STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205149	A. BUILDING _____ B. WING _____	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KATAHDIN NURSING HOME	22 WALNUT STREET MILLINOCKET, ME 04462

(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 On 3/11/24 through 3/13/24, on-site visits were conducted at Katahdin Nursing Home for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification, and facility reported incident #ME00046682. It was determined that Katahdin Nursing Home was not in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities	F 000	This plan of correction constitutes my written allegation of compliance for deficiencies during the recent survey on March 12,2024. However, submission of this plan of correction is not the admission that a deficiency exist or that was cited correctly. This plan of correction is submitted to meet the requirement established by State and Federal Law.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 657		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Brown	administrator	4/3/24

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 657	Continued From page 1 assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to update a care plan for the problem area of care/assistance for 1 of 1 residents reviewed for fall with major injury (Resident #10 [R10]). Finding: On 3/11/24 at 11:26 a.m., a surveyor observed R10 sitting in a wheelchair with a cast on his/her left lower leg. On 3/13/24, R10's clinical record was reviewed which indicated that the resident fell on 2/10/24 and sustained a fractured left lower leg and is now non-ambulatory and wheelchair dependent. As of 3/11/24, R10's care plan had not been revised and/or updated with interventions related to his/her fall with major injury. Review of Minimum Data Set (MDS) 3.0 Nursing Home Comprehensive (NC) Version 1.18.11 Effective 10/01/2023 significant change form was completed on 2/27/24 and signed by MDS Coordinator on 2/28/24 indicated care area triggered related to falls and addressed in the care plan. Review of the care plan, dated 1/23/24, lacked evidence that it was updated to reflect the change in ambulation status from "I walk without help I use a roller walker", to non-weight bearing. On 3/12/24 at 2:19 p.m., during an interview with a surveyor, the MDS Coordinator stated that the care plan for the ambulation status, and falls was not updated after a fall with major injury, and it should have been. The above finding was confirmed at this time.	F 657	F657 *Care plan for ambulation status and falls was updated immediately by the MDS Coordinator on 3/13/24. *No other resident was affected by this alleged deficient practice. *Any resident with a significant change or fall with injury will be audited and completed by the Clinical Supervisor and/or the DON to confirm the care plan has been updated properly. *Weekly audits will be done by the Clinical Supervisor and/or the DON to confirm care plans are being updated and audit results will be brought to QAPI monthly for 3 months. *Corrective date for care plan 3/13/24	and on going
F 684 SS=E	Quality of Care	F 684		

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F 684	Continued From page 2 CFR(s): 483.25 § 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 record reviews, Medication Administration Records (MARs) and interviews, the facility failed to follow physician orders for 4 of 9 sampled residents (Resident #15 [R15], R4, R19, and R31). Findings: 1. On 3/12/24, R15's clinical record was reviewed. R15 had a medication order for Sucralfate (a protectant) 1 gram, give 1 tablet by mouth three times a day at 6:00 a.m., 11:00 a.m. and 4:00 p.m. for gastroesophogeal reflux disease. A review of R15's MAR indicated that R15 did not receive Carafate on 12/3/23, 12/4/23, 12/5/23 and 12/6/23. On 3/12/24 at 11:00 a.m., in an interview with a surveyor, the Clinical Supervisor confirmed that R15 had not received Carafate for four days. She stated they have had problems getting medications from the Pharmacy and medications are not always ordered timely. 2. On 3/12/24, R4's clinical record was reviewed and included a physician order for Lantus	F 684	F684 #1 *If medication is unavailable at the time of scheduled dose the doctor will be notified and an order to hold the scheduled medication or a new medication order will be obtained. Also the local pharmacy may be used for quicker delivery purposes. *A licensed meeting was held after survey completion. Education was provided to Licensed Staff on the procedures of missing medications and the plan/process moving forward. *Med Tech and Licensed Staff are to print off exception reports at the end of each shift and turn them into the Clinical Supervisor and/or the DON for follow up. *The exception report provided by the Med Tech and Licensed Staff will be reviewed by the Clinical Supervisor and/or the DON for any deficiencies. Any deficiencies found will be addressed,corrected, and results brought to QAPI monthly for 3 months. *Correction Date: Resident R15 medications received on 12/7/2023 with no recurring incident. F684 #2 *Licensed Staff meeting was held after survey completion. All Licensed Staff were educated on insulin administration. Physician will be notified before holding insulin. Licensed Staff will check the Pyxis for missing medications before obtaining an order to hold a medication or to start a new medication. *Random audits will be done on residents in the facility. No other residents were affected by this alleged deficient practice. *Med Tech and Licensed Staff are to print off the exception report at the end of each shift and turn into the Clinical Supervisor and/or the DON for follow up. *Exception reports provided by the Med Tech or the Licensed Staff will be reviewed by the Clinical Supervisor and/or the DON. Any deficient findings will be addressed, corrected, and results brought to QAPI monthly, for 3 months. *Correction Date: Resident R4 medications received on 2/5/2024 with no reoccurring incidents.	and on going And on going

