STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555010	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Long Beach Post Acute	1201 Walnut Avenue Long Beach, CA 90813

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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on interview and record review, the facility failed to ensure one of two residents (Resident 61), who was diagnosed with post-traumatic stress disorder (PTSD - mental health condition that can develop after someone experiences a deeply distressing or disturbing event), received trauma informed care (a model that aims to provide effective mental health services by taking into account a person's past experiences with trauma). This deficient practice had the potential to result in resident 61's re-traumatization and can be detrimental for the resident's psychosocial status. Findings: During a review of Resident 61's Admission Record, the record indicated Resident 61 was admitted to the facility on [DATE] with diagnoses including paranoid schizophrenia (mental health disorder that can cause people to lose touch with reality), major depressive disorder (mental health condition characterized by persistent sadness or loss of interest in activities), anxiety disorder (mental health condition that causes people to experience excessive, persistent, and uncontrollable worry), and PTSD. During a review of Resident 61's Minimum data Set (MDS), a federally mandated assessment tool, dated 9/19/2024, the MDS indicated Resident 61's cognition (ability to make decisions of daily living) was intact, and Resident 61 needed moderate assistance (helper does less than half the effort) with activities of daily living (ADL), tasks related to personal care. During a review of Resident 61's Brief Trauma Questionnaire and Life Events Checklist, dated 9/13/2024, the list indicated Resident 61 experienced five traumatizing events. Resident 61 experienced a fire, transportation accident, physical assault, sexual assault, and other unwanted or uncomfortable sexual experiences. During an interview on 10/1/2024 at 2:52 p.m., with the Social Services Director (SSD), the SSD stated Resident 61 was assessed for trauma the resident experienced or witnessed by using the Brief Trauma Questionnaire and Life Events Checklist. The SSD stated the care plan and interventions to address the trauma was developed by the nursing staff. (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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and review on 10/2/2024 at 1:50 p.m. with the Assistant Director of Nursing (ADON), Resident 61's care plans and social services notes were reviewed and there were no trauma informed care plans for Resident 61. The ADON reviewed Resident 61's medical records and stated there was no documented evidence of the identification of triggers that can cause re-traumatization, and there were no personalized trigger specific interventions addressing Resident 61's PTSD. The ADON stated moving forward they would develop and implement a care plan for Resident 61. During an interview with the Director of Nursing (DON) on 10/3/2024 at 12:00 p.m., the DON stated the nurses need to develop individualized trauma informed care for residents who suffered PTSD, so the nurses know exactly how to take care of the resident. During a review of the facility's policy and procedure (P&P) titled, Trauma Informed Care, revised 2/2018, the P&P indicated residents who are trauma survivors will receive culturally competent, trauma informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences to eliminate or mitigate triggers that may cause re traumatization of the resident. The facility will provide nursing and related services to assure resident safety and attain or maintain the highest well-being of each resident, as determined by resident assessments and individualized plans of care and considering the number, acuity, and diagnoses of the resident population. Based on the comprehensive assessment the resident will receive the appropriate treatment and services to correct the assessed problem to attain the highest level of well-being (as linked to the history of PTSD). treatment and services to correct the assessed problem to attain the highest level of well-being (as linked to the history of PTSD).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45891 Based on observation, interview and record review, the facility failed to: a. Ensure one of four sampled residents (Resident 116)'s narcotic (drug that affects mood or behavior) was documented in the narcotic record when it was administered on 9/11/2024 at 5 pm. b. Ensure one of three sampled resident's (Resident 53)'s home medications were documented when facility staff received it. These deficient practices had the potential to result in medication errors and drug diversion (illegal distribution or abuse of prescription drugs or their use for purposes not intended by the prescriber) of narcotics. Findings: a. During a review of Resident 116's Admission Record, the record indicated Resident 116 