STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075264	A. Building B. Wing	02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Touchpoints at Bloomfield	140 Park Ave Bloomfield, CT 06002

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48335 Based on review of the clinical record, review of facility documentation, review of facility policy and interviews for one sampled resident (Resident #112) reviewed for resident-to-resident mistreatment, the facility failed to provide the necessary supervision to prevent a resident-to-resident altercation. The findings include: Resident #112's diagnoses included unspecified dementia, schizophrenia, and post-traumatic stress disorder. The annual Minimum Data Set assessment dated [DATE] identified Resident #112 was cognitively intact, required the assist of one for toileting, showering, lower extremity dressing, required maximum assistance for personal hygiene and received psychological therapy. A reportable event report dated 11/12/23 at 9:30 PM identified Resident #112 was hit in the nose by another resident over a disagreement regarding the community television resulting in a skin tear to the bridge of the nose. The report notes that the residents were immediately separated, 911 was called and the resident who did the hitting was placed on one-to-one observation. The report further noted that Resident #112 was sent to the hospital to be evaluated. A nurse's note dated 11/13/23 at 9:34 AM identified Resident #112 was involved in a verbal altercation with another resident which resulted in an injury to Resident #112's nose and right eye orbital area. The resident sustained a skin tear to the bridge of the nose and bruising to the right eye orbital. The residents were subsequently separated, 911 was called for each resident and both were transported to the hospital. The DNS and MD were notified as well as the conservators. Resident #112 returned to the facility. The Psychiatric APRN's note dated 11/14/23 identified Resident #112 was alert, confused, irritable and perseverative regarding the recent incident, and felt safe but wanted to leave the unit. In addition, the note indicated to continue psychotherapy for coping and behavior management and no new orders were identified. Interview on 2/27/24 at 1:44 PM with the former DNS (RN #6) identified that the other resident did not have regular outbursts and did not usually act out and noted that the resident required a different level of care and had not returned to the facility after being sent to the hospital. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/27/26 at 2:17 PM with NA #2 identified that the Resident #112 and the resident who hit him/her are roommates on the specialized unit, and Resident #112 has a television, but the roommate did not, and the roommate requested that a television provided for his/her side of the room. NA #2 further identified that she told the resident she would put the request in the maintenance book and encouraged the resident to watch television I the dining room. She further identified that Resident #112 likes to walk around the unit and had the dining room television remote in his/her pocket and changed the channel while the other resident was watching the television. The other resident became notably upset and NA #2 identified that she suggested Resident #112 go to his/her room and watch television so the other residents could watch what they wanted on the dining room television. She noted that she then left the dining room because it was time for rounds, and then heard yelling and the other resident came out of the television room and told her that they were tired of Resident #112. Additionally, she noted that the resident (aggressor) was holding what looked to be a wheelchair footrest but noted that she did not see when Resident #112 was hit. Review of the Abuse policy dated 10/22/22 directed, in part, that residents will not be subjected to abuse by anyone, including but not limited to facility staff, other residents, consultants, volunteers and staff of other agencies serving the resident, family members, or legal guardians, friends or other individuals.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on clinical record review, facility documentation review, facility policy review, and interviews for one sample resident (Resident #241) who was newly admitted to the facility from an acute care hospital, the facility failed to ensure that a registered nurse assessed the resident upon admission in accordance with the facility's policy and professional standards of care. The findings include: Resident # 241 was admitted to the facility on [DATE] with diagnoses that included osteoarthritis to the left shoulder, bicipital tendinitis to the left shoulder, and status post arthroplasty to the left shoulder. The late entry nurse's note written by RN #6 (former DNS) dated 8/27/22 at 8:00 PM identified Resident #241 arrived at the facility via stretcher with diagnoses of arthritis to the left shoulder, bicipital tendinitis to left shoulder, and status post arthroplasty to the left shoulder. It noted Resident #241 was alert, oriented and able to verbalize needs. The note further noted that the physician was notified of the resident's admission, physician's orders were sent to the pharmacy and Resident #241 had complaints of pain to the left shoulder. In addition, the note identified that the for Dilaudid 2 mg every 6 hours as needed was discontinued because the resident verbalized that it was ineffective and a new order for Dilaudid 4 mg every 6 hours as needed for pain was obtained. Resident #241's clinical record lacked documentation that a registered nurse assessed Resident #241 upon admission in the facility. Interview and clinical record review with RN #6 (former DNS) on 2/27/24 at 10:30 AM identified that Resident #241 was admitted to the facility on [DATE] approximately between 7:30 PM and 8:00 PM with status post arthroplasty to the left shoulder. Review of the admission assessment form with RN #6 failed to reflect documentation to identify Resident #241's clinical condition was comprehensively assessed by a registered nurse. She identified that there was not a completed admission assessment for Resident #241 because he/she requested to be discharged against medical advice the following day. The Admission Process policy identified that the facility would obtain an accurate resident history and assess his/her clinical condition/status. The admission nursing process and documentation would be started as soon as possible on all new admissions. The license nurse is responsible for completing the admission documentation and every section of the admission documentation should be addressed.