STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475058	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menig Nursing Home	215 Tom Wicker Lane Randolph Center, VT 05061

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40258 Based on observation and interview, the facility failed to ensure each resident has a right to self-determination and access to persons and services outside of the facility, by locking all doors to the facility 24 hours a day, 7 days a week. By creating a locked facility, there is a failure to ensure the right of each resident to exercise their rights as a citizen (or resident) of the United States or make personal choices about going outside without interference. This has the potential to affect all residents of the facility and all visitors, including family, legal representatives and advocates. Per observation on 7/22/24 at approximately 10:00 AM at the entrance to the building, the main front entrance doors within the foyer were locked. A staff member approached the inside doors to the foyer, using a badge they placed over the censor, they opened the doors for the survey team to enter. Throughout the survey from 7/22-7/25/24, in order to enter the building, visitors were observed using a doorbell to alert staff they were in the foyer, and then a staff member would arrive to unlock the door. Visitors also needed to seek out staff to let them leave the facility when their visit was over. Per interview with Resident #1 on 7/22/24 at 2:36 PM visitors are only allowed 10:00 AM -7:00 PM. Per interview with Resident #24's family member on 7/22/24 at 3:48 PM visitors are asked not to come between noon and 1:00 pm because staff are busy helping others with their meals and can't stop to let visitors in and out. Sometimes it is difficult because visiting hours end at 7:00 PM. A Resident Council meeting with the survey team occurred on 7/23/2024 at approximately 2:00 PM, there were 5 attendees, Residents #4 stated at first when I learned the doors were locked, I felt like I was in jail, now I understand it has to be that way so the people that get confused don't get out. Resident #13 stated that s/he would have visitors later if able to. Resident #13 then asked what time do visitors have to leave, what is the curfew? Per review of the facility policy and procedure effective 5/6/2024 titled: Secure Entry and Visitation Rights at [NAME], under Safety Procedure: 1. All doors are Secured Access doors- allowing direct access to only for those with a [NAME] (ownership entity) badge with security access. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475058	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menig Nursing Home	215 Tom Wicker Lane Randolph Center, VT 05061

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. All other people are classified as visitors (resident family friends) will ring one of the doorbells to alert staff they are at one of the doorways. a. A staff member will provide for entry for the visitor, by either walking them to the door or providing entry or using the release option from the team stations. b. When the visitor is ready to leave a staff person will provide door release by the same method as entry. The facility policy effective 3/17/2023 titled: Security Program, under section E Locking/Unlocking Of Exterior Doors #7 states Mening Nursing Home is locked 24/7/365 with badge access only. Per interview on 7/25/24 at 2:18 PM the facility Administrator and the VP of Quality and Compliance Officer confirmed that the facility doors are kept locked 24 hours per day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475058	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menig Nursing Home	215 Tom Wicker Lane Randolph Center, VT 05061

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40258 Based on observation, interview, and record review the facility failed to ensure Residents' rights were maintained by not allowing unrestricted visitation based on resident choice. This has the potential to affect all residents of the facility and all visitors, including family, legal representatives and advocates. Per interview with Resident #1 on 7/22/24 at 2:36 PM visitors are only allowed 10:00 AM -7:00 PM. Per interview with a Resident's family member on 7/22/24 at 3:48 PM they are asked not to visit between noon and 1:00 pm because staff are busy helping others with their meals and can't stop to let visitors in and out. Sometimes it is difficult because visiting hours end at 7:00 PM. While exiting the facility on 7/22/24 at 4:12 PM a sign with visiting hours was observed posted between the two entrances. Per visitation posting visiting hours consist of 2 hours before lunch, 4 hours between lunch and dinner, then one hour after dinner. This would be a total of 7 available hours throughout the day to visit. The posting was dated March 25, 2024 and read; Visitation at [NAME] Nursing Home * Visitation is welcomed Monday through Sunday: 10:00 AM - 7:00 PM with the exception of meal times: Lunch 12:00 - 1:00PM Supper 5:00 PM- 6:00 PM * If you are not feeling well, please do not visit. Per review of the facility policy and procedure effective 5/6/2024 titled: Secure Entry and Visitation Rights at [NAME], under Safety Procedure: 1. All doors are Secured Access doors- allowing direct access to only for those with a [NAME] (ownership entity) badge with security access. 2. All other people are classified as visitors (resident family friends) will ring one of the doorbells to alert staff they are at one of the doorways. a. A staff member will provide for entry for the visitor, by either walking them to the door or providing entry or using the release option from the team stations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475058	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menig Nursing Home	215 Tom Wicker Lane Randolph Center, VT 05061

