs on medication administration on 04/12/24. She said the monitoring was overlooked. She said the risk of antipsychotic medication not monitored was potential adverse reactions and side effects. The DON said her expectation was all medication to be given as ordered and monitored for side effects as required. During an interview on 04/30/24 at 03:41 p.m., the Administrator said her expectation was all physician orders followed as ordered and all medication be monitored for side effects as required. She said the risk of antipsychotic medication not monitored was potential side effects. Record review of the facility's policy, revised July 2022, titled, Antipsychotic Medication Use indicated: . Antipsychotic medication will be prescribed at the lowest possible dosage for the shortest period of time and are subject to gradual dose reduction and re-review. 18. Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medication to the attending physician: a general / anticholinergic: constipation, blurred vision, dry mouth, urinary retention, sedation, .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32217 Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5 percent. There were 2 errors out of 25 opportunities which resulted in an 8 percent error rate involving Residents' #58 and #92. LVN O administered Resident #58's midodrine HCL 5 mg (a medication used to treat low blood pressure) when the blood pressure was outside the prescribed parameters. LVN P administered Resident #92's clopidogrel 75 mg (a medication used to thin blood and prevent clotting) over 3 hours past the administration time frame listed on the medication administration record, according to the facility's policy that medications are scheduled according to the routine schedule of 7am. This failure could place residents at risk of not receiving the therapeutic benefits of their medications as ordered. Findings included: ERROR #1 Physician orders dated April 2024 indicated Resident #58, admitted [DATE] was [AGE] years old with a diagnosis of high blood pressure. Physician orders indicated Resident #58 was to receive midodrine HCl tablet 5 mg. Give 1 tablet by mouth three times a day for hypotension (low blood pressure). Hold if SBP (systolic blood pressure - first number in a blood pressure reading) is greater than 100. During an observation of the medication pass on 04/30/24 at 7:48 a.m., LVN O administered Resident #58's midodrine HCL 5 mg. Resident #58's blood pressure was 127/47. During an interview and record review on 04/30/24 at 1:54 p.m., LVN O said she should have held Resident #58's midodrine due to prescribed parameters. She said she had misread the parameter and thought it was diastolic greater than 100 held instead of systolic. She said she should have held Resident #58's morning dose of midodrine medication. She said she was educated in medication administration and was aware of following prescribed parameters. She said she was responsible for giving the medication incorrectly. She said the risk for Resident #58 was hypertension. During an interview on 04/30/24 at 2:31 p.m., the DON said Resident #58's midodrine should have been held when blood pressure was outside the prescribed parameters. During an interview on 4/30/24 at 3:40 p.m., the administrator said the charge nurse was responsible for following physician orders administrating medication to the residents. She said her expectation was for physician orders to be followed and all medication to be given within parameters. She said the risk was that blood pressure could be lowered if medication was given out of parameters. ERROR #2 (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician orders dated April 2024 indicated Resident #92, admitted [DATE], was [AGE] years old with a diagnosis of coronary artery disease. Physician orders included clopidogrel bisulfate 75 mg daily as an anticoagulant. (Used to thin blood and prevent clotting). During an observation of the medication pass on 04/30/24 at 10:55 a.m., LVN P administered clopidogrel bisulfate 75 mg tablet to Resident #92 over 3 hours past the designated administration time of 7:00 a.m. During an interview on 04/30/24 at 12:25 p.m., LVN P said Resident #92 was administered clopidogrel bisulfate 75 mg tablet at 10:55 a.m. instead of the designated administration time of 7:00 a.m. She said we have 1 hour before and 1 hour after to give meds. She said she was just running late. She gave no reason. During an interview on 04/30/24 at 1:00 p.m., the DON said her expectation was for medications to be given as ordered and in a timely manner. If medications were not given as ordered the nurses should notify the physician and herself. She said we have an hour before and after the medication is due to administer medications. She said none of the nurses had reported to her of medications being late. A policy titled Administering Medications dated April 2019 indicated the following. 4. Medications are administered in accordance with prescriber orders. A policy titled Medication Administration Schedule dated November 2020 indicated the following. Medications are administered according to established schedules. 1. Medications are administered according to the following routine schedule.daily.7 a.m. 3.Scheduled medications are administered within one hour of their prescribed time, unless otherwise specified.

