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	205085	A. BUILDING _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS On 8/26/24 through 8/28/24 on-site visits were conducted at Horizons Living and Rehabilitation Center for the purpose of a recertification survey. It was determined that Horizons Living and Rehabilitation Center was not in substantial compliance with 42 CFR 483, Sub-part B Requirements for Long Term Care Facilities.	F 000		
F 558 SS=D	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 accommodations were made for a resident, to include the facility's bathing schedule and resident preferences for 1 of 1 resident reviewed for activities of daily living (Resident #24). Findings On 8/26/24 at 8:20 a.m. and again on 8/27/24 at 7:55 a.m. during interviews, Resident #24 stated he/she had not received a shower in seven days and prefers to be bathed in the morning two times a week. Resident #24 stated he/she has informed the Certified Nurses Aide (CNA), a Registered Nurse, and the Nurse Practitioner of his/her preferences on multiple occasions. On 8/26/24 at 12:46 p.m., observation of the	F 558		

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

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F 558	Continued From page 1 Stowes Unit weekly shower schedule dated 5/2/24 indicated Resident #24 was to receive a shower Wednesday evenings. At this time during a brief interview, CNA #11 stated, the posted shower schedule was incorrect, and she follows the daily CNA schedule, which has the showers to be completed for that shift highlighted. She confirmed Resident #24 does not receive showers twice weekly. On 8/27/24 review of CNA bathing documentation stated Resident #24 received showers on 8/7/24 and 8/14/24 with the last shower documented on 8/18/24 on the evening shift. The admission Minium Data Set dated 8/5/24 under section F preferences for customary routine and activities states it is important for him/her to choose their bathing options. On 8/27/24 the Staffing and Transport Coordinator provided the updated Stowes Unit weekly shower schedule, which states Resident #24 receives showers on Thursday evenings once a week. On 8/28/24 at 2:15 p.m., the above information was discussed with the Administrator and Director of Nursing.	F 558		
F 585 SS=C	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been	F 585		

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furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

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F 585	Continued From page 3 (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency	F 585		

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confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on interviews and record review the facility failed to develop and implement a grievance policy which includes the resident's rights to a grievance, how to file and/or access grievance forms including anonymously and the response or resolution to grievances.

Findings:

On 8/27/24 at 1:30 p.m. during an interview with resident council members. Residents #32, #35, and #40 were unaware that they could file a grievance, how to make a formal grievance, or that a grievance could be filed anonymously. Resident #32 stated on each unit there is a box where he/she believes a resident can make a complaint. He/she stated the box on the Chamberlain Unit is behind the medication cart, inaccessible and too high for residents to reach in wheelchairs.

On 8/27/24 observation of the comment and suggestion boxes on all three units (Chamberlain, Longfellow, and Stowe) are inaccessible for residents in wheelchairs, in addition Chamberlain's comment and suggestions box was located behind the medication cart.

On 8/26/24 at 1:50 p.m., during an interview, the Director of Social Services stated the facility does not have a formal grievance process/policy or

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F 585	Continued From page 5 have forms accessible to residents. On 8/26/24 at 2:22 p.m., during an interview, the Administrator stated the facility has no grievance policy or procedure in place and residents are to come to him with concerns, and he will determine if the concern/complaint is a grievance.	F 585		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;	F 623		

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(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and

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(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k).
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to notify the resident, family and/or the resident's representative in writing of the transfers/discharge to an acute care hospital for 5 of 6 residents sampled for hospitalizations (Residents #7, #108, #31, #28 and #35).

Findings:

1. Documentation in Resident #7's clinical record indicated that the resident was transferred to the hospital on 3/2/24 and 4/7/24 and subsequently

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admitted. The clinical record lacked evidence that Resident #7 and/or the resident representative were provided with written transfer/discharge notices upon either transfer.

2. Documentation in Resident #108's clinical record indicated that the resident was transferred to the hospital on 8/23/24 and returned on 8/24/24. The clinical record lacked evidence that Resident #108 and/or the resident representative were provided with written transfer/discharge notices upon transfer.

On 8/26/24 at 2:34 p.m., in an interview with a surveyor, the nurse manager of the Longfellow Unit stated the nurses do not send the notices with the resident at the time of transfer.

On 8/26/24 at 2:40 p.m., in an interview with a surveyor, the Admissions Director stated once a resident is admitted to the hospital, he/she or the facility's social worker, will send the notices to the resident's family. The notices are not sent for residents who are not admitted to the hospital. The Admissions Director confirmed that Resident #108 was not provided with a transfer/discharge notice.