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. When the visitor is ready to leave a staff person will provide door release by the same method as entry. The section Visitation: Visiting hours are as posted in the nursing home with accommodations made as needed. Per interview on 7/25/24 at 2:18 PM with the facility Administrator and Quality and Compliance Officer, there are preferred visiting hours and it has been communicated to Residents and their families that if needed, accommodations can be made. The Administrator confirmed that there are posted visiting hours to include not visiting during mealtimes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475058	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menig Nursing Home	215 Tom Wicker Lane Randolph Center, VT 05061

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135 Based on interview, record review, and review of facility policy, the facility failed to complete a Significant Change in Status (SCSA) Minimum Data Assessment (MDS) for one of 17 sampled residents (Resident #15). Findings include: Per record review, Resident #15 has diagnoses that include: Alzheimer's dementia, recurring urinary tract infections, emphysema, and heart failure. Per review of Resident #15's quarterly assessment dated [DATE], s/he does not have behaviors of inattention, does not have physical behavioral symptoms not directed toward others, s/he does not have exhibit rejection of care, needs partial assistance for getting dressed, is independent in transferring, is always continent of bowels, and weighs 200 pounds. Review of Resident #15's weights reveal that s/he had both had both significant weight loss over the past 6 months of 11.57% when weighed at 188.8 pounds on 6/10/24 (from 202.2 pounds on 12/11/24) and significant weight loss over the past month of 8.06% when weighed at 180.2 pounds on 5/13/24 (from 196.0 pounds on 4/22/24). A 7/2/24 Dietician dietary progress note reveals that Resident #15 previously had diet restrictions related to previous weight gain but over the past quarter his/her appetite has decreased, has inconsistent meal intake, has refused meals, and has had significant weight loss. Because of the significant weight loss, the Dietician had recommended discontinuing any dietary restrictions as weight loss was a concern. Starting around 5/6/24 and increasing in frequency, nursing progress notes reveal an overall deterioration of Resident #15's condition by rejecting care including medications, meals, ADL (activities of daily living) care, and getting out of bed; s/he has an increase of aggressive behaviors, and is regularly incontinent of feces. Per review of Resident #15's MDS records, a SCSA was not completed until 7/4/24, which was approximately 6 weeks after a consistent pattern of change in weight and condition. Facility policy titled Criteria for Determining Significant Change in a Resident Condition, effective 3/5/19, reads, A significant change in Status MDS is required when: A resident experiences a consistent pattern of change, with either two or more areas of decline . The policy outlines areas of decline that meet a significant change include Unplanned weight loss problem (5% change in 30 days or 10% change in 180 days), and Overall deterioration of a resident's condition. Per interview on 7/25/24 at 10:57 AM, the Clinical Coordinator confirmed that Resident #15 had started to consistently refuse meals, medication, care, and have an increase in behaviors in May. S/He confirmed that both her decline and significant weight loss would qualify for a SCSA MDS to be completed at that time and stated that s/he didn't think about doing it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475058	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menig Nursing Home	215 Tom Wicker Lane Randolph Center, VT 05061

