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	205143	A. BUILDING _____ B. WING _____	07/17/2024

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CUMMINGS HEALTH CARE FACILITY	**5 CROCKER STREET HOWLAND, ME 04448**

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F 000	INITIAL COMMENTS From 7/15/24 through 7/17/24, unannounced on-site visits were conducted at Cummings Healthcare Facility for the purpose of completing the annual Long Term Care Survey Process for Federal Recertification. It was determined that Cummings Healthcare Facility was not in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities.	F 000		
F 568 SS=B	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure quarterly statements were provided to the Resident or Resident representative for 1 of 1 Resident with a trust account (Resident #8 [R8]). In addition, the facility failed to ensure quarterly statements were provided to all Residents or Resident representatives with trust accounts. Finding:	F 568		

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

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F 568	Continued From page 1 On 7/15/24 at 12:25 p.m. during a resident interview, R8 stated that he/she did not recall receiving any quarterly statements with an accounting of his/her resident trust account. On 7/17/24 at 8:41 a.m. during an interview with a surveyor, the Accountant stated they were unable to find documentation to support that R8 was sent his/her quarterly statements and that quarterly statements are not sent out to Residents unless a statement is sent with a cost of care statement or their trust account drops to a negative balance. A surveyor confirmed, at this time, with the Accountant that R8 did not receive any quarterly statements, and that quarterly statements are not sent out to Residents or Resident representatives.	F 568		
F 577 SS=B	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding	F 577		

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F 577	Continued From page 2 years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to post, in a place readily accessible to residents, family members, and legal representatives, the results of the most recent survey of the facility in 2 of 2 survey folders (located in the dining room and entrance foyer). Findings: On 7/16/24 at 8:15 a.m., a surveyor observed the survey folder located in the dining room, located on a rack on the wall. This folder included the State Survey results, with the most recent results from a survey dated 2/11/20, although the State Agency had completed multiple surveys after that date. On 7/16/24 at 8:20 a.m., during an interview with a surveyor, the Administrator stated there were two survey folders, one in the dining room and one in the entrance foyer area for family members, The Administrator and surveyor observed both survey folders with the most recent survey in the entrance foyer folder was 5/11/23, although the State Agency had completed an additional survey after that date on 3/5/24; the Administrator and surveyor also observed the folder in the dining room with the most recent survey dated 2/11/20. During these observations,	F 577		

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F 577	Continued From page 3 the surveyor confirmed that both survey folders did not contain the most recent surveys in them.	F 577		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to complete a comprehensive Minimum Data Set 3.0 (MDS 3.0) assessment within 14 days after a resident experienced a significant change of condition, when hospice services were discontinued for 1 of 1 sampled residents (Resident #5 [R5]). Finding: On 7/15/23, during a review of R5's clinical record, a surveyor could not find evidence that R5 was receiving hospice services even though the most recent MDS, dated 5/16/24, indicated under section O110-K1 that R5 was. On 7/15/24 at 1:17 p.m., during an interview with a surveyor, the Director of Nursing (DON) stated that R5 ended hospice services on 6/3/24. The surveyor asked	F 637		

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F 637	Continued From page 4 both the DON and MDS Coordinator if a significant change MDS was completed when hospice services ended and both replied no. The surveyor confirmed that when a resident comes off of hospice a significant change MDS needed to be done.	F 637		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the Annual Minimum Data Set (MDS) 3.0 was coded accurately on two annual MDS assessments to indicate that a resident had a State Level II Preadmission Screening and Resident Review (PASRR) for 1 of 1 sampled residents reviewed for PASRR (Resident #21 [R21]). Finding: On 7/15/24, R21's clinical record was reviewed and included a PASSR, dated 3/4/20, that indicated that R21 qualified for Level II services. Review of R21's annual MDS, dated 8/3/23, Section: A1500 was coded to indicate that R21 did not have a Level II PASRR and had been coded incorrectly starting with the 8/12/22 annual MDS. On 7/16/24 at 10:12 a.m., during an interview with a surveyor, the MDS Coordinator stated that R21 did have a Level II PASRR and that the MDS was coded inaccurately. The surveyor confirmed this	F 641		

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F 641	Continued From page 5 finding during this interview.	F 641		
F 684 SS=D	Quality of Care 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 review and interviews, the facility failed to follow their fall protocol for neurological assessments and failed to follow physician orders for 1 of 1 residents reviewed for hospitalization (Resident #22 [R22]). Finding: The facility's policy, "Falls Protocol," undated, indicated that staff were to initiate Neuro Checks if a resident sustained a head injury and/or had an unattended fall and directed the licensed nurse to complete a Neurological Evaluation. The Neurological Assessment flowsheet directed staff to complete these every 15 minutes times (x) 4, 30 minutes x 4, 2 hours x 4, and every 4 hours x 4. On 7/16/24, R22's clinical record was reviewed and indicated that R22 had a fall on 6/8/24 at 7:30 a.m., bumped his/her head, and was sent to the hospital later in the day. A review of the Neurological Assessment flowsheet completed	F 684		