3. Documentation in Resident #31 clinical record indicated that resident was transferred to the hospital on 8/19/24 and 8/21/24 and admitted for overnight observation and treatment. The clinical record lacked evidence that Resident #31 and/or the resident representative were provided with written transfer/discharge notices upon either transfer.

4. Documentation in Resident #28's clinical

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F 623	Continued From page 9 record indicated that the resident was transferred to the hospital on 5/1/24 and 6/24/24 and subsequently admitted. The clinical record lacked evidence that Resident #28 and/or the resident representative were provided with written transfer/discharge notices upon either transfer. 5. Documentation in Resident #35's clinical record indicated that the resident was transferred to the hospital on 1/12/23, 10/29/23 and 4/7/24 and subsequently admitted. The clinical record lacked evidence that Resident #35 and/or the resident representative were provided with written transfer/discharge notices with all three transfers. On 8/27/24 at 9:05 a.m. during an interview, the Admissions Director confirmed the above residents and/or the resident representative were not provided with written transfer/discharge notices upon transfers.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding	F 625		

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bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to issue a bed hold notice which included the daily bed hold cost, to a resident, known family member and/or legal representative for 5 of 6 sampled residents who had been transferred to the hospital ((Residents #7, #108, #31, #28 and #35).

Findings:

1. Resident #7's clinical record revealed the resident was transferred to an acute care hospital on 3/2/24 and 4/7/24 and subsequently admitted. The clinical record lacked evidence that Resident #7 and/or the resident representative were provided with a written bed hold notices upon either transfer.

2. Resident #108's clinical record revealed that the resident was transferred to the hospital on 8/23/24 and returned on 8/24/24. The clinical record lacked evidence that Resident #108 and/or the resident representative were provided with a written bed hold notice upon transfer.

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F 625	Continued From page 11 3. Resident 31's clinical record revealed the resident was transferred to an acute care hospital on 8/1924 and 8/21/24 and admitted. The clinical record lacked evidence that Resident #31 and/or the resident representative were provided with a written bed hold notices upon either transfer. 4. Resident #28's clinical record revealed the resident was transferred to an acute care hospital on 5/1/24 and 6/24/24 and subsequently admitted. The clinical record lacked evidence that Resident #28 and/or the resident representative were provided with a written bed hold notices upon either transfer 5. Resident #35's clinical record reveals the resident was transferred to an acute care hospital on 1/12/23, 10/29/23 and 4/7/24 and subsequently admitted. The clinical record lacked evidence that Resident #35 and/or resident representative were provided with a written bed hold notices upon all three transfers. On 8/27/24 at 9:05 a.m. during an interview, the Admissions Director confirmed the above residents and/or resident representative were provided with a written bed hold notices upon transfers.	F 625		
F 678 SS=E	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.	F 678		

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This REQUIREMENT is not met as evidenced by:
Based on interviews and record reviews the facility failed to ensure all facility staff maintain training in cardiopulmonary resuscitation (CPR) for Healthcare Providers, resulting in staff who are responsible for providing CPR without an active CPR certificate for 8 of 27 days reviewed. This has the potential to effect all of the residents.

Findings:

On 8/27/24 an anonymous staff member expressed concerns about facility staff not recieving education or maintaining their CPR Certification.

On 8/27/24 at 2:24 p.m., during an interview, the Director of Nursing (DON) stated she herself was not CPR certified, it's not a facility requirement for staff and she does not know what staff are current with their CPR certification.

On 8/27/24 at 3:20 p.m., the Administrator confirmed there are 7 of 56 residents who are "Full Code" and could potentially require CPR however, all residents are at risk for choking.

A review of the facility staffing with CPR certification for the month of August had the following shifts where there were no staff available with current CPR certification:
8/1/24 night shift did not have any staff who were current in their CPR certification
8/2/24 night shift did not have any staff who were current in their CPR certification
8/4/24 evening and night shift did not have any staff who were current in their CPR certification
8/9/24 night shift did not have any staff who were