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135 Based on interview and record review, the facility failed to review and revise resident care plans for 3 residents related to falls (Residents #15, #20, and #21), for 1 resident related to refusal of care (Resident #15), and 1 resident related to nutrition (Resident #15) out of a sample of 17 residents. Findings include: 1. Per record review, Resident #15 has diagnoses that include: Alzheimer's dementia, recurring urinary tract infections, emphysema, and heart failure. Starting around 5/6/24 and increasing in frequency, nursing progress notes reveal an overall deterioration of Resident #15's condition by rejecting care including medications, meals, ADL care, and getting out of bed. A 7/2/24 Dietician dietary progress note reveals that Resident #15 previously had diet restrictions related to previous weight gain but over the past quarter his/her appetite has decreased, has inconsistent meal intake, has refused meals, and has had significant weight loss. Because of the significant weight loss, the Dietician had recommended discontinuing any dietary restrictions and recommended scheduling egg salad sandwich snacks because Resident #15 loves them. A 7/16/24 progress note reveals that Resident #15 fell while transferring to the bathroom. Per record review, Resident #15's care plan, updated 7/11/24, does not address the Dietician's recommendations above and continues to contain an intervention to restrict portions sizes because of weight gain. The care plan does not include revised interventions to address Resident #15's increased behaviors of refusing care including taking medications, eating meals, accepting ADL care, and not getting out of bed. Resident #15's care plan was not revised after his/her fall on 7/16/24. Per interview on 7/25/24 at 10:57 AM, the Clinical Coordinator confirmed that Resident #15's care plan was not revised to reflect his/her refusal of care and accurate information about weight loss and should have been. At 2:44 PM, the Clinical Coordinator confirmed that Resident #15's care plan was not revised with new interventions after their fall on 7/16/24. 2. Per record review, Resident #21's care plan reveals that s/he is at risk for falling because s/he has Alzheimer's disease and has no safety awareness. Per review of progress notes, Resident #21 experienced a fall on 1/7/24, 5/3/24, and 7/11/24. Per interview on 7/24/24 at 10:57 AM, the Clinical Coordinator confirmed that Resident #21's care plan was not updated after his/her fall on 1/7/24 or 7/8/24 fall and should have been. S/He said that interdisciplinary team only reviews initial care plan for falls and that the floor nurse should update their care plan with interventions after the fall. S/He explained that there is a check off sheet for staff to complete after a fall and it did not include reviewing and revising the care plan. A review of this check off sheet confirms that it does not include reviewing or revising the care plan. Per interview on 7/24/24 at approximately 2:15 PM, the Administrator stated that the facility did not have a fall prevention or management policy. 50336 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475058	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menig Nursing Home	215 Tom Wicker Lane Randolph Center, VT 05061

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3). Per observation on 07/22/2024 at 5:00 PM this surveyor observed Resident #20 as having yellow/green discoloration below the left eye, and on the bridge of his/her nose. Per interview Resident #20 stated that s/he had recently fallen out of his/her wheelchair and hit their face. Resident #20 stated you should have seen my nose after it happen, it hurt. Per record review Resident #20 was admitted to the facility on [DATE]. S/He began having falls at the facility on 10/15/2022. Resident #20 had a facility fall risk assessment documented in their medical record on 04/06/2024, 05/27/2024, and 07/10/2024 in which s/he was identified as a fall risk. The following Nurse's note written on 05/27/2024 regarding fall for Resident #20 stated Unwitnessed fall. [Resident#16] found on the floor face down with [his/her] w/c [wheelchair] tipped down partially on top of her with the foot rest still on. [S/he] was screaming and anxious, observed on the floor . Hematoma (bleeding under the skin that forms a bruise) on [his/her] forehead. Per chart review there is no documented evidence of fall care plan or revision for Resident #20 before or after actual falls. Per medical record Resident #20 experienced actual falls on 05/27/2024 and 06/30/2024. Per interview with the Clinical Coordinator (CC) on 07/24/2024 at 2:20 PM, s/he stated that Resident #20 is a fall risk and should have had a fall care plan in place. The CC also confirmed no current fall care plan for Resident #20. The CC stated the fall care plan had been active prior to 04/12/2024. Per further interview the CC stated the care plan was discontinued on 4/12/2024 and should not have been.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475058	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menig Nursing Home	215 Tom Wicker Lane Randolph Center, VT 05061