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F 684	Continued From page 6 for R22 indicated that the assessments were not completed for the 9:45 a.m. and 10:15 a.m. assessment times, but were completed after those times up to 2:15 p.m., thereafter the resident was at the hospital. On 7/16/24 at 11:39 a.m., during an interview with a surveyor, Licensed Practical Nurse #1 (LPN1) stated she missed those assessments because she thought someone else was going to get them. R22's clinical record also included a physician order, dated 6/28/24, for Metoprolol (blood pressure medication) with parameters that directed staff to call the Medical Provider if R22's systolic blood pressure (SBP) was greater than 170. On 7/6/24 for the morning reading, the SBP was documented at 181 and on 7/15/24 for the morning reading, the SBP was documented at 267. The clinical record lacked evidence of the Medical Provider being called. On 7/16/24 at 11:21 a.m. during an interview with the Minimum Data Set (MDS) Coordinator and the Director of Nursing, a surveyor confirmed this finding. They were unable to find evidence that indicted the Medical Provider was notified each time.	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 7 §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 monthly schedule 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 6 days of 2 months reviewed for staffing (January and February 2024). Findings: On 7/17/24 at 8:20 a.m., a surveyor, Office Manager and Administrator, reviewed the schedules for January and February 2024. The following were confirmed: 1. For January, on 1/9/24, 1/11/24 and 1/29/24, the facility failed to ensure that an RN was working for 8 consecutive hours. 2. For February, on 2/9/24, 2/10/24 and 2/22/24, the facility failed to ensure that an RN was working for 8 consecutive hours.	F 727		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced	F 730		

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F 730	Continued From page 8 by: Based on review of Employee Job Performance Evaluations and interview, the facility failed to complete an annual performance evaluation at least every 12 months, for 2 of 5 sampled Certified Nursing Assistants (C.N.A.) employed greater than 1 year (Certified Nurse Assistant #2 [C.N.A.2] and Certified Nurse Assistant-Medications [C.N.A.-M]). Findings: On 7/17/24 at 10:00 a.m., a surveyor and Administrator reviewed C.N.A.2 and C.N.A.-M's employee files with the following confirmed: 1. C.N.A.2 was hired on 5/9/2018. The annual evaluation was due by 5/9/2024. There was no evidence that the evaluation had been completed as of 7/17/2024. 2. C.N.A.-M was hired on 8/17/2009. The annual evaluation was due by 5/9/2023. There was no evidence that the evaluation had been completed as of 7/17/2024.	F 730		
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	F 812		

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F 812	Continued From page 9	F 812		

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 interview, the facility failed to store food in a sanitary manner on 1 of 3 survey days, and the facility failed to keep accurate and complete temperature logs of the walk-in refrigerator, walk-in freezer, and refrigerator/freezer in the kitchen (7/15/24).

Findings:

On 7/15/24 from 10:35 a.m. through 11:10 a.m. during the initial observation of the kitchen with the Food Safety Supervisor (FSS), it was observed:

1. Thirty chocolate Hormel Magic dessert cups and thirty-five vanilla Hormel Magic dessert cups in the freezer portion of the refrigerator/freezer had a thick buildup of ice crystals around them, and one chocolate Hormel Magic dessert cup was open. Approximately half of the dessert cups were affected by the thick buildup of ice crystals.

2. Two large bins/containers of white dry substances (flour and sugar per interview during observation with the FSS) not labeled or dated in kitchen to the left of the oven.

3. One bag of confectioner sugar open and not

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F 812	Continued From page 10 dated, and one large open box of chocolate chips in an open bag inside the box, not sealed, and not dated in the dry goods storage room. 4. Walk-in freezer temperatures were missing from the temperature log sheet posted on the walk-in freezer for 7/13/24, 7/14/24, and 7/15/24. 5. Walk-in refrigerator temperatures were missing from the temperature log sheet posted on the walk-in refrigerator for 7/13/24, 7/14/24, and 7/15/24. 6. Refrigerator/freezer temperatures were missing from the temperature log sheet posted on the refrigerator/freezer for 7/13/24, 7/14/24, and 7/15/24. In an interview with the FSS at time of observation, a surveyor confirmed the above findings. The FSS states the temperatures were last done on 7/12/24, and it is supposed to be done by the cook.	F 812		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a garbage storage area in a sanitary condition to prevent the harborage and feeding of pests for one trash dumpster for 1 of 3 days of survey (7/17/24). Finding:	F 814		

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F 814	Continued From page 11 On 7/17/24 at 7:40 a.m., a surveyor observed a trash dumpster with the top right lid open with two black bags on top of the dumpster exposing trash. On 7/17/24 at 7:44 a.m., in an interview and observation of the trash dumpster with the Administrator, a surveyor confirmed the above finding.	F 814		
F 880 SS=E	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 §483.70(e) 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:	F 880		

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F 880	Continued From page 12 (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 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:	F 880		

