Reviewed and Accepted POC
5/6/25 44114

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056079	A. BUILDING _____ B. WING _____	C 04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENDORA GRAND, INC	805 W. ARROW HWY. GLENDORA, CA 91740

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during an abbreviated standard survey. Complaint Numbers: CA00953432, CA00953904, and CA00956138 The inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility. No deficiencies were issued for complaint number: CA00953432. No deficiencies were issued for complaint number: CA00956138. Three deficiency was issued for complaint number: CA00953904 (Refer to F684, F656, and F726).	F 000	Please accept this Plan of Correction as our Credible Allegation of Compliance. The deficiencies cited will be corrected as specified and they will be monitored to prevent recurrence. Preparation and /or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies and plan of correction. The Provider submits this Plan of Corrections with the intention that it is inadmissible by any third party in any civil or criminal action or proceedings against the Provider, its employees, agents, officers, directors, or shareholders. Plan of Correction is submitted to meet requirements established by state and federal law The Provider reserves the right to challenge the cited findings if at any time the Provider determines that the disputed findings are relied upon in a manner adverse to the interest of the Provider, either by the governmental agencies or third party. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and California Evidence Code Section 1151 and should be admissible in any proceedings on that basis.	4/30/25
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 5/2/25

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.

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F 656	Continued From page 1 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement one of two sampled residents (Resident 1)'s care plan, in accordance to the facility's policy and procedure titled, "Comprehensive Care Plans" by failing to perform daily body checks for Resident 1.	F 656	**F 656** **Develop/Implement Comprehensive Care Plan** **CFR(s): 483.21(b)(1)(3)** Resident 1 was re admitted back to our facility on 3/28/25.He was assessed by the RN supervisor on 3/28/25. Left wrist noted with dry scab with no signs of infection. Care plan reviewed and revised by the RN supervisor on 3/28/25. DON, RN/LVN supervisors performed body/skin checks to the current residents on census as of 4/10/25 to identify any resident affected with the findings. Body/skin checks were completed on.4/30/25. No other residents were affected. DON in serviced licensed nurses regarding Comprehensive Care Plan Implementation on 4/9, 4/11 and 4/28. At least quarterly, every 10th, DON will in service regarding Comprehensive Care Plan Implementation.	4/30/25

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F 656	Continued From page 2 This failure resulted in Resident 1 sustaining an infected wound (a wound where bacteria or other microorganisms have entered and are multiplying, causing an infection) to Resident 1's left wrist. Cross reference: F684 and F726 Findings: During a review of Resident 1's Admission Record (AR), the AR indicated the facility initially admitted Resident 1 on 4/30/2015 with diagnoses including mild intellectual disabilities (limitations on intelligence, learning and everyday abilities) and abnormalities of gait (walk) and mobility. During a review of Resident 1 ' s CP titled, "Care Plan Report", dated 12/11/2024, the CP indicated Resident 1 had a risk for development of pressure ulcers secondary to multiple health conditions, limited mobility, effects of medication, impaired cognition. The CP ' s goal indicated, will minimize risk of development of pressure ulcers every day (Q Day). The CP ' s interventions indicated, daily body check for redness and open areas, keep skin clean and dry, and protect skin from moisture. During a review of Resident 1's Minimum Data Set (MDS -a resident assessment tool) dated 1/26/25, the MDS indicated Resident 1's cognition was moderately impaired. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with showering/bathing, upper body dressing, and with putting on/taking off footwear. The MDS	F 656	Weekly, during IDT care plan meetings, MDS nurse, RN/LVN supervisors assigned and Social Services designee will review the care plan of residents on schedule to ensure that body/skin assessment was performed as written in the care plan. Findings will be corrected and will be reported to the DON for follow up. Any significant findings will be reported by the DON during the quarterly QA&A meetings for discussion and recommendation for 6 months.	4/30/25