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on clinical record review, observation, facility documentation review, facility policy review, and interviews for one of four sampled residents (Resident #46) who had a facility acquired pressure ulcer, the facility failed to ensure the initial assessment of the wound was completed by a registered nurse and failed to provide treatment in a timely manner. The findings include: Resident #46 's diagnoses included end stage renal disease, dependence on renal dialysis, type 2 diabetes mellitus, anemia, and left foot drop. The Braden scale risk assessment used to predict the risk for pressure ulcer development dated 10/30/23 identified Resident #46 was at mild risk with a score of 16 (a score of 19-23 is indicative of low risk, a score of 15-18 is indicative of mild risk, a score of 13-14 is indicative of moderate risk, a score of 10-12 is indicative of high risk and a score of 9 or below is indicative of severe risk). The admission MDS assessment dated [DATE] identified Resident #46 had intact cognition, required extensive assistance with bed mobility, transfers, toileting, and hygiene, was at risk for the development of pressure ulcers but did not have the presence of a pressure ulcer. The Resident Care Plan (RCP) dated 11/9/23 identified Resident # 46 was at risk for skin breakdown related to co-morbidities that affect his/her overall health condition. Care plan interventions directed to encourage and assist resident to off-load heels as tolerated, provide a pressure reduction chair cushion and pressure reduction mattress as appropriate. The nurse's note written by LPN #6 dated 12/3/23 at 2:23 PM identified Resident #46 had a pressure ulcer to the left heel and the wound nurse was notified. The wound documentation written by RN #1 dated 12/4/23 (one day after the wound was noted) identified Resident #46 had a Deep Tissue Injury (DTI) to the left heel that measured 3.0 centimeters (cm) in length by 3.0 centimeters (cm) in width with 0 depth. The Wound Specialist's (APRN #1) progress note dated 12/4/23 (one day after the wound was noted) identified Resident #46 had a DTI to the left heel with persistent non-blanchable deep red, maroon and /or purple discoloration pressure injury. The wound measurement was 3 cm in length by 3 cm in width by 0 cm depth. There was no drainage noted and peri-wound skin texture was normal. A physician's order dated 12/4/23 (one day after the wound was noted) directed to apply skin prep to the left heel and leave open to air daily. Review of the treatment administration record (TAR) from 12/3/23 to 12/4/23 failed to identify a treatment was provided to Resident #46's left heel pressure injury. APRN #1's note dated 12/11/23 identified Resident #46's left heel DTI had progressed to an unstageable pressure injury. The wound measured was 1.5 cm in length by 2 cm in width by 0.1 cm in depth with a moderate amount of serosanguineous drainage and no odor. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 2/21/24 at 10:30 AM identified Resident #46 lying on an air mattress with a clean, dry, and intact dressing to the left heel that was elevated off of the mattress with a pillow. Interview with RN #1(wound nurse) on 2/27/24 at 9:20 AM identified that he was responsible for assessing and monitoring wounds. He also identified that any new wound would be assessed by a registered nurse promptly and an appropriate treatment provided timely. He further identified that he was working as the nursing supervisor on 12/3/23 when LPN #6 reported that Resident #46 had a pressure wound to the left heel and was certain that he looked at Resident #46's wound but had forgotten to document until the next day and could not recall whether he initiated a treatment to the left heel on 12/3/24 but noted that the TAR did not have a treatment order noted until 12/4/23. Interview with LPN #6 on 2/27/24 at 10:30 AM identified that Resident #46 had a blood stain on the bed sheet, and she noted that Resident #46 had a wound to the left heel and noted that she notified the nursing supervisor at the time, but the nursing supervisor did not come with her to assess the resident's left heel and she did not know whether or not the supervisor assessed the heel independently. She further noted that the TAR (treatment administration record) did not contain a treatment order to the heel until 12/4/23. Interview with DNS on 2/27/24 at 10:45 AM identified that the wound nurse was responsible for wound assessments and weekly wound monitoring. He also identified that any new wound required an RN assessment and provision of an appropriate treatment. He further identified that he would have expected the RN #1 to assess the Resident #46's wound at the time the wound was found, and to implement an appropriate treatment promptly and not wait until the next day. The facility policy entitled Wound Documentation identified that the nurse is responsible for initiating a weekly wound flow sheet for all newly identified wounds, and a plan of care developed and revised as necessary.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402 Based on clinical record review, and interviews for one sampled resident (Resident #77) reviewed for enteral nutrition, the facility failed to ensure physician's orders were clearly and completely written as well as transcribed onto the medication administration record (MAR) and failed to notify the physician when medications and enteral nutrition were not administered due to the clogging of the gastrojejunostomy tube (g-tube/j-tube). The findings include: Resident #77's diagnoses included gastrojejunostomy placement, Huntington's disease, and unspecified dementia. The admission MDS assessment dated [DATE] and the quarterly MDS assessment dated [DATE] identified Resident #77 had intact cognition, and required extensive assistance with bed mobility, transfers, did not ambulate, required a wheelchair, and utilized a feeding tube. The Resident Care Plan dated 2/4/2024 identified Resident #77 had a feeding tube because it is unsafe for them to eat or drink with interventions that included: if there is poor skin turgor, decreased urinary output, dry lips, or mucous membranes, increased confusion, or temp, consider dehydration, keep the head of the bed elevated during feedings and for one hour after, provide flushes as ordered, provide feedings as ordered. A physician's order dated 11/2/22 directed to administer Jevity 1.2 (therapeutic nutrition) via jejunostomy tube (j-tube: a feeding tube located in the jejunum) at a continuous rate of 70ml/hr (milliliters per hour). Administer medications via gastrostomy tube with the exception of sodium bicarbonate ordered in conjunction with Viokase (pancreatic enzymes) two times per week to prevent jejunostomy tube clogs. Review of the medication administration record (MAR) for November 2022 identified an order for Jevity 1.2 70 ml/hour for 24 hours starting 11/2/22. The MAR did not specify that the Jevity should be administered via the j-tube as ordered. Review of the MAR for September 2023 identified Resident #77 was administered Glucerna 1.2 at 105 ml/hr via g-tube over 24 hours. Physician's order dated 10/15/23 ordered Glucerna 1.2 at 105ml/hr via g-tube over 24 hours. Review of the MAR for October 2023 and November 2023 failed to indicate that the Glucerna should be administered via the g-tube. A verbal physician's order obtained by the DNS dated 11/21/23 directed to start Glucerna 1.2 at 95cc/hr x 24 hours with a 500 ml flush every shift with no route indicated. Review of the MAR for December 2023 indicated Resident #77 was administered the Glucerna via g-tube. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's order dated 1/2/24 directed to administer Jevity 1.5 start 20ml then goal rate at 55ml/hr titrate 10ml/hr every 6 hours with no route indicated. The physician's order dated 1/3/24 directed to send Resident #77 to the hospital for reinsertion of the gastrojejunostomy tube (j-tube/g-tube). The physician's orders dated 1/4/24 directed to administer Glucerna 1.2 at 95 ml/hr. The order did not specify whether the Glucerna should be administered through the j-tube or the g-tube. Physician's orders dated 2/4/24 directed to administer Glucerna 1.2 at 60ml/hr. The order did not specify whether the Glucerna should be administered through the j-tube or the g-tube. The nurse's note dated 2/14/24 written by LPN #8 identified Resident #77's j-tube was clogged, supervisor aware of situation, blood glucose at 12:00 PM was 204. The note further identified that LPN #8 was unable to administer medications or flushes via the j-tube. Review of the MAR for February 2024 indicated that Glucerna, Prednisone, Senna plus Docusate Sodium, Carvedilol, Amlodipine, Calcium Carbonate plus Vitamin D were not administered. The physician's order dated 2/15/24 at 8:27 AM directed to send the resident to the hospital to replace the GJ tube secondary to the inability to flush the J tube. May use g-tube secondary to j-tube not functioning. Interview with LPN #8 on 2/27/24 at 9:08 AM identified that on 2/14/24 she had been utilizing the J-tube for all medications and enteral nutrition (tube feeding) as that was the way she knew it to be ordered upon admission as the g-tube was hooked up to drainage upon admission. She further noted that currently she was just doing flushes as ordered through the g-tube and due to the diagnosis of Huntington's disease they were instructed to utilize the j-tube portion for both as to not put too much fluid in the stomach. On 2/14/23 she notified the ADNS on two separate occasions regarding the inability to administer the medications and enteral nutrition due to the clogged j-tube. She believed that later that evening there may have been a new order received but was not sure. Interview with RN #1 (supervisor/ADNS) on 2/27/24 at 9:37 AM indicated she was the supervisor working on 2/14/24 during LPN #8 's shift and was never made aware of the issue with Resident #77 and never contacted the physician until the following day when she was made aware of the situation. RN #1 stated that if she had been made aware she would have tried to unclog the tube herself or if unable to would have notified the physician regarding missed medications and feeding. Subsequent interview with RN #1 on 2/27/24 at 4:30 PM upon exit indicated she spoke to MD #1 and received a telephone order to start the feeding through the J-tube and the medications via the G-tube. A message was left for MD #1 on 2/27/24 at 1:49 PM, but a return phone call was not received; therefore, an interview with MD #1 was not obtained. Although policies regarding G/J tube feeding, Admission orders, and Prescribers orders were requested, none were provided. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to ensure that physician's orders and the transcribed orders (MAR) regarding the gastrojejunostomy tubes were written in a complete and clear manner to promote consistency.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on clinical record review, facility documentation review, facility policy review, and interviews for two sampled residents (Resident #107 & #241) reviewed for pain, the facility failed to ensure pain assessments were completed on admission and failed to document the administration of as needed pain medication and the assessment of the effectiveness of the pain medication. The findings include: 1. Resident #107's diagnoses included left leg fracture, anxiety, and suicide attempt. The admission Minimum Data Set assessment dated [DATE] identified Resident #107 had intact cognition, required supervision or touch assistance for showering, lower body dressing, transferring from bed to chair, and had pain. The care plan dated 1/5/24 identified Resident #107 had pain with interventions that included: provide pain medication as ordered, observe its effectiveness, and provide non-pharmacological interventions. A physician's order dated 1/8/24 directed to administer Oxycodone (Opioid) 5mg one tablet by mouth every 6 hours as needed for moderate pain, and Oxycodone 5mg-2 tablets (10mg) by mouth every 6 hours as needed for severe pain. Interview on 2/20/24 at 2:05 PM with Resident #107 identified that he/she takes medication for pain and noted that he/she has a hard time getting his/her pain medication. He/she noted that the pain medication is ordered as a prn (as needed) so he/she was told that he/she had to ask for it but conveyed that they make him/her wait. Resident #107 further identified that he/she had back surgery about six months ago and noted that he/she has back pain and left leg pain. In addition, he/she noted that yesterday he/she requested pain medication at 4:30 AM and noted that they made him/her wait until 6:30 AM. He/she noted that the nurse told the oncoming nurse that he/she had not asked for it. There was a nurse aide in the hallway that heard me ask for the pain medication. He/she further noted that he/she felt that he/she was being treated differently than other residents and did not know why. Interview on 2/21/24 at 12:03 PM with Resident #107, identified he/she requested pain medication at 6:30 AM today and was only given one tablet when he/she had requested two tablets and is usually given two tablets. He/she further identified that the nurse told him/her there weren't any more tablets and that he/she was out of medication. Resident #107 further identified that he/she asked if there was any in the emergency box, because that is where they have gotten the pain medication before. The nurse told him/her that the emergency box was empty. In addition, the resident commented that he/she wondered why they could not order his/her medication on time, and he/she should not have to be in pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/21/24 at 3:05 PM with RN #1 (Nursing Supervisor Day shift) identified that she did not know how to check the automated medication dispensing system to ascertain if a medication had been taken out for a resident and noted that she would have to ask someone to run a report. RN #1 further noted that she had contacted the pharmacy to order more Oxycodone for Resident #107 once the 11-7 nurse told me the resident had run out at the end of the 11-7 shift. Further, she identified she would reevaluate the resident's level of pain and contact the doctor to see what the doctor would like to do as Resident #107 is requesting to be medicated for pain often. In addition, she noted that she has encouraged the nursing staff to check the blister packs regularly, so medications do not run out for any of the residents. Interview on 2/21/24 at 3:08 PM with LPN #1 (11-7 shift) identified that she gave the resident the last tablet of Oxycodone 5mg at 6:30 AM this morning. The medication was reordered from the pharmacy and is coming in today. She further noted that she medicated the resident with medication from the emergency medication supply (ebox), one tablet of Oxycodone 10mg at 12:00 noon. She noted that the nursing supervisor retrieved the medication for her from the ebox. Interview on 2/21/24 at 3:12 PM with RN #1 Nursing Supervisor Day shift identified that they had Oxycodone in the old emergency medication supply (ebox), there was no Oxycodone in the automated medication dispensing system but noted that the DNS was ordering Oxycodone that day. Interview on 2/22/24 at 10:28 AM with Resident #107 identified that his/her pain level was usually between 7 to 9 on a pain scale of 1 to 10 especially in the morning, that's when it's the most severe. Interview on 2/22/24 at 10:40 AM with LPN #1 identified that when they administer as needed pain medication, they are supposed to document the effectiveness of the medication on the back of the MAR. Interview on 2/22/24 at 11:11 AM with RN #1 identified that LPN #2 medicated Resident #107 on 2/21/24 at 6:30 AM with Oxycodone 5mg and a pain assessment should have been completed. Interview on 2/22/24 at 11:18 AM with the Staff Development Nurse identified that they would be initiating a pain assessment and documentation education with all of the nursing staff. Interview on 2/22/24 at 1:31 PM with LPN #2 identified Resident #107 requested pain medication and appeared comfortable. She noted that she did not use the pain scale or evaluate the resident for pain because the resident requested it and knew when it was due. The resident had inquired earlier when medicated at 12:30 AM when it was due next. LPN #2 further identified that when the Oxycodone was administered at 6:30 AM, the resident conveyed that he/she is usually given two tabs. LPN #2 noted that she explained that there was only one tablet left. She did not notify the nursing supervisor right away because the order is for one or two tablets and verbalized that she did not have to assess the resident for pain because the resident asked for the medication. In addition, once she inquired if there were any Oxycodone in the ebox, the nursing supervisor identified that there were only 10mg tablets located in the ebox. She also noted that it was a little busy, and she must have missed documenting on the MAR that she'd administered the Oxycodone 5mg to the resident. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 2/26/24 at 8:58 AM with the DNS identified that the process for assessing pain is the nurse asks the resident what their pain level is using a pain score, then depending on the score, the nurse may administer the pain medication as ordered. A follow up assessment should be done to ensure that the pain medication was effective and if it was ineffective, the nurse can check to see if there is any other medication that can be given or contact the physician for further direction/orders. Although requested, facility policies addressing pain assessment and the documentation of pain assessments were not provided. Review of the Pain Management policy dated 10/2/23 identified that pain management should include the resident in collaboration with the interdisciplinary team and pain management interventions should be reassessed and revised as appropriate. 2. Resident # 241 was admitted to the facility on [DATE] with diagnoses that included osteoarthritis to the left shoulder, bicipital tendinitis to the left shoulder, and status post arthroplasty to the left shoulder. Review of the acute care hospital's medication administration record dated 8/27/22 identified Resident #241 was administered Dilaudid (Opioid) 2 milligrams (mg) by mouth at 5:00 PM. A physician's order dated 8/27/22 directed to administer Dilaudid 2 mg by mouth every 6 hours as needed for pain, Robaxin (muscle relaxant) 500 mg by mouth every 6 hours as needed for muscle spasm and pain assessment every shift using a pain scale (0 = no pain, 1-3 = mild pain, 4-6 = moderate pain and 7-10 = severe pain). The late entry nurse's note written by RN #6 (former DNS) dated 8/27/22 at 8:00 PM identified Resident #241 arrived at the facility via stretcher, was alert, oriented and able to verbalize needs. The physician was notified of the resident's admission and physician's orders were sent to the pharmacy. Resident #241 had complaints of pain in the left shoulder. The note further identified that new orders were obtained to discontinue Dilaudid 2 mg every 6 hours as needed for pain because the resident verbalized Dilaudid 2 mg was ineffective and start Dilaudid 4 mg every 6 hours as needed for pain. Review of the clinical record failed to identify that the residents pain level was assessed on 8/28/22 for the 11-7 am shift or the 7-3 am shift. A physician's order dated 8/28/22 directed Dilaudid 2 mg by mouth every 6 hours for moderate pain and Dilaudid 4 mg by mouth every 6 hours for severe pain. The nurse's note dated 8/28/22 at 11:02 AM identified Resident #241 had a visitor in the lounge that was ready to take the resident home. Resident #241 identified that the hospital gave the wrong information regarding his/her medications. Resident #241 also identified that the hospital gave him/her the option to be discharged home or to go to a rehabilitation facility and he/she had changed his/her mind and wanted to go home. Resident #241 was educated about the implication of discharging against medical advice (AMA) and he/she verbalized understanding, signed the release of responsibility for discharge AMA and left the faciity on [DATE] at 11:10 AM. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medication administration record (MAR) noted that pain assessments should be done on each shift. The MAR indicated that from the 3-11 shift on 8/27/22 to the 7-3 shift on 8/28/22 the assessments were not completed and for the 11-7 shift on 8/28/22, the pain level score was noted as 0. Further review failed to identify that the resident had been administered Dilaudid to manage his/her pain. Interview and clinical record review with RN #6 (former DNS) on 2/27/24 at 10:30 AM identified that Resident #241 was admitted to the facility on [DATE] between 7:30 PM and 8:00 PM status post arthroplasty to the left shoulder. RN #6 identified that Resident #241 requested to be discharged home against medical advice the next day. She also identified that Resident #241 complained of pain to the left shoulder and Dilaudid 2 mg was not effective. Review of the MAR with RN #6 failed to reflect documentation of pain assessments and failed to reflect that Resident #241 had been medicated for pain. The facility's policy entitled Pain Management identified that all residents admitted to the facility will have an initial pain evaluation completed by a licensed nurse and will be re-assessed on re-admission, quarterly, and with a significant change of condition. The pain strategies would include non-pharmacologic and pharmacologic interventions and would be reassessed and revised as appropriate. 48335

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on clinical record review, facility documentation review, facility policy review, and interviews for one sample resident (Resident #34) reviewed for dialysis, the facility failed to ensure fluid intake was monitored for a resident with a fluid restriction. The findings include: Resident #34 's diagnoses included end-stage renal disease, anemia, type 2 diabetes mellitus and dependence on renal dialysis. A physician's order dated 1/8/24 directed a 1500 milliliters (ml) fluid restriction per day. The quarterly MDS assessment dated [DATE] identified Resident #34 had intact cognition, required extensive assistance with mobility, transfers, toileting, hygiene, and received dialysis services. The Resident Care Plan (RCP) dated 1/22/24 identified Resident #34 had end stage renal disease that required hemodialysis. Care plan interventions directed to arrange follow-up with nephrologist as needed, cover the wound, and apply firm pressure if bleeding noted to the access site, monitor weight and vital signs as ordered, provide communication book when going to the dialysis center, and the dialysis center will provide care to the access site. The dialysis communication form dated 1/23/24 identified Resident #34 had to limit his/her fluid intake. Interview with LPN #9 on 2/26/24 at 12:15 PM identified there was an alert in the MAR identifying the resident was on fluid restriction. She identified that Resident #34 was on 1500 ml fluid restriction. She also identified that she was not documenting the fluid that she gave during the medication administration because there was no input and output paper where she could document the resident's fluid intake. She further identified that she did not know who monitored the fluid intake when there was a physician's order for a fluid restriction. Interview with NA #1 on 2/26/24 at 2:10 PM identified that she gets the information from the nurse when a resident is on a fluid restriction. She also identified that she did not know how much fluid to give a resident each meal when a resident is on a fluid restriction. She further identified that she would give the resident the choice of fluid for each meal and document the fluid intake in the computer. Interview with RN #1 (nursing supervisor for 7-3 shift) on 2/26/24 at 2:15 PM identified that the dietary staff had the breakdown of how much fluid to give a resident on a fluid restriction. She identified that Resident #34 was on a 1500 ml fluid restriction but could not identify who monitors the resident's fluid intake when fluids are restricted. She further identified that Resident #34's fluid intake should be monitored because he/she was on 1500 ml fluid restriction. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 2/26/24 at 2:20 PM identified that the dietary staff had the breakdown of how much fluid to give a resident on fluid restriction. He could not identify who was responsible for monitoring the fluid intake for residents on a fluid restriction. He further identified that Resident #34's fluid intake should be monitored to ensure he/she was not exceeding his/her 1500ml fluid restriction. Review of the Hemodialysis policy identified that the protocol for residents receiving dialysis is to evaluate the access site every shift, to maintain fluid intake and output, fluid restriction as ordered by the physician, dietary restrictions as ordered by the physician, and monitor vital sign as needed.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 47900 Based on review of facility documentation, review of facility policy, and interviews for four of five sampled nurse aides (NA #4, NA #7, and NA #8) reviewed for yearly performance evaluations, the facility failed to complete performance evaluations for 2022. The findings include: Review of NA #4's personnel file identified a hire date of 5/30/2017 and failed to identify that a yearly performance evaluation was completed for 2022. Review of NA #7's personnel file identified a hire date of 9/24/2007 and failed to identify that a yearly performance evaluation was completed for 2022. Review of NA #8's personnel file identified a hire date of 4/3/2019 and failed to identify that a yearly performance evaluation was completed for 2022. Interview with the DNS and the Former DNS on 2/27/24 at 3:30 PM identified that it was the responsibility of the shift supervisor to complete the annual performance review of the nursing assistant staff. The Former DNS also added that the DNS would assist with the process, however none was completed for the year 2022. A policy for Annual Performance Evaluation was requested but was not provided by the facility. Interview with the Administrator on 2/27/24 at 3:00 PM identified that it was the practice of the facility was to conduct annual performance review annually during the period of August to October, in which the cooperate office would notify the facility that they were due, but none was done for 2022 only for 2023.

