STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075314	A. Building B. Wing	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Touchpoints at Manchester	333 Bidwell St Box 1296 Manchester, CT 06040

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46046 Based on review of facility smoking policy and Leave of Absence (LOA) policy and staff interviews, the facility failed to ensure that facility policies honored the resident's rights. The findings included: 1. On 7/21/2023 at 1:00 PM an interview and policy review with the Administrator, the [NAME] President of Operations, Registered Nurse (RN #6), and the Director of Nursing Services (DNS) identified the smoking policy and smoking agreement signed by the resident/responsible party indicated in part a potential removal of smoking privileges from a resident who was not complied with the facility smoking rules. The Administrator and [NAME] President of Operations further indicated the smoking rules were in place to ensure that residents who smoke adhere to the rules to prevent a potential emergent situation of all residents if a fire was started by a resident who was not following the rules, kept smoking items in their own possession and started a fire in the facility. The Administrator further indicated to his knowledge smoking privileges have yet to be taken away from any residents in the facility. The Administrator also indicated it is the hopes of the facility that by having the rules in place and signing the agreement that would prevent any unexpected outcomes. RN #6 indicated that the determination of need for changes in a resident's smoking privileges would be reviewed by the Interdisciplinary Team including an infraction sheet kept for those residents who do not follow the policy rules for smoking. The [NAME] President of Operations indicated that although it may seem punitive to take away smoking privileges if all facility smoking is supervised by staff members in an approved location with smoking materials kept by the facility until time of distribution, the goal is to provide a safe environment for all the residents. RN #6 indicated smoking privileges suspension is decided by the physician. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/21/2023 at 1:20 PM a telephone call with the facility Medical Director (MD # 3) indicated he/she is only involved in the medical aspect of residents who smoke and is not involved in the actual determination of removal of smoking privileges. The Medical Director (MD #) further indicated he would meet with any smoker and discuss smoking is not healthy and offer the use of a smoking patch to assist in cessation, reinforce smoking materials used during the supervised smoking sessions cannot be brought back into the facility by the residents. MD #3 also indicated to his/her knowledge the facility has not had to provide a 30-day notice of discharge to any resident due to frequent reminders by staff to follow the smoking policies. The MD #3 further indicated that he/she is not actively involved in the decision process regarding whether a resident's smoking privileges would be taken away but to the contrary is informed by facility staff of issues that have occurred. The Medical Director did indicate he/she is involved with review of the facility policies and to his/her knowledge no smoking privileges have been suspended. The facility Smoking Agreement revised 12/6/2021 indicated in part that violation of the smoking policies may result in being placed on frequent checks, a progressive modification of smoking schedules up to and including the elimination of smoking breaks, restriction of LOA privileges, smoking privileges being suspended, immediate termination of smoking privileges if the resident places other residents or the environment at risk and the issuance of a 30 day notice of discharge. 2. A review of the facility Leave of Absence (LOA) policy with RN #6 on 7/21/2023 at 1:00 PM in the presence of the Administrator and [NAME] President of Operations identified the Leave of Absence policy requires residents to give a 72-hour notice so that staff has adequate time to obtain medications for residents LOA period and for the Interdisciplinary Team to decide if the resident is appropriate to leave the facility. RN#6 indicated a short notice LOA would be considered on a case-by-case basis. On 7/21/2023 at 1:20 PM a telephone call with the facility Medical Director (MD #3) identified that his/her role in the Leave of Absence policy which requires the provision of 72-hour notice to the facility is to determine whether the nursing home resident is physiologically, psychologically, and emotionally ready to safely go into the community or home for a LOA. The Medical Director further indicated it is necessary that the caretaker understands the medical conditions and can identify changes in the residents and to screen residents to see if they are safe and medically stable to have an LOA. The Medical Director further indicated that being a smoker is not a hard stop to not providing the ability to have a LOA of but is part of determining safety. The Medical Director also indicated the facility informs him/her of the resident circumstances of violation of policy and the residents are provided with instructions for safety but if they had a repeated violation, the facility would decide the next step. He further indicated that the Medical Director is involved with the medical aspect of the resident to determine if any testing, laboratory work or new orders might be needed based on any changes of the resident upon return from an LOA. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy labeled Smoking-Resident, last revised 9/19/2016 presented as the current policy in effect, indicated in part on admission a facility representative would review the smoking agreement with the resident (or responsible party) who is an active smoker or smoking up to the time of hospitalization and would obtain appropriate signatures on the agreement form. The policy further indicated that if a smoker who has LOA privileges may request his/her smoking material for the LOA the resident must return them for safe storage by the facility upon return. The policy further indicated that the Interdisciplinary Team may suspend a resident's leave of absence (LOA) privileges when the resident's safety or the environment is at risk. The policy further indicated that in the event of a policy infraction(examples: failure to extinguish cigarette/smoking materials appropriately, lighting cigarette from another resident's cigarette, improper sharing of cigarettes, collecting cigarette butts, shoving /pushing in line, bringing smoking materials into the facility, smoking in the facility, smoking in unsupervised areas and/or any unsafe behavior related to smoking) corrective action to promote and ensure safety will be applied in a progressive manner based on the severity of the infraction and the resident's needs with examples of interventions that included in part an individualized behavior plan and smoking schedule modification. The facility policy for Travel Pass for Leave of Absence dated 12/8/2022 presented as the most current policy indicated in part that all patient's and or the Conservator will need to provide a 72-hour notice for each request to be reviewed for consideration by the interdisciplinary team, but consideration will be given on a case-by-case basis for approval with shorter notice. The interdisciplinary team will review each request in accordance with the individual resident's needs and make recommendations based on that review. The physician will then sign off or deny the request for a travel pass.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. 48336 Based on observations, review of facility documentation and staff interviews, the facility failed to act on recommendations from Resident Council concerns. The findings include: Review of Resident Council meeting minutes dated 4/27/23 indicated the residents requested to receive silverware and drinks before getting their meals. Facility's response indicated they would communicate to Nurse Aides (NAs) and kitchen staff to improve timing and that silverware and drinks would be passed earlier to ensure residents receive them before the meal. Observation of dining on the first floor A Wing on 7/18/23 at 11:20 AM identified a steam table was brought to the unit by Dietary staff, food was plated and served to residents eating in their room (by Dietary staff). Additionally, a NA was observed to be passing juices from a cart and another NA was passing out silverware, however, residents had to wait to receive juices/silverware because they were not delivered with the meal. Interview with the Food Service Director on 7/18/23 at 11:40 AM identified that NAs are responsible for passing out silverware and drinks. He was not aware of how it was timed and indicated that this was the process they use. Interview with NA #1 on 7/18/23 at 2:13 PM indicated NAs are were responsible for handing out silverware and drinks prior to meals being served, but if the NAs were providing resident care, the silverware and drinks would be passed after the meal was served. During the Resident Council meeting on 7/19/23 at 10:05 AM, residents indicated that silverware and drinks were still being passed out after the meal was served. The Resident Council noted that nothing had improved since their request at the 4/27/23 Resident Council meeting. Interview with the Administrator on 7/20/23 at 10:33 AM failed to identify NAs/dietary staff had been educated on the timeliness of passing juices/silverware as a result of facility interventions from 4/27/23. The facility began staff education regarding passing out silverware and drinks prior to meals being served after they were made aware of the concern during the survey. Education was provided to staff by the Infection Control Nurse and the Director of Food Services beginning on 7/20/23.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48336 Based on observations, review of facility documentation, and staff interviews, the facility failed to ensure the environment was maintained in good repair and in a homelike manner. The findings include: Observations on 7/21/23 at 1:04 PM through 1:45 PM with the Administrator, Director of Operations, Director of Maintenance and the Regional Director of Housekeeping identified the following issues: a. A curtain rod was observed to be bent causing the [NAME] to sag in the second floor East lounge. b. Approximately 24 tiles were observed with linear zigzag cracking located from the doorway to the far wall in the second floor East lounge. c. The ceiling between 2 windows were noted with a black stain and drip marks, paint was observed to be peeling on the wall below the drip marks in the second floor East lounge. d. The second floor Social dining room was observed missing the cove base molding on all 5 walls, exposing peeling, chipped sheetrock. Debris and dust was noted where tile meets the wall. In addition, a light cover was missing over the light closest to the doorway, dust and debris was noted inside other light covers. e. room [ROOM NUMBER], #226 and #227 were observed with window blinds with broken slats. f. room [ROOM NUMBER] was observed with a wardrobe bureau which was damaged and chipped, the baseboards and walls were observed to be soiled, and broken cabinets were noted. g. room [ROOM NUMBER] B was observed to have trim above the head of the bed pulled away from the wall with the tips of 8 screws exposed. h. room [ROOM NUMBER] was observed with a black substance noted in the vents of the window unit air conditioner. i. room [ROOM NUMBER] was observed with peeling paint on the walls. Quality Rounds were completed on 5/4/23 by the Director of Maintenance but none of the surveyor identified areas were on the list. Quality Rounds were completed on 6/29/23 but none of the surveyor identified areas were on the list. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Maintenance on 7/17/23 at 1:05 PM indicated that maintenance of the facility was ongoing. The Director of Maintenance indicated that staff were responsible to notify the maintenance department with issues or problems that require repair via a work log binder that was kept at the Nurses Station. The Director of Maintenance indicated he checks this log daily and completed repair orders were filed in a binder in his office. The Director of Maintenance indicated he does Quality Audits every 2 weeks and this month they were focusing on furniture in the Quality Audits. Interview with the Administrator on 7/21/23 at 1:10 PM indicated he was aware of the issues identified with the environment during the survey. The Administrator indicated it was the responsibility of the maintenance department to oversee the repairing of any issues regarding the facility. The Administrator indicated a contract had been signed for renovations on the second floor, which included the second floor East lounge and second floor Social dining room which would include painting (walls and ceiling) and replacing furniture. In addition, the resident rooms would be painted and furniture replaced. The Administrator identified that the contract for renovations had been signed, a deposit placed for the renovations and the renovations were scheduled to begin the end of August 2023.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47460 Based on clinical record review, facility documentation, and policy review and interviews for 1 of 1 sampled resident (Resident #33) reviewed for specialized treatment, the facility failed to ensure the resident's care plan for weight monitoring was followed. The finding include: Resident # 33's diagnoses included: Acute and Chronic Respiratory Failure, diabetes mellitus, depression, Heart Failure, Congestive Heart Failure (CHF), COPD, End Stage Renal Failure, and Kidney Transplant with Rejection. An admission MDS assessment dated [DATE] identified Resident #33 as alert and cognitively intact, the resident required limited assistance of one for transfers, dressing, toilet use, and personal hygiene, supervision with assistance of one for bed mobility, and independent with set-up for eating. The Treatment Administration Record (TAR) for the month of June 2023 indicated daily weights per CHF/COPD guidelines, if over 2 pounds in 24 hours or 5 pounds in 1 week, notify MD. A physician's order dated 7/10/23 indicated weigh weekly x 4, then monthly. A Resident Care Plan dated 7/10/23 identified the resident was at risk for device failure related to chronic conditions. Interventions included: monitoring weights and vital signs pre and post specialized treatment, sending resident out with special treatment communication book when out for treatments as a means of communicating with the staff from both the center and the nursing home, monitoring for worsening of symptoms of a weight gain of 2 pounds in a day or 5 pounds in a week should be reported, weights daily, at the same time and in the same amount of clothing, ideally in the morning after using the bathroom and before breakfast and a fluid restriction as indicated. The TAR dated 7/10/23 failed to indicate weight monitoring for a resident with chronic disease processes. According to the Journal of Cardiac Failure Volume 29, Issue 1, January 2023, heart failure fluctuations in weight can provoke symptoms, worsen outcomes and is responsible for almost half of the deaths of patients on dialysis. The facility Dialysis Communication Form(s) provided by the facility located in the Communication binder included forms dated 7/11, 7/13, 7/15, 7/18 and 7/20/23, and identified the facility provided the residents vital signs, and the nurse's signature. However, the dialysis complete forms dated 7/11, 13, 18 and 20, 23 failed to include the resident's weights. The areas on the form completed by the Specialized Treatment Center failed to provide vital signs, pre and post treatment weights, care provided/recommendations, a provider's signature, or date of signature. Interview and review of facility documentation on 7/20/23 at 2:22 PM with RN #1 identified monthly weights are kept in a binder at the nursing station, she was unable to provide information how often the weights were to be checked for Resident #33. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview and review of facility documentation review with DNS identified the last weight change history in the EMR was dated 7/10, and further indicated the care plan identified weights were to be obtained daily and were to be reported if weight gain was noted of 2 pounds in a day or 5 pounds in a week. She additionally indicated that she felt it was the physician's decision and should not be because of an automatic enrollment in a program. Interview and clinical record review on 7/20/23 at 2:59 PM with MDS Coordinator #1 identified Resident #33's care plan interventions indicated monitoring and reporting a weight gain of 2 pounds in 24 hours or 5 pounds in a week. He further indicated that he used a template typical for a specific disease process, but failed to identify if staff were following the care plan.