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F 656	Continued From page 3 indicated Resident 1 was at risk for developing pressure ulcers/injuries. The MDS indicated Resident 1 did not have any skin conditions. During a review of Resident 1 ' s General Acute Care Hospital (GACH) 1 ' s Emergency Department Provider Notes (EDPN), dated 3/21/2025, the EDPN indicated "Skin: Rubber band embedded in the left wrist that appears infected." During a review of GACH 1 History of Present Illness (HPI), dated 3/21/2025 at 1:04 p.m., the HPI indicated Resident 1 had an infection related to an embedded bracelet. During an interview on 4/9/2025 at 1:00 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated LVN 1 was assigned to Resident 1 on 3/20/2025. LVN 1 stated LVN 1 noticed a foul smell coming from Resident 1 ' s body, but did not know where the smell was coming from. LVN 1 stated a full body assessment of a resident was not within LVN 1 ' s scope of practice. LVN 1 stated Resident 1 was given a shower on 3/20/2025. LVN 1 stated LVN 1 noticed the smell from Resident 1 the following day (3/21/2025). LVN 1 stated LVN 1 notified RN 1 of the smell, so LVN 1 and RN 1 went to Resident 1 ' s room. LVN 1 stated LVN 1 was instructed by RN 1 to give Resident 1 a shower. LVN 1 stated LVN 1 notified RN 1 that a shower was given to Resident 1 on 3/20/2025 but the smell did not go away. During a concurrent interview and record review on 4/9/2025 at 2:20 p.m. with the Director of Nursing (DON), the facility P&P titled, "Skin Assessment" was reviewed. The DON stated the policy indicated, it is our policy to perform a full	F 656		

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F 656	Continued From page 4 body skin assessment as part of our systematic approach for pressure ulcer prevention and for the promotion of healing of various skin conditions, including pressure ulcers. This P&P included the following procedural guidelines in performing the full body skin assessment. Policy Explanation and Compliance Guidelines: A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission and as needed. The assessment may also be performed after a change of condition or after any newly identified pressure ulcer." The DON stated the LN ' s did not follow the facility ' s policy. The DON stated the facility has LVN ' s who perform weekly body checks and when LVN ' s notice anything unusual, LVN ' s are to report to RN ' s for further assessment of residents. DON stated RN 1 who was assigned to Resident 1 should have assessed further to find where the odor was coming from. DON stated the GACH transfer form filled out by RN 1 indicated "swelling to left hand/arm" but did not document anything else. During a review of the facility's P&P titled, "Comprehensive Care Plans," undated, the P&P indicated, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.	F 656	F 684 Quality of Care CFR(s): 483.25 Resident 1 was re admitted back to our facility on 3/28/25.He was assessed by the RN supervisor on 3/28/25. Left wrist noted with dry scab with no signs of infection. RN1 and LVN 1 were given a one on one in service and 1:1 Skills and Policy review by the DON on 4/11/25 Disciplinary action was given by the DON to the RN1, LVN1 and the CNAs who were assigned to Resident 1. DON, RN/LVN supervisors performed body/skin checks to the current residents on census as of 4/10/25 to identify any resident affected with the findings. Skin/Body checks was completed on.4/30/25. No other residents were affected. DON in serviced licensed nurses on 4/9/25, 4/11/25 and 4/28/25 regarding Skin assessment Policy upon admission/readmission, change of condition and as needed. DSD in serviced CNAs on 4/9/25 regarding skin and body assessment including reporting to licensed nurses for any changes. A follow up in service to CNAs, LVNs and RNs given on 4/25/25 by the DSD.	4/30/25
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		