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46135 Based on observation, interview, and record review, the facility failed to ensure that resident environments were free of accident hazards related to safe handwashing water temperatures; the facility failed to ensure that each resident receives adequate supervision to maintain safety and prevent accidents for 4 of 17 sampled residents (Residents #20, #21, #22, #24, and #28); and the facility failed to develop policies that ensure that each resident receives adequate supervision to maintain safety and prevent accidents related to falls and elopement. Findings include: 1. Per observation on 7/22/24 at approximately 5:30 PM, the hot water was assessed from a faucet in an unlocked, common area bathroom, accessible to all residents. The water was too hot to hold a hand under comfortably, so a thermometer was used to take the temperature of the water. The highest reading was 124. 0 degrees Fahrenheit (F). The sample was then expanded to include other common areas sinks and resident rooms. The left hallway sink read 121.8 degrees F, a right hallway sink read 121.7 degrees F, a second common area bathroom read 121.1 degrees F, and Resident #4's bathroom sink read 123.4 degrees F. Water temperatures were taken by the Facility Maintenance Technician starting on 7/22/24 at 6:17 PM along with the surveyor. Temperatures for the common area bathroom sink read 124 degrees F by the facility thermometer,124 degrees F for the left hallway sink, and 126 degrees F in Resident #4's room. Interview with the Facility Maintenance Technician on 7/22/24 at 6:59 PM revealed that water temperatures are monitored in three places daily in the basement of the facility: on a computer reading of the system, the return temperature, and the sink in the basement. The facility did not provide any evidence that temperatures were monitored on the units. The Maintenance Technician explained that the reading from downstairs can be a few degrees different from the actual water temperatures upstairs. S/He explained that the water that evening read 119 degrees F in the basement following the identified concern on the units; it did not reflect the actual temperature taken moments before on the unit. Per the facility matrix dated 7/22/24, 19 of the 27 residents in the facility are identified as having dementia or Alzheimer's. On 7/23/24 at 10:14 AM a Registered Nurse reviewed the current census and indicated that 20 of the 27 residents in the facility could ambulate or self-propel in a wheelchair. A list provided by the Administrator on 7/25/24 indicated that 7 of the 27 residents in the facility had neuropathy (nerve damage). Cognitive impairment and the potential inability to feel pain due to nerve damage are conditions that put residents at increased risk for burns caused by scalding. Facility policy titled Water/Wastewater Distribution System, effective 1/17/17 reads The domestic hot water supplied to all areas of the hospital shall not exceed 120 degrees F. The procedure titled Procedure 126, sent in an email from the Director of Plant Operations and Facilities to the Administrator on 7/22/24 at 6:54 PM describes the process to monitor water temperatures in the building of hospital daily to assure that safe operating water temperatures are maintained between 105 and 120 degrees F. This procedure does not describe a process to monitor the nursing home facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475058	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menig Nursing Home	215 Tom Wicker Lane Randolph Center, VT 05061

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Per interview on 7/22/24 at approximately 7:05 PM, the Administrator was unable to produce evidence that water temperatures were monitored in resident accessible areas in the nursing home facility. S/He confirmed that the above policy and procedure is not specific to the nursing home facility. 40258 2. Per record review Resident #28 has diagnoses that include Alzheimer's disease and wanders throughout the facility. Review of Nursing Progress Notes from 3/4/2024 - 7/25/24 reveals that there were 78 entries that indicated Resident #28 was expressing behaviors such as wandering throughout the facility, wandering into other Resident's rooms, and exit seeking. On 12 of the 78 occasions documentation reflected that resident was exit seeking or focused on the exit door. A Wandering Assessment done on admission, 3/4/24, states that Resident #28 is not at risk for elopement. Another Wandering assessment dated [DATE], also states the Resident is not at risk of elopement. A care plan focus dated 6/19/24 indicates that Resident #28 moves about the unit: independently with supervision or touching assistance when s/he goes into areas that s/he should not be in, such as other's rooms. Per observations made throughout the survey Resident #28 was seen wandering throughout the facility including hall bathrooms, common areas, and other Resident's rooms unsupervised. On 7/22/24 at approximately 5:00 PM Resident #28 was observed wandering up the hall, s/he walked around the common area and then entered the restroom and shut the door. There were no staff members in the area. Per observation on 7/25/24 at 9:21 AM, Resident #28, who is ambulatory, and Resident #21, was sitting in a Geri-chair (padded recliner on wheels), were in the foyer and no staff were visible in any direction. Resident #28 was moving Resident #21's arms. Resident #21 began to yell. Resident #28 continued to touch Resident #21 and moved the Geri-chair a few feet. At 9:25 AM, the first staff member to be present in the foyer area was the Care Manager, 4 minutes after this initial observation of the above residents being unsupervised. At 9:26 AM the Care Manger explained that there are no staff assigned specifically to supervise the residents in the foyer. Per interview on 7/24/24 at approximately 2:15 PM, the Administrator stated that the facility did not have an elopement prevention policy or procedure. Per interview with the facility Administrator and the Clinical Coordinator on 7/24/24 at 2:44 PM, Resident #28 was not assessed as an elopement risk because s/he did not exit seek. When asked how the assessment differentiated no risk, low risk, and high risk the Administrator and Clinical Coordinator were unable to explain. 3. Per record review Resident #24 was admitted to the facility with diagnoses that include Alzheimer's disease. Per care plan Resident #24 is unable to go outside on their own for their safety because of memory loss. The care plan also reflects that the Resident requires 1 helper providing supervision or touching assist at times. Progress notes from 10/11/23 - 7/18/24 there were 45 entries that indicated that Resident # 24 was expressing behaviors such as wandering throughout the facility and wandering into other Resident's rooms. An Elopement Risk assessment dated [DATE] indicates that Resident #24 is a Total Risk Score of 7 and that s/he is not at risk for elopement. Elopement Risk Assessments were also initiated on 1/20/24 and 4/19/24 however, there is no Risk Score present. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475058	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menig Nursing Home	215 Tom Wicker Lane Randolph Center, VT 05061