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F 678	Continued From page 13 current in their CPR certification 8/13/24 night shift did not have any staff who were current in their CPR certification 8/15/24 night shift did not have any staff who were current in their CPR certification 8/16/24 night shift did not have any staff who were current in their CPR certification 8/23/24 night shift did not have any staff who were current in their CPR certification The following facility Policy's and Procedures: > "Emergency response policy", last revised 9/4/2013 states, "It is the policy of Horizons Living and Rehab Center to provide emergency care with a quick response, during a life or death situation regardless of code status. Examples of emergency may include (but are not limited to) severe bleeding and choking." > "Finding a resident with no pulse or respiration", last revision on 7/16/2013, instructing staff to "If a resident is a full code, Call 911" and "Immediately begin CPR". > "Obstructed airway/choking episode/Heimlich Maneuver" last revision on 9/3/2013, instructing staff to "establish that the victim is actually choking" ... "immediately begin Heimlich maneuver". On 8/28/24 at 2:00 p.m., the facility provided documentation of current CPR certifications for 4 of 14 Registered Nurses, 2 of 12 Licensed Practical Nurses and 7 of 51 Certified Nurses Aids. The above was confirmed with both the Administrator and the Director of Nursing who stated going forward there would be a CPR certified staff on every shift while other staff are obtaining their certification.	F 678		
F 684 SS=D	Quality of Care	F 684		

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F 684	Continued From page 14 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 interviews and record reviews, the facility failed to provide follow up care for 1 of 1 resident reviewed with a pacemaker. (Resident #11) Finding: Review of the admission Minimum Data Set (MDS) assessment completed on 12/6/23 noted he/she had an implanted pacemaker listed under diagnosis. A further review of the Electronic Medical Record (EMR) lacked any details about the implanted pacemaker or facility follow and/or monitoring of the pacemaker's functioning. The care plan instructed the Registered Nurse (RN) to monitor/document/report a pulse rate lower than programmed rate. The programmed rate was not located in the EMR. On 8/27/24 at 1:04 p.m. during an interview, the Licensed Practical Nurse #1 confirmed she did not know Resident #11 had a pacemaker. On 8/27/24 at 2:00 p.m. during an interview, the RN #2 stated anyone with a pacemaker would be followed by cardiology. RN #2 was unable to	F 684		

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F 684	Continued From page 15 provide documentation on Resident #11's pacemaker programmed rate, if his/her pacemaker checks had been completed and if he/she was seen or followed by a cardiologist since admission on 12/6/23. On 8/28/24 at 9:45 a.m., during an interview, the Director of Nursing confirmed the standard of care for a pacemaker was not met for Resident #11.	F 684		
F 730 SS=E	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 by: Based on review of annual evaluations and interviews, the facility failed to complete a annual performance evaluation for Certified Nursing Assistants (CNA) at least every 12 months, for 5 of 5 CNA's reviewed with employment greater than 1 year (CNA #12, CNA #13, CNA #14, CNA #15, CNA #16). Findings: On 8/28/24, a surveyor reviewed the following employee files: 1. CNA #12 was hired on 8/19/2020. The employee file lacked evidence of an annual review being completed since date of hire.	F 730		

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F 730	Continued From page 16 2. CNA #13 was hired on 8/4/2021. The employee file lacked evidence of an annual review being completed since date of hire. 3. CNA #14 was hired on 8/10/2022. The employee file lacked evidence of an annual review being completed since date of hire. 4. CNA #15 was hired on 9/16/2021. The employee file lacked evidence of an annual review being completed since date of hire. 5. CNA #16 was hired on 7/29/2020. The employee file lacked evidence of an annual review being completed since date of hire. On 8/28/24 at 12:30 p.m., during an interview, the Director of Nursing confirmed that the annual performance review for 5 of 5 employees had not been completed since their date of hire.	F 730		
F 812 SS=D	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	F 812		

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F 812	Continued From page 17 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 serve and store food in a sanitary manner during 1 of 1 observations of the refrigerator in the main dining room. Finding: On 8/26/24 at 12:20 p.m., observaton of the main dining room refrigerator lacked documentation of temperature monitoring and a very large amount of a red fluid covered the bottom of the freezer. At this time, the food service manager confirmed the observation.	F 812		
F 835 SS=E	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on the cumulative effect of deficiencies cited during the recertification survey from 8/26/24 through 8/28/24, the facility was not administered in a manner that enabled residents to attain or maintain their highest practicable well-being as evidenced by Federal findings listed under 483.10- Resident rights (F558, F585);	F 835		

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483.15- Resident Notification (F623, F625); 483.24- Quality of Life (F678); 483.25- Quality of Care (F684); 483.35- Nursing Services (F726, F730, T206); 483.60- Food Safety (F812) and 483.95- Training Requirements (F940, F947). These failures to assure a process was in place to monitor staff development and resident care resulted in the facility failing to assist residents to maintain their highest functional and practicable well-being and has the potential to affect all 56 residents. In addition, the Administration failed to follow the Facility Assessment ensuring staff education/training and competencies were completed and failed to ensure policies and procedures were reviewed and updated annually.