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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. 25779 Based on observation, interview and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety for 1 of 3 dining rooms and 1 of 1 kitchen reviewed for sanitation. (Main dining room) The facility failed to ensure an air conditioner return air vent in the dining room was free of dust particles. The facility did not ensure kitchen equipment was sanitary and in good repair. This failure could place the residents at risk of food borne illnesses. Findings included: 1. During observations of the noon meal in the main dining room on 4/29/24 at 12:00 p.m., an AC return air vent, approximately 8 ft high by 4 foot wide, had dust approximately 1/4 thick on each slat of the vent. Air was blowing through the vent slats. Approximately 20 residents were sitting in the dining room eating lunch. During an interview on 4/29/24 at 12:02 p.m., the DM said the air conditioner return air vent had thick dust and needed to be cleaned. She said maintenance was supposed to clean it. She stated the dust is thick and nasty. During an interview on 4/29/24 at 12:07 p.m., the administrator said the return air vent was filthy and needed to be cleaned. She said it was housekeeping's responsibility to keep it clean. She said her expectations were for housekeeping to keep the air vents clean. She said the negative outcome would be the dust particles could get in the residents' food. During an interview on 4/29/24 at 12:09 p.m., the HS said she was responsible for making sure the air conditioner return air vents were cleaned. She said the return air vent in the dining room had thick dust and needed to be cleaned. She said the possible negative outcome would be the dust could get in the resident's food and they could ingest it. 2. During observations of the kitchen on 4/29/24 at 8:47 a.m., the three-compartment sink's metal pipe frame was rusted, had chipped paint, was oxidized and corroded. A metal plate to the back inside of the left sink was rusted and the plate was hanging from a rusted opening that was approximately 4 inches in width. The paint on the wall behind the left sink had peeled and was hanging from the wet surface of the wall. There was an approximate 5 inch by 1 inch area of a brown/black substance in the crease between the wall and the floor to the left of the three-compartment sink. The floor had a small, pooled area of standing water under the left sink. During an observation on 4/29/24 at 8:49 a.m., two slender refrigerators next to the box freezer had multiple lines of rust down the doors from the top of the refrigerators to the bottom. (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During observations and interview on 4/29/24 at 8:57 a.m., the underside of 2 metal shelves that hung on the wall over the juice machine had multiple areas of rust on the surface. The DM said the shelves were rusted and were not sanitizable. During observation and interview on 4/29/24 at 9:00 a.m., the double oven had a thick black substance on the interior walls, on the metal racks and on the base/floor of the oven. The DM said the oven was not used and had not worked since she started working at the facility about a year ago. The DM said the double oven did have thick build up and needed to be cleaned and repaired. During observations and interview on 04/30/24 at 10:38 a.m., the seven water wells of the steam table had rust in the bottom of the pans and a thick brown build up on the sides of the pans. The base shelf and legs of the steam table had knicks in the paint and the metal was oxidized. The dietary manager said the pans were rusted and were not sanitizable. She said the water well pans had been like that for at least a year that she knew of. She said the pans needed to be replaced. She said the base of the steam table and the legs were not sanitizable. She said the water wells and steam table needed to be replaced. During observation and interview on 5/01/24 at 8:34 a.m., the dietary manager observed the three-compartment sink, the double oven, the 2 refrigerators, the 2 shelves, the water wells and the base of steam table with the surveyor. She said the kitchen equipment was not sanitizable and the negative outcome was the rust could get in the resident's food. During observations of the three-compartment sink and interview on 05/01/24 at 11:10 a.m., the dietary manager said the left sink leaked water onto the back wall because the metal plate inside of the sink had rusted through. The left sink of the three-compartment sink was filled with water. The water line was even with the rusted hole where the rusted round metal plate that was not attached on the inside back wall of the sink. The underside of each sink of the three-compartment sink had large areas of thick rust. The wall behind the left three-compartment sink had areas of peeled paint hanging from the wet surface of the wall. There was an approximate 5 inch by 1 inch area of a brown/black substance in the crease between the wall and the floor to the left of the three-compartment sink. The floor had a small, pooled area of standing water under the left sink. The DM said the public health department had come out a few months ago and told the facility then, that the three-compartment sink needed to be replaced. She said the three-compartment sink was not santizable and needed to be replaced. During observations of the kitchen equipment and interview on 5/1/24 at 11:22 p.m., the dietitian said the three-compartment sink, the 2 shelves, the 2 refrigerators, the water wells, the base of the steam table, and the three-compartment sink were rusted, oxidized and unsanitizable. She said corporate office was aware of the concerns of the rusted kitchen equipment but had not fixed them at this time. She said the equipment should be in working condition and be sanitizable. She said the negative outcome would be the equipment would not be sanitizable and the residents could ingest the rust particles. During an interview on 05/01/24 at 11:16 a.m. the Administrator said her expectations were for the kitchen equipment to be fixed, in working order, sanitizable and to not contain rust. She said the possible negative outcome of the kitchen equipment surfaces being chipped, oxidized and containing rust would be the surfaces would not be sanitizable and the residents could ingest food containing rust particles. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the Public Health Food Inspection Report dated 2/29/24 indicated: . Observed a kitchen shelf in disrepair, chipping, worn. Record review of the Environment policy dated 01/2021 indicated: Policy Statement- All food preparation areas, food service areas and dining areas will be maintained in a clean and sanitary condition. Record review of the Equipment policy dated 01/2001 indicated: Policy Statement- All food service equipment will be clean, sanitary and in proper working order.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 25779 Based on observation, interview, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition for 1 of 1 kitchen reviewed for essential equipment. The facility did not ensure the gas stove and the convection ovens were in safe operating condition. This failure could place the residents at risk of a fire and not receiving their meals timely. Findings included: During observation and interview on 4/29/24 at 9:00 a.m., the double oven had a thick black substance on the interior walls, on the metal racks and on the base/floor of the oven. The DM said the oven was not used and had not worked since she started working at the facility about a year ago. The DM said the oven needed to be repaired. She said there was not an open work order for repair of the oven. During observation and interview on 4/30/24 at 10:45 a.m., the left and right sides of oven were not hot and there was no food in the oven. The DM said the oven did not work, the single gas convection oven did not work and the bottom half of the double convection oven did not work, so they only had the top of the double convection oven for use in cooking the resident's food. She said if one cook had to bake a dessert and another cook had to bake food, they would have to wait on each other because all they had to use to cook the food was the top section of the double convection oven. She said she had worked at the facility for almost a year and the double oven, the single gas convection oven and the bottom section of the double convection oven had been broken since she started. During an interview on 5/01/24 at 8:34 a.m., the dietary manager said the double oven was broke and should be in working order. She said the single gas convection oven and the double convection oven were broke and needed to be fixed. She said the possible negative outcome would be the residents may not receive their meals on time. She said her expectations were for the kitchen equipment to be in working order. During an interview on 05/01/24 at 11:16 a.m., the Administrator said her expectations were for the kitchen equipment to be fixed, in working order, be able to be sanitized sanitizable and to not contain rust. She said the negative outcome of the kitchen equipment not working could be a delay in meal service. Record review of the Equipment policy dated 01/2001 indicated: Policy Statement- All food service equipment will be clean, sanitary and in proper working order. According to the FDA Food Code 2022 accessed at https://www.fda.gov/food/retail-food-protection/fda-food-code 4-5 Maintenance and Operation 4-501 Equipment 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 30664 Based on interview and record review, the facility failed to ensure employees received the required training effective communications mandatory training was completed for 6 of 21 employees (LVN F, ST, PT, CNA K, CNA M, and the HS) reviewed for training. The facility did not ensure effective communication training was completed by LVN F, ST, PT, CNA K, and CNA M during orientation. The facility did not ensure effective communication training was completed by the HS annually. These failures could place residents at risk of miscommunication and social isolation due to lack of staff training. Findings included: Record review of the employee files and trainings indicated: * LVN F, hire date 02/29/24, had not completed a communication training during orientation; * ST, hire date 04/18/24, had not completed a communication training during orientation; * PT, hire date 05/23/23, had not completed a communication training during orientation; * CNA K, hire date 04/23/24, had not completed a communication training during orientation; * CNA M, hire date 04/23/24, had not completed a communication training during orientation; and * HS, hire date 05/16/18, last completed a communication training on 03/21/23. During an interview on 05/01/24 at 11:16 a.m. the DON indicated she expected nursing staff to have all of the trainings during orientation and for them to have their annual trainings as required. She indicated all trainings were done in the computer except for the skills competencies she conducted on CNAs and LVNs upon hire. She indicated staff not having the trainings as required could cause residents not to receive the care needed. During an interview on 05/01/24 at 01:08 p.m. the Administrator indicated she expected all trainings required during orientation to be done during orientation. She indicated she also expected trainings to be done annually as required. She indicated ultimately, she was responsible to ensure staff completed their trainings. She indicated staff not completing the trainings could cause residents not to receive the care required. During an interview on 05/01/24 at 01:32 p.m. the HR indicated there was an issue in the computer-based trainings and it did not triggered the required trainings for staff for orientation and annually. (continued on next page)

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a Training Programs policy dated October 2021 indicated Purpose: To ensure employees are provided the necessary training to perform their job at a high level while meeting state and federal regulations regarding annual training and in-servicing. Policy: Upon hire, and on an ongoing basis, employees will be provided the appropriate training to include state and federally mandated training information and topics. The Director of Staff Development along with the HR Director will be responsible for ensuring the appropriate training needs of staff are met.