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F 684	Continued From page 3 (long-acting insulin) , dated 2/12/24, to administer 40 units in the a.m. and 50 units in the p.m. The order for the Lantus did not include parameters to hold. Documentation on the Medication Exception Report indicated that Lantus was held multiple times due to low blood sugar between 2/12/24 and 3/11/24. The physician orders contained a standing order, dated 10/5/23, that indicated the physician should be notified prior to holding any insulin; this standing order was displayed on the MAR. On 3/12/24 at 10:54 a.m., during an interview with a surveyor, Licensed Practical Nurse (LPN)1 stated that she used her nursing judgement to hold the Lantus (multiple times) but did not notify the physician or obtain an order to hold the insulin. R4's clinical record included a physician order, dated 10/5/23, to administer Duloxetine (an antidepressant) 60 milligrams (mg) in the morning. The medication administration record (MAR) for February 2024 indicated that this medication was held on 2/4/24 with no reason documented on the Medication Exception Report but the MAR indicated this medication was reordered on 2/3/24. Duloxetine 30 mg tablets were available in the emergency stock. R4's clinical record included a physician order, dated 2/15/24, to administer Tramadol (an opioid pain reliever) 50 mg, 3 times a day for pain. The MAR for February 2024 indicated that this medication was held on 2/27/24 for the 3:00 p.m. 9:00 p.m., and on 2/28/24 for the 9:00 a.m. dose, with documentation on the Medication Exception Report because the medication was not available. This medication was reordered on 2/27/24 and was available in the emergency stock.	F 684	F684 #3 *Any over the counter medications that are ordered by the doctor will be obtained locally to ensure administration starts immediately. *There are no other residents with this same medication order at this time therefore, no other resident was affected by this alleged deficiency. *Med Tech and Licensed Staff are to print off the exception report at the end of each shift and turn into the Clinical Supervisor and/or the DON. *The exception report provided by Med Tech and Licensed Staff will be reviewed by the Clinical Supervisor and/or the DON and any deficiencies found will be addressed, corrected, and results brought to QAPI monthly, for 3 months. *Correction Date: 3/25/2024 F684 #4 *If medication is unavailable at the time of scheduled dose the doctor will be notified and an order to hold the scheduled medication and/ or a new order for medication will be obtained. Also, use of the local pharmacy for quicker delivery. *A Licensed meeting was held after survey completion. Education was provided to Licensed Staff on the procedures of missing medications and moving forward. Med Techs and Licensed Staff were also educated on not holding medications to timing unless they have a doctor's order. *Med Tech and Licensed Staff are to print off the exception report at the end of the each shift and turn into the Clinical Supervisor and/or the DON for follow up. *The exception report provided by the Med Tech and Licensed Staff will be reviewed by the Clinical Supervisor and/or the DON and any deficiencies will be addressed, corrected, and results brought to QAPI monthly, for 3 months. *Correction Date: Resident R31 medications were received on 2/6/2024 and no reoccurring incidents.	and on going and on going

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F 684	Continued From page 4	F 684		

3. On 3/12/24, R19's clinical record was reviewed and included a physician order, dated 2/4/24, to start Mucinex (an expectorant work by thinning and lossening mucus in the airways, clearing congestion, and making breathing easier) on 2/5/24, twice a day for 7 days. A review of the MAR and Medication Exception Report indicated the medication was never given because it was not available. On 3/12/24 at 12:42 p.m., during an interview with a surveyor, the Clinical Supervisor stated that she was unaware that this medication was not available, and we could have gone to Hannaford to go get it. We are supposed to get an order to hold a medication if needed.