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F 684	Continued From page 5 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 1 and Registered Nurse (RN) 1 assessed/checked one of two sampled residents (Resident 1) ' s body on 3/20/2025 and 3/21/2025 to prevent injury/wound (an injury to living tissue, specifically a break or disruption in the skin or other body tissues caused by an external force) from embedded (implanted, an object fixed firmly and deeply in a surrounding mass) bracelets (ornamental/decorative band, hoop, or chain worn on the wrist or arm). These failures resulted in Resident 1 developing an infected wound (a wound that harbors harmful bacteria, leading to symptoms like increased redness, pain, swelling, and pus) to Resident 1 ' s left wrist. Cross Reference: F656 and F726 Findings: During a review of Resident 1's Admission Record (AR), the AR indicated the facility initially admitted Resident 1 on 4/30/2015 with diagnoses including mild intellectual disabilities (limitations on intelligence, learning and everyday abilities)	F 684	To monitor compliance, DON and or Designee will conduct random Skin assessment review to licensed nurses on a weekly basis. Any issues will be addressed and correctly immediately. Findings will be reported by the DON during quarterly QA&A meetings for 6 months.	4/30/25

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F 684	Continued From page 6 and abnormalities of gait (walk) and mobility. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 1/26/25, the MDS indicated Resident 1's cognition was moderately impaired. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with showering/bathing, upper body dressing, The MDS indicated Resident 1 did not have any skin conditions. During a review of Resident 1's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 3/28/2025, the H&P indicated Resident 1 was able to make needs known but could not make medical decisions. During a review of Resident 1's Nursing Weekly Assessment (NWA), dated 3/19/2025, the NWA indicated Resident 1 ' s skin was intact. During a review of Resident 1 ' s EMS run report (a standardized document used by emergency medical service care providers), dated 3/21/2025 and timed at 11:25 a.m., the report indicated, the emergency medical technicians (EMTs) arrived at the facility on 3/21/2025 at 11:30 a.m., and was at Resident 1 ' s bedside to evaluate Resident 1 at 11:31 a.m. The EMS run report indicated, the EMTs noticed swelling to (left) arm, upon exposing arm, EMT noted a hospital bracelet and personal bracelets cutting into Resident 1 ' s skin and showing signs and smell of infection with discharge coming from the wound (on the left wrist).	F 684		

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F 684	Continued From page 7 During a review of Resident 1 ' s GACH 1 ' s Emergency Department Provider Notes (EDPN), dated 3/21/2025, the EDPN indicated "Skin: Rubber band embedded in the left wrist that appears infected." During a review of GACH 1 History of Present Illness (HPI), dated 3/21/2025 at 1:04 p.m., the HPI indicated Resident 1 had an infection (on Resident 1 ' s left wrist) related to embedded bracelets. During an interview on 4/9/2025 at 1:00 p.m. with LVN 1, LVN 1 stated LVN 1 was assigned to Resident 1 on 3/20/2025. LVN 1 stated LVN 1 noticed a foul smell coming from Resident 1 ' s body, but did not know where the smell was coming from. LVN 1 stated a full body assessment of a resident was not within LVN 1 ' s scope of practice. LVN 1 stated LVN 1 did not check/assess other area on Resident 1 ' s body nor notify Resident 1 ' s foul smell to LVN 1 ' s supervisor/Registered Nurse (RN). LVN 1 stated Resident 1 was given a shower on 3/20/2025. LVN 1 stated LVN 1 noticed the smell from Resident 1 the following day (3/21/2025). LVN 1 stated LVN 1 notified RN 1 of the smell, so LVN 1 and RN 1 went to Resident 1 ' s room. LVN 1 stated LVN 1 was instructed by RN 1 to give Resident 1 a shower. LVN 1 stated LVN 1 notified RN 1 that a shower was given to Resident 1 on 3/20/2025 but the smell did not go away. During a concurrent interview and record review on 4/9/2025 at 2:20 p.m. with the Director of Nursing (DON), the facility policy and procedure (P&P) titled, "Skin Assessment," was reviewed. The P&P indicated the procedural guidelines in	F 684		

