

Delivery via email to: Gsanders@belfairseniorliving.com

June 21, 2022

License Number: AL6304

Ms. Gay Sanders, Administrator
Belfair Of Shawnee
1723 N Airport Drive
Shawnee, OK 74804

RE: Survey Event ID: 08HN11

Dear Ms. Sanders:

On **June 9, 2022**, agents from our office concluded a State Licensure survey at your facility. The deficiencies found during the survey are identified on the enclosed STATE FORM.

Please note the items listed in the deficiency column of the STATE FORM. You have two choices of methods to prepare the written the plan of correction (POC). The first method is to type the plan of correction and anticipated date of completion in the space provided on the right half of the STATE FORM. If additional space is needed, supplemental sheets may be attached. The second method is to prepare your plan on the Optional Plan of Correction Template (attached). Use of the template is voluntary. It is intended to help you submit a complete and acceptable plan of correction. If you choose to use the optional template, complete one template for each deficiency cited on the STATE FORM. In the space provided on the right half of the STATE FORM, type a notation that the plan of correction is being submitted using the optional template. Copies of the form and instructions are available at: <http://www.ok.gov/health>. This link opens the OSDH home page. To find the optional POC, **click on Protective Health** on the left side of the home page, then **click on Long Term Care** on the right side of the page. The link to the forms can be found by selecting **Long Term Care Forms** on the left menu column.

To be found acceptable by the OSDH, the plan of correction must:

- (1) Address how corrective action will be accomplished for affected residents;
- (2) Address how other residents with the potential to be affected will be identified;
- (3) Address measures or systemic changes to ensure the deficiency will not recur;
- (4) Indicate how the center plans to monitor performance to ensure corrections are sustained;
- (5) Include dates when corrective action and monitoring will be completed for each violation;
- (6) Be signed by the administrator.

Your development of the evidence referenced in item 4, above, is very important for establishing the actual date your assisted living center corrected deficiencies and achieved compliance under the Continuum of Care and Assisted Living Act. If the required evidence is available when the OSDH conducts a revisit, then the earliest date of compliance shown in the evidence

can be used by the OSDH to establish the effective date of correction and compliance. However, if there is no evidence of quality assurance being implemented, the correction date can be no earlier than the date of the OSDH revisit. If the required evidence is not available, the revisit may result in a repeated deficiency statement and another plan of correction may be required.

Avoid naming individuals, business firms or brand names on the enclosed form and any attachments. The document will be a public record and any such names will be available for disclosure.

Please sign, date and return the completed form, along with any attachments, supplements and templates, to this office within ten (10) OSDH business days of your receipt of this letter. OSDH business days are Monday through Friday, excluding state holidays. Failure to submit a Plan of Correction will not delay the subsequent revisit or any other phase of the enforcement process. Please retain a copy of the completed form for your files.

In accordance with O.S. 63-1-895, you have one opportunity to dispute citations of deficient practice through an informal dispute resolution (IDR) process. *The IDR in no way is to be construed as a formal evidentiary hearing; it is an informal administrative process to discuss deficiencies.* If you choose to contest a cited deficiency, the facility must complete an IDR Request Form (ODH Form 833AL). An explanation must be listed for each disputed deficiency. An attachment is acceptable if additional space is required for the dispute explanation. The IDR Coordinator may be contacted at (405) 426-8200 or at the address below to acquire a copy of the ODH Form 833AL and the Oklahoma IDR Process for Assisted Living Centers.

The IDR request must be submitted within 10 business days from receipt of the State Form deficiency statement. This is the same requirement for submitting an acceptable Plan of Correction (PoC). Failure to submit a completed IDR Request form and supporting documentation within this timeframe waives your right to the IDR. Failure to complete the IDR timely will not delay the effective date of any enforcement action against the facility. A designee of the Department shall conduct the IDR. The IDR may be accomplished by a desk review or conducted in a face-to-face meeting. The facility shall receive written confirmation of the IDR results.

The facility must submit the completed IDR Request Form and supporting documentation under separate cover to:

IDR Coordinator
Long Term Care
Protective Health Services
Oklahoma State Department of Health
123 Robert S. Kerr Ave, Ste. 1702
Oklahoma City, OK 73102-6406

Facilities may not use the IDR process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

- Remedy(ies) imposed by the Department,
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; or
- Alleged inadequacy or inaccuracy of the informal dispute resolution process

If you have any questions regarding the IDR process, please contact the IDR Coordinator via email at IDRCoordinator@health.ok.gov, or telephone at (405) 426-8200.

If you have questions or need assistance, please feel free to send an email to LTCEnforcement@health.ok.gov or call (405) 426-8200. When writing or calling, indicate whether you are asking about the enforcement process, or about the survey process and deficiencies, and your inquiry will be directed to the appropriate available staff members.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Enclosure

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Belfair of Shawnee
Address: 1723 North Airport Drive
City, State, Zip: Shawnee, OK 74804
Provider #: AL6304
Complaint #: #OK00058904
Investigation Date(s): 06/06/22 through 06/09/22

ALLEGATION(S)	S = SUBSTANTIATED
	US = UNSUBSTANTIATED

1. The facility neglected to provide adequate supervision to prevent falls.	S
2. The facility failed to protect residents from abuse.	US
3. The facility failed to follow infection control policies and procedures.	US

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

An unannounced on-site investigation was initiated on 06/06/2022 at 10:40 a.m.

A sample of four residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1505 and C0552 for details.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation was conducted specific to abuse.

A) Incident reports were reviewed for allegations related to abuse. The administration records for allegations of abuse were requested, and no records were obtained. The abuse policy was reviewed. A closed record was reviewed to include the assessment, nurses progress notes, and hospice records.

A tour of the facility was conducted and staff were observed assisting residents with activities of daily living. Staff were observed to treat residents with dignity and respect. Staff were observed to allow residents sufficient time to take their medication during the medication pass and observed socializing during activities. Staff were observed walking with residents, assisting with repositioning, and escorting residents to meals.