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder (a mental health disorder that affects the mood and behavior), depressive episodes (feeling sad, irritable, and empty), and generalized anxiety disorder (a mental health condition that causes people to experience excessive, persistent, and uncontrollable worry). During a review of Resident 116's Minimum data Set (MDS), a federally mandated assessment tool, dated 7/10/2024, the MDS indicated Resident 116's cognition (ability to make decisions of daily living) was intact, and Resident 116 was independent with all activities of daily living (ADL - tasks related to personal care). During a review of Resident 116's Physician's Order Summary Report, the order summary indicated, starting on 7/23/2024, Ativan (Lorazepam - medication used to treat anxiety) 0.5 milligrams by mouth every six hours as needed for anxiety manifested by panic attack (brief episode of intense anxiety, which causes the physical sensations of fear). During a concurrent observation, interview and record review on 9/30/2024 at 1:55 p.m., at the station 1 medication room, with the Assistant Director of Nursing (ADON), Resident 116's Antibiotic or Controlled Drug Record for Lorazepam 0.5 milligram was reviewed, and the record indicated the last dose was administered on 9/11/2024 at 7:45 a.m. and there should be 18 tablets left in the bubble pack (a card that packages doses of medication within small, clear, plastic bubbles). The ADON counted the Lorazepam and noted 17 tablets in the bubble pack. The ADON stated there was a discrepancy with the count and narcotic record because we are missing one 0.5 milligram tablet of lorazepam. During a concurrent interview and record review on 9/30/2024 at 3:00 p.m. with the ADON, Resident 116's Medication Administration Record (MAR) for 9/2024 was reviewed and the MAR indicated Ativan (Lorazepam) 0.5 milligrams was last administered on 9/11/2024 at 5:00 p.m. The ADON stated the nurse should have recorded the last dose on Resident 116's Narcotic Record for Lorazepam so the nurses know when the resident received it. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 53's Admission Record, the record indicated Resident 53 was initially admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, depressive episodes, and generalized anxiety disorder. During a review of Resident 53's MDS, dated [DATE], the MDS indicated Resident 53's cognition was intact, and Resident 53 needed partial assistance (helper does less than half the effort) with ADLs. During a concurrent observation and interview on 9/30/2024 at 2:18 p.m., at the station 1 medication room, with the ADON, Resident 53's sealed, unopened, opaque plastic bag with unidentified medications were noted. The ADON stated we don't know what medications were in the bag because the bag was never opened and there was no home medication list with the medications. The ADON stated there should have been a medication list, so we know what medications Resident 53 was taking. During an interview with the Director of Nursing (DON) on 10/3/2024 at 12:00 p.m., the DON stated the Narcotic record needs to be accurate because we always need to know the disposition of narcotics. The DON stated inventory of all belongings including home medications were important so residents can leave with their personal belongings. During a review of the facility's policy and procedure (P&P), titled, Preparation and General Guidelines, IIA5: Controlled Medications, effective date 8/2014, the P&P indicated medications included in the Drug Enforcement Administration classification as controlled substances were subject to record keeping in the facility in accordance with federal, state, and applicable laws and regulations. When controlled medications were administered the licensed nurse administering the medication immediately enters the information on the accountability record and the MAR: 1. Date and time of administration 2. Amount administered 3. Signature of nurse administering the dose on the accountability record at the same time the medication is removed from the supply. During a review of the facility's P&P titled, Medication Storage in the Facility, ID3: Controlled Medication Storage, effective 8/2014, the P&P indicated at each shift change a physical inventory of all controlled medications, including the emergency supply, is conducted by two licensed nurses and it is documented on the Controlled Medication Accountability Record. Any discrepancy and controlled substance medication counts is reported to the DON immediately. The director or designee investigates and makes every reasonable effort to reconcile all reported discrepancies. During a review of the facility's P&P titled, Medication Ordering and Receiving from Pharmacy, IC 120: Medications brought to the facility by a resident or Family Member, effective 8/2014, the P&P indicated a licensed nurse: a. Receives medication delivered to the facility and documents delivery of the medication on the appropriate form. b. Verifies medications received and directions for use with the original medication order.