4. On 3/12/24, R31's clinical record was reviewed and included a physician order, dated 1/25/24, for Sucralfate 1 gram (GM) tablet for R31, to be given by mouth four times a day (7:30 a.m., 11:30 a.m., 4:30 p.m., and 8:00 p.m.) for a diagnosis of gastroesophageal reflux disease.

The clinical record indicated that on 2/3/24 R31's refill order was sent to the pharmacy for Sucralfate 1GM. R31 did not receive Sucralfate on 2/4/24 or 2/5/24 (a total of 8 missed doses), the record indicated "medication [not available], waiting on pharmacy".

On 2/18/24 at 1:39 p.m., R31's indicated Sucralfate 1GM was not given due to "morning meds given too late."

On 2/26/24 at 1:47 p.m., R31's clinical record indicated Sucralfate 1GM was not given due to "morning meds given too late."

On 3/03/24 at 2:32 p.m., R31's clinical record

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F 684	Continued From page 5 indicated Sucralfate 1GM was not given due to "morning meds given too late." On 03/13/24 at 10:09 a.m., in an interview with a surveyor, LPN2 stated, normally we order a medication refill when the card (medication blister pack) reaches the blue strip (the last row on the card). LPN2 stated there are times when they don't have the medicine residents need because the pharmacy does not deliver the medications in time. LPN2 stated she usually gives R31's Sucralfate before meals. LPN2 stated there is no documentation to indicate the medication needs to be given before meals. LPN2 stated the physician was not notified of held doses as the computer automatically notifies the charge nurse electronically. LPN2 stated sometimes she gets stuck down at the other end helping, then it is too late to pass the medication. On 03/13/24 at 10:14 a.m., a surveyor confirmed with LPN2 that R31 did not receive Sucralfate as ordered by the physician on 2/4/24, 2/5/24, 2/18/24, 2/26/24, and 3/3/24.	F 684		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.	F 727		

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F 727	Continued From page 6 §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on time card reviews and interviews, the facility failed to use the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week for 2 of 2 weekend dates reviewed for RN coverage (2/25/24 and 3/9/24). Finding: On 3/11/24, a surveyor requested from the Business Office Manager a printed copy of time cards for RNs for the dates of Sunday 2/25/24 and Saturday 3/9/24. On 3/12/24 at 8:36 a.m., the Business Office Manager and surveyor reviewed the time cards for RNs for those dates and the surveyor confirmed that there was not RN coverage for 8 consecutive hours for either of those 2 dates reviewed. On 3/12/24 08:45 a.m., during an Interview a surveyor, the Director of Nursing (DON) stated that there was a RN that was out on medical leave at this time that worked every other weekend. The DON stated that she does not punch a time card herself but has been filing in on those weekends, but denied working either 2/25/24 or 3/9/24.	F 727	F727 *No residents were affected by the alleged deficient practice. *No residents have the potential to be affected by the alleged deficient practice. There was a Charge Nurse in the building at all times *MDS Nurse and ICP Nurse will be rearranging their schedules every other weekend to ensue we have an RN in the building on the weekends where we are lacking. *DON will monitor the License Schedule and make sure there is a RN scheduled daily X8 hrs., and fill in when needed. This will be done 1 wk in advance and any call out of RN's the DON will be notified immediately. *The Licensed Schedule will be brought to QAPI 1x monthly and reviewed for deficiencies. *Date of correction: 3/23/24	and on going
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in	F 773		