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F 0755 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47900 Based on review of facility documentation, review of facility policy, and interviews for three of five controlled substance medication reconciliation and disposition records, the facility failed to maintain controlled substance accountability records on file. The findings include: A review of the facility's disposal of controlled substance medication records for medication disposed of on 1/14/24 by the former DNS with another nurse, the facility failed to provide the Control Substance Disposition Record white copy sheet for the unit and the yellow copy for the office for Prescription Number (Rx #) 1882731, Rx # 1394477, and Rx #2028718. The white copy is used by the nurse to record usage and the yellow copy was kept by the DNS or its designee. Interview with the DNS on 2/26/24 at 12:45 PM identified that he was unable to locate the white and yellow copy of the Control Substance Disposition Record for Rx # 1882731, Rx # 1394477, and Rx #2028718. Interview with the Former DNS (RN #6) on 2/26/24 at 1:05 PM identified that she utilized the white copy of the Control Substance Disposition Record to scan to the pharmacy electronic system along with the number/amount of the medication to be destroyed, after which the white copy is returned to the Assistant Director of Nursing for record keeping. Interview with the ADNS on 2/27/24 at 9:15 AM identified that she was responsible for matching the yellow copy of the Control Substance Disposition Record with the white copy when it was returned by the nurses. The ADNS further identified that she searched for the missing Control Substance Disposition Record but was unable to locate the white and yellow copy for Rx # 1882731, Rx # 1394477, and Rx #2028718. The ADNS added that when the white copy is returned to her it was not clear that those medications were discarded/disposed but moving forward a new system will be in placed to file and retain the records accordingly. Review of the Controlled Substance Handling policy identified that to keep all controlled substance accountability records and audit records on file for a period of no less than 5 years.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47900 Based on observations, clinical record review, facility policy review, and interviews for four residents (Resident #36, 61, 62, 242), the facility failed to ensure expired medications were not in use and removed from the medication cart, failed to date insulin when opened, and failed to ensure medications were stored according to the manufacture's recommendation. The findings include: a. Resident #36's diagnoses included type 2 diabetes mellitus, hyperlipidemia, and anxiety disorder. Resident #36's physician's orders for the month of February 2024 directed to administer Lantus 100units/milliliter (U/ml) inject 30 units subcutaneously (SC) at bedtime for diabetes. The medication administration record (MAR) for the month of February 2024 identified Resident #36 was administered Lantus 30 units subcutaneously at 9pm nightly from February 1, 2024, to February 25, 2024. Observation of the Windsor right medication cart on 2/26/24 at 11:34 AM with Charge Nurse (LPN #5) identified an opened vial of Lantus 100u/ml for Resident #36 that was 1/4 full with a label that consisted of an opened date of 1/12/24 and an expiration date of 2/9/24, which was 17 days past the expiration date, and another opened vial of Lantus 100u/ml for Resident #36 that was 3/4 full with a label consisted of an open date of 2/21/24. Interview with LPN #5 on 2/26/24 at 11:37 AM identified that it was the responsibility of the nurse who opened the insulin to affix a label that consists of the opened date and the expiration date. LPN #5 further identified that Resident #36 received Lantus 30units nightly based on the MAR, and nurses are responsible for checking the expiration date of the medication prior to administration. Interview and observation with the DNS on 2/26/24 at 12:10 PM identified there were two vials of Lantus 100u/ml for Resident #36 with one vial consisting of an opened date of 1/12/24 and an expiration date of 2/9/24, and the other Lantus 100u/ml vial consisting of an opened date of 2/21/24. The DNS indicated that the Lantus was expired and should be discarded, and it was the responsibility of every nurse to check the expiration date prior to administering a medication. Interview with the DNS on 2/27/23 at 3:45 PM identified that the facility does not have an insulin specific policy, but it was the practice of the facility to label insulin with the date opened and it is usually expired 28 days after the opening date unless specified by the pharmacy. Review of the Storage of Medication policy identified that expiration dating of certain medications such as multiple dose injectable vials require an expiration date shorter than the manufacture's expiration date once opened to ensure medication purity and potency. The Storage of Medication policy further identified that the nurse would check the expiration date of each medication prior to administration. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Resident #61 diagnoses included type 2 diabetes mellitus, hypertension, and bipolar. The physician's order for the month of February 2024 directed Insulin Lispro (Humalog) 100units/milliliter (U/ml) inject subcutaneous before meals with coverage per sliding scale as follows for blood sugar (BS) of 170-200 give 2 units, BS of 201- 250 give 4units, BS of 251-300 give 6units, BS of 301-350 give 8 units, BS of 351-400 give 10 units, and greater than 400 notify the physician for diabetes. Resident #62 diagnoses included type 2 diabetes mellitus, hypertension, and dementia. The physician's order for the month of February 2024 directed Insulin Lispro (Humalog) 100u/ml inject 16 units subcutaneously three times daily with meals for diabetes. Observation of the Windsor right medication cart top drawer on 2/26/24 at 11:34 AM with Charge Nurse (LPN #5) identified the following insulin vials without an opening and expiration date: * An opened Insulin Lispro (Humalog) 100u/ml vial 3/4 full stored in a container in the top drawer of the medication cart for Resident #61 without a label that consisted of when the medication was opened or would be expired. * An opened Insulin Lispro (Humalog) 100u/ml vial stored in a container in the top drawer of the medication cart for Resident #62 without a label that consisted of when the medication was opened or would be expired. Interview with LPN #5 on 2/26/24 at 11:37 AM identified that it was the responsibility of the nurse who opened the insulin to affix a label that consisted of the opening date and the expiration date. Interview with the DNS on 2/27/23 at 3:45 PM identified that the facility does not have an insulin specific policy, but it is the practice of the facility to label insulin with the opening date when opened and it is usually expired 28days after the opening date unless specified by the pharmacy. Review of the Storage of Medication policy identified that when the original seal of the manufacturer's container or vial is initially broken, the container or vial will be dated. c. Resident #242 diagnoses included type 2 diabetes mellitus, muscle weakness, and laryngeal cancer. The physician's order for the month of February 2024 directed Morphine Sulfate oral solution 20milligram/milliliter (mg/ml) Concentrate give 1.5ml (30mg) by mouth every 4 hours around the clock and give 1ml (20mg) by mouth every hour as needed for pain, shortness of breath or labored breathing. Observation of the Touchpoint unit medication room refrigerator on 2/22/24 at 1:46 PM with Charge Nurse (LPN #3) identified an affixed locked box that contained Morphine Sulfate Oral Concentrate (Opioid) 20milligram/milliliter (mg/ml) that contained 30ml and the refrigerator thermometer read 38 degrees Fahrenheit. The Morphine Sulfate Oral Concentrate container had a manufacture's label that stated to store at 68 to 77 degrees Fahrenheit, room temperature. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #3 on 2/22/24 at 1:46 PM identified that storage of medication received from the pharmacy was the responsibility of the receiving nurse to place the medication in the appropriate storage area. LPN #3 further identified the Morphine Sulfate medication was in the fridge in the morning during the shift-to-shift count, and during the count nurses would match the medication amount on hand with the controlled substance disposition record for accuracy. Interview with the Pharmacist on 2/22/24 at 3:20 PM identified that Morphine Sulfate Oral Concentrate 20 mg/ml is required to be stored at room temperature, and if stored in the refrigerator the medication will precipitate, form crystal, making it less effective. Interview with the DNS on 2/22/24 at 3:31 PM identified that Morphine Sulfate Oral Concentrate is not generally stored in the refrigerator, and it was the responsibility of the charge nurse who receives medication from the pharmacy to store the medications appropriately. The DNS further indicated that the medication would be removed, and another one would be ordered immediately. Interview with Charge Nurse (LPN #4) on 2/26/24 at 5:20 AM identified that she placed the Morphine Sulfate medication in the refrigerator after receiving the medication. LPN #4 further identified that she would store medications based on memory and by reading the label sent by the pharmacy. LPN #4 indicated that moving forward she will review the label to ensure that the medication is stored correctly. Review of the Storage of Medication policy identified medications and biologicals should be stored at their appropriate temperatures according to the United States Pharmacopeia (USP) guidelines for temperature ranges.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47402 Based on observation, review of facility policy and interviews, the facility failed to ensure dietary staff wore proper hair restraints, food served within acceptable temperature parameters and that the kitchen was maintained in a clean and sanitary condition. The findings include: Observation during the initial tour of the kitchen on 2/20/24 at 9:45 AM with the Food Service Director identified the floor was sticky and had multiple areas that contained visible debris. Interview on 2/20/24 at 9:50 AM with the Food Service Director identified that the Dietary Aide was just about to mop the floor, and that it is done twice daily. When a sign off on the task list was requested the food Service directed noted there was no sign off for the task just a list of tasks to be completed. Observation on 2/20/24 at 10:02 AM identified Dietary Aide #1 portioning cake onto plates with long hair several inches past her shoulders with no hair restraint. Interview with the Food Service Director on 2/20/24 at 10:08 AM identified that Dietary Aide #1 should be wearing a hair restraint while portioning cake for the upcoming meal and was unsure why she was not and that it may have fallen off. Observation of the cook taking the food temperatures on 2/26/24 at 11:30 AM identified the chicken temperature was 135 degrees (Fahrenheit), mashed potatoes were 150 degrees and stuffed shells were 125 degrees, they were all put back into the ovens. Second temperature check at 2/26/24 11:50 AM, stuffed shells were 180 degrees, chicken was 150 degrees and mashed potatoes were 150 degrees, the chicken and mashed potatoes were put back into the oven. Third check on 2/26/24 at 12:02 PM chicken was heated to 170 degrees and mashed potatoes were heated to 170degrees. Observation of food service on 2/26/24 starting at 12:10 PM identified the dietary aide called out the specific resident choice from the form (ticket) to the cook, who then plated the meal, the meal was then passed to the dietary aide who added gravy and covered the plate with a top and placed the plate on an open rolling cart, which was then delivered to either a resident room or the dining room. Carts were noted to sit in the hallway for a period of time between four minutes to twelve minutes before being delivered. A test tray was obtained at the end of service on the Windsor Left unit on 2/26/24 at 1:07 PM, the Food Service Manager checked the temperature of the food on the plate at 1:10 PM. The chicken was 128 degrees, the vegetable was 120 degrees, and the mashed potatoes were 140 degrees. Interview with the Food Service Manager on 2/26/24 at 1:15 PM identified that all foods should be reading between 138-140 degrees and that the reason the food was cooler than expected was because it probably sat too long before being distributed to the residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the suggested guideline for the kitchen duties for the 8am-12pm person identified that the kitchen floor should be swept and mopped between 9:00 am and 11:00 am and this should occur again between 6:15pm and 8pm. Review of the Hair Restraint policy identified that anyone within the kitchen, who will have close contact with the preparation or service of food, food storage areas, equipment will keep hair effectively/appropriately retrained to include facial hair. Allowable restraints are hairnets, beard guard, chef caps, chef hats, and ballcaps. Review of the palatability policy directed food to be served at a preferable temperature to the residents. Hot foods will be held at 135 degrees or higher on the steam table in accordance with compliance with holding foods outside the food danger zone.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 47900 Based on review of facility documentation, review of facility policy, and interview, the facility failed to review the infection prevention control program policies and procedures at least annually, and failed to provide documentation that environmental rounds were conducted on a quarterly basis. The findings include: a. Review of the facility's Infection Control Program Policies and Procedure manual for the past two years on 2/22/24 at 10:52 AM identified that the policies and procedures manual was reviewed on 1/19/23 but was not reviewed in 2022. Interview with the Infection Preventionist Nurse (RN #3) on 2/22/24 at 10:52 AM identified that the policy and procedures manual should be reviewed annually but was not working at the facility during the time it was due to be completed. A policy for review and renewal of the infection control program policies and procedures was requested but was not provided by the facility. Interview with the Administrator on 2/27/24 at 3:30 PM identified she was unable to locate a policy but identified that it was the practice of the facility to review and renew policies and procedures annually. The Administrator further identified that it was the responsibility of the Administrator to ensure that the policies and procedures were reviewed but she was not working at the facility during the time when the renewal was due in 2022. b. Review of the infection control environmental round documentation for the past two years with the Infection Preventionist (RN #3) on 2/26/24 at 1:25 PM identified that quarterly environmental rounds were not completed for the months of January 2023 and October 2023. Interview with RN #3 on 2/26/24 at 1:25 PM identified that he was unable to locate the environmental rounds survey worksheets for the months of January 2023, and October 2023. RN #3 further added that he started working at the facility in November of 2023 and it would have been the responsibility of the previous IP nurse to ensure that the other department heads complete the rounds. Interview with the Corporate Director of Education and Infection Preventionist (RN #5) on 2/26/24 at 1:25 PM that she was unable to locate the environmental rounds for January 2023 and October 2023. Review of the Environmental Rounds policy identified that Professional Development Coordinator (PDC/IP) and other department heads to complete environmental rounds quarterly. The policy further indicated that the environmental survey worksheets will be retained for review to illustrate the improvement of quality of life within the facility and for review or comparison purposes within the facility over a period.