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on observation, interview, and record review, the facility failed to follow up and ensure one of eight sampled residents (Resident 7) received follow up dental care recommended by the dentist. This deficient practice had the potential to cause further decline in Resident 7's teeth and dental pain. Findings: During a review of Resident 7's Admission Record, the Admission Record indicated Resident 7 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), generalized anxiety disorder (a mental health condition that causes people to experience excessive, uncontrollable, and irrational worry about everyday things), and depression (a mental state that can affect a person's thoughts, feelings, behavior, and sense of well-being). During a review of Resident 7's Oral/Dental care plan dated 4/7/2024, the care plan indicated Resident 7 needed supervision for oral care. Goals for Resident 7 included Resident 7 would not complain of dental pain related to poor teeth condition with interventions that included dental consult and follow-up as needed and to follow up with dental treatment as needed. During a review of Resident 7's Dental Notes dated 5/29/2024, Resident 7 required dental crowns (a type of dental restoration that completely caps or encircles a tooth) on his two top front teeth (number 8 and number 9 teeth). Resident 7 denied treatment on this day (5/9/2024) but was willing to try a different day. During a review of Resident 7's Dental Notes dated 6/12/2024, Resident 7 refused to be seen that day but Resident 7 agreed to try a different day. There were no further Dental Notes or follow ups for dental care in Resident 7's chart after 6/12/2024. During a review of Resident 7's Resident Care Conference Review form dated 9/10/2024, the form indicated Resident 7 was last seen by the dentist on 6/12/2024. During a review of Resident 7's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 9/10/2024, the MDS indicated Resident 1 was cognitively intact (the person was able to think, learn, and remember clearly, and to carry out daily activities effectively). During an observation on 9/30/2024 at 2:59 p.m., Resident 7's two top front teeth were broken. During an interview on 10/1/2024 at 2:50 p.m., Resident 7 stated the dentist came to see him three times and took x-rays (imaging creates pictures of the inside of your body) to fix his broken teeth but he never came back to do the crowns. Resident 7 stated he would feel better about himself if his teeth were fixed. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/3/2024 at 11:01 a.m., the social services director (SSD) stated the last time Resident 7 was seen by the dentist was 6/12/2024. The SSD stated the dentist came to the facility as needed or every two months if there wasn't an immediate need. The SSD reviewed her ancillary notes and there were no attempts from the dentist to follow up with Resident 7 since he declined being seen by the dentist on 6/12/2024. The SSD stated she did not have it written down in her notes that Resident 7 was pending dental crowns. The SSD stated Resident 7 had cracked front teeth when she talks to him. During an interview on 10/3/2024 at 11:19 a.m., Resident 7 stated he did not remember declining dental treatment and hopes the dentist comes back soon to do the work because it would help him feel better about himself. During an interview on 10/3/2024 at 11:49 a.m., the director of nursing (DON) stated it was important to track ancillary services (supportive or diagnostic services beyond primary healthcare) and ensure the residents received follow up ancillary care because the facility needed to ensure the residents were getting the care and treatments they needed. The DON stated if a resident refused ancillary treatment, it should have been in the progress notes and the facility should have done an interdisciplinary care plan meeting to ensure they follow up with the resident regarding the treatment. The DON stated it was important to follow up with the resident to reevaluate how the resident was feeling because one day they may decline the treatment, but they may agree the next day or next week and then they could call the dentist to come back and do the work when the resident was up for it. The DON stated the potential outcome of not getting recommended dental treatment done was not good (the DON, did not specify what not good was). During a review of the facility's policy titled Social Services Department- Dental, Optometry, and Audiology Evaluations, undated, indicated dental evaluations were scheduled on annual basis and/ or as needed.