Residents were interviewed and voiced no abuse allegations. Observations were made of the staff while providing care to determine if residents were treated with respect. Staff were observed knocking on the resident doors prior to entering their room. Staff were observed interacting and redirecting residents in a calm and respectful manner.

B) See allegation #1 related to falls.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.

An investigation was conducted specific to infection control.

Incident reports were reviewed for issues or concerns related to infection control. Quarterly QA [Quality Assurance] meeting minutes were reviewed for trends and incidents. The incidents reports were reviewed and did not identify any infection control concerns. Two staff in-services related to handwashing had been conducted to ensure proper handwashing. Signs were posted around the facility to encourage handwashing.

Staff were observed throughout the survey to use the handwashing stations and observed to use hand sanitizer throughout the survey.

A handwashing station was located on each end of the memory care unit in the common areas for staff use. Numerous observations were made of staff washing their hands before, during, and after care. Each station was supplied with soap. Staff were observed to use hand held sanitizer in their pockets and used after the repositioning of a resident.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Deficient practice was unsubstantiated for allegation #2 and #3. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Julie Edmiaston Digitally signed by Julie Edmiaston
Date: 2022.06.14 14:31:03 -05'00'

Julie Edmiaston RN, BSN

Date report completed: 06/14/2022

**INVESTIGATIVE REPORT
LICENSURE**

Facility: Belfair of Shawnee
Address: 1723 N Airport Drive
City, State, Zip: Shawnee, OK 74804
Provider #: AL6304
Complaint #: OK00058940
Investigation Date(s): 06/06/22 through 06/09/22

ALLEGATION(S)	S = SUBSTANTIATED US = UNSUBSTANTIATED
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1. The center failed to provide the necessary care and services to attain the highest practicable physical well-being.	S
2. The center failed to provide ADL assistance to dependent residents.	US
3. The center failed to have adequate staff.	US

☒ **Violation (s) unrelated to this complaint were also cited during the investigation.**

A sample of four residents including any identified residents, was selected for the investigation based on the concerns relevant to the allegations.

The investigation was conducted following standards set by the statutes, rules and regulations of the State of Oklahoma utilizing Investigative Protocols. Evidence was obtained through observations; interviews with residents, family members, staff members and others as indicated; and review of pertinent written and electronic records.

A Description of Significant Findings Related to Each Allegation is Provided Below:

Allegation #1: Deficient practice was substantiated related to this allegation. See the Statement of Deficiencies, Form 2567, Tag C1505 and C0552 for details.

Allegation #2: Deficient practice was unsubstantiated related to this allegation.

An investigation was conducted specific for residents who required assistance with ADL's.

The resident shower/skin observation reports were documented on individual forms. These forms were recorded in a book on each end of the memory care unit. The memory care unit documented refusals and second attempts for showers. Reviewed the shower logs, nurse's progress notes, and care plans related to personal hygiene.

Residents were fully dressed and out in the common areas of the facility during the initial tour. Staff were observed interacting and assisting residents with ADL's. Individual rooms were clean and tidy and free from odors. Staff were observed assisting residents with ambulation, meals, and activities.

Residents were interviewed and voiced no concerns related to staff assistance for ADL's. Residents were well-groomed and observed out of bed throughout the survey with clean clothes.

Allegation #3: Deficient practice was unsubstantiated related to this allegation.

An investigation was conducted related to staffing ratio and adequate staffing.

The staffing schedules to include weekend schedules were reviewed. The center's census was 34 and it was reported by various employees the normal staffing ratios were two CNA's [certified nurse aides], two CMA's [certified medication aides], and a charge LPN [licensed practical nurse]. The third shift documented an LPN on shift with two nurse aides.

During the survey and throughout the survey the staff were observed assisting residents with ADL's, medication administration, and meals. The residents were observed during the survey process engaged in activities to include bouncing a balloon back and forth and listening to music.

Residents were interviewed and voiced no concerns related to care or staffing. The staff voiced no specific staffing issues except they had several TNAs [Nurse aide in training]. The staff reported there was an LPN, ACMA, CMA and a Registered Nurse on staff. Staff also reported they had two TNAs on staff that day as well. Staff reported they were normally staffed that way on the first and second shift.

Determination Summary and Follow-Up Action:

Deficient practice was substantiated for allegation #1. The facility will be required to submit a plan of correction (POC). The surveyor team will review the POC to ensure it is sufficient for compliance and a follow-up investigation will be conducted.

A determination that an allegation was substantiated (S) means the survey team found evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred. The deficient findings would be detailed in the Statement of Deficiencies.

Deficient practice was unsubstantiated for allegation #2 and #3. No further action is required.

A determination that an allegation was unsubstantiated (US) is not a judgment, or any reflection of the accuracy of the allegation, nor is it a dismissal of your concern. It means the survey team did not find sufficient evidence at the time of the investigation to confirm a deficient practice or violation of the state regulations had occurred in relation to the allegation.

Thank you for bringing these concerns to our attention.

Julie Edmiaston

Digitally signed by Julie
Edmiaston
Date: 2022.06.14 14:33:48 -05'00'

Julie Edmiaston RN, BSN

Date report completed: 06/14/2022

Oklahoma State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AL6304	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 06/09/2022
NAME OF PROVIDER OR SUPPLIER BELFAIR OF SHAWNEE		STREET ADDRESS, CITY, STATE, ZIP CODE 1723 N AIRPORT DRIVE SHAWNEE, OK 74804		
(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) COMPLETE DATE
N 000	Initial Comments A relicensure survey was conducted from 06/06/22 through 06/09/22. Complaint investigations (#OK00058904 and #OK00058940) were conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document: ADL's- Activities of Daily Living BOM- Business Office Manager BP- Blood Pressure CM- Centimeters CMA - Certified Medication Aide CNA- Certified Nurse Aide C/O - Complaint Of CT- Computed Tomography DR- Dining Room Dx- Diagnosis ED - Emergency Department EKG- Electrocardiogram EMS- Emergency Medical Service ER- Emergency Room Eval- Evaluate Fx- Fracture I. E.- For Example IJ - Immediate Jeopardy Lbs - pounds LPN- Licensed Practical Nurse Lt- Left LTCA - Long Term Care Aide MAR - Medication Administration Record MM- Millimeters O2 Sats- Oxygen Saturations OOF- Out of Facility OSDH - Oklahoma State Department of Health OT/PT- Occupational Therapy/Physical Therapy POA- Power of Attorney PT- Physical Therapy	N 000		