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a phone interview on 7/25/24 at 12:56 PM the facility Medical Director stated that there is a very low risk for elopement from the facility because it is a locked facility. During interview on 7/24/24 at 2:50 PM the facility Administrator and the Clinical Coordinator confirmed that there were no Risk Scores identified on the 1/20/24 and 4/19/24 Elopement Risk Assessments. The Clinical Coordinator stated that the assessments had not been finished and therefor there was no score to identify if the Resident was at risk. 4. Per record review, Resident # 22 has a diagnosis of Alzheimer dementia and wanders through out the facility most of the day. An elopement risk assessment was done upon admission with a score of 9, assessing him/her with poor safety/environment awareness, impulsive behavior, disoriented at all times. The assessment listed the resident not at risk for elopement. However, on 7/23/2024 at approximately 5:15 PM, Resident #22 was observed in the main foyer trying to open every door. There were no staff visible. 50336 5) Per record review Resident #20 was admitted to the facility on [DATE] and began having falls on 10/15/2022. Facility fall risk assessment completed on 04/06/2024, 05/27/2024 and 07/10/2024 all identified Resident #20 as being a risk for fall. Per chart review there is no documented evidence of fall care plan or revision for Resident #20 before or after actual falls on 05/27/2024 and 06/30/2024. Per observation on 07/22/2024 at 5:00 PM this surveyor observed the Resident #20 as having yellow/green discoloration below the left eye, and on the bridge of his/her nose. Per interview Resident #20 stated that s/he had recently fallen out of his/her wheelchair and hit their face. Resident #20 stated you should have seen my nose after it happen, it hurt. The following Nurse's note written on 05/27/2024 regarding fall for Resident #20 stated Unwitnessed fall. [Resident#16] found on the floor face down with [his/her] w/c [wheelchair] tipped down partially on top of her with the foot rest still on. [S/he] was screaming and anxious, observed on the floor . Hematoma (bleeding under the skin that forms a bruise) on [his/her] forehead. Per chart review there is no documented evidence of fall care plan or revision for Resident #20 before or after actual falls. Per medical record Resident #20 experienced actual falls on 05/27/2024 and 06/30/2024. Per interview with the Clinical Coordinator (CC) on 07/24/2024 at 2:20 PM, S/he stated that Resident #20 had been identified as a fall risk and should have an active care plan and interventions to prevent falls. CC confirmed there was no active fall care plan for Resident #20. The CC further explained that interdisciplinary team only reviews initial care plan for falls and that the floor nurse should update their care plan with interventions after the fall. S/He explained that there is a check off sheet for staff to complete after a fall and it did not include reviewing and revising the care plan. A review of the post fall check off list, confirmed that it does not include reviewing or revising the care plan. Per interview on 7/24/24 at approximately 2:15 PM, the Administrator stated that the facility did not have a fall prevention or management policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475058	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menig Nursing Home	215 Tom Wicker Lane Randolph Center, VT 05061