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on observation, interview, and record review, the facility failed to serve a snack that was prepared as prescribed by the physician for one of two sampled residents (Resident 33). This deficient practice had the potential to cause the resident to choke on their food. Findings: During a review of Resident 33's Admission Record, dated 9/22/2024, the Admission Record indicated Resident 33 was initially admitted to the facility on [DATE] with diagnoses including Dysphagia (difficulty swallowing). During a review of Resident 33's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 9/19/2024, the MDS indicated Resident 33 was cognitively (ability to make decisions of daily living) intact and able to recall recent events During a review of Resident 33's physician orders, dated 9/13/2024, the order sheet indicated Resident 33 was prescribed a pureed (consisting of foods that are ground, pressed, or strained until they have a smooth, soft consistency, similar to pudding) texture regular diet. During a review of Resident 33's s Speech Language Pathologist (SLP- a licensed professional who diagnoses and treats speech, language, communication, cognitive, and swallowing disorders in people of all age) Evaluation and Plan of Treatment, dated 9/16/2024, the evaluation indicated the SLP recommends Solids = Puree Consistencies for Resident 33. During an observation on 10/2/2024 at 10:14 a.m., Certified Nurse Assistant 3 (CNA 3) was observed passing snacks that included soft baked chocolate chip cookies and lemon cookies and juice on a cart. During a concurrent observation and interview on 10/2/2024 at 10:28 a.m., with Resident 33, Resident 33 was observed sitting up with one empty cookie wrapper. one cookie still in its packaging, and a cup of juice. Resident 33 stated they had just eaten one cookie and planning to eat the second cookie on the table. There were no other items observed on the table. During an interview on 10/2/2024 at 10:29 a.m., with CNA 3, CNA 3 was unable to state which residents were on pureed diets. and will find out. During an interview on 10/2/2024 at 10:39 a.m., with CNA 3, CNA 3 stated that she found out that Resident 33 was on a pureed diet and they can have yogurt and pudding that comes from the kitchen. CNA 3 stated they gave Resident 33 a yogurt. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 10/2/2024 at 2:50 p.m., with Licensed Vocational Nurse 1 (LVN 1), the document titled, Situation-Background-Assessment-Recommendation (SBAR-document that indicates resident's change of condition) dated 10/2/2024 was reviewed. LVN 3 stated Resident 33 was being monitored for aspiration((food or liquid accidentally entering the lungs) because Resident 33 ate a cookie earlier. During an interview on 10/2/2024 at 3:21 p.m., with the SLP, the SLP stated appropriate snacks for a resident on a pureed diet included pudding, applesauce, or pureed fruits. The SLP stated Resident 33's diet recommendation is pureed and cookies are not an appropriate snack for a resident on a pureed diet. During an interview on 10/3/2024 at 11:49 a.m., with the Director of Nursing (DON), the DON stated it is important for staff to follow physician orders. The DON stated if a resident who is prescribed a pureed diet is provided a cookie as a snack, the resident is at risk for aspirating or choking. During a review of the facility's Charge Nurse job description (undated), the job description indicated general duties and responsibilities include, Perform treatments-administer medications, and/or implement other nursing interventions as indicated by the resident care plan r as ordered by the physician.

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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. 45891 Based on observation, interview, and record review, the facility failed to ensure the storage, preparation and distribution of food was done under sanitary conditions for 63 of 63 residents by not: 1. Labeling perishable food items (two open pasta bags) with open date. 2.Thawing diced beef according to facility policy. These deficient practices had the potential to cause food-borne illnesses. Findings: During a concurrent observation and interview on 9/30/2024 at 8:45 a.m., with the Dietary Supervisor (DS) in the dry storage room, two bags of dried pasta (one macaroni and one farfalle) were previously opened without an open date. The DS stated the bags did not have an open date. During an observation on 10/1/2024 at 11:45 a.m., in the kitchen meal prep sink, three bags of meat were sitting in a tray of still (not running) water. The sink faucet was off. During a concurrent observation and interview on 10/1/2024 at 12:13 p.m., with [NAME] 1, [NAME] 1 turned on the sink faucet. [NAME] 1 stated the bagged meat was diced beef for tomorrow's lunch. [NAME] 1 stated the water was running over the diced meat earlier, but does not know when the water was turned off. [NAME] 1 stated thawing meat should be placed under continuous running water and reach a goal of under 40 degrees Fahrenheit (a unit of measure of temperature) in two hours. During an observation on 10/1/2024 at 12:18 p.m., [NAME] 1 removed the thawing meat tray from under the running water, did not take the temperature, covered and labeled the tray, and placed the tray in the refrigerator. During an interview on 10/1/2024 at 12:20 p.m., with the DS, the DS stated when defrosting under running water, the process includes thawing the meat under running water with a goal of below 70 degrees Fahrenheit in two hours. The DS stated if food is not thawed properly, there is a risk for residents to contract a food borne illness. During an interview on 10/3/2024 at 11:26 a.m., with the DS, the DS if there is unlabeled opened food, the staff would not know when it was opened and when the food will expire. The DS stated the quality of food such as the texture would be compromised. During a review of the facility's policy and procedure (P&P), titled Labeling and Dating of Foods, dated 2020, The P&P indicated Newly opened food items will need to be closed and labeled with an open date . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure (P&P), titled Storage of Food and Supplies, dated 2020, The P&P indicated Dry food items which have been opened, such as pudding, gelatin, biscuit mix, pancake mix, dry cereal, spices, coffee, noodles, etc., will be tightly closed, labeled and dated. During a review of the facility's policy and procedure (P&P), titled Food Preparation, dated 2018, The P&P indicated Thawing meat properly can be done in these four ways: 3. Submerge under running, potable water at a temperature of 70?F or lower, with a pressure sufficient to flush away loose particles. a. The food product cannot remain in the temperature danger zone (41degrees Farenheit to 140 degrees Farenheit) for more than four hours, which includes the time the food is thawed. Use immediately.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45891 Based on observation, interview, and record review the facility failed to ensure to document the visual monitoring for behaviors, every 15 minutes for one of one resident's (Resident 113)'s medical records. The deficient practice indicated an inaccurate account of care and services received by Resident 113, and the inability of the facility to recognize and act on trends of Resident 113's behaviors. Findings: During a review of Resident 113's Admission Record, the record indicated Resident 113 was admitted to the facility on [DATE] with diagnoses including schizophrenia (mental health disorder that can cause people to lose touch with reality), depressive episodes (feelings of sadness, tearfulness, emptiness, or hopelessness), and generalized anxiety disorder (mental health condition that causes people to experience excessive, persistent, and uncontrollable worry). During a review of Resident 113's Minimum data Set (MDS), a federally mandated assessment tool, dated 10/1/2024, the MDS indicated Resident 113's cognition (ability to make decisions of daily living) was moderately impaired, and Resident 113 needed supervision (helper provides verbal cues and touching assistance as resident completes activity) with eating, oral hygiene, dressing, and personal hygiene, and moderate assistance (helper does less than half the effort) with showering and toileting hygiene. During a review of Resident 113's care plan titled, Activities of Daily Living Self Care Deficit, dated 9/25/2024, the care plan goal indicated Resident 113 needed assistance with bed mobility, transfer, walking, dressing, eating, toilet use, personal hygiene, and bathing. The care plan intervention indicated to visually check resident frequently. During an observation and interview on 9/30/2024 at 10:12 a.m., with Certified Nurse Assistant (CNA) 1, at the hallway adjacent to Resident 113's room, CNA 1 was noted to be watching Resident 113 and just sitting in the hallway. CNA 1 stated he was closely monitoring Resident 113 to make sure Resident 113 does not wander in other residents' rooms and take things. CNA 1 stated he visually monitors Resident 113 at least every 15 minutes. CNA 1 stated every 15-minute visual check for behaviors was not documented anywhere in Resident 113's chart. During an observation and interview on 9/30/2024 at 10:52 a.m., with CNA 2, at the hallway adjacent to Resident 113's room, CNA 2 was noted standing in front of Resident 113's room looking at Resident 113. CNA 2 stated she was closely monitoring Resident 113 and making sure she can see Resident 113 continuously. CNA 2 stated they do not document that they were monitoring the resident continuously in the chart. (continued on next page)

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	555010	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Long Beach Post Acute	1201 Walnut Avenue Long Beach, CA 90813

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 10/1/2024 at 12:05p.m., with the Assistant Director of Nursing (ADON), Resident 113's progress notes, care plans, and medical records were reviewed and there was no documented evidence of the staff closely monitoring and visually checking Resident 113 every 15 minutes. The ADON stated the facility staff closely monitors new admissions to ensure the resident was safe and was acclimated to the environment. The ADON stated it was an intervention in the care plan to visually check resident frequently, but it was not documented anywhere that the CNA's were providing the service. During an interview and record review with the Director of Nursing (DON) on 10/3/2024 at 12:00 p.m., the facility's policy and procedure (P&P) titled, Documentation Principles, revised 2/2018, was reviewed. The DON read a portion the P&P and stated it was the policy of the facility that clinical records shall be current and kept in detail consistent with good medical and professional practice based on care provided to each resident. The DON stated CNA documentation should be accurate. During a review of the facility's policy and procedure (P&P) titled, Documentation Principles, revised 2/2018, the P&P indicated clinical records shall be current and kept in detail consistent with good medical and professional practice based on care provided to each resident. Entries must be accurate, timely, objective, specific, concise, legible, clear, and descriptive. During a review of the facility's P&P titled, Certified Nurse Assistant Documentation, revised 10/2015, the P&P indicated certified nurse assistants document per shift, accurately and consistently.