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F 684	Continued From page 8 performing the full body skin assessment. The policy explanation and compliance guidelines indicated a full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission and as needed. The policy indicated the assessment may also be performed after a change of condition or after any newly identified pressure ulcer/ (localized damage to the skin and underlying tissue caused by sustained pressure) wound. The DON stated the policy indicated, it is the facility ' s policy for staff (LVNs and RNs) to perform a full body skin assessment as part of our systematic approach for pressure ulcer/wound prevention and for the promotion of healing of various skin conditions. The DON stated the LVN 1 and RN 1 did not assess/check Resident 1 ' s skin condition as indicated in the facility ' s policy. During an interview and record review on 4/10/2025 at 3:00 p.m. with LVN 1, LVN 1 stated, LVN 1 was to assess Resident 1 further on 3/20/2025 when LVN 1 first noticed the smell coming from Resident 1 ' s body. LVN 1 stated when the EMS arrived at the facility on 3/21/2025, one of the members from the EMS (EMT 1) asked where the smell was coming from. LVN 1 stated EMT 1 was preparing to take Resident 1 ' s blood pressure when EMT 1 noticed Resident 1 ' s bracelets (on Resident 1 ' s left wrist). LVN 1 stated the beaded bracelets, and the hospital arm band (on Resident 1 ' s left wrist) were cut off and LVN 1 witnessed the items (the beaded bracelets and the hospital arm band) falling to the floor. LVN 1 stated LVN 1 did not see Resident 1 ' s wrist due to all the EMS staff huddling around Resident 1, but LVN 1 heard	F 684		

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F 684	Continued From page 9 them (EMS staff) said, "oh this is where the smell is coming from," and LVN 1 saw EMT 1 wrap Resident 1 ' s left arm with gauze. LVN 1 stated once the EMT 1 cut the bracelets off from Resident 1 ' s left wrist the smell got stronger, and it smelled like an infected wound.	F 684	F 726 Competent Nursing Staff CFR(s):483.35(a)(3)(4)(c)	
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident	F 726	Resident 1 was re admitted back to our facility on 3/28/25.He was assessed by the RN supervisor on 3/28/25. Left wrist noted with dry scab with no signs of infection. RN1 and LVN 1 were given a one on one in service and 1:1 Skills and Policy review by the DON on 4/11/25 regarding Skin assessment Policy Disciplinary action was given by the DON to the RN1, LVN1 and the CNAs who were assigned to Resident 1. DON, RN/LVN supervisors performed body/skin checks to the current residents on census as of 4/10/25 to identify any resident affected with the findings. Skin/Body checks was completed on.4/30/25 No other residents were affected.	4/30/25

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F 726	Continued From page 10 assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure Licensed Vocational Nurse (LVN) 1 and Registered Nurse (RN) 1 assessed/checked one of two sampled residents (Resident 1) when foul (bad) smell was noticed on 3/20/2025 and 3/21/2025 from Resident 1. This failure resulted in unnoticed and untreated infected wound to Resident 1 ' s left wrist. Cross reference F684 and F656 Findings: During a review of Resident 1's Admission Record (AR), the AR indicated the facility initially admitted Resident 1 on 4/30/2015 with diagnoses including mild intellectual disabilities (limitations on intelligence, learning and everyday abilities) and abnormalities of gait (walk) and mobility. During a review of Resident 1's Minimum Data Set (MDS -a resident assessment tool), dated 1/26/25, the MDS indicated Resident 1's cognition (mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating, oral hygiene, toileting hygiene, lower body dressing, and personal hygiene. The MDS also indicated Resident 1 required partial/moderate assistance	F 726	Monthly, Skin assessment In service will be given by the DON and DSD to licensed nurses and CNAs. To monitor compliance, DON and/or designee will conduct random Skin assessment review to licensed nurses on a weekly basis. Any issues will be addressed and correctly immediately. Skills Competency training and evaluation by return demonstration will be done annually and as needed by the DON and or designee and DSD to the licensed nurses and CNAs. Findings will be reported by the DON during quarterly QA&A meetings for 6 months.	4/30/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056079	A. BUILDING _____ B. WING _____	C 04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENDORA GRAND, INC	805 W. ARROW HWY. GLENDORA, CA 91740

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F 726	Continued From page 11	F 726		

(helper does less than half the effort) with showering/bathing, upper body dressing, and with putting on/taking off footwear. The MDS indicated Resident 1 ' s did not have any skin conditions.