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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** 47491 Based on clinical record review and interviews for 1 of 2 sampled residents (Resident # 79) reviewed for Accidents, the facility failed to ensure physician's orders were verified for daily weights to meet professional standards and facility practice. The findings include: Resident # 79's diagnoses included heart disease, pulmonary hypertension, and dementia. The annual Minimum Data Set assessment dated [DATE] identified Resident # 79 was severely cognitively impaired and required one-person limited assistance with bed mobility and locomotion on the unit, and one-person extensive assistance with dressing, toilet use, and personal hygiene. The Resident Care Plan dated 6/4/23 identified a diagnosis or history of coronary artery disease and pulmonary hypertension, nutritional risk secondary to medical condition, and need of more assistance with activities of daily living related to diagnosis, decline in mobility and right hip fracture. Interventions directed weight as ordered and to monitor status for any changes. A physician's order dated 6/4/2023 directed to weigh resident daily per CHF/COPD guidelines. A review of Resident #79's weight record identified weights taken once weekly on 6/6/23 at 115 lbs., 6/13/23 at 114 lbs., 6/20/23 at 115 lbs., and 6/27/23 at 113 lbs. However, further review of the resident's weight record on 7/19/23 failed to reflect daily weights were conducted on 6/5/23, 6/7/23 through 6/12/23, 6/14/23 through 6/19/23, 6/21/23 through 6/26/23 and 6/28/23 through 7/18/23. Interview with RN#1 on 7/19/23 at 2:07 PM indicated the 11:00 PM to 7:00 AM nurse on flip night (the night physician's orders are reviewed for the following month) is responsible for reviewing the physician's orders, ensuring the accuracy of the physician's orders, and implementing the orders into the plan of care. Interview with the Director of Nursing Services (DNS) on 7/19/23 at 2:47 PM identified the nurse that obtain a telephone order and verify the physician's orders are responsible for reviewing and ensuring the accuracy of the physician's order. The DNS identified Resident #79 was never on the heart failure program, which required daily weights, as Resident #79 had stable weights and experienced no exacerbations during her/his stay at the facility. Subsequent to inquiry, a physician's order for daily weights was discontinued. Interview with RN #2 on 7/20/23 at 7:40 AM identified the responsibility of reviewing physician's orders for accuracy and implementing them into the plan of care was primarily the charge nurse's responsibility. RN #2 further indicated the physician's order for daily weights for Resident #79 could have been overlooked, but s/he was unsure, and policy directed to check the physician's orders for accuracy and to correct errors. Although requested, a facility policy for physician's orders was not provided.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 14448 Based on clinical record review, facility policy review and interviews for 1 of 1 sampled resident (Resident # 120) who was reviewed for death, the facility failed to ensure licensed staff were CPR Certified, obtain a physician order to release a body to a funeral home, failed to date and time a physician's order for IV therapy and staff failed to transcribe a physician's order. The findings included: 1 a. Resident #120 was admitted on [DATE], diagnoses included Type 2 diabetes mellitus, sepsis, and pressure ulcer of the sacral region. The admission MDS assessment dated [DATE] identified the resident was severely cognitively impaired, required extensive to total care with ADLs and noted the resident utilized 6 antibiotics in the last 7 days. The care plan dated [DATE] indicated in part for Resident #120 at risk for alteration in nutritional status with interventions that included: to monitor diet tolerance, assist with meals as needed/accepted and to obtain weights and laboratory blood work as ordered. The care plan further indicated that Resident #120 had skin alteration that included a stage 4 pressure ulcer of the right ischium and an unstageable pressure ulcer of the right heal. Interventions included providing treatments, pressure relieve devices as ordered and repositioning as indicated. A physicians noted dated [DATE] at 6:43 PM indicated Resident #120 had a history of infection, presumably of the sacral pressure ulcer, treated in the hospital. Resident#120 was at baseline and has poor oral intake. Resident # 120, due to elevated white blood cells was started on a 5-day course of 2 antibiotics. A physician's order on [DATE], no time indicated, directed to start a