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F 773	Continued From page 7 accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure that physician ordered labs (bloodwork) were attempted or completed for 1 of 6 sampled residents reviewed (Resident # [R]19). Finding: On 3/12/24, R19's clinical record was reviewed and contained a physician order, dated 1/14/24, to attempt to draw blood for 5 laboratory tests (if possible); this order was entered into the electronic treatment administration record (TAR) to be completed on 1/16/24 but was not signed off as being completed. The surveyor was unable to find evidence that this was attempted or completed in the clinical record. On 3/12/24 at approximately 12:15 p.m., during an interview with a surveyor, Licensed Practical Nurse 1 stated that the Clinical Supervisor draws blood for laboratory work. At 12:28 p.m., during an interview with a surveyor, the Clinical Supervisor stated that R19 was a hard stick (difficult to draw blood) and that if she cannot draw blood, she will let the Director of Nursing know so she can try; she will do some research on what happened. At 12:44 p.m., the Clinical Supervisor stated she called the lab and the bloodwork was not done. The surveyor confirmed that there was no	F 773	F 773 *Any labs ordered will be completed by the Clinical Supervisor and/ or the DON. If unable to obtain blood for labs then doctor will be notified and a nursing note will be entered with doctor's recommendations. *No other resident was affected by the alleged deficient practice. *A Licensed Meeting was held immediately following survey completion and education was provided to all Licensed Staff regarding the expectations around labs draws. When a lab draws appears on the TAR for a resident, the Charge Nurse will alert the DON and/or the Clinical Supervisor. It will not be signed off until the DON and/or Clinical Supervisor has verified the lab has been drawn and if it has not then a reason will need to be entered. *DON and/ or Clinical Supervisor will do audits 1 x weekly and check all lab orders for the week to ensure all have been drawn and documented and if they have not, the DON and/or Clinical Supervisor will make sure the process was followed. *The audits will be brought to QAPI 1x monthly x 3 months. *Correction Date: 3/25/2024.	

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F 773	Continued From page 8 evidence that these were attempted.	F 773	F812 #1 *On 3/11/24 in the dry storage area, with the deep freezer, the open bag of garlic bread sticks was resealed with a bread tie. Any food in the deep freezer will be resealed when open and labeled. ziplock bags will also be available to use. * On 3/11/24 the chicken patty bag was thrown away. *On 3/13/24 the open bread rolls were sealed and labeled. Staff have be instructed to use ziplock bags, seal, and label. *On 3/11/24 immediately upon discovery, the DS sealed the 15lb package of bacon. A seal container will be purchased to store the bacon in to ensure it sealed and will be labeled. *No resident were affected by this alleged deficient practice but all residents have the potential to be affected. *On March 20, 2024 the DS had a Dietary Staff Meeting to educate on the proper food storage. *3 days a week DS will audit the deep freezer in the dry storage room, the walk in freezer, and the walk in to ensure food is being sealed and labeled from the environment. *Monthly the DS will share audit results at QAPI. Any deficient practice will be addressed upon the finding and education will be provided. *Correction Date: 3/13/24	And on going
F 812 SS=E	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 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, and interviews, the facility failed to store, prepare, and serve food in accordance with professional standards for food service safety by not storing food in a sanitary manner, not sanitizing the thermometer used for food temperature checks, as well as not monitoring sanitizer levels in the chemical sanitizer bucket to prevent food borne illness for 2 of 3 days of survey (3/11/24, 3/12/24). This has the potential to effect all residents in the facility. Findings:	F 812	F 812 #2 *Cook # 1 happen to be in tray line when the thermometer had fallen to the floor. Cook #1 obtained a new thermometer to take food temps. Unsure if the Surveyor at the time realized that Cook #1 had obtained a new thermometer because both thermometers looked identical. The soiled thermometer was swirled around in the red bucket and left by the red bucket. *On 3/11/24 the DS immediately in-serviced the kitchen staff on proper sanitization for the thermometer. On 3/20/2024 all Dietary Staff were educated on proper sanitization procedures.	cont.