During a review of Resident 1's History and Physical (H&P, physician's clinical evaluation and examination of the resident), dated 3/28/2025, the H&P indicated Resident 1 can make needs known but cannot make medical decisions.

During a review of Resident 1 ' s General Acute Care hospital (GACH) 1 ' s Emergency Department Provider Notes (EDPN), dated 3/21/2025, the EDPN indicated "Skin: Rubber band embedded in the left wrist that appears infected."

During a review of GACH 1 History of Present Illness (HPI), dated 3/21/2025 at 1:04 p.m., the HPI indicated Resident 1 had an infection related to an embedded bracelet.

During an Interview on 4/9/2025 at 1:00 p.m. with LVN 1, LVN 1 stated LVN 1 was assigned to Resident 1 on 3/20/2025. LVN 1 stated LVN 1 noticed a foul smell coming from Resident 1 ' s body, but did not know where the smell was coming from. LVN 1 stated a full body assessment of a resident was not within LVN 1 ' s scope of practice. LVN 1 stated LVN 1 did not check/assess other area on Resident 1 ' s body nor notify Resident 1 ' s foul smell to LVN 1 ' s supervisor/Registered Nurse (RN). LVN 1 stated Resident 1 was given a shower on 3/20/2025. LVN 1 stated LVN 1 noticed the smell from Resident 1 the following day (3/21/2025). LVN 1

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F 726	Continued From page 12	F 726		

stated LVN 1 notified RN 1 of the smell, so LVN 1 and RN 1 went to Resident 1 ' s room. LVN 1 stated LVN 1 was instructed by RN 1 to give Resident 1 a shower. LVN 1 stated LVN 1 notified RN 1 that a shower was given to Resident 1 on 3/20/2025 but the smell did not go away.

During a concurrent interview and record review on 4/9/2025 at 2:20 p.m. with the Director of Nursing (DON), the DON stated the facility has LVN ' s who perform weekly body checks and when LVN ' s notice anything unusual, LVN ' s are to report to RNs for further assessment of residents. The DON stated the DON was not aware of the wound until the date of transfer to GACH 1 (3/21/2025).The DON stated the LVN 1 and RN 1 did not assess/check Resident 1 ' s skin condition as indicated in the facility ' s policy.

During a review of the facility ' s P&P titled, "Skin Assessment," undated, the P&P indicated, it is our policy to perform a full body skin assessment as part of our systematic approach for pressure ulcer prevention and for the promotion of healing of various skin conditions, including pressure ulcers. This policy includes the following procedural guidelines in performing the full body skin assessment. A full body, or head to toes, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission and as needed. The assessment may also be performed after a change of condition or after any newly identified pressure ulcer.

During a review of the facility ' s P&P titled, "Charge Nurse Job Description," undated, the P&P indicated, LNs provides direct nursing care to the residents and supervises the day-to-day

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F 726	Continued From page 13 nursing activities performed by the certified nursing assistants in accordance with current federal, state, and local regulations and guidelines and established facility policies and procedures. Required Qualifications, "A Nursing Degree from an accredited college or university or a graduate of an approved LPN/LVN program., Current unrestricted license as a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) in practicing state. Major Duties and Responsibilities Observes for changes in residents ' status, notifying the physician and resident ' s family or representative and documenting accordingly. Reports any incidents or unusual occurrences to the supervisor, unit manager, assistant director or nursing or director of nursing and participates in the investigative process as needed.	F 726		