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 46135 Based on interview and record review, the facility failed to monitor weights as care planned for 1 of 18 residents sampled (Resident #15) and the facility failed to develop policies that ensure that each resident receives adequate supervision to maintain nutrition status related to weight monitoring and weight loss. Findings include: Per record review, Resident #15 has diagnoses that include: Alzheimer's dementia, recurring urinary tract infections, emphysema, and heart failure. Resident #15's care plan, effective 11/3/23, and last reviewed on 7/11/24 has the following nutritional interventions: weigh weekly, chart weights weekly, and reweigh the next day if weight has changed by 3 pounds. The care plan does not address Resident #15's increased refusal to be weighed. Resident #15 has weights documented on the following days since 1/1/24: (1/1/24, 1/29/24, 2/12/24, 2/25/24, 3/4/24, 3/18/24, 3/25/24, 4/8/24, 4/22/24, 5/13/24, 5/31/24, 6/3/24, 6/10/24, 6/24/24, and 7/1/24). Of the 28 weeks from 1/1/24 through 7/22/24, Resident #15 was only weighed 15 times. There is no documentation that Resident #15 refused to be weighed or reattempts to weigh him/her were made for the 13 weeks they were not weighed from 1/1/24 through 7/22/24. Per interview on 7/24/24 at 10:57 AM, the Clinical Coordinator confirmed that Resident #15 frequently refused being weighed and that nursing staff did not document the refusals and should have.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475058	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menig Nursing Home	215 Tom Wicker Lane Randolph Center, VT 05061

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40258 Based on observation and staff interview the facility failed to store and prepare food in accordance with professional standards for food safety. Findings include: Per observations made during the initial kitchen tour on [DATE] at approximately 10:15 AM there was an open box of pasta, 2 tubs of cream cheese icing with expiration dates of [DATE], and 1 tub of chocolate fudge icing with expiration date of [DATE] on a food storage shelf. On the bottom shelf of another food storage shelf there was a cardboard box with a bag of lentils open and spilling out into the box. The dietary supervisor on shift during the tour confirmed that the icing was expired, and that the pasta and lentils were open. During observation on [DATE] at 11:15 AM of the kitchenette off the main dining room was a plate of uncovered deviled eggs that had been placed on the hand washing sink. There were no staff present at the time. At 11:20 a dietary aide entered the kitchenette and confirmed that the deviled eggs should have not been left on the sink and that they should have been covered. At 11:30 a Dietary Aide was observed bringing the plate of deviled eggs through the facility hall to the outside area that was set up for a resident and staff picnic. The Dietary Aide was interviewed at that time and confirmed that the deviled eggs should have been covered while on the sink and during transport through the facility. During an interview with the Food Service Manager on [DATE] at approximately 11:45 AM, s/he confirmed that the eggs should have been covered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475058	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menig Nursing Home	215 Tom Wicker Lane Randolph Center, VT 05061

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 46135 Based on record review and staff interview, the facility failed to address in their facility assessment what staff trainings and policies are necessary to provide the level and types of care needed for the population identified in the facility assessment. This deficient practice had the potential to affect all 27 residents residing in the facility. Findings include: 1. During a review of employee education records, the facility was unable to produce evidence of the following required regulatory training topics for 7 of 7 staff: communication, QAPI (quality assurance and performance improvement), compliance and ethics, and behavioral health; and was unable to produce evidence of 12 hours of required in-service for 4 of 4 nurse aides. See F 940, F 941, F 944, F 946, F 947, and F 949 for more information. A review of the facility assessment dated 2024 reveals that it does not include or address and evaluation for the facility's training program. 2. Per interview on 7/25/24 at 12:56 PM, the Medical Director explained that s/he was unaware that patient care policies did not exist for fall prevention and management, obtaining weights, weight loss prevention and management, and elopement prevention. See F841 for more information. A review of the facility assessment dated 2024 reveals that it does not address or include an evaluation of what policies and procedures required to provide care for their patient population. Per interview on 7/25/24 at 3:45 PM, the Administrator and the VP of Quality and Compliance Officer confirmed that the facility assessment did not address staff training and the patient care policies need to care for the population identified in the assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475058	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menig Nursing Home	215 Tom Wicker Lane Randolph Center, VT 05061

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. 46135 Based on interview and policy review, the facility failed to ensure the Medical Director assisted the facility with the development and implementation of resident care policies. This deficient practice had the potential to affect all 27 residents residing in the facility. Findings include: During an annual recertification survey on 7/22/24 through 7/25/24, multiple patient care policies and or procedures were requested including policies related to concerns identified with fall prevention and management, obtaining weights, weight loss prevention and management, and elopement prevention. See F 657, F 689, and F 692 for more information. The Clinical Care Coordinator and the Administrator were unable to produce policies related to the above concerns. Per interview on 7/24/24 at approximately 2:15 PM, the Administrator confirmed that the facility did not have policies or written procedures related to the above concerns. Facility policy titled Medical Director, effective 11/27/17, reads The Medical Director is responsible for: Implementation of resident care policies that reflect current professional standards of practice . Per interview on 7/25/24 at 12:56 PM, the Medical Director explained that s/he is aware that the facility has had concerns with residents having falls, weight loss and elopement while in his/her role but was unaware that there were no patient care policies related to these care areas.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475058	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menig Nursing Home	215 Tom Wicker Lane Randolph Center, VT 05061