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 47900 Based on review of facility documentation, review of facility policy and interviews, the facility failed to ensure that a review of the antibiotic stewardship program including antibiotic usage was presented at the quarterly medical staff meetings. The findings include: A review of the infection control program for the past two years with the Infection Preventionist Nurse (RN #3), Corporate Director of Education (RN #4) and Corporate Director of Education and Infection Preventionist (RN #5) on 2/22/24 at 10:52 AM failed to identify documentation related to monthly review of the antibiotic stewardship program for the period of January 2022 to September 2022, December 2022, and February 2023 to June 2023. The facility also failed to provide quarterly review Medical Staff Meeting Reports documentation related to quarterly review of antibiotic usage for 2022 and 2023. RN # 3 identified that he started working at the facility in November of 2023 and would contact the physician or the facility APRN's directly if he had any issues that needed to be addressed such as laboratory reports, antibiotics prescribe, which was done on a case-by case basis and was not aware of any formal documentation regarding the antibiotic stewardship program for the Medical Staff meetings. Subsequent to surveyor inquiry, the facility only provided documents labeled Medical Staff Meeting dated April 19, 2023, and Medical Staff Meeting dated July 19, 2023. The documentation identified the facility's infection rates for urinary tract infection (UTI), lower respiratory infection (LRI), upper respiratory infection (URI) and skin/wound for the months within the quarter being reviewed. A further review of the documents failed to identify any additional documentation related to the antibiotic stewardship program that included antibiotic usage for any of the other Medical Staff meetings documentation provided that was conducted quarterly. Interview with RN #3 on 11/3/23 at 10:57 AM identified that an Individual Infection Tracking Report should be completed when a resident is on an antibiotic which consisted of: the nature of the infection, McGreers Criteria, date of onset, symptoms, treatment ordered, culture, x-ray, precautions, practitioner review, and resolved date. RN #3 further identified that it was the responsibility of the IP nurse to complete the report. RN #3 failed to indicate why the individual tracking report was not completed or as to why a report on antibiotic usage was not presented at the quarterly meetings as he was new to the role as an IP nurse, and to this facility. Interview with the former DNS who oversight the infection control program (RN #6) on 2/22/24 at 12:29 PM identified that a review of infections within the facility was done weekly at the Risk Meetings and Quarterly meetings with attendees consisted of the DNS, IP, Administrator, APRN for Health Drive, ADNS, therapy, and the dietician. However, RN #6 was unable to provide any documentation of the review of the antibiotic stewardship program which included antibiotic usage that was discussed at the meetings. RN #6 identified that the APRN's would review the antibiotic used by the resident and document a note in the resident's chart, and the ADNS and herself would review nurses note for signs and symptoms of infection to calculate the monthly infection rates. Although requested, the facility failed to provide any further and additional documentation related to quarterly medical staff meetings for 2022 and 2023 that contained antibiotic usage and tracking. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075264	A. Building B. Wing	02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Touchpoints at Bloomfield	140 Park Ave Bloomfield, CT 06002

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Antibiotic Stewardship policy identified that all infections will be tracked by the IP or designee and reviewed for trends. The policy further directed that the facility would review the antibiotic usage and present findings quarterly at the medical staff meeting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075264	A. Building B. Wing	02/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on review of facility documentation, review of facility policy and interviews for five of five sampled nurse aides (NA #4, NA #5, NA #6, NA #7, and NA #8), the facility failed to ensure that the required 12 hours of in-service training including abuse were provided to staff in 2022 and 2023. The findings include: Review of the facility's mandatory yearly in-service training for NA #4, NA #7, and NA #8's identified the facility was unable to provide documentation that a total 12 hours of training that included abuse and dementia was completed for the year 2022. Review of the facility's mandatory yearly in-service training for NA #4, NA #5, NA #6, NA #7, and NA #8's identified the facility was unable to provide documentation that a total 12 hours of training that included abuse and dementia was completed for the year 2023. Interview with Staff Development Nurse (RN #3), Corporate Director of Education (RN #4) and Corporate Director of Education and Infection Preventionist (RN #5) on 2/27/24 at 3:10 PM identified that they did not have documentation that identified the nurse aides completed the required hours of in-service training for the years 2022 and 2023. RN #3 identified that he started working at the facility in November 2023 and that the then Staff Development Nurse would have been responsible to ensure that the required hours of in-services were completed. Interview RN #3 on 2/27/24 at 3:10 PM identified that the nurses' aides are rotated on each unit when staffing becomes short, and any of the nurses' aides can be utilized to work on the behavioral unit. A policy for staffing education was requested but was not provided by the facility. Interview with the Administrator on 2/27/24 at 3:30 PM identified that the facility does not have such policy, but it was the practice of the facility to conduct annual completed and training to meet the requirements, which is reflected in the facility's assessment. The Administrator indicated that the staff also completes an online in-service by Medline University but was unable to locate any in-service completion for the nurse's aide. Review of the Facility assessment dated [DATE] identified that nurse aide competencies that includes dementia management, abuse prevention, and areas of weakness identified in the performance reviews, infection control, resident rights, compliance and ethics, behavioral health, abuse neglect and exploitation, and effective communication on hire and a part of the annual mandatory in-services. 48335