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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 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 30664 Based on interview and record review, the facility failed to ensure the rights of the resident and responsibilities of the facility were completed for 3 of 21 employees (OT, CNA M, and HS) reviewed for training. The facility failed to ensure the rights of the resident and responsibilities of the facility training was completed by OT and CNA M during orientation. The facility failed to ensure the rights of the resident and responsibilities of the facility training was completed by HS annually. These failures could affect residents and place them at risk of being uninformed due to lack of staff training. Findings include: Record review of the employee files and trainings indicated: * OT, hire date 09/28/23, had not completed rights of the resident and responsibilities of the facility training during orientation; * CNA M, hire date 04/23/24, had not completed rights of the resident and responsibilities of the facility training during orientation; and * HS, hire date 05/16/18, last completed rights of the resident and responsibilities of the facility training on 03/23/23. During an interview on 05/01/24 at 11:16 a.m. the DON indicated she expected nursing staff to have all of the trainings during orientation and for them to have their annual trainings as required. She indicated staff not having the trainings as required could cause residents not to receive the care needed. During an interview on 05/01/24 at 01:08 p.m. the Administrator indicated she expected all trainings required during orientation to be done during orientation. She indicated she also expected trainings to be done annually as required. She indicated ultimately, she was responsible to ensure staff completed their trainings. She indicated staff not completing the trainings could cause residents not to receive the care required. During an interview on 05/01/24 at 01:32 p.m. the HR indicated there was an issue in the computer-based trainings and it did not triggered the required trainings for staff for orientation and annually. (continued on next page)

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a Training Programs policy dated October 2021 indicated Purpose: To ensure employees are provided the necessary training to perform their job at a high level while meeting state and federal regulations regarding annual training and in-servicing. Policy: Upon hire, and on an ongoing basis, employees will be provided the appropriate training to include state and federally mandated training information and topics. The Director of Staff Development along with the HR Director will be responsible for ensuring the appropriate training needs of staff are met.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 30664 Based on interview and record review, the facility failed to ensure employees received the required training on Abuse, Neglect, and Exploitation (ANE) for 2 of 15 (OT and HS) and dementia management for 2 of 15 employees (OT and LVN C) reviewed for training. The facility did not ensure dementia management training was completed by the OT and LVN C during orientation. The facility did not ensure ANE training was completed by the OT during orientation. The facility did not ensure ANE training was completed by the HS annually. This failure could place residents with dementia at risk of abuse, neglect, and exploitation and a poor quality of care by staff with inadequate training when caring for dementia residents. Findings included: Record review of the employee files indicated: * LVN C, hire date 07/12/23, had not completed dementia management training during orientation; * OT, hire date 09/28/23, had not completed ANE and dementia management training during orientation ; and * HS, hire date 05/16/18, last completed ANE training on 03/23/23. During an interview on 05/01/24 at 11:16 a.m. the DON indicated she expected nursing staff to have all of the trainings during orientation and for them to have their annual trainings as required. She indicated staff not having the trainings as required could cause residents not to receive the care needed. During an interview on 05/01/24 at 01:08 p.m. the Administrator indicated she expected all trainings required during orientation to be done during orientation. She indicated she also expected trainings to be done annually as required. She indicated ultimately, she was responsible to ensure staff completed their trainings. She indicated staff not completing the trainings could cause residents not to receive the care required. During an interview on 05/01/24 at 01:32 p.m. the HR indicated there was an issue in the computer-based trainings and it did not triggered the required trainings for staff for orientation and annually. (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a Training Programs policy dated October 2021 indicated Purpose: To ensure employees are provided the necessary training to perform their job at a high level while meeting state and federal regulations regarding annual training and in-servicing. Policy: Upon hire, and on an ongoing basis, employees will be provided the appropriate training to include state and federally mandated training information and topics. The Director of Staff Development along with the HR Director will be responsible for ensuring the appropriate training needs of staff are met.