STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205099	A. BUILDING _____ B. WING _____	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RUMFORD COMMUNITY HOME	11 JOHN F KENNEDY LANE RUMFORD, ME 04276

(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 From 2/4/25 through 2/7/25 and 2/10/25, on-site visits were conducted at Rumford Community Home for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification and investigation of complaints #ME00046473, #ME00046978, and #ME00049030. It was determined that Rumford Community Home was not in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure resident preferences were followed for 2 of 3 residents reviewed for bathing (Residents #23 #8). Findings: 1.Resident #23 and has a Brief Interview for Mental Status (BIMS) of 10 out of 15, indicating he/she is moderately cognitively impaired. Review of Resident #23's care plan revealed, " ... requires extensive assist by 1 staff with bathing BID [2 times a day] and as necessary ...often refuses care reapproach and offer several times as needed ..."	F 558		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 3/6/25

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.

Provider Identification Number	Date Survey Completed
205099	February 4- February 10, 2025
Name of Provider or Supplier	**Street Address, City, State, Zip Code**
Rumford Community Home	11 John F Kennedy Lane, Rumford ME 04276

ID TAG	SUMMARY STATEMENT OF DEFICIENCIES	ID TAG	PROVIDER'S PLAN OF CORRECTION
F558 S/S=E	**Reasonable Accommodations Needs/Preferences** CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure resident preferences were followed for 2 of 3 residents reviewed for bathing (Residents #23 #8). Findings: 1.Resident #23 and has a Brief Interview for Mental Status (BIMS) of 10 out of 15, indicating he/she is moderately cognitively impaired. Review of Resident #23's care plan revealed, " ... requires extensive assist by 1 staff with bathing BID [2 times a day] and as necessary ...often refuses care reapproach and offer several times as needed ..." Review of "East/West Bath Schedule," updated 1/25/25, revealed that Resident #23 is to receive a shower or bed bath on Thursday day shift. Review of Resident #23's clinical record lacked evidence that he/she was offered/refused a shower or bed bath on 10/10/24, 1/2/25, 1/9/25, 1/16/25, 1/30/25, and 2/6/25. During an interview on 2/5/25 at 11:33 a.m., Certified Nursing Assistant (CNA) #7 stated Resident #23 primarily receives bed baths but is showered occasionally and sometimes refuses to bathe, though not often. 2. Resident #8 has a BIMS of 15 out of 15, indicating he/she is cognitively intact. Review of Resident #8's Annual Minimum Data Set (MDS) dated 4/11/24, under "Section F- Preferences for Customary Routine and Activities, Interview for Daily Preferences," revealed it is very important for Resident #8 to choose his/her bathing options. Review of Resident #8's care plan states, " ...self-care performance deficit r/t [related to] Activity Intolerance, Impaired balance ... BATHING/SHOWERING ...requires extensive assist by 1 staff for bathing daily and as necessary ..." Review of "East/West Bath Schedule," updated 1/25/25, revealed that Resident #8 is to receive a shower on Thursday night shift. During an interview on 2/5/25 at 10:00 a.m., Resident #8 stated his/her shower day is Thursday and that he/she is supposed to get a shower but that staff does not want to give him/her one, so they provide a bed bath	F558 S/S=E	Residents have potential to be affected. Resident #8 was asked and confirmed she prefers a shower on Thursday evenings. Record indicates resident #8 received a bed bath on 2/13 and 2/27 and a shower on 2/20 and 3/6. Resident #23 was asked and confirmed he prefers a shower or bed bath on Thursday during the day. Record indicates resident #23 received a bed bath on 2/13 and 2/27, and a shower on 3/6. Residents were asked their preference for type of bath and what day and shift they prefer on 2/8/25. Bath schedule has been updated, and audit complete to ensure POC ADL documentation matches resident preference and bath schedule. New admissions will be asked about bathing preferences during initial resident preference assessment completed by activity department. The activity department will ask about preferred method,

	instead. During a follow-up interview on 2/7/25 at 11:09 a.m., Resident #8 stated that he/she wanted to get a shower last night, but staff did not offer a shower and instead gave him/her a bed bath. Review of Resident #8's "Bathing Task," revealed he/she received a shower on 12/12/24. Further review lacked evidence he/she was offered/refused a shower or bed bath on 10/17/24, 10/24/24, 10/31/24, 11/7/24, 11/14/24, 11/21/24, 11/28/24, 12/5/24, 12/19/24, 12/26/24, 1/2/25, and 1/23/25. During an interview on 2/5/25 at 11:33 a.m., CNA #7 stated Resident #8's shower day is Thursday and that he/she requires a Hoyer lift to transfer to a shower chair and is dependent on assistance for bathing.		day and shift and document within assessment. C.N.A documentation requirement added to electronic medical record to identify what type of bath was provided (sponge bath, whirlpool, bed bath). Option added to document resident refusals. Re-education to be provided to clinical staff regarding updated bath schedule and additional documentation requirements. Charge nurse is to document refusals in a nurse note. Director of Nursing or designee will audit weekly bathing documentation and new admission bath preferences X 8 weeks and monthly X 4 months to ensure continued compliance. Outcomes from audits will be brought to QAPI meetings X 1 year. *Compliance Date: 3/18/2025*
F584 S/S=E	**Safe/Clean/Comfortable/Homelike Environment** CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services	F584 S/S=E	Residents have the potential to be affected. Laundry Carts- Wood on laundry carts has been removed, treated with polyurethane and reinstalled. Conference Room- Ceiling lights in conference room have been cleaned to remove dirt/debris.

	necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to adequately maintain maintenance and housekeeping services necessary to maintain the facility in good repair and sanitary conditions for 2 of 2 units (East and West), a laundry cart, the conference room and the laundry room for 2 of 2 environmental tours (2/5/25 and 2/6/25). Findings: 1. On 2/05/25 at 10:30 a.m., a surveyor and the Administrator observed a laundry cart being used in the East Unit Hallway that had untreated wood holding the laundry bin to the wheeled unit. At this time, in an interview, the Administrator confirmed the wood was not treated and created uncleanable surfaces. 2. On 2/06/25 from 8:35 a.m. to 9:10 a.m., an environmental tour was conducted with the Director of Ancillary Services in which the following findings were observed: Conference Room - There were four (4) ceiling lights that had dirt/debris in them. East Unit - Resident Room 1 - The baseboard heater was coming apart, hanging down and in a disrepair. The room entrance door had chipped/gouges on the face of the door and had rough edges creating an uncleanable surface. - The wheelchair storage closet, across from resident Room 3, had chipped/missing paint and gouges on the door creating an uncleanable surface. - Resident Room 3 - The room entrance door had chipped, gouged and missing paint creating uncleanable surfaces. - Resident Room 4 - The baseboard heater was broken apart, hanging down and in disrepair. The caulking around the base of the toilet was stained yellowish brown. - Resident Room 5 - The baseboard heater has chipped/missing paint creating an uncleanable surface. - Resident Room 6 - The baseboard heater in the bathroom has chipped/missing paint creating an uncleanable surface. The toilet seat was stained yellowish brown. - The base board heater in the dining room had chipped/missing paint creating an uncleanable surface. West Unit - Resident Rooms 7, 8, 10, 11, 12, 13, 15, 16 and 18 had room entrance doors that had chipped, gouged and missing paint creating uncleanable surfaces. - Resident Room 14 - The room entrance door had chipped, gouged and missing paint creating uncleanable surfaces. The walls had		East Room 1- Baseboard heater has been reinstalled and secured. Room door/frame has been sanded down to remove rough edges and painted to remove gouges and chips. WheelChair Storage (Covid Supply Room)- door has been sanded down to remove rough edges and painted. East Room 3- door has been sanded down to remove rough edges and painted. East Room 4- baseboard heater has been repaired and secured. The caulking around the base of the toilet has been replace. East Room 6- baseboard heater in bathroom has been painted and toilet seat replaced. West Rooms 7, 8, 10, 11, 12, 13, 15, 16, 18- doors have been sanded down and painted. West Room 14- door has been sanded and painted. Walls have been sanded and painted. Hallway outside Therapy- baseboard heater has been painted Laundry Room- Ceiling has been cleaned and painted. Floor has been cleaned. Audit has been completed of all resident room doors, walls, bathrooms, light fixtures and heaters. Director of Ancillary Services will complete monthly audits of resident rooms and common areas to ensure continued compliance.

	chipped/missing paint and there was a large area of spackled wall near the bathroom door. - The hallway base board heater, near the Rehab room, had chipped/missing paint creating an uncleanable surface. Laundry Room: - The ceiling above the 2 bay sink had a large brown stain on it. - The floor was dirty and stained brown throughout the laundry. Director of Ancillary Services confirmed the findings.		Administrator to randomly audit for compliance. Re-education to be completed with all staff related to requirement to keep facility in good repair and sanitary conditions. Outcomes from audits will be brought to QAPI meetings X 1 year. *Compliance Date: 3/18/2025*
F655 S/S=D	**Baseline Care Plan** FR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) (ii) A summary of the resident's medications and dietary instructions. (iii) (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and facility policy, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the problems, interventions, and initial goals needed to provide minimum healthcare information necessary to properly care for 1 of 15 residents reviewed for baseline care plans. (Resident #15). Findings: Review of policy "Baseline Care Plan Policy and Procedure"	F655 S/S=D	Residents have the potential to be affected. Resident #15 care plan was updated when pointed out by surveyor, resident is now discharged. Resident #85 is deceased therefore care plan was not updated. Audit of baseline care plan completed for current residents. Residents were reviewed to ensure EBP care plans were developed on those residents who have those identified medical needs indicated for EBP Re-education to be completed with licensed staff related to requirements of baseline care plan and to complete within 48 hours of admission. DON or designee to complete audit of new admissions to ensure