Findings:

1. Based on interviews and record review, the facility failed to ensure that accommodations were made for a resident, to include the facilities bathing schedule and resident preferences for 1 of 1 resident reviewed for activities of daily living (Resident #24). (F558)

2. Based on interviews and record review the facility failed to develop and implement a grievance policy which includes the resident's rights to a grievance, how to file and/or access grievance forms including anonymously and the response or resolution to grievances. (F565)

3. Based on record review and interview, the facility failed to notify the resident, family and/or the resident's representative in writing of the transfers/discharge to an acute care hospital for 5 of 6 residents sampled for hospitalizations (Residents #7, #108, #31, #28 and #35). (F623)

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4. Based on record review and interview, the facility failed to issue a bed hold notice which included the daily bed hold cost, to a resident, known family member and/or legal representative for 5 of 6 sampled residents who had been transferred to the hospital ((Residents #7, #108, #31, #28 and #35). (F625)

5. Based on interviews and record reviews the facility failed to ensure all facility staff maintain training in cardiopulmonary resuscitation (CPR) for Healthcare Providers, resulting in staff who are responsible for providing CPR without an active CPR certificate for 8 of 27 days reviewed. (F678)

6. Based on interviews and record reviews, the facility failed to provide follow up care for 1 of 1 resident reviewed with a pacemaker (Resident #11). (F684)

7. Based on observations, interviews and record reviews, the facility failed to ensure that staff maintained the appropriate competency and skill required to provide Cardio-Pulmonary Resuscitation (CPR) for 11 of 12 newly hired nursing staff reviewed. This has the potential to effect 7 residents in the facility that maintained a "Full Code" status. (F726)

8. Based on review of annual evaluations and interviews, the facility failed to complete an annual performance evaluation for Certified Nursing Assistants (CNA) at least every 12 months, for 5 of 5 CNA's reviewed with employment greater than 1 year (CNA #12, CNA #13, CNA #14, CNA #15, CNA #16). (F730)

9. Based on record reviews and interviews, the

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facility failed to ensure nursing policy & procedure were in place, to develop and implement continuing education for nursing staff, evaluate nurse competencies and develop and maintain a job description for each level of nursing personnel. (T206)

10. Based on observations and interviews, the facility failed to serve and store food in a sanitary manner during 1 of 1 observations of the refrigerator in the main dining room. (F812)

11. Based on interview and employee personnel record reviews, the facility failed to implement and maintain effective training programs for nursing staff in the areas of cardiopulmonary resuscitation (CPR), nursing competencies, dementia care, resident rights and the required 12 hours of annual in-service education training for Certified Nurses Aid (CNA) for 11 of 12 newly hired nursing staff reviewed and 4 of 5 randomly selected CNAs employed greater than 1 year. (F940)

12. Based on Certified Nursing Assistant (CNA) employee education record review and interview, the facility failed to monitor and ensure that the CNA attended the required 12 hours of annual in-service education training and the mandatory yearly trainings for dementia care and resident rights for 4 of 5 randomly selected CNAs employed greater than 1 year (CNA #13, CNA #14, CNA #15, CNA #16). (F947)

13. Review of the Facility Assessment, revised on 8/17/24 states "The facility assessment collects information about the facilities resident population to identify the number of resident; facility capacity; the care required; staff competencies ... the

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facilities resources are identified and evaluated to ensure that care can be provided to meet residents needs during the day-to-day operations."
Under section, Staff education, Training and Competencies states, "every position has a job description that identifies the required education and credentials for the specific job. All credentials in education are verified before hiring ... competencies are based on current standards of practice and may include knowledge and a test, knowledge and a return demonstration and observed ability, knowledge and observed behavior in an annual performance evaluation. Competencies are based on the care and services needed by the resident population."
Under section, Policies and Procedures for the Provision of Care states, Policy and procedures are reviewed and updated at least annually and as needed with the introduction of new resident care needs, new technology or equipment or a change in the physical plant or environmental hazards. Creation of new policies/revision of existing policies will be done in consultation with the regulatory view in resident needs."

On 8/28/24 at 11:42 a.m., during an interview, the Administrator and the Director of Nursing confirmed the facility had never developed or implemented a skills fair or competencies for the nursing staff neither upon hire or annually. In addition, the Director of Nursing confirmed the lack of job descriptions and was unable to provide job descriptions for the following staff: Registered Nurses, Licensed Practical Nurses, Certified Nurses Aid and Certified Medication Technician.