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 50336 Based on record review and staff interviews, the facility failed to develop, implement, and maintain an effective training program for all new and existing staff related to QAPI (quality assurance and performance improvement), communication, compliance, and ethics training, and behavioral health training for 10 of 10 of sampled direct care staff and failed to develop a system that demonstrated the required 12 hours of annual training for the Licensed Nurse Aides (LNA's), for 4 of 4 of sampled staff. Findings include: Per the facility assessment, last reviewed 4/29/2024, on page #1, [the facility] has created and implemented competency standards for its staff. The competency program defines competency standards for each position and verifies that these competencies are continuously being met. The purpose of the program is to establish procedures that ensure that the competence of all staff members is assessed, maintained, demonstrated, and improved on an ongoing basis.1). Competency assessment is the responsibility of each department manager and human resources officer. E).The department manager will determine that all required competencies have been satisfactorily completed during the introductory period (six months) and thereafter annually. Per review of the following employee files: LNA#1, hired 9/14/20; LNA #2, hired 4/21/21; LNA #3, hired 2/29/2016; LNA #4, hired 1/9/2019; LNA #5, hired 7/22/2024; RN #1, hired 6/3/2016; RN #2, hired 6/24/24; RN#3, hired 6/24/2024; LPN#1, hired 2/29/16; LPN #2, hired 7/25/2024, there is no evidence of required communication, QAPI, compliance and ethics, or behavioral health training. Additionally, 4 of the 4 sampled LNA employee files did not show evidence of the required 12 hours of annual training. Per interview with the Director of Nursing on 7/24/2024 at approximately 2:20 PM, s/he stated s/he was a temporary employee and did not know how the LNA training and competencies might be documented. S/he explained that the facility shared software systems with the hospital, and this information might be there. S/he was unable to produce evidence that the training was documented. S/he states that either s/he or the Clinical Coordinator gives an onboarding packet to new hires, including temporary staff. A review of the onboarding packet supplied to new staff, including the temporary staff, revealed no QAPI, communication, compliance, and ethics, or behavioral health training. Per interview with the Administrative Assistant and the Clinical Coordinator on 7/25/2024 at approximately 3:00 PM, the Administrative Assistant stated they were unaware of a system documenting the training and competencies of the LNA's. They confirmed they were unaware of a system that tracked the required 12 hours of annual LNA training.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475058	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menig Nursing Home	215 Tom Wicker Lane Randolph Center, VT 05061

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 48017 Based on staff interviews and record review, the facility failed to include mandatory training that outlines and informs staff of the elements of effective communication, including speaking to others in a way they can understand, active listening, and observing verbal and nonverbal cues. Findings include: Per review of the training records for 7 sampled staff members, none of the 7 staff members had any evidence of training in communication: LNA#1(Licensed Nursing Assistant), hired 9/14/20; LNA #2, hired 4/21/21; LNA #3, hired 2/29/2016; LNA #4, hired 1/9/2019; RN #1(Registered Nurse), hired 6/3/2016; RN #2, hired 6/24/24; LPN#1, hired 2/29/16. Per interview on 7/25/24 with the Administrative Assistant and the Clinical Coordinator at approximately 3 PM, it was confirmed that the facility does not have mandatory training regarding effective communication, but that training is informal on a case-by-case basis and discussed at the morning meeting. They confirmed that attendance is not taken to ensure all staff receive this information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475058	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menig Nursing Home	215 Tom Wicker Lane Randolph Center, VT 05061