	revised 3/17/23 noted: "...The baseline care plan must (i) Be developed within 48 hours of a resident's admission ..., (ii) include the minimum healthcare information necessary to properly care for a resident including, but not limited to: a. initial goals based on admission orders, b. Physician orders-Code status, c. dietary orders, d. therapy service e. social service- discharge, f. PASRR recommendations (if applicable). On 2/04/25 at 12:54 p.m., a surveyor observed Resident #15 sitting in his/her room in his/her recliner chair with his/her foley catheter bag hanging on his/her walker. The surveyor observed no EBP signage on the resident's door or door frame and did not observe any PPE readily available. Resident #15 was admitted to the facility on 1/22/25 with order that included "Foley care every shift -active 1/23/25. On 2/04/25 at 3:20 p.m., a surveyor and the Director of Nursing (DON) reviewed a list of residents identified to be on Enhanced Barrier Precautions (EBP). The surveyor pointed out that Resident #15 was not on the list and he/she had a foley catheter. The DON stated that he/she had been missed and he/she had not been identified as needing to be on EBP. On 2/4/25 at 3:20 p.m., a surveyor reviewed Residents #15's Base Line Care plan, initiated 1/22/25, and it did not include Problems, Goals, and Interventions for Enhanced Barrier Precautions. At this time, in an interview, the DON confirmed that the base line care plan did not include EBP 2. Resident #85 was admitted on 2/22/24 under hospice care and had diagnoses to include heart failure, chronic respiratory failure with oxygen dependence, hearing loss, falls with rib fractures, and anxiety, Review of Resident #85's clinical record revealed the following active orders for February 2024: -Order with a start date of 2/22/24 for "Pregabalin Oral Capsule 25 MG [milligrams] * Controlled Drug* Give 1 capsule by mouth one time a day for Pain." -Order with a start date of 2/23/24 for "Morphine Sulfate Oral Solution 20MG/5ML [milliliters] (Morphine Sulfate) *Controlled Drug* Give 0.25ml by mouth every 3 hours as needed for Pain for 30 Days." - Order with a start date of 2/23/24 for "Lorazepam Oral Tablet 0.5 MG *Controlled Drug* Give 1 tablet by mouth every 4 hours as needed for agitation for 30 Days." -Order with a start date of 2/23/24 for "Lasix Oral Tablet 20 MG Give 1 tablet by mouth one time a day for CHF [congestive heart failure]" -Order with a start date of 2/23/24 for "Cleanse skin tear to right forearm with N/S, apply bacitracin ointment, cover with non-adherent dressing and wrap with gauze ..." -Order with a start date of 2/24/24 for "Fall mat on floor beside bed every shift" -Order with a start date of 2/26/24 for "Oxygen 2L [liters] continuously via nasal cannula 4-6L for comfort every shift." Review of Resident #85's baseline care plan, initiated 2/23/24, revealed, "Focus: Residents/POA [Power of Attorney]/guardians goal is for resident to remain in long term care facility at this time ..." and "Focus: The resident is (SPECIFY: independent/dependent on staff etc.) for meeting emotional, intellectual, physical, and social needs r/t [related to] (if dependent) Disease process (Specify) ..." but lacked evidence that goals and interventions were put into place for these focus areas. Further		deadline is met and all required areas are included. Outcomes from audits will be brought to QAPI meetings X 1 year. *Compliance Date: 3/18/2025*