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F 812	Continued From page 9 1. On 3/11/24 at 10:15 a.m., during initial tour of the kitchen a surveyor observed: In the dry storage area, within the deep freezer, 1 open bag of garlic bread sticks, unlabeled and open to the environment. In the walk-in freezer, 1 bag of chicken patties, and 1 open bag containing bread rolls, unlabeled and open to the environment. In the walk-in fridge, 1 open, unwrapped box labeled 15 pounds sliced bacon, open to the environment. On 3/11/24 at 10:30 a.m., a surveyor and Cook #1 observed and confirmed each of the above findings. On 3/12/24 at 11:28 a.m., a surveyor observed 1 open bag containing bread rolls, open to the environment within the walk-in freezer. The surveyor confirmed the bread rolls were not stored in a sanitary manner with Cook #2 at the time of the observation. 2. On 3/11/24 at 11:21 a.m., a surveyor observed Cook #1 check food temperatures. During the observation Cook #1 attempted to use a thermometer to check food temperatures after the thermometer had been dropped on the floor and then swirled it in a red bucket. At this time the surveyor asked what was in the red bucket. On 3/11/24 at 11:45 a.m., in an interview with a surveyor, the Dietary Supervisor (DS) stated the red bucket contained sanitizer solution. DS stated "you don't use this with dishes. You use the dishwasher to sanitize dishes." On 3/11/24 at 11:50 a.m., the surveyor confirmed	F 812	F812 # 2 Cont., On 3/12/24 Cook # 2 was talking to a co-worker while getting ready to perform a temperature check.Cook #2 realized they touched the trash can with their gloves on. Cook #2 changed their gloves and got a new thermometer that was identical to the soiled thermometer. This may have been done while the surveyor was checking the sanitation bucket, so surveyor may not have noticed. The soiled thermometer was left over with the dirty dishes. *No residents were affected by this alleged practice however all residents have the potential to be affected. *Weekly the DS will audit the Cook when taking food temperatures to ensure proper and safe sanitized temperatures are being taken. *Monthly for 3 months the DS will report their findings to QAPI. *Correction Date: 3/20/204 F812 # 3 *Immediatly on 3/11/2024 the sanitized solution in the bucket was thrown away. The employee was immediately educated on appropriate concentration levels for the sanitized bucket. Signage was also posted directly in front of the sanitization station. *All work surfaces have the potential to be affected by this alleged practice. No residents were affected by this. *On 3/20/2024 a Dietary Staff Meeting was held to educate Dietary Staff on proper concentration levels to prevent food borne illness. *Random testing audits of concentration levels in the sanitation bucket will be conducted to prevent food borne illness. Any deficient findings will be immediately addressed by educating staff. *All testing audits will be brought monthly to QAPI, for three months. *Corrective Date: 3/20/2024	And on going And on going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205149	A. BUILDING _____ B. WING _____	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 10 with DS that the thermometer was not sanitized in manner to prevent food borne illness. On 3/12/24 at 11:25 a.m., the surveyor observed Cook #2 check food temperatures. During this observation Cook #2 sanitized the thermometer with alcohol wipes, lifted a trash lid (while holding the thermometer), rinsed the thermometer with water, used a towel to wipe the thermometer, then attempted to check food temperatures with the same soiled gloves and thermometer. At this time the surveyor confirmed with Cook #2 that the gloves were contaminated, and the thermometer was not sanitized in a manner to prevent food borne illness. 3. On 3/11/24 at 11:45 a.m., in an interview with a surveyor, the DS performed a test strip on the sanitizer solution which resulted in a concentration of 100 parts per million (ppm). According to manufacturer's specifications, the appropriate concentration result should be 200-400ppm to prevent food borne illness. On 3/11/24 at 11:50 a.m., the surveyor confirmed with DS that the sanitizer bucket did not meet the appropriate concentration to prevent food borne illness. On 3/12/24 at 11:25 a.m., a surveyor observed Dietary Aid#1 test the sanitizer solution, the test strip result indicated a concentration of 100-200ppm. This finding was confirmed at the time of the observation.	F 812		
F 947 SS=B	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse	F 947		

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F 947	Continued From page 11 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 § 483.70(e) 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 employee file reviews and interview, the facility failed to implement and maintain an effective training program which includes, at a minimum, annual training on dementia for 2 of 3 Certified Nursing Assistants (CNA) reviewed (CNA4, CNA5). Findings: On 3/13/24, the following employee records were reviewed: 1. CNA4 was hired on 12/15/22. There was no documented dementia training completed by CNA4 in the employee file. 2. CNA5 was hired on 12/31/21. The most recent dementia training completed by CNA5 was	F 947	F 947 *No residents were affected by this alleged deficient practice. *FAH will be using Relias learning platform for all in-services starting 3/24/2024. This platform has dementia training and requires 4 hours per year. An email/text will be sent out to each staff member when the in-service is due, with a deadline. *Each dept head will be responsible to check the transcripts weekly to make sure their staff have completed in-services on time. *Results will be brought to QAPI 1x month x 3 months. *Correction Date: 3/24/2024	

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F 947	Continued From page 12 8/13/22. There was no documented dementia training completed by CNA5 for 2023. On 3/13/24 at 8:51 a.m., during an interview with the Business Office Manager, a surveyor confirmed this finding.	F 947		