Oklahoma State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Oklahoma State Department of Health

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N 000	Continued From page 1 Re- Reason Res- Resident R or RT- Right RN/DON- Registered Nurse/Director of Nurses ROM- Range of Motion SN- Skilled Nurse ST- Skin Tear TV-Television UTI- Urinary Tract Infection VS- Vital Signs W/C- Wheelchair WNL- Within Normal Limits X- Times Y/O - Year Old	N 000		
N1105 SS=E	310:677-11-1 (a)(1)(2)(3) General Requirements - LTC (a) The facility shall: (1) Complete a performance review of every nurse aide at least once every twelve (12) months and provide two (2) hours of inservice training specific to their job assignment each month. (2) Have in-service education generally supervised by a registered nurse who has at least two years nursing experience with at least one (1) year of which shall be in the provision of long term care services. (3) Ensure that each nurse aide certification is current and not expired.	N1105		

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N1105	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to ensure CNA performance skill reviews were conducted annually for three (#13, #15, and #20) of three CNAs who had been employed at the facility for more than one year and failed to ensure that each nurse aide certification was current and not expired for two (#16 and #17) of 15 sampled nurse aide certifications. Executive Director identified 34 residents who resided in the center. Findings: 1. On 06/07/22 at 12:27 p.m., the employee files were reviewed with the BOM. On 06/08/22 at 2:45 p.m., the Executive Director was asked to provide documentation of annual performance reviews for the three CNAs who were employed by the center for longer than one year. On 06/08/22 at 3:01 p.m., the Executive Director stated the center had not completed annual competencies for the three CNAs. No documentation was provided for the annual competency for CNA #13 (hire date 03/09/20), CNA #15 (hire date 02/28/21), or CNA #20 (hire date 02/25/21). 2. On 06/07/22 at 12:27 p.m., the employee files were reviewed with the BOM. The BOM reported three CNAs' certifications had expired. The BOM stated she was unaware CNA #16's certification had expired. The BOM stated CNA #17's	N1105		

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N1105	Continued From page 3 certification was expired. CNA #15's had expired but had not been on the schedule. The BOM stated the RN/DON would know if the applications for recertification had been sent to the Nurse Aide Registry. On 06/08/22 at 10:47 a.m., the Executive Director stated some of the CNAs had sent off for their certification renewals on their own. On 06/08/22 at 12:32 a.m., the Executive Director stated the center could not provide documentation the CNAs had applied for renewal of their certifications and the CNAs had not kept any documentation.	N1105		
N1442 SS=E	310:677-13-7 (c) Skills And Functions (c) Skills review. The facility, center or home shall validate certified medication aide skills before the certified medication aide performs medication administration. The certified medication aides' skills shall be reviewed annually for performance competency. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the center failed to validate CMAs' skills for five (#7, 18, 19, 23, and #24) of six CMAs before the CMAs were allowed to perform medication administration and failed to ensure the CMAs' certifications were renewed for three (#2, 18, and #19) of six CMAs	N1442		

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N1442	Continued From page 4 who worked at the center. The Executive Director identified 34 residents who resided in the center. Findings: On 06/07/22, a review of current employee records was conducted and the following was documented: CMA #2, hired on 05/13/15, medication aide certification had expired on 12/31/21. CMA #18, hired on 07/18/21, medication aide certification had expired on 10/31/21. CMA #18's file did not document an initial skills check competency. CMA #24, hired on 08/05/21, employee file did not document an initial skills check off. CMA #19, hired on 09/23/21, medication aide certification had expired on 04/30/21. CMA #19's file did not document an initial skills check competency. CMA #7, hired on 04/20/22, employee file did not document an initial skills check off CMA #23, hired on 05/26/22, employee file did not document an initial skills check off. On 06/08/22 at 10:47 a.m., the Executive Director stated some of the CMA's had sent off for their certification renewals on their own. On 06/08/22 at 12:32 a.m., the Executive Director stated the facility could not present documentation the CMA's had applied for renewal	N1442		

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N1442	Continued From page 5 of their certifications and the CMA's had not provided the documentation they attempted to renew to the center. On 06/08/22 at 3:01 p.m., the Executive Director stated the center had not performed initial medication check offs for newly hired CMAs or completed annual competencies for the CMAs on staff for greater than one year.	N1442		
C 000	INITIAL COMMENTS A relicensure survey was conducted from 06/06/22 through 06/09/22. Complaint investigations (#OK00058904 and #OK00058940) were conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document: ADL's- Activities of Daily Living BOM- Business Office Manager BP- Blood Pressure CM- Centimeters CMA - Certified Medication Aide CNA- Certified Nurse Aide C/O - Complaint Of CT- Computed Tomography DR- Dining Room Dx- Diagnosis ED - Emergency Department EKG- Electrocardiogram EMS- Emergency Medical Service ER- Emergency Room Eval- Evaluate Fx- Fracture I. E.- For Example IJ - Immediate Jeopardy	C 000		