	review of Resident #85's baseline care plan lacked evidence that goals and interventions were put into place for hospice care, activities of daily living, pain, anxiety, diuretic use, impaired skin integrity, falls, oxygen use, and nutrition. On 2/7/25 at 12:47 p.m., the Director of Nursing (DON) reviewed Resident #85's care plan and confirmed it did not contain goals and interventions for the above concerns.		
F684 S/S=D	**Quality of Care** § 483.25 Quality of care 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 interviews, observations, and record review, the facility failed to document and adequately monitor a resident after an unwitnessed fall for 1 of 2 residents reviewed for falls (Resident #28). In addition, the facility failed to ensure that physician orders were followed for 1 of 2 residents reviewed. (Resident #8 & (Resident #7) Findings: 1. Review of Resident #28's clinical record indicated that he/she sustained an unwitnessed fall on 1/23/25 at 10:45 p.m. Further review of the clinical record lacked evidence that a fall risk assessment and "Post Fall Observation Tool" were completed or that neurological checks were initiated following the unwitnessed fall. Review of policy, "Falls Management Policy," revised 12/4/24, states, "Complete a fall risk assessment upon admission ...quarterly ...and after a fall ...Complete Post Fall Observation Tool, following a fall ...If the fall is unwitnessed ...neurological checks will be initiated as outlined on the Neurological Assessment Flow Sheet ..." On 2/10/25 at 10:53 a.m., during an with the Director of Nursing (DON) stated it is her expectation that after an unwitnessed fall, the nurse completes a post-fall observation tool and initiates neuro-checks. At this time, the DON confirmed that the facility failed to complete the required documentation and monitoring for the above unwitnessed fall. 2. Review of Resident #8's clinical record revealed a physician order, with a start date of 1/17/24, for "Continuous Oxygen 2L/min [liters per minute] to maintain O2 [oxygen] sat [saturation] >88%" On 2/4/25 at 10:49 a.m. and 2/5/25 at 9:59 a.m., Resident #8 was observed lying in bed, receiving continuous oxygen via a nasal cannula, connected to an oxygen concentrator located on the floor next to the bed, out of Resident #8's reach, with the oxygen flow rate set to 2.5 L/min. On 2/5/25 at 10:00 a.m., during an interview, Resident #8 stated that he/she does not adjust his/her oxygen concentrator, and that staff make all adjustments to the oxygen flow rate. On 2/5/25 at 11:50 a.m., the finding was reviewed with the Administrator.	F684 S/S=D	Residents have the potential to be affected. Review and revision of Fall Policy completed. Re-education to be provided to licensed staff, med techs and C.N.As on fall policy and following procedure after a fall occurs. Fall management binder updated and at nurses' station for reference. Colored folders created with reference sheet and all required documentation for a fall. Audits to be completed by DON or designee weekly X 8 and monthly X 4 to ensure staff are following policy & procedure post fall (duration). Audit of residents with oxygen orders complete. Orders have been updated To provide clear instructions. TAR has been updated to include the number of liters concentrator/tank is set to in addition to confirming when the oxygen is on. Re-education to be completed for licensed nurses related to

	3. On 2/6/25, a review of Resident #7's clinical record was completed. Resident #7 had a Physician order on 12/31/24 to obtain bloodwork (labs) for a Complete Blood Count (CBC) without diff, Comprehensive Metabolic Panel (CMP), Erythrocyte sedimentation rate (ESR) and C-Reactive Protein (CRP) the next lab day. A review of the physicians orders written on the Medication Administration Record (MAR) revealed the resident required labs to be drawn on 12/31/24 for a CBC without diff, CMP, ESR and CRP. A review of the lab results for Resident #7 revealed the physicians ordered labs were not done until 1/28/25. On 2/6/25 at 9:34 a.m., in an interview, the DON stated that the providers order for labs was missed and she had provided education to nursing staff regarding the process of adding provider orders for lab work to the binder used for the lab.		requirement to follow doctors orders related to oxygen. Audit of lab orders has been completed. Re-education to be completed with licensed nurses related to requirement to put copy of any lab orders in lab book. Audit to be completed twice monthly to ensure all ordered labs have been drawn, or medical records includes documentation if resident refused. Outcomes from audits will be brought to QAPI meetings X 1 year. *Compliance Date: 3/18/2025*
F689 S/S=D	**Free of Accident Hazards/Supervision/Devices** CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of Safety Data Sheets (SDS), the facility failed to ensure that the resident's environment was free of accident hazards relating to the storage of chemicals being properly secured for 1 of 5 days of survey (2/10/25). Findings: . The Safety Data Sheet for "Oxivir Tb Wipes(Virucidal - Bactericidal - Fungicidal - Tuberculocidal) Disinfectant Cleaner" wipes noted the following: 4. First Aid Measures: Eyes: Rinse with plenty of water. If irritation occurs and persists, get medical attention. Ingestion: IF SWALLOWED: Call a Poison Center or Doctor/Physician if you feel unwell. On 2/10/25 at 8:00 a.m., a surveyor observed a 1.8 pound container of Oxivir Tb Wipes(Virucidal - Bactericidal - Fungicidal - Tuberculocidal) Disinfectant Cleaner wipes in the conference room which had the door open. The chemical was not secured and accessible to confused and vulnerable residents who ambulate and residents who also move about the facility in wheelchairs. On 2/10/25 at 8:35 a.m., in an interview, the Administrator confirmed the wipes were left unsecured in an unlocked room and accessible to	F689 S/S=D	Residents have the potential to be affected. Oxivir wipes are not routinely stored in the conference room but had been brought to a surveyor for review the Friday before. Conference Room is routinely locked. Locked cabinet purchased and installed in conference room to store any hazardous chemicals to ensure resident safety. Re-education provided to staff related to importance of keeping hazardous chemicals within a locked cabinet.