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 48017 Based on staff interviews and record reviews, the facility failed to include mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI (Quality Assurance Performance Improvement) program as part of the QAPI program. Findings include: Per review of the training records for 7 sampled staff members, none of the 7 staff members had any evidence of training on the facility's QAPI program. : LNA#1(Licensed Nursing Assistant), hired 9/14/20; LNA #2, hired 4/21/21; LNA #3, hired 2/29/2016; LNA #4, hired 1/9/2019; RN #1(Registered Nurse), hired 6/3/2016; RN #2, hired 6/24/24; LPN#1, hired 2/29/16 Per interview of LNA #1, LNA#2, and LNA# 3 on 7/25/2024 at approximately 3:00 PM, all three confirmed that they had not received any training on the QAPI program. Per interview on 7/25/24 at approximately 3:30 PM with the Administrative Assistant and the Clinical Coordinator, it was confirmed that the facility does not provide mandatory training for staff regarding it's QAPI program.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475058	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menig Nursing Home	215 Tom Wicker Lane Randolph Center, VT 05061

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide training in compliance and ethics. 48017 Based on record review and interview, the facility failed to include mandatory training on compliance and ethics that outlines and informs staff of the standards, policies, and procedures through a training program or in another practical manner that explains the requirements under the program. Findings include: Per review of the training records of 7 sampled direct care staff members, none of the 7 staff members had any evidence of training on the Compliance and Ethics program: LNA (Licensed Nurse Aide) #1, hired 9/14/20; LNA #2, hired 4/21/21; LNA #3, hired 2/29/2016; LNA #4, hired 1/9/2019; RN (Registered Nurse) #1, hired 6/3/2016; RN #2, hired 6/24/24; LPN(Licensed Practical Nurse) #1, hired 2/29/16 Per interview on 7/25/2024 at 2:47 PM with an LPN (Licensed Practical Nurse), s/he indicated s/he does not remember attending training or an in-service on ethics. Another interview on 7/25/2024 at 3 PM with two LNAs revealed that neither could recall any training or mention of an ethics curriculum that might have been provided to them. Per an interview on 7/25/2024 at approximately 3 PM with the Administrative Assistant and the Clinical Coordinator, it was confirmed that the employee training program did not contain the mandatory compliance and ethics.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475058	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menig Nursing Home	215 Tom Wicker Lane Randolph Center, VT 05061

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 48017 Based on record review and interview, the facility failed to develop a system to document the minimum 12 hours of nurse aide training per year required to ensure the continuing competence of the nurse aides. Findings include: Per review of the training records for 4 sampled staff members, none had evidence of the total 12 hours of training per year required to meet identified staff or resident needs. Per interview on 7/25/2024 at approximately 2:30 PM, LNA #1 (Licensed Nursing Assistant) stated s/he did not know how the education hours were documented. In a second interview with LNA # 2, s/he stated s/he often attended offered training but did not know if s/he met the minimum standard of 12 hours annually. During an interview with the Clinical Coordinator and the Administrative Assistant on 5/25/2024 at approximately 3:30 PM, they confirmed they did not have a system to document the mandatory 12 hours of nurse aide training. They were unable to identify how these hours were being accounted for or a system that could provide this information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475058	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menig Nursing Home	215 Tom Wicker Lane Randolph Center, VT 05061

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 48017 Based on staff interviews and record review, the facility failed to develop, implement, and maintain an effective training program for all staff, which includes, at a minimum, training on behavioral health care and service that is appropriate and effective, as determined by staff need and the facility assessment for 7 of 7 sampled staff. The facility's Facility Assessment [an assessment that determines what resources are necessary to care for the residents competently during both day-to-day operations and emergencies], last updated 1/24/2024, indicates that the facility can provide care and services for individuals with Psychiatric/Mood Disorders Part 2 Services and care we offer based on our Resident's needs .mental health and behavior: Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities. Section 2.1 of the facility assessment indicates 8 residents with behavioral health needs during this assessment period. Review of 7 direct care staff education records revealed there was no evidence of a behavior health training course that includes the competencies and skills necessary to provide care for residents with behavioral health needs: LNA#1, hired 9/14/20; LNA #2, hired 4/21/21; LNA #3, hired 2/29/2016; LNA #4, hired 1/9/2019; RN #1, hired 6/3/2016; RN #2, hired 6/24/24; LPN#1, hired 2/29/16 Per interview on 7/25/2024 at approximately 3:30 PM with the Administrative Assistant and the Clinical Coordinator on 7/25/2024, they indicated they do not have a training program that includes training on behavioral health as part of the direct care staff training program.