Oklahoma State Department of Health

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C 000	Continued From page 6 Lbs - pounds LPN- Licensed Practical Nurse Lt- Left LTCA - Long Term Care Aide MAR - Medication Administration Record MM- Millimeters O2 Sats- Oxygen Saturations OOF- Out of Facility OSDH - Oklahoma State Department of Health OT/PT- Occupational Therapy/Physical Therapy POA- Power of Attorney PT- Physical Therapy Re- Reason Res- Resident R or RT- Right RN/DON- Registered Nurse/Director of Nurses ROM- Range of Motion SN- Skilled Nurse ST- Skin Tear TV-Television UTI- Urinary Tract Infection VS- Vital Signs W/C- Wheelchair WNL- Within Normal Limits X- Times Y/O - Year Old	C 000		
C 391 SS=E	310-663-3-8(a) FOOD STORAGE, PREPARATION AND SERVICE (a) Food shall be stored, prepared and served in accordance with Chapter 257 of this Title (relating to food service establishments) with the following additional requirements. This STANDARD is not met as evidenced by: Based on record review, observation, and interview, the center failed to ensure:	C 391		

Oklahoma State Department of Health

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C 391	Continued From page 7 a. employee hair and beards were covered while in the kitchen area. b. mold was not on the top of containers in the refrigerator. c. the fryer, floor under and around the fryer, the side of the oven, and the side and shelf of the steamer were free of grease splattered from the fryer. The Executive Director identified 34 residents who received nutrition from the kitchen. Findings: 1. Chapter 257, effective September 11, 2016, read in parts: "...310:257-3-20. Effectiveness...food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles..." A policy and procedure titled, "Employee Hygiene," dated 11/30/02, read in part: "...Employees must wear a hair net when in the kitchen..." On 06/07/22 at 10:00 a.m., upon entering the kitchen multiple staff members were observed and were not wearing hair nets except one. On 06/07/22 at 10:04 a.m., the director of dining services stated hair nets were only required in the food preparation area.	C 391			

Oklahoma State Department of Health

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C 391	Continued From page 8 On 06/07/22 at 10: 35 a.m., observed two staff entered the kitchen and came around the side into the food preparation area to get hair nets. Both staff members had beards and did not don beard guards. 06/08/22 at 11:38 a.m., the dietitian was interviewed by telephone. She stated she had told the center kitchen staff that anywhere past the hand washing sink was considered the kitchen area they would need to contain facial and head hair with a hair net. 2. Chapter 257, effective September 11, 2016, read in parts: "...310:257-5-60. Ready-to-eat, Time/Temperature Control for Safety Food, date marking Pf...refrigerated, ready-to-eat, Time/Temperature Control for Safety Food prepared and held in a food establishment for more than twenty-four (24) hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of seven (7) days. The day of preparation shall be counted as day one (1). (b)...shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than twenty-four (24) hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified..." On 06/07/22 at 10:10 a.m., two buckets of margarita mix were observed in the refrigerator, one sitting on top of the other bucket. The first bucket of margarita mix was observed to have had mold all over the lid of the bucket. No open date or date of disposal was documented on the margarita buckets.	C 391		

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C 391	Continued From page 9 On 06/07/22 at 10:14 a.m., the director of dining services stated the margarita mixes were from an activity at the center and had been left in the refrigerator. She threw both buckets in the trash and stated she had forgotten they were in the refrigerator. 3. Chapter 257, effective September 11, 2016, read in part: "... 310:257-7-82. Equipment, food-contact surfaces, nonfood-contact surfaces, and utensils (a) Pf Equipment food-contact surfaces and utensils shall be clean to sight and touch. (b) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (c) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. [Source: Added at 23 Ok Reg 2358, eff 6-25-06]..." A form, titled "Dining Services Cook Cleaning Schedule," dated 12/28/20, documented on Sundays, the p.m. cook was to dump old grease and clean the fryer. No documentation from dining services was provided regarding if the cleaning schedule had been followed. On 06/07/22 at 10:28 a.m., grease was observed to cover the front of the fryer, the floor around the fryer, on the side of the oven, and on the side and shelf of the steamer. On 06/07/22 at 10:38 a.m., the director of dining services was asked about the fryer. She acknowledged a build up of grease on and around the fryer and stated the dietitian had mentioned the fryer had a build up of grease and needed to be cleaned.	C 391		

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C 391	Continued From page 10 06/08/22 at 11:40 a.m., the dietitian stated she observed the fryer to be grease covered with splatters on the machine and behind on the wall. She stated she had instructed the center to clean the area.	C 391		
C 543 SS=D	310:663-5-4(c) CONDUCT OF ASSESSMENT (c) The assisted living center shall ensure that each comprehensive assessment includes a personal interview between the resident and the person completing the form. If the resident is mentally impaired, the assisted living center shall include in the interview at least one (1) of the persons listed in (d)(2) and (d)(3) of this section. This Rule is not met as evidenced by: Based on record review and interview, the center failed to conduct a personal interview between the resident and the person completing the form for one (#2) of eight sampled residents reviewed for comprehensive assessments. The Executive Director identified 34 residents who resided in the center. Findings: 1. Res #2's "Resident Assessment Form," dated 05/05/22, read in part, "...Alert x 1, confused, forgetful, P [Poor] Judgment..." On 06/06/22 at 3:50 p.m., the RN/DON was asked if Res #2's personal interview was	C 543		

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C 543	Continued From page 11 conducted. She stated she had forgot to get the POA to sign it and Res #2 stated he would not sign it.	C 543		
C 552 SS=E	310:663-5-5(2) USE OF ASSESSMENT The assisted living center shall use the results of the resident's assessment for the following: (2) to develop a care plan for the resident, in consultation with the resident. This Rule is not met as evidenced by: Based on record review and interview, it was determined the center failed to ensure care plans were completed for three residents (#2, 4, and #6) of eight sampled residents reviewed for care plans. The Executive Director identified 34 residents who resided in the center. Findings: 1. Res #2 admitted to the center on 05/05/22, and had diagnosis which included dementia, depression, chronic pain, allergies and a history of falls. The closed clinical record did not contain a plan of care after seven documented falls at the center. 2. Res #4 admitted to the facility on 05/03/22, and had diagnoses which included history of falls, depressive disorder, and dementia.	C 552		