	confused and vulnerable residents who ambulate and residents who also move about the facility in wheelchairs.		Outcomes from audits will be brought to QAPI meetings X 1 year. *Compliance Date: 3/18/2025*
F695 S/S=E	**Respiratory/Tracheostomy Care and Suctioning** CFR(s): 483.25(i)§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to maintain respiratory equipment in a sanitary manner to help prevent the development and transmission of disease and infection related to respiratory care for 3 of 4 days of survey. (2/4/25, 2/5/25 and 2/10/25) Findings: 1. On 2/4/25 at 10:40 a.m., a surveyor observed Resident #13's oxygen concentrator tubing and nasal cannula was observed stored on top of resident's bureau on some of his/her personal belongings and not bagged. The resident stated to the surveyor that he/she only wears oxygen at night and it is stored during the day. 2. On 2/5/25 at 8:15 a.m., a surveyor observed Resident #13's oxygen concentrator tubing and nasal cannula was observed stored on top of her concentrator and not bagged. On 2/05/25 at 10:25 a.m., in an interview, the Administrator confirmed that the oxygen tubing and nasal canula should be stored in a bag and not just draped on the resident's belongings on the night stand or coiled up and stored on top of the O2 concentrator. At this time, the surveyor asked for the oxygen/respiratory policy and procedure for storing equipment in the resident. On 2/05/25 at 11:50 a.m., the Administrator reached out to the Regional Director of Clinical Operation-Maine for input and a policy on O2 storage and equipment storage. The Regional Director of Clinical Operation-Maine informed the Administrator that National Health Care Associates Inc. does not have a specific policy on that however, they store tubing in respiratory bags when they are not in use. The facility could not produce a policy and procedure on storing oxygen/respiratory equipment in the resident rooms. 3. On 2/10/25 at 9:25 a.m.. Resident #13's oxygen concentrator tubing and nasal cannula was observed lying on the floor next to the head of her bed and was not bagged. On 2/10/25 at 9:30 a.m., in an interview, LPN #1 confirmed that Resident #13's oxygen concentrator tubing and nasal cannula was lying on the floor next to the head of her bed and was not stored in a bag.	F695 S/S=E	Residents have the potential to be affected. Oxygen storage policy has been reviewed and updated. Policy updated to include where to store oxygen mask, nasal canula and tubing when not in use. Audit completed of residents with orders for oxygen. Re-education to be provided to clinical staff related to policy update and expectations of where to store oxygen tubing and masks when not in use. Director of Nursing or designee will audit weekly X 8 to ensure continued compliance. Outcomes from audits will be brought to QAPI meetings X 1 year. *Compliance Date: 3/18/2025*
F757 S/S=	**Drug Regimen is Free from Unnecessary Drugs** CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate	F757 S/S=	Residents have the potential to be affected. Provider to document addendum in record

	indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to show evidence of an attempt of a gradual dose reduction (GDR) and lacked documentation to justify the continued use of an antidepressant medication for 1 of 5 residents reviewed for unnecessary medications (#5.) Finding: Resident #5 has diagnosis of Bipolar Disorder, Major Depressive Disorder. Resident #5's Medication Administration Record (MAR) indicated that Resident #5 had been receiving the antidepressant medication Venlafaxine Extended Release (ER) 225 milligrams (mg) once daily, since 6/15/24. A Pharmacy Report dated 11/20/24 indicated that Resident #5 had been receiving antidepressant Venlafaxine ER 225 mg daily since 6/15/24. Consider gradual dose reduction (GDR) or document contraindication. The clinical record lacked evidence that a GDR was attempted or documented that it was clinically contraindicated for this resident between the dates of 11/20/24 and 2/7/25. The surveyor discussed this finding in an interview with the Administrator on 2/6/25 at 7:45 a.m.		providing rationale for not agreeing with pharmacy recommendation of GDR for 1 of 3 medications. Audit has been completed to ensure GDR recommendations were reviewed and either accepted or rationale for not accepting the recommendation is documented in medical record. Re-education to be provided to providers and licensed nurses related to requirements when accepting or declining pharmacy recommendations. DON or designee will reconcile pharmacy recommendations after provided to provider to ensure pharmacy recommendations have been addressed (accepted or declined). Outcomes from audits will be brought to QAPI meetings X 1 year. *Compliance Date: 3/18/2025*
F812 S/S=	**Food Procurement, Store/Prepare/Serve-Sanitary** CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F812 S/S=	Residents have the potential to be affected. Ceiling tiles above the food preparation area have been replaced. Food debris on floor behind stove and around edges of floor was immediately corrected.

	serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, review of the Dish Machine Temperature Logs (dated 2013), and review of the Food Storage policy (dated 2013), the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for ceiling tiles, floors, and a wall mounted fan; failed to ensure foods were sealed, labeled and dated in a reach-in freezer and in a walk-in refrigerator; failed to ensure that the kitchen ice machine was plumbed in accordance with code requirements to prevent food contamination and failed to ensure that the dish machine was monitored for proper wash and rinse temperatures to ensure clean and sanitized utensils and dishes, all for 1 of 1 kitchen tour for 1 of 1 day of survey (2/4/25). Findings: 1. On 2/4/25 from 9:10 a.m. to 10:00 a.m., a surveyor conducted a kitchen tour with the Food Service Director in which the following findings were observed: - There were three ceiling tiles above a food preparation area that had brown stains on them. - There was trash and food debris on the floor under the equipment and around the edges of the floor. - The dish room had a wall mounted fan that was dusty/dirty and a base board heater that had chipped/missing paint creating an uncleanable surface. - There was an unlabeled and undated plastic container of cereal on a food preparation table. - There was a large bin of flour that was unlabeled and undated. - The walk-in refrigerator had one pie crust wrap that was unlabeled and undated. Also, there was a container of peeled eggs that was not securely shut/sealed and open to the air. - The walk-in freezer had one large package of meatballs, one package of stuffed shells, one package of chicken patties and two packages of pancakes that were unlabeled and undated. - The kitchen ice machine air gap was not plumbed in accordance with code requirements to prevent food contamination. The facility's "Food Storage" policy noted: Procedure: 13. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. 14. Refrigerated food storage: F. All food should be covered, labeled and dated. 16. Frozen foods: All food should be covered, labeled and dated. "This direct connection of waste water and potable water was in violation of the 10-114 State of Maine Rules Chapter 226, definition Section A, which defines an Air-Gap Separation - A physical separation between the free-flowing discharge end of a potable water supply pipeline and an open or non-pressure receiving vessel. An air-gap separation shall be at least twice the diameter of the supply pipe measured vertically above the overflow rim of the vessel - in no case less than one inch (2.54 cm) and the Code of Federal Regulation, Title 21, Part 1250, Section 1250, 30 (d) states "all plumbing shall be so designed, installed, and maintained as to prevent contamination of the water supply, food, and food utensils." On 2/4/25 at 10:00 a.m., in an interview, the Food Service Director (FSD) confirmed the findings. 2.		Dish Room- The wall mounted fan was taken down and cleaned immediately. Baseboard heater was painted. Additional labels purchased to provide easier way to label and date going forward The kitchen ice machine air gap plumbing was corrected during survey and found to be in compliance. Food items identified without label/date were corrected at time of survey. Re-education to be completed with dietary department related to important of clean/sanitary environment, label/dating of all food items and importance of completing the temperature log for the dishwashing machine. Food Service Director or designee to complete audit of cleanliness, label and dating of food and dishwasher temperature logs daily X 7, weekly X 7 to ensure continued compliance. Quarterly rounds with maintenance and administrator scheduled going forward. Outcomes from audits will be brought to QAPI meetings X 1 year. *Compliance Date: 3/18/2025*

	Upon review of the Dish Machine Temperature Logs, the surveyor found the following missing dates of monitoring/documentation. November 2024: Breakfast - 2, 3, 8, 15, 16, 17 and 19. Lunch - 16, 18, 24, 27 and 28. Dinner - 22, 27 and 28. December 2024: Breakfast - 1, 6, 10, 19, 2 and 30. Lunch - 1, 5, 19, 20 and 25. January 2025: Breakfast - 7, 21, 30 and 31. Lunch - 5, 8, 12, 13, 14, 16, 22 and 23. Dinner - 1, 2, 3, 5, 8, 12-16, 21 and 22. The facility's "Dish Machine Temperature Log" noted: Policy: Dishwashing staff will monitor and record dish machine temperatures to assure proper sanitizing of dishes. 3. Staff will be trained to record dish machine temperatures for the wash and rinse cycles at each meal. a. The food service manager will spot check this log to assure temperatures are appropriate and staff is actually monitoring dish machine temperatures. On 2/5/25 at 2:00 p.m., in an interview, the FSD confirmed there were missing dates of monitoring/documentation of the dish machine temperatures for November 2024, December 2024 and January 2025.		
F880 S/S=D	**Infection Prevention & Control** CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents. identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must	F880 S/S=D	Residents have the potential to be affected. Review of Facility Policies added to ongoing agenda for quarterly QAPI meetings. Infection Prevention & Control Policy reviewed and updated. Re-education completed with leadership team to ensure understanding of policy review and/or update required at minimum, on an annual basis. Administrator or designee will audit and track required policy reviews and updates to be completed at quarterly QAPI meetings. Outcomes from audits will be brought to QAPI meetings X 1 year. *Compliance Date: 3/18/2025*

	handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to conduct an annual review of it's Infection Prevention and Control Program (IPCP). Finding: On 2/6/25, during a review of the facility's IPCP policy and procedures, a surveyor noted various policies within the program lacked dates indicating a review and/or revision was completed. Policies included: "Infection Control/Exposure Control Plan Review Policy revised 9/2018, North Country Associates: Infection Control Immunizations - Influenza, Pneumococcal Policy revised 9/2018, COVID-19 (Vaccine Policy revised 5/2/23 and National: Clinical Services Infection Prevention & Control Policy dated 6/1/23. On 2/6/25 at 10:07 a.m., the Administrator confirmed that the IPCP policies and procedures had not been reviewed on annually.		
F882 S/S=D	**Infection Preventionist Qualifications/Role** CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facility failed to designate a qualified staff member to function as the Infection Preventionist, who is responsible for the facility's Infection Control Program since 12/4/22. Finding: On 2/4/25 at approximately 9:37 a.m., during an interview with the Director of Nursing (DON), the surveyor inquired who was responsible for the facilities infection control program. The DON stated that she had been the facilities Infection Preventionist until she transitioned to the DON position on 12/4/22 and a new acting IP and (Assistant Director of Nursing) ADON was hired in January 2024. As of today, the new acting IP has not completed the infection control training for the IP role. A review of the Infection Prevention & Control Policy indicates under Roles and Responsibilities: Administration: Designate one or more individual(s) as the Infection Preventionist(s) who is responsible for the facility's IPCP. The IP will: i. Have primary professional training in nursing, medical technology, microbiology, epidemiology, or another related field. ii. Be qualified by education, training experience, or certification. iii. Work at least part-time at the facility. iiii. Have completed specialized training in infection prevention and control. Be an active member of the facility's quality assessment and assurance committee and reports to the committe on a regular basis. On 2/4/25 at 3:00 p.m. a surveyor	F882	In accordance with 42 CFR §488.331, the facility has one (1) opportunity, which is through the IDR process, to dispute the deficiencies cited at the survey. Required documentation will be submitted to initiate IDR process for F882 tag only.

	confirmed with the Administrator that the facility did not have a designated and qualified IP since 12/4/22.		
F883 S/S= D	**Influenza and Pneumococcal Immunizations** CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on immunization record review, review of the facility's immunization policy and interview, the facility failed to implement their Influenza, Pneumococcal, COVID policy for 1 of 5 residents whose immunization records were reviewed. (#19) Finding: The facility's "Infection Prevention & Control Policy" revised 6/1/23 indicated under Immunizations- Influenza: It is the policy of this facility that every fall, residents will be offered immunization against influenza. The time for immunization will follow the recommendations of the Centers for Disease Control and Prevention (CDC) and the state department of health. Residents or their responsible party will be educated about the risk/benefit of the vaccine. Resident #19's clinical record indicated that the resident was admitted to the facility on 6/2023. Resident #19's immunization records lacked evidence that the resident's Influenza Vaccination was administered as directed by the facility's "Infection	F883	Residents have the potential to be affected. Audit of resident immunization records related to annual influenza vaccine complete. New admission immunization records will be added to spreadsheet to ensure ongoing tracking and compliance. Re-education to be provided to licensed staff regarding Influenza administration guidelines according to the CDC requirement to document refusals in medical record. DON or designee to complete audit of new admission influenza vaccine compliance monthly X 4 or until compliant. Outcomes from audits will be brought to QAPI meetings X 1 year. *Compliance Date: 3/18/2025*

	Prevention & Control Policy. On 2/6/25 at 8:30 a.m., the Director of Nursing (DON) stated that Resident #19's consent for the Influenza Vaccination was obtained from the Power of Attorney (POA) in October 2024. At that time, Resident #19 had refused the vaccination, and staff had planned on reapproaching the resident. Since then, she had lost site of the vaccines. Resident #19 received the Influenza vaccine on 2/5/25.		
F887 S/S=D	**COVID-19 Immunization** CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on immunization record review, review of the facility's immunization policy and interview, the facility failed to implement their Infection Prevention & Control Policy for 1 of 5 residents whose immunization records were reviewed. (#19) Finding: The facility's "Infection Prevention & Control Policy" revised 6/1/23 indicated under Immunizations - COVID: The facility will offer the COVID-19 vaccine series to all eligible residents as per recommendations of the Center for Disease Control and Prevention. (CDC) Vaccines are offered by the facility or		Residents have the potential to be affected. Audit of resident immunization records related to annual covid-19 vaccine complete. New admission immunization records will be added to spreadsheet to ensure ongoing tracking and compliance. Re-education to be provided to licensed staff regarding covid-19 administration guidelines according to the CDC and requirement to document refusals in medical record. DON or designee to complete audit of new admission influenza vaccine compliance monthly X 4 or until compliant Outcomes from audits will be brought to QAPI meetings X 1 year. *Compliance Date: 3/18/2025*