peripheral IV (PIV) and to start D5(dextrose 5%) ,d+[DATE] normal saline solution at 100 cc per hour intravenously for a total of 2 liters. The order further directed to obtain a Basic Metabolic Panel (BMP) and Complete Blood count (CBC) on [DATE], and to limit out of bed to chair to no more than 2 hours a day. A review of physician's orders failed to reflect a date and time the physician's order on [DATE] for D5(dextrose 5%) ,d+[DATE] normal saline solution at 100 cc per hour intravenously for a total of 2 liters was obtained by the physician. An interview and clinical record review with the DNS on [DATE] at 4:02 PM indicated there was no physician orders on [DATE] with date and time for Intravenous (IV) fluids for hydration or evidence that the IV order for hydration was transcribed by the nursing staff. b. Resident #120 was admitted on [DATE], diagnoses included Type 2 diabetes mellitus, sepsis, and pressure ulcer of the sacral region. The advanced directives dated [DATE] indicated Resident #120's code status decision was for Cardiopulmonary Resuscitation (CPR) and signed by the physician on [DATE]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The admission MDS assessment dated [DATE] identified the resident was severely cognitively impaired, required extensive to total care with ADLs. A physicians noted dated [DATE] at 6:43 PM identified Resident # 120's advanced directives as a full code status (provide CPR). The 24-hour Report sheet dated [DATE] for A unit completed for the ,d+[DATE] PM shift with a notation under admissions identified Resident #120 passed away at 4:30 PM and the body was released to the funeral home. No notes were entered on the 24-hour Report sheet for the ,d+[DATE] PM shift. A progress note dated [DATE] at 6:55 PM indicated in part that Resident #120 was observed unresponsive at 3:30 PM, CPR was initiated, 911 called and CPR continued until emergency medical technicians (EMT's) arrived, took charge of the resident providing care later pronouncing asystole. The progress notes further indicated the funeral home of family's choice was notified and Resident #120's body was released to the funeral home at 7:40 PM. A telephone call with RN #8 on [DATE] at 3:00 PM indicated that once Resident #120 was found to be unresponsive CPR was started by the unit manager, while RN #8 and the DNS brought the emergency cart and Automated Electronic Defibrillator (AED) to the bedside and provided CPR until the EMT's arrived and took over. RN #8 indicated Resident #120 was being treated for an infection of the sacral wound and RN#8 had cared for Resident #120 on a full-time basis and no changes in status occurred during that time that would have been indicative of requiring CPR on [DATE]. RN #8 further indicated he/she received report at the change of shift and was told that the family had been visiting daily and that the responsible party wanted Resident #120 to continue with advanced directives to provide CPR in the event it was needed. An interview and clinical record review with the DNS on [DATE] at 4:02 PM indicated there was no physician notification of change in condition, no physician order to release the body to the funeral home and no progress note written by APRN #1 and no nurses note regarding when APRN #1 visit. The DNS further identified that there was no order for removal of the body to a funeral home and no physician notification of change in condition (death). The DNS also indicated there were no nurse's notes by nursing staff and no progress note made by the APRN regarding the orders written on [DATE] directing to start an IV to provide 2 liters of IV fluid and to obtain a BMP and CBC on [DATE] per facility practice. Although a request for CPR certification for licensed staff, particularly the licensed personnel who provided CPR for Resident #120 was requested, the facility was unable to provide documents of CPR certification as these documents are not kept in the facility by the staff development nurse but are kept at the corporate office. The DNS further indicated her CPR card was at home. The facility policy labeled Emergency Intervention-CPR, Cardiopulmonary Resuscitation Policy revision date [DATE] indicated in part that licensed staff are required to be certified in CPR. The procedure indicated in part to activate EMS, obtain the code cart and the AED machine, verify code status of the resident and if Full Code/CPR to begin CPR and use the AED. 46046

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Touchpoints at Manchester	333 Bidwell St Box 1296 Manchester, CT 06040