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C 552	Continued From page 12 A significant change assessment, dated 06/01/22, documented Res #4 was alert, confused with poor judgment. The assessment documented Res #4 required assistance of two staff for bathing, transferring, toileting, and ambulation. Res #4 required the assistance of one staff member for eating and dressing. Res #4 did not have a care plan from admit date of 05/03/22 from the center. On 06/07/22 at 4:13 p.m., the RN/DON stated the center did not have a care plan for resident #4. 3. Res #6 was admitted to the center on 04/21/22. The home health chart was not available for review. On 06/08/22 at 10:30 a.m., the RN/DON stated she had not completed a care plan for Res #6. Res #6 had orders for home health.	C 552		
C 911 SS=E	310:663-9-1(1) NURSE Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged: (1) registered nurse supervision of skilled nursing interventions;	C 911		

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C 911	Continued From page 13 This Rule is not met as evidenced by: Based on record review and interview, the center failed to provide qualified staff to perform neurological assessments after a known fall for one (#2) of four sampled residents with documented falls. Findings: The Executive Director identified 34 residents who resided in the center. Res #2's "Incident Report", dated 05/26/22, documented, "...Res was heard screaming out for help. Upon arrival, Res found in floor. ST to top of RT hand. Steri Strips applied & covered [with] Island dressing. Small abrasion R forehead. Neuro [checks] started ..." The incident report was signed by LPN #27 and CMA #7. Res #2's "Neurological Flow Sheet", dated 05/26/22 and 05/27/22, documented, "... Vital Signs and Neuro Checks, Level of Consciousness, Movement, Hand Grasps, Pupil Size Rt, Pupil Size Lt, Pupil Reaction: Rt, Pupil Reaction: Lt, Speech, BP, Pulse, Respiration, Temperature ..." The initials for each time slot on the neurological flow sheet were initialed by CMA #7. On 06/06/22 at 3:54 p.m., RN/DON was asked about the initials on the neurological flow sheet.	C 911		

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C 911	Continued From page 14 She stated it would have been CMA #7. She was asked if CMA #7 was qualified to perform neurological assessments. She stated CMA #7 was not qualified to perform neurological assessments.	C 911		
C1505 SS=J	310:663-15-1 & 63 OS 1-1918(B)(5) RESIDENT RIGHTS - Medical Care Each assisted living center and its staff shall be familiar with and shall observe all resident rights and responsibilities enumerated under Title 63 O.S. Supp. 1997, Section 1-1918.B 63 O.S. 1-1918.(B)(5) (5) Every resident shall have the right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community. Every resident, unless adjudged to be mentally incapacitated, shall be fully informed by the resident's attending physician of the resident's medical condition and advised in advance of proposed treatment or changes in treatment in terms and language that the resident can understand, unless medically contraindicated, and to participate in the planning of care and treatment or changes in care and treatment. Every resident shall have the right to refuse medication and treatment after being fully informed of and understanding the consequences of such actions unless adjudged to be mentally incapacitated.	C1505		

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C1505	Continued From page 15 This REQUIREMENT is not met as evidenced by: On 06/07/22 at 3:30 p.m., an Immediate Jeopardy (IJ) situation was determined to exist when the center failed to develop a policy and procedure for falls and failed to develop a plan of care after Res #2 had a hospitalization for a subdural hematoma and repeated falls after the hospitalization. The center failed to intervene and update care plans to reduce or prevent falls for Res #5 after a fall which resulted in a fractured arm. On 06/07/22, at 3:44 p.m., the Oklahoma State Department of Health (OSDH) verified the existence of the IJ situation. On 06/07/22, at 3:48 p.m., the Executive Director was notified of the IJ situation related to a failure to develop and implement a policy and procedure for falls, for failure to develop a plan of care related to documented falls with injury, and failure to update a current plan of care related to a documented fall with injury. On 06/07/22 at 4:49 p.m., the Executive Director submitted a written plan of removal. The plan of removal documented the following: "Re: Falls To decrease the number of falls and prevent injuries to residents, Belfair of Shawnee will implement the following: -Fall Policy and Procedure will be developed to	C1505		

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C1505	Continued From page 16 ensure consistent and effective monitoring of resident on an ongoing basis. This policy will be developed and implemented no later than 6/8/22 at 3:00pm. Policy will include initial assessments, monitoring post fall, interventions, communication, and Falling Star details. -All current residents will have a full fall risk assessment completed by 6/8/22 at 3:00pm. -All future residents will be assessed for fall risk upon admission and added to the Falling Star program, if appropriate. -Facility will identify a list of "high fall risk" residents by 6/8/22 at 3:00pm. -Facility will implement "Falling Star" program for all high-risk residents by 6/8/22 at 3:00pm -The falling star form will be completed on all high-risk residents and placed in a notebook on the nursing station to improve communication between staff and shifts. The original will be kept in the DON office and will be updated as needed. -All direct care staff will be inserviced on the Policy and Procedures for residents at risk for falling no later than 6/8/22 at 3pm. -Daily Huddle form will be updated to include communication specific to falls and interventions. Completed no later than 6/8/22 at 9:30am. Belfair Falling Star Name: Date Initiated Intervention Date Initiated Intervention Provide Walker/Cane Shoe/Footware [sic] Assessment Provide Gripper Socks (remove all others) Evaluate clothing for fall risks Routine Check Blood Sugars Routine Check VS (BP, O2 sats etc.) Evaluate Medications	C1505		

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C1505	Continued From page 17 Monitor for Change in continence Evaluate and modify room lighting Evaluate Pain Evaluate for changes in condition Evaluate room layout Increase frequency for incontinence Change to 2 person assist Urinal at bedside Low bed or mattress on floor Concave mattress Place on couch or in recliner Evaluate w/c cushion (wedge or pommel) Mark w/c breaks with bright colored tape Floor/fall mat Bed call mat in place Increase participation in activities Adjust w/c for drop seat Provide increased snacks/drinks Eval/treat for therapy (OT/PT) Check for UTI Assess positioning in wheel chair for comfort and circulation Turn on TV or music when in room 1:1 safety companion" On 06/07/22 at 5:02 p.m., the plan of removal was accepted and verified with the Oklahoma State Department of Health. The Executive Director was notified. On 06/09/22 at 9:34 a.m., the IJ immediacy was removed, effective 06/09/22 at 9:34 a.m., when all components of the plan of removal had been completed. The deficiency remained at a pattern with the potential for more than minimal harm. Based on record review, observation, and interview, the center failed to develop a policy or procedure for falls and failed to develop/update care plans with fall interventions for two (#2 and	C1505		