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 30664 Based on interview and record review, the facility failed to ensure Quality Assurance and Performance Improvement (QAPI) training that outlines and informs staff of the elements and goals of the facility's QAPI program was completed for 15 of 21 employees (Administrator, BOM, DON, ST, PT, SW, AD, LVN C, LVN D, LVN F, CNA G, CNA H, CNA J, CNA K, CNA L and CNA M) reviewed for training. The facility did not ensure QAPI training was completed by the Administrator, BOM, DON, ST, PT, SW, AD, LVN C, LVN D, LVN F, CNA G, CNA H, CNA J, CNA K, CNA L and CNA M. This failure could place staff and residents at risk for not being aware of facility programs, implementation, and monitoring. Findings included: Record review of employee files indicated QAPI training was not done for the following staff: * Administrator, hire date 01/17/23, * BOM, hire date 03/18/24, * DON, hire date 08/02/22, * PT, hire date 05/25/23, * ST, hire date 04/18/24, * SW, hire date 02/29/24, * AD, hire date 12/21/20, * LVN C, hire date 07/12/23, * LVN D, hire date 10/26/23, * LVN F, hire date 02/29/24, * CNA G, hire date 02/03/23, * CNA H, hire date 08/03/22, * CNA J, hire date 05/25/22, * CNA K, hire date 04/23/24, (continued on next page)

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* CNA L, hire date 02/01/24, and * CNA M, hire date 12/07/23. During an interview on 05/01/24 at 11:16 a.m. the DON indicated she expected nursing staff to have all of the trainings during orientation and for them to have their annual trainings as required. She indicated all trainings were done in the computer except for the QAPI training she had done in January 2024. She indicated staff not having the trainings as required could cause residents not to receive the care needed. During an interview on 05/01/24 at 01:08 p.m. the Administrator indicated she expected all trainings required during orientation to be done during orientation. She indicated she also expected trainings to be done annually as required. She indicated ultimately, she was responsible to ensure staff completed their trainings. She indicated staff not completing the trainings could cause residents not to receive the care required. During an interview on 05/01/24 at 01:32 p.m. the HR indicated there was an issue in the computer-based trainings and it did not trigger the required trainings for staff for orientation and annually. Record review of a Training Programs policy dated October 2021 indicated Purpose: To ensure employees are provided the necessary training to perform their job at a high level while meeting state and federal regulations regarding annual training and in-servicing. Policy: Upon hire, and on an ongoing basis, employees will be provided the appropriate training to include state and federally mandated training information and topics. The Director of Staff Development along with the HR Director will be responsible for ensuring the appropriate training needs of staff are met.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood of Beaumont	4195 Milam St Beaumont, TX 77707

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 33460 Based on interview and record review, the facility failed to ensure standards, policies, and procedures for an infection prevention and control program was completed for 4 of 21 staff (LVN C, OT, HS, and CNA M) reviewed for training. The facility did not ensure infection prevention and control training was completed by the OT, CNA M, and LVN C during orientation. The facility did not ensure infection prevention and control training was completed by the HS annually. These failures could place residents at risk of illness due to lack of staff training. Findings included: Record review of employee files indicated: * OT, hire date 09/28/23, had not completed infection prevention and control training during orientation; * LVN C, hire date 07/12/23, had not completed infection prevention and control training during orientation; * CNA M, hire date 04/23/24, had not completed infection prevention and control training during orientation; and * HS, hire date 05/16/18, last completed infection prevention and control training on 03/31/23. During an interview on 05/01/24 at 11:16 a.m., the DON indicated she expected nursing staff to have all of the trainings during orientation and for them to have their annual trainings as required. She indicated staff not having the trainings as required could cause residents not to receive the care needed. During an interview on 05/01/24 at 01:08 p.m., the Administrator indicated she expected all trainings required during orientation to be done during orientation. She indicated she also expected trainings to be done annually as required. She indicated ultimately, she was responsible to ensure staff completed their trainings. She indicated staff not completing the trainings could cause residents not to receive the care required. During an interview on 05/01/24 at 01:32 p.m. the HR indicated there was an issue in the computer-based trainings and it did not trigger the required trainings for staff for orientation and annually. (continued on next page)

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a Training Programs policy dated October 2021 indicated Purpose: To ensure employees are provided the necessary training to perform their job at a high level while meeting state and federal regulations regarding annual training and in-servicing. Policy: Upon hire, and on an ongoing basis, employees will be provided the appropriate training to include state and federally mandated training information and topics. The Director of Staff Development along with the HR Director will be responsible for ensuring the appropriate training needs of staff are met.