	through an arrangement with a pharmacy partner, local health department or other appropriate health entity. Residents and/or healthcare representative (s) will be provided with education by a physician or licensed nurse regarding COVID-19 immunization using the Emergency Authorization Use (EAU) Fact Sheet for Recipients and Caregivers. Any new vaccine information will be dispersed as they become available. Resident #19's clinical record indicated that the resident was admitted to the facility on 6/27/23. Resident #19's immunization records lacked evidence that the resident's Covid-19 immunization was administered as directed by the facility's "Infection Prevention & Control Policy. On 2/6/25 at 8:30 a.m., the Director of Nursing (DON) stated that Resident #19's consent for the COVID-19 immunization was obtained from the Power of Attorney (POA) in October 2024. At that time, Resident #19 had refused the vaccination, and staff had planned on reapproaching the resident. Since then, she had lost site of the vaccines. Resident #19 received the Covid-19 vaccine on 2/5/25.		
F909 S/S=F	**Resident Bed** CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on interviews, the facility failed to conduct regular inspection of all bed frames, mattresses, and bed rails as part of a regular maintenance program to identify areas of possible entrapment for 32 of 32 beds. This has the potential to affect the safety of all residents. Finding: On 2/10/25 at 11:30 a.m., a surveyor asked the Administrator for the bed gap measurements and side rail gap measurement documentation. A surveyor received and reviewed the documentation with the Administrator and she confirmed that the bed gap measurements and side rail gap measurements had not been completed since February 2023. On 2/10/25 at 12:05 a.m., a surveyor and the Director of Ancillary Services reviewed the bed gap measurements and side rail gap measurement documentation. At this time, in an interview, the Director of Ancillary Services confirmed that regular inspection of all bed frames, mattresses, and bed rails as part of a regular maintenance program to identify areas of possible entrapment and bed gap measurements and side rail gap measurements have not been completed since February 2023.		Residents have the potential to be affected. Entrapment Zone Testing completed for all resident beds and documented on correct form. Re-education to be completed with clinical and maintenance department related to requirement to complete any time mattress is changed or resident changes beds. Director of Ancillary Services or designee to complete audit monthly of mattress identification numbers to ensure testing is complete if new mattress is used or resident changes beds. Outcomes from audits will be brought to QAPI meetings X 1 year. *Compliance Date: 3/18/2025*

F947 S/S=E	**Required In-Service Training for Nurse Aides** CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must-§483.95(g) (1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year §483.95(g) (2) Include dementia management training and resident abuse prevention training. §483.95(g) (3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g) (4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on Certified Nursing Assistant (CNA) employee education record review and interview, the facility failed to monitor and ensure that the Certified Nursing Assistants (CNAs) received the required 12 hours of annual in-service education training for 5 of 5 randomly selected CNAs employed greater than 1 year (CNA #1, CNA #2, CNA #3, CNA #4, and CNA #5) Findings On 2/6/25, a surveyor reviewed the following employee education files: 1. CNA #1 was hired 3/27/23. A review of CNA #1's education records revealed they had not received the required 12 hours of education/in-service training including Resident Rights, Dementia, Quality Assurance and Performance Improvement Program (QAPI), and Infection Control in 2024. 2. CNA #2 was hired 4/10/23. A review of CNA #2's education records revealed they had not received the required 12 hours of education/in-service training including Resident Rights, QAPI, and Infection Control in 2024. 3. CNA #3 was hired 1/8/24. A review of CNA #3's education records revealed they had not received the required 12 hours of education/in-service training including Dementia, QAPI, and Infection Control in 2024. 4. CNA #4 was hired 9/13/1994. A review of CNA #4's education records revealed they had not received the required 12 hours of education/in-service training including QAPI and Infection Control in 2024. 5. CNA #5 was hired 11/1/2016. A review of CNA #5's education records revealed they had not received the required 12 hours of education/in-service training including Resident Rights, QAPI and Infection Control in 2024.		Residents have the potential to be affected. Annual Safety and Skills Education to be completed by C.N.As. to include Dementia, resident rights, QAPI and infection control. Opportunities for ongoing C.N.A CEUs posted on education board for C.N.As going forward. Re-education to be completed by C.N.As related to requirement to complete CEUs annual requirements, including all mandatory annual education. Administrator or designee to audit education records monthly going forward to ensure C.N.As are completing required CEUs on an annual basis. Outcomes from audits will be brought to QAPI meetings X 1 year. *Compliance Date: 3/18/2025*