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C1505	Continued From page 18 #5) of four sampled residents reviewed for falls. Res #2 had seven documented falls and one with injury and Res #5 had four documented falls with one injury. Findings: The Executive Director identified 34 residents who resided at the center. 1. Res #2's "Residence and Care Agreement" dated 05/05/22, read in parts, "...Please note that as an Assisted Living facility...is not permitted to use restraints on its residents, and the use of restraints is inconsistent with our philosophy. We encourage our residents to participate in physical activities to the extent of their capabilities. Thus, falls and other personal injuries may occur from time to time. If you are not comfortable with this type of environment, we suggest that you consider a higher level of care. Although we will exercise care to protect you from injury while you reside at..., you recognize that there are certain risks inherent in the operation of...and in everyday living and that accidents and injuries may occur which are not the result of intentional or negligent behaviors..." Res #2's "Resident Assessment Form" read in parts, "...Admission Date: 05/05/22, Assessment Date: 05/19/22, Assessment Type: 14-day. Disease Diagnoses and Medically Defined Conditions...Dementia, Depression, Diabetes, Chronic pain, Allergies...List Number of Persons to Assist Resident with Activities of Daily Living to Include: Bathing (1), Eating (0), Dressing (0), Transferring (0), Toileting (0), Ambulation (0). Bladder: Continent, Bowel: Continent, Toileting Ability: Independent...Elopement Risk..."	C1505		

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C1505	Continued From page 19 Res #2 was not identified as a fall risk and had no fall risk assessment conducted upon admission to the center or after documented falls. Res #2 had no plan of care developed at the time of admission or after seven documented falls from 05/05/22 through 05/29/22 that occurred at the center. Res #2's "Oklahoma State Department of Health Incident Report Form" combined initial and final, read in parts, "...Incident Date: 05/05/22 [on the first day of Res #2's admission], Incident Type: Certain Injuries, Notification Made: Physician, Family...Part B: Description of Incident. Please include injuries sustained as well as measures taken to protect the resident(s) during investigation...Nurse heard a loud noise, observed resident [#2] lying supine in hallway. Injuries to left shoulder, forehead/eyebrow and righ [sic] hand. DON, physician and family notified. 911 called and resident sent to ER for eval and treat. Investigation initiated. Please include relevant resident history (i.e., cognitive status, fall risk assessment, relevant care plan instructions prior to this incident, etc... [Res #2] 74 y/o male with dementia and depression. [Res #2] requires assistance from nursing staff for ADLs and ambulates independently in the facility. Resident has a history of falls and ambulates with a forward posture. Part C: For 5 day and final reports, please include a summary of the investigation (include investigative actions, findings and causative factors) and corrective measures implemented to prevent recurrence...Upon completion of the investigation, including watching video footage,	C1505		

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C1505	Continued From page 20 the resident was observed walking in the hallway when he began to gain momentum and lose his balance forward. Resident was observed hitting his head on the wall and falling into the supine position. Resident returned from the hospital with sutures and orders for follow up appointments. Staff inserviced on importance of insuring residents have on shoes when out of room on tiled floors. Physician, and family notified..." Signed by Executive Director. Res #2's "Hospital Admission Record" read in parts, "...Arrival Date... 5/5/2022, Procedure Orders: Laceration Repair...Chief Complaint: Fall. Discharge Information: Pt discharged...Discharge Provider to [Name Deleted-Medical ER]..." This is a 75-year-old male with history of dementia who fell right [sic] from local nursing home after having a fall in his room. They feel that he likely struck his head on the door handle. Reports laceration above his left eye as well as pain in his left shoulder...Denies any other injury. Denies any dizziness, chest pain or syncope to the fall...Head: Approximately 4 cm crescent-shaped laceration noted just above the left eyebrow lateral portion... Musculoskeletal...Patient does report tenderness over the left shoulder...Laceration Repair: Repair method: Sutures...Number of sutures: 9...CT Brain without contrast...Impression: 1. Left front temporoparietal subdural hematoma measuring approximately 9 mm in thickness. 2. Left frontal scalp laceration...Lacerations repaired please see procedure note. CT of the head C-spine as well as x-ray of left shoulder obtained and reviewed...CT of the head does show a subdural hematoma. Patient is not on anticoagulation. Since we do not have neurosurgery...contacted	C1505		

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C1505	Continued From page 21 the trauma referral center and the patient was graciously accepted to the [hospital name deleted]..." Res #2's "Hospital Discharge Instructions" read in parts, "...Condition at Discharge: Stable...Pre-printed home care instructions given: Yes. Fall and seizure precautions...Arrival Date...05/06/22...Sent home with no anticoagulants/antiplatelets at this time. Okay to resume Aspirin in 5 days (5-11-22)... No strenuous activity. No lifting over 10 lbs..." Res #2's "MAR" dated May 2022, read in parts, "... Aspirin 81 mg chew tab take 1 tablet by mouth once daily...Suspended 07 May 2022 to 12 May 2022: Subdermal [sic] Hematoma..." Aspirin 81 mg was administered starting on May 12, 2022 as outlined in the hospital discharge instructions. The following falls for Res #2 occurred from 05/08/22 through 05/28/22: Res #2's "Incident Report" dated 05/08/22, read in parts, "...Res got out of w/c at the lunch table & walked a few feet & fell. [No injury noted]. VS WNL. ROM done [without] problem...Was resident sent out to the hospital? No...Summary of Prevention: Try to keep him in his w/c..." Res #2's "Incident Report" dated 05/09/22, read in parts, "...Res found on floor by CNA's small skin tear/abrasion above RT eye Ref [refused] vitals, was combative with staff...Was resident sent out to the hospital? No...Summary of Prevention: [Blank]..." Res #2's "Incident Report" dated 05/17/22, read in parts, "...Nurse at station heard loud noise from	C1505		