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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 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide training in compliance and ethics. 30664 Based on interview and record review, the facility failed to ensure compliance and ethics training was completed for 21 of 21 employees (Administrator, BOM, DON, ADON, ST, OT, PT, SW LVN D, LVN E, LVN F, CNA G, CNA H, CNA J, CNA K, CNA L, and CNA M) reviewed for training. The facility did not ensure compliance and ethics training was completed for the BOM, ADON, LVN C, LVN D, LVN F, ST, OT, PT, SW, MD, CNA K, CNA L, and CNA M during orientation. The facility did not ensure compliance and ethics training was completed by the Administrator, DON, LVN E, AD, HS, CNA G, CNA H, and CNA J annually since the company had a total of 6 facilities. This failure could affect residents and place them at risk of poor care or victimization due to lack of staff training. Findings included: Record review of employee files indicated the following staff had not completed compliance and ethics training during orientation: * BOM, hire date 03/18/24, * ADON, hire date 10/02/23, * LVN C, hire date 07/12/23, * LVN D, hire date 10/26/23, * LVN F, hire date 02/29/24, * ST, hire date 04/18/24, * OT, hire date 09/28/23, * PT, hire date 05/25/23, * SW, hire date 02/29/24, * MD, hire date 08/28/23, * CNA K, hire date 04/23/24, * CNA L, hire date 02/01/24, and * CNA M, hire date 12/07/23. (continued on next page)

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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 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of employee files indicated the following staff had not completed compliance and ethics training annually: * Administrator, hire date 01/17/23, * DON, hire date 08/02/22, * LVN E, hire date 03/01/15, * AD, hire date 12/21/20, * HS, hire date 05/16/18, * CNA G, hire date 02/03/23, * CNA H, hire date 08/03/22,and * CNA J, hire date 05/25/22. During an interview on 05/01/24 at 11:16 a.m., the DON indicated she expected nursing staff to have all of the trainings during orientation and for them to have their annual trainings as required. She indicated staff not having the trainings as required could cause residents not to receive the care needed. During an interview on 05/01/24 at 01:08 p.m., the Administrator indicated she expected all trainings required during orientation to be done during orientation. She indicated she also expected trainings to be done annually as required. She indicated ultimately, she was responsible to ensure staff completed their trainings. She indicated staff not completing the trainings could cause residents not to receive the care required. During an interview on 05/01/24 at 01:32 p.m., HR indicated there was an issue in the computer-based trainings and it did not trigger the required trainings for staff for orientation and annually. Record review of a Training Programs policy dated October 2021 indicated Purpose: To ensure employees are provided the necessary training to perform their job at a high level while meeting state and federal regulations regarding annual training and in-servicing. Policy: Upon hire, and on an ongoing basis, employees will be provided the appropriate training to include state and federally mandated training information and topics. The Director of Staff Development along with the HR Director will be responsible for ensuring the appropriate training needs of staff are met.