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F 880	Continued From page 13 Based on record review and interviews, the facility failed to develop a water management program to prevent the growth and spread of legionella and other water-borne pathogens, and the facility failed to develop policy and procedures for enhanced barrier precautions to reduce the transmission of multidrug-resistant organisms. Findings: 1. On 7/16/24 at 1:36 p.m., a surveyor and the facility's Director of Nursing (DON) reviewed the facility's infection control policies. The DON stated there is not a policy for enhanced barrier precautions. The surveyor confirmed at this time that the facility did not have policy and procedures for enhanced barrier precautions to reduce the transmission of multidrug-resistant organisms 2. On 7/16/24 at 1:36 p.m., in an interview with a surveyor, the DON stated not knowing of a water management policy for legionella and directed the surveyor to the Administrator. On 7/17/24 at 8:27 a.m., in an interview with a surveyor, the Maintenance Technician stated he did not know of a program that identifies where standing water would be and referred to the Administrator. On 7/17/24 at 8:49 a.m., in an interview with the Administrator, the surveyor confirmed the facility has not completed a risk assessment to determine potential areas of microbial growth, and there is not a policy or procedure for Legionella and other water-borne pathogens.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations	F 883		

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	205143	A. BUILDING _____ B. WING _____	07/17/2024

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F 883	Continued From page 14 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	F 883		

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F 883	Continued From page 15	F 883		

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 record review, facility policy review, and interview, the facility failed to offer Pneumococcal Vaccinations (Prevnar 20) to 3 of 5 residents reviewed (Resident #10 [R10], R28, and R32).

Findings:

On 7/16/24 at 9:02 a.m., clinical record review indicated:
1. R10 was admitted on 3/2/24. There was no evidence R10 had received, been offered, or refused the Prevnar 20 vaccination.
2. R28 was admitted on 2/19/24. There was no evidence R28 had received, been offered, or refused the Prevnar 20 vaccination.
3. R32 was admitted on 9/29/23. There was no evidence R32 had received, been offered, or refused the Prevnar 20 vaccination.

On 7/16/24 at 1:45 p.m., review of the Influenza,

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F 883	Continued From page 16 Pneumococcal, and COVID-19 Immunization Policy indicated, "each resident is offered a pneumococcal immunization unless the immunization is medically contraindicated, or the resident has already been immunized." On 7/17/24 at 8:23 a.m., in an interview with the DON, a surveyor confirmed the Prevnar 20 vaccine was not offered to R10, R28, and R32.	F 883		
F 887 SS=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	F 887		

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F 887	Continued From page 17 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 record review, facility policy review, Centers for Disease Control and Prevention (CDC) recommendations, and interview, the facility failed to offer the updated 2023-2024 Coronavirus (COVID-19) vaccine for 1 of 5 residents reviewed (Resident #28 [R28]). Finding:	F 887		

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F 887	Continued From page 18 On 7/16/24 at 9:02 a.m., clinical record review indicated R28 was admitted on 2/19/24 and is currently 71 years old. R28's last documented COVID-19 vaccination was on 4/28/22. There was no evidence R28 had received, been offered, or refused the COVID-19 vaccination. On 7/16/24 at 1:45 p.m., review of the Influenza, Pneumococcal, and COVID-19 Immunization Policy indicated "each resident is offered a COVID-19 immunization unless the immunization is medically contraindicated, or the resident has already been immunized." On 7/16/24 at 1:36 p.m., in an interview with a surveyor, the Director of Nursing (DON) stated she uses the CDC website as a resource. Review of the CDC website, "Stay Up to Date with COVID-19 Vaccines | CDC", indicated that CDC recommends the 2023-2024 updated COVID-19 vaccines: Pfizer-BioNTech, Moderna, or Novavax, to protect against serious illness from COVID-19 and that people aged 65 years and older who received 1 dose of any updated 2023-2024 COVID-19 vaccine (Pfizer-BioNTech, Moderna or Novavax) should receive 1 additional dose of an updated COVID-19 vaccine at least 4 months after the previous updated dose, and that you are up to date when you have received 2 updated 2023-2024 COVID-19 vaccine doses. On 7/17/24 at 8:23 a.m., in an interview with the DON, a surveyor confirmed the COVID-19 vaccine was not offered to R28.	F 887		
F 947 SS=E	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 19	F 947		

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 interviews, the facility failed to ensure that a Certified Nursing Assistant (C.N.A.) received at a minimum 12 hours of annual in-service training that included abuse prevention, resident rights and dementia for 1 of 5 Certified Nursing Assistants (C.N.A.s) reviewed (Certified Nurse Assistant #1 [C.N.A.1]).

Finding:

On 7/17/24 at 9:45 a.m., a surveyor, the Office Manager and Administrator reviewed C.N.A.1's employee file for in-service training during C.N.A.1's annual evaluation period from 2/21/23 to 2/21/24. There was no evidence that C.N.A.1 completed abuse training, resident rights or dementia in-servicing for her annual evaluation period.

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F 947	Continued From page 20 The Office Manager and Administrator confirmed this finding at the time of review.	F 947		