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C1505	Continued From page 22 Res room. Res seen on his back in the floor no injuries noted at this time...Was resident sent out to the hospital? No...Summary of Prevention: [Blank]..." Res #2's "Incident Report" dated 05/27/22, read in parts, "...Res walking rapidly through DR leaning forward and lost balance falling forward and landing on R side with abrasion to R eyebrow...Was resident sent out to the hospital? No...Summary of Prevention: Encourage resident to walk slowly..." Res #2's "Incident Report" dated 05/28/22, read in parts, "...Res walked out of his room with his blanket around him and tripped in front of room...Was resident sent out to the hospital? No...Summary of Prevention: [Blank]..." Res #2's "Incident Report" dated 05/28/22, read in parts, "...CNA called SN to room. Resident in floor by bed. No injury noted. VS WNL. ROM done [without] problem. [Name deleted-family] in room...Was resident sent out to the hospital? No...Summary of Prevention: Will order PT..." Res #2's nurse's note dated 05/29/22, read in parts, "...12:00 [p.m.] EMS called per [family name deleted] request. 12:20 [p.m.] resident OOF [out of facility] to ER by EMS..." There was no documentation of Res #2's right arm swelling as noted in the hospital notes below. Res #2's "Hospital Admission Record" read in parts, "...Arrival Date...05/29/2022...ED Provider Notes...Procedures Orders: Critical Care...Pre-procedure Diagnoses 1. Fall, initial encounter...Post procedure Diagnoses...1. Fall, initial encounter...2. Acute Renal injury...3. Altered mental status, unspecified altered mental	C1505		

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C1505	Continued From page 23 status type...4. Cardiac arrest...Chief Complaint: Patient presents with fall. Arrives via [ambulance service]; c/o fall on Friday [05/27/22]; right arm swelling and pain... This is a 75 year old male who is a resident at local nursing home who arrives to the ER ...with concerns for right arm swelling. According to staff he has had several falls recently with the last one being 2 days ago [05/27/22]. Patient is confused at baseline. His [name deleted-family member], who arrived shortly after his arrival states he has seemed more confused than normal and has been mumbling incoherently over the last several days. I did see this patient approx. 3 weeks ago after another fall. At that time, he was found to have a subdural hematoma and was transferred to [name deleted hospital] Physical Exam...Appearance: He is ill-appearing. Comments: Awake, mumbling incoherently...Head...Comments: Old appearing contusion noted to right temporal scalp...Musculoskeletal: Comments: Moderate swelling noted to patients right arm. Multiple bruises noted, no obvious deformity. Difficult to asses [sic] for specific pain given the patients mental status...Critical Care....Critical care was necessary to treat or prevent imminent life-threatening deterioration of the following conditions: Cardiac failure and circulatory failure..." Res #2's "Death Certificate" read in parts, "...If Death Occurred in a hospital: ER/Outpatient...Date of Death: May 29, 2022...Time of Death: 19:33 [7:33 pm] ...Was Medical Examiner Contacted: Yes...Was an Autopsy Performed: Yes...Cause of Death: Hypertensive Atherosclerotic Cardiovascular	C1505		

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C1505	Continued From page 24 Disease..." On 06/06/22 at 11:57 a.m., the Executive Director was asked about the center's policy and procedures for falls. She stated the center did not have an actual policy for falls. On 06/06/22 at 3:54 p.m., RN/DON was asked if she performed a fall risk assessment for Res #2. She stated, "No, I did not find one." RN/DON was asked about Res #2's plan of care. She stated they did not have a care plan meeting with them. RN/DON was asked about Res #2's actual plan of care. She stated she did not write one out and had not started one yet. She was asked when would she normally start a plan of care. She stated within 30 days. On 06/07/22 at 11:10 a.m., RN/DON was asked if Res #2 had a subdural hematoma on 05/05/22. She stated there was a head laceration and Res #2 was sent out to the ER and did not have a subdural hematoma. On 06/07/22 at 11:21 a.m., RN/DON was asked to review Res #2's hospital admission record from 05/29/22. She was asked if she knew anything about Res #2's right arm swelling. She reviewed the hospital paperwork and stated, "I don't remember anybody saying anything about right arm swelling." RN/DON was asked if she knew about the subdural hematoma when Res #2 was sent to the hospital on 05/05/22. She stated, "No, I did not." On 06/07/22 at 1:00 p.m., RN/DON was asked if Res #2 was on home health or hospice services. She stated, "No." 2. Res #5's "Resident Assessment Form" read in	C1505		

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C1505	Continued From page 25 parts, "... Assessment Date: 08/20/2021, Assessment Type: Annual. Disease Diagnoses and Medically Defined Conditions...Anxiety, Depression...Alzheimer's Disease...List Number of Persons to Assist Resident with Activities of Daily Living to Include: Bathing (1), Eating (1), Dressing (1), Transferring (1), Toileting (1), Ambulation (1). Bladder: Incontinent, Bowel: Incontinent, Toileting Ability: Assist..." Res #5's "Plan of Care" dated 03/16/22, read in parts, "...03/08/22 fall from w/c received rug burn to forehead...Mobility dependent requires assistance from bed to chair and vice versa...On occasion will stand and walk with stand by assist...5/19/22 fall resulting in Fx R arm..." The plan of care did not include interventions in place to prevent falls. Res #5's "Oklahoma State Department of Health Incident Report Form" combined initial and final, read in parts, "...Incident Date: 05/19/22...Incident Type: Certain Injuries, Notification Made: Physician, Family...Part B: Description of Incident. Please include injuries sustained as well as measures taken to protect the resident(s) during investigation. Res observed in floor in common area...Res. noted to have 2 skin tears on her R arm and hand. Physician and family notified and investigation initiated. On 05/24/22, res. arm began to swell, reddened and warm to the touch. Physician notified and x-ray ordered. Res. sent to ER for eval and treatment...Res. requires max assist from staff for ADLs, mobility in wheelchair. Res occasionally attempts to stand and ambulate without an assistive device, she also frequently leans forward in her chair which causes loss of balance. Part C...please include a summary of the	C1505		