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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. 30664 Based on interview and record review, the facility failed to ensure CNAcans completed Abuse, Neglect, and Exploitation (ANE) and dementia management trainings for 1 of 6 CNAs (CNA M) revicanewedreviewed for training. The facility did not ensure ANE and dementia management trainings were completed by CNA M during orientation. This failure could place residents with dementia at risk of abuse, neglect, and exploitation and a poor quality of care by staff with inadequate trainincang when caring for dementia residents. Findings included: Record review of employee files indicated: * CNA M, hire date 12/07/23, had not completed ANE and dementia management trainings during orientation. Record review of a Training Programs policy dated October 2021 indicated Purpose: To ensure employees are provided the necessary training to perform their job at a high level while meeting state and federal regulations regarding annual training and in-servicing. Policy: Upon hire, and on an ongoing basis, employees will be provided the appropriate training to include state and federally mandated training information and topics. The Director of Staff Development along with the HR Director will be responsible for ensuring the appropriate training needs of staff are met. During an interview on 05/01/24 at 11:16 a.m., the DON indicated she expected nursing staff to have all of the trainings during orientation and for them to have their annual trainings as required. She indicated staff not having the trainings as required could cause residents not to receive the care needed. During an interview on 05/01/24 at 1:08 p.m., the Administrator indicated she expected all trainings required during orientation to be done during orientation. She indicated she also expected trainings to be done annually as required. She indicated ultimately, she was responsible to ensure staff completed their trainings. She indicated staff not completing the trainings could cause residents not to receive the care required. During an interview on 05/01/24 at 1:32 p.m. HR indicated there was an issue in the computer-based trainings and it did not trigger the required trainings for staff for orientation and annually. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a Training Programs policy dated October 2021 indicated Purpose: To ensure employees are provided the necessary training to perform their job at a high level while meeting state and federal regulations regarding annual training and in-servicing. Policy: Upon hire, and on an ongoing basis, employees will be provided the appropriate training to include state and federally mandated training information and topics. The Director of Staff Development along with the HR Director will be responsible for ensuring the appropriate training needs of staff are met.

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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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 30664 Based on interview and record review, the facility failed to ensure training on behavioral health was completed for 4 of 21 employees (Administrator, OT, LVN C, and CNA M) reviewed for training. The facility did not ensure behavioral health training was completed by the OT, LVN C, and CNA M during orientation. The facility did not ensure behavioral health training was completed by the Administrator annually. This failure could place residents with behaviors at risk of not receiving care to attain or maintain their highest practicable physical, mental, and psychosocial well-being due to lack of staff training. Findings included: Record review of employee files indicated: * OT, hire date 09/28/23, had not completed behavioral health training during orientation,; * LVN C, hire date 07/12/23, had not completed behavioral health training during orientation,; * CNA M, hire date 12/07/23, had not completed behavioral health training during orientation,; and * Administrator, hire date 01/17/23, last completed behavioral health training on 01/24/23. Record review of a Training Programs policy dated October 2021 indicated Purpose: To ensure employees are provided the necessary training to perform their job at a high level while meeting state and federal regulations regarding annual training and in-servicing. Policy: Upon hire, and on an ongoing basis, employees will be provided the appropriate training to include state and federally mandated training information and topics. The Director of Staff Development along with the HR Director will be responsible for ensuring the appropriate training needs of staff are met. During an interview on 05/01/24 at 11:16 a.m., the DON indicated she expected nursing staff to have all of the trainings during orientation and for them to have their annual trainings as required. She indicated staff not having the trainings as required could cause residents not to receive the care needed. During an interview on 05/01/24 at 01:08 p.m., the Administrator indicated she expected all trainings required during orientation to be done during orientation. She indicated she also expected trainings to be done annually as required including herself. She indicated ultimately, she was responsible to ensure staff completed their trainings. She indicated staff not completing the trainings could cause residents not to receive the care required. (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/01/24 at 01:32 p.m., the HR indicated there was an issue in the computer-based trainings and it did not trigger the required trainings for staff for orientation and annually. Record review of a Training Programs policy dated October 2021 indicated Purpose: To ensure employees are provided the necessary training to perform their job at a high level while meeting state and federal regulations regarding annual training and in-servicing. Policy: Upon hire, and on an ongoing basis, employees will be provided the appropriate training to include state and federally mandated training information and topics. The Director of Staff Development along with the HR Director will be responsible for ensuring the appropriate training needs of staff are met.