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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 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** 47460 Based on review of clinical records, review of facility policy and interviews for 1 of 2 residents (Resident #222) reviewed for pressure ulcers, the facility failed to ensure a resident's air mattress was set at the appropriate settings. The finding include: Resident #222's diagnoses included atrial fibrillation, patella fracture, arthritis, osteoporosis, anxiety, anemia, and unstageable pressure ulcer of the coccyx. The resident was admitted to the facility on [DATE]. The admission Minimum Data Set assessment dated [DATE] indicated the resident was alert with moderately impaired cognition, and required extensive assistance of two for bed mobility, limited assistance of one for transfers, dressing, toilet use, personal hygiene, and independent with set-up for eating. Additionally, the assessment indicated the resident weighed 110 pounds. The baseline care plan dated 7/1/23 for at risk for skin breakdown secondary to incontinence and wound on coccyx, heels, and right buttocks. Interventions directed to apply a pressure reduction mattress and cushion, to offer to assist resident with changing positions every two hours as needed, to off load heels as appropriate and to offer a Low Air Loss (LAL) mattress. A physician's order dated 7/4/23 directed to apply LAL mattress, check setting, and function every shift while resident in bed and to place your hand between LAL mattress bed frame to ensure appropriate inflation. However, the physician's order failed to identify what the setting of the LAL should be for the resident. The Treatment Administration Record (TAR) for July 2023 directed LAL air mattress, check settings and functioning every shift while resident in bed and to place your hand between LAL mattress However, the July 2023 TAR order failed to identify what the setting of the LAL should be for the resident The wound consultation dated 7/5/23 for the pressure ulcer on the left buttocks identified the area measured 3.5 Centimeters (CM) by 1.5 CM by 0.10 depth with small amount of serosanguinous drainage. Observation on 7/17/23 at 8:22 AM identified Resident #222 was lying on a LAL (Low Air Loss) mattress in his/her bed, with no staff present. Observation and interview with ADNS, RN #1 on 7/17/23 at 8:24 AM identified Resident #222 lying in bed on a LAL mattress pump settings indicated the mattress was set at static, firm, and at 485 pounds (with resident weight at 110 lbs.). Subsequent to inquiry, on at 8:24 AM and prior to interview and observation with DNS at 8:32 AM the mattress setting was set to 150 lbs. Observation and interview with DNS on 7/17/23 at 8:32 AM regarding observation made with ADNS 7/17/23 at 8:24 AM about setting of 485 identified setting of mattress could have been related to nurse aides providing care. She also indicated the setting should be at 150 pounds. The DNS also could not identify when was the last time the resident's LAL mattress was inspected. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Medline Advantage Select Pressure Redistribution Mattress given to surveyor on site of the residents LAL mattress notes in part for Single Site Stage 11 the most advanced pressure redistribution mattress features our thickest three-layer design to completely conform to your resident's body. The soft sculpted top layer of our finest high-quality foam redistributes pressure for residents up to 450 lbs while maintaining its comfort and durability.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47460 Based on clinical record review, observations and interviews for 1 of 1 sampled resident (Resident #221) reviewed for intravenous therapy the facility failed to follow professional standards of practice of assessing and maintaining parenteral access. The findings include: Resident #221's diagnoses included: heart failure, respiratory failure, peripheral vascular disease, diabetes mellitus, and osteomyelitis. A Resident Care Plan dated 7/5/23 indicated the resident had a chronic disease process that required a continuous intravenous infusion of medication to sustain organ function and was at risk for worsening symptoms of organ failure. Interventions included monitoring his/her level of shortness of breath, swelling, increased tiredness, weight changes, providing education regarding signs and symptoms of organ failure, what to do if signs and symptoms occurred, and directed facility staff to report symptoms to the clinic. However, the RCP failed to identify care planning interventions specific for intravenous site care and maintenance. An Inter-Agency Patient Referral Report (W-10) dated 7/5/23 indicated the resident had been hospitalized [DATE] through 7/5/23 for a revisional procedure and was returning to skilled