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C1505	Continued From page 26 investigation (include investigative actions, findings and causative factions and corrective measures implemented to prevent recurrence...Investigation completed. Res returned from hospital with dx. of R arm fx. ER splinted arm and returned resident to community. No abuse or neglect suspected. Wedge cushion will be placed in chair for positioning and safety..." On 06/06/22 at 1:00 p.m., RN/DON was asked about Res #5's recent falls. She stated, "Obviously, I have not updated it in a while." She was asked about fall interventions put into place for the fall on 03/08/22. She stated, "I don't see anything, we did not write anything down here." She was asked if she had any fall interventions documented on the care plan related to the falls. She stated, "No," they were going to get better with that in the future with the falling star program. She was asked what policy or procedures related to falls was in place at the time these falls had occurred. She stated just whatever we were doing. She stated we did not have a policy and had not put the falling star program in place at that time. She stated they used to put the fall interventions in the incident reports or in the nurse's notes. On 06/06/22 at 2:15 p.m., RN/DON was asked how many falls Res #5 actually had at the center. She stated, "I wrote in 04/20/22, I told you it [care plan] was not updated." RN/DON stated, "I wrote in 05/02/22, she fell on her bottom with no injury." The RN/DON added those two falls to the care plan during the interview. On 06/07/22 at 10:25 a.m., Res #5 was sitting in her w/c in the common area. R arm splint in place. A w/c cushion was noted in the w/c; however, no wedge cushion was observed. The	C1505		

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C1505	Continued From page 27 RN/DON was asked about the wedge cushion and she stated they removed it, because Res #5 was short and could not propel self in w/c. RN/DON was asked if Res #5 was on hospice services. She stated, "Yes." LPN #21 assisted Res #5 up in the w/c. On 06/08/22 at 11:45 a.m., LPN #21 was asked about the outdated hospice plan of care in Res #5's hospice record. She stated that one was outdated. She notified hospice to request the current plan of care.	C1505		

Delivery via email to: Gsanders@belfairseniorliving.com

July 7, 2022

License Number: AL6304

Ms. Gay Sanders, Administrator
Belfair Of Shawnee
1723 N Airport Drive
Shawnee, OK 74804

RE: Survey Event 08HN11

Dear Ms. Sanders:

On **June 9, 2022**, agents from our office completed an Assisted Living Center survey at your facility. Deficiencies were identified and we have received your plan of correction for these deficiencies. The plan of correction you submitted is not acceptable for the following reasons:

- **C391** – related to plan of correction date being before the last date of survey. Page 8 is missing from 2567 and appears part of the plan of correction may be on the missing page.

Please provide a new plan of correction for these deficiencies and return with amendments as soon as possible.

Sincerely,

Lisa Calvin

Lisa Calvin, Enforcement Reviewer/Analyst
Long Term Care
Protective Health Services

Oklahoma State Department of Health

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N 000	Initial Comments A relicensure survey was conducted from 06/06/22 through 06/09/22. Complaint investigations (#OK00058904 and #OK00058940) were conducted in conjunction with the survey. Listed below are abbreviations that will be used throughout this document: ADL's- Activities of Daily Living BOM- Business Office Manager BP- Blood Pressure CM- Centimeters CMA - Certified Medication Aide CNA- Certified Nurse Aide C/O - Complaint Of CT- Computed Tomography DR- Dining Room Dx- Diagnosis ED - Emergency Department EKG- Electrocardiogram EMS- Emergency Medical Service ER- Emergency Room Eval- Evaluate Fx- Fracture I. E.- For Example IJ - Immediate Jeopardy Lbs - pounds LPN- Licensed Practical Nurse Lt- Left LTCA - Long Term Care Aide MAR - Medication Administration Record MM- Millimeters O2 Sats- Oxygen Saturations OOF- Out of Facility OSDH - Oklahoma State Department of Health OT/PT- Occupational Therapy/Physical Therapy POA- Power of Attorney PT- Physical Therapy	N 000	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance.	

Oklahoma State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Ray Sanders

TITLE

Executive Director

(X6) DATE

6/30/22

STATE FORM

6899

08HN11

If continuation sheet 1 of 28

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N 000	Continued From page 1 Re- Reason Res- Resident R or RT- Right RN/DON- Registered Nurse/Director of Nurses ROM- Range of Motion SN- Skilled Nurse ST- Skin Tear TV-Television UTI- Urinary Tract Infection VS- Vital Signs W/C- Wheelchair WNL- Within Normal Limits X- Times Y/O - Year Old	N 000		
N1105 SS=E	310:677-11-1 (a)(1)(2)(3) General Requirements - LTC (a) The facility shall: (1) Complete a performance review of every nurse aide at least once every twelve (12) months and provide two (2) hours of inservice training specific to their job assignment each month. (2) Have in-service education generally supervised by a registered nurse who has at least two years nursing experience with at least one (1) year of which shall be in the provision of long term care services. (3) Ensure that each nurse aide certification is current and not expired.	N1105	(1) The facility will ensure all nurse aide performance reviews are updated and kept up to date annually by developing a tracking system and monitoring it by the Business Office Manager with oversight of the Executive Director. The Business Office Manager will track and give a report to the Executive Director and DON at the beginning of each month with a list of all nursing staff approaching their annual review date. (2) This facility will continue with scheduled monthly training under the supervision of the RN/DON. (3) As of 7/1/22 all CNA staff are current on their certifications. An audit has been performed of all CNA files to ensure the accuracy. This facility will ensure all nurse aides have a current/active certification by Business Office Manager under the oversight of the Executive Director. All certification updates will be completed in advance	6/30/22