Review of the following policies, contained the following:

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F 835	Continued From page 22 > "Emergency Response", was last revised 9/4/2013. > "Obstructed airway/choking episode/Heimlich Maneuver" was last revised on 9/3/2013. In addition, the policy does not reflect the need for Basic Life Support / Cardiopulmonary Resuscitation (CPR) training for staff. > "Finding a resident with no pulse or respiration", was last revised on 7/16/2013 and instructs staff to confirm the resident code status by visualizing a "Green dot" on the resident's chart binder indicating the resident is a "FULL CODE" and "No dot indicates resident is a DNR (Do Not Resuscitate)". The policy does not reflect the need for CPR training and/or maintaining a CPR certificate. On 8/26/24 upon entrance to the facility, the Administrator stated there were no longer any hard charts for the residents, all the resident's records are now in an Electronic Medical Record form (online). On 8/26/24 at 2:22 p.m., during an interview, the Administrator confirmed the facility did not have a grievance policy or procedure in place.	F 835		
F 940 SS=E	Training Requirements CFR(s): 483.95 §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.71. Training topics must include but are not limited to- This REQUIREMENT is not met as evidenced	F 940		

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by:
Based on interview and employee personnel record reviews, the facility failed to implement and maintain effective training programs for nursing staff in the areas of cardiopulmonary resuscitation (CPR), nursing competencies, dementia care, resident rights and the required 12 hours of annual in-service education training for Certified Nurses Aid (CNA) for 11 of 12 newly hired nursing staff reviewed and 4 of 5 randomly selected CNAs employed greater than 1 year.

Findings:

Review of the Facility Assessment, revised on 8/17/24 under section, "Staff education, Training and Competencies" states, "every position has a job description that identifies the required education and credentials for the specific job. All credentials in education are verified before hiring. All employees are trained in the following topics upon hire and annually: Resident rights and Dementia and dealing with difficult behaviors and competencies are based on current standards of practice and may include knowledge and a test, knowledge and a return demonstration and observed ability, knowledge and observed behavior in an annual performance evaluation. Competencies are based on the care and services needed by the resident population."

1. On 8/27/24 at 2:24 p.m., during an interview, the Director of Nursing (DON) stated she herself was not CPR certified and the facility does not require a CPR certification for staff. On 8/28/24 at 2:00 p.m., the facility was only able to provide documentation of current CPR certifications for 4 of 14 Registered Nurses, 2 of 12 Licensed Practical Nurses and 7 of 51 Certified Nurses

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F 940	Continued From page 24 Aids. 2. On 8/28/24 at 11:42 a.m., during an interview, the Administrator and the Director of Nursing stated the facility had never developed or implemented a skills fair or competencies for the nursing staff neither upon hire nor annually. 3. On 8/28/24, review of CNA #13, CNA #14, CNA #15 and CNA #16 employee education files lacked dementia and/or resident rights education as well as 12 required hours for continuing education yearly. On 8/28/24 at approx. 2:15 p.m., the above was discussed with the Administrator and Director of Nursing	F 940		
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 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	F 947		

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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 CNA attended the required 12 hours of annual in-service education training and the mandatory yearly trainings for dementia care and resident rights for 4 of 5 randomly selected CNAs employed greater than 1 year (CNA #13, CNA #14, CNA #15, CNA #16).

Findings

On 8/28/24, a surveyor reviewed the following employee education files:
1. CNA #13 was hired 8/4/21. Review of CNA #13 Employee In-service/attendance Records lacked evidence of dementia and resident rights training. In addition, she has 7.5 of the 12 hours required for continuing education for the year of 2023.

2. CNA #14 was hired 8/10/22. Review of CNA #14 Employee In-service/attendance Records lacked evidence of dementia training. In addition, she has 9 of the 12 hours required for continuing education of the year 2023.

3. CNA #15 was hired 9/16/21. Review of CNA #15 Employee In-service/attendance Records lacked evidence of dementia training and resident rights training. In addition, she has 11 of the 12 hours required for continuing education of the year 2023.

4. CNA #16 was hired 7/29/20. Review of CNA #16 Employee In-service/attendance Records

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F 947	Continued From page 26 lacked evidence of resident rights training. In addition, she has 5.5 of the 12 hours required for continuing education of the year 2023. On 8/28/24 at 12:30 p.m., in a interview, the Director of Nursing confirmed the above findings.	F 947		