nursing facility. The hospital discharge summary dated 7/5/23 indicated resident was discharged with a continuous intravenous catheter infusion to aide in organ function, and intermittent intravenous infusion of antibiotics to treat infection of that organ and his/her wound. A nursing note dated 7/5/23 at 3:30 PM indicated the resident returned from the hospital with an intravenous drip catheter with a double lumen. A physician's order dated 6/14/23 directed Vancomycin every 12 hours in 250 ml and directed to discontinued on 7/8/23. A quarterly MDS assessment dated [DATE], identified Resident #221 as alert and cognitively intact, and required limited assistance of one for dressing, supervision of one for bed mobility, toilet use, personal hygiene, and independence with set up for transfers and meals. Observation and interview on 7/17/23 at 8:42 AM with DNS of Resident #221's IV (intravenous) catheter dressing identified the dressing was last changed on 7/4. The DNS further indicated she expected staff to change the IV dressing one time per week. Additionally, the DNS identified that the date on dressing was 7/4, infusion via Computerized Ambulatory Delivery Device (CADD) pump also noted to be on a continuous infusion. A physician's order dated 6/14/23 for Vancomycin every 12 hours in 250 ml, was to be discontinued on 7/8/23. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of facility documentation on 7/21/23 at 11:39 AM with the Regional Staff Educator indicated the policy on Intravenous Manual was last reviewed on 2/10/23. Additionally, she indicated that policy 1.2 Introduction: Requirements for Licensed Nurses Relating to Infusion Therapy, 2.9 Infusion Therapy Procedures: CADD Patient -Controlled Analgesia Pump (PCA Pump), 3.5 Administration Procedures: continuous Infusion, 4.5 Peripheral Venous Access Devices: Peripherally Inserted Central Catheters Modified Seldinger Technique for Insertion, and 5.2 Central Venous Access Devices, and Site Care and Dressing Change were reviewed on 2/10/23. Review of facility Pharmscript Continuous Infusion manual section titled Administration Procedures identified venous access devices are to be flushed as ordered, assess venous access site per facility policy, and documentation in the medical record includes, but is not limited to date and time, medication/solution, rate, and method of infusion, prescribed flushing agent(s), site assessment, complications and interventions, and resident response to procedure and/or medication. Review of the facility's Annual Review of Policy and Procedure Manuals identified the Intravenous Manual was reviewed on 2/10/23 and was signed by the Administrator, Director of Nursing Services, Medical Director, Infection Preventionist and the Maintenance Director. Review of the facility's Guidelines for Inotropic Therapies indicated that inotropic therapy is continuous and should not be stopped. Review of the facility's Policy Number 3.5 Administration Procedures Policy: Continuous Infusion indicated checking the IV site for any signs and or symptoms of IV complications. If these are present, discontinue IV device, and re-access a new IV site following IV insertion guidelines. If these are not present, continue with the administration of the solutions. Additionally, observe IV insertion site for redness, pain or swelling to assure proper placement of catheter, and document initiation of infusion including the patient's tolerance to the procedure and insertion site assessment, and frequently reassess the infusion site, drip rate, and patient condition. Review of the facility's Policy Number 5.2 Central Venous Access Devices: Site Care and Dressing Change indicated considerations for the catheter insertion site as a potential entry site for bacteria that may cause a catheter-related infection, a transparent dressing is the preferred dressing, and that licensed nurses caring for residents receiving infusion therapies are expected to follow infection control and safety compliance procedures. Guidance indicated that dressing changes using a transparent dressing are performed 24 hours post-reinsertion, at least weekly, and if the integrity of the dressing has been compromised (wet, loose, or soiled).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19953 Based on clinical record review, observations, review of facility documentation, review of facility policy and interviews for 1 of 2 sampled residents (Resident #2) reviewed for oxygen therapy, the facility failed to assess the resident for competency to apply/remove oxygen independently and failed to ensure a physician's order identified the frequency for monitoring oxygen saturation levels. The findings include: Resident #2 's diagnoses included chronic respiratory failure with hypoxia, acute and chronic systolic (congestive) heart failure and morbid obesity with alveolar hypoventilation. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had intact cognition, and required supervision of 1 for bed mobility, transfers, dressing, toilet use and personal hygiene. The MDS further identified Resident #2 utilized oxygen while in the facility. A Resident Care Plan (RCP) dated 4/27/22 identified a problem with respiratory status with interventions that included to provide oxygen per physician's order and report signs and symptoms of respiratory distress. A physician's order dated 4/28/22 through 7/19/23 directed oxygen (O2) continuous at 2 liters (L) during the day. A physician's order dated 8/26/22 through 7/19/23 directed supplemental O2 at 3L/minute via nasal cannula (NC) during the day. A RCP dated 7/20/23 identified a problem with respiratory status and the use of supplemental oxygen with interventions that included to provide oxygen per physician order and report oxygen saturation below the parameters outlined by provider. Medication Administration Record (MAR) and Treatment Administration Record (TAR) for May 2023, June 2023 and July 2023 indicated that oxygen was used continuously at 2L during the day from 5/1/23 through 7/20/23. a. Interview with Resident #2 on 7/20/23 at 10:55 AM indicated that he/she felt comfortable applying and removing his/her oxygen and switching to a portable tank by him/herself without staff assistance. Resident #2 further identified he/she does remove and apply his/her own oxygen, and further identified he/she calls a nurse if he/she has any problems. Interview with Licensed Practical Nurse (LPN) #4 on 7/20/23 at 12:20 PM indicated that there was no formal assessment to identify if Resident #2 was competent to independently apply and remove his/her nasal cannula and confirm the oxygen setting was appropriate. Interview with the DNS on 7/20/23 at 2:10 PM indicated that the facility preferred that residents do not apply oxygen independently and it should always be done by a nurse. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. A physician's order initiated on 5/27/22 and continuously active through 7/19/23 directed to titrate O2 to keep saturation (sats) over 88% to 92% every shift (but failed to reflect how often to monitor O2 sats to ensure parameters were met). The MAR and TAR for May 2023, June 2023 and July 2023 identified O2 sats were charted daily from 5/1/23 through 7/20/23. Interview with the DNS on 7/21/23 at 10:05 AM indicated that she was not aware how staff know when to check oxygen saturations on a resident without a physician's order indicating the frequency. She indicated that she would check into it. She also identified that there was not a written policy regarding oxygen saturation monitoring. Review of the facility oxygen policy indicated that there was no guidance for assessment of a resident's competency to apply/remove their own oxygen. 47460

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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** 47460 Based on clinical record review, facility documentation, policy review and staff interviews for o1 of 1 sampled resident (Resident #33) reviewed for specialized treatment, the facility failed to ensure that treatment site monitoring, weight monitoring, and communication with the treatment center was consistent and within the plan of care. The findings included: Resident # 33's diagnoses included: Acute and Chronic Respiratory Failure, diabetes mellitus, depression, Heart Failure, Congestive Heart Failure (CHF), COPD, End Stage Renal Failure, and Kidney Transplant with Rejection. An admission MDS assessment dated [DATE] identified Resident #33 as alert and cognitively intact, the resident required limited assistance of one for transfers, dressing, toilet use, and personal hygiene, supervision with assistance of one for bed mobility, and independent with set-up for eating. The Treatment Administration Record (TAR) for the month of June 2023 indicated daily weights per CHF/COPD guidelines, if over 2 pounds in 24 hours or 5 pounds in 1 week, notify MD. A physician's order dated 7/10/23 indicated weigh weekly x 4, then monthly. A Resident Care Plan dated 7/10/23 identified the resident was at risk for device failure related to chronic conditions. Interventions included: monitoring weights and vital signs pre and post specialized treatment, sending resident out with special treatment communication book when out for treatments as a means of communicating with the staff from both the center and the nursing home, monitoring for worsening of symptoms of a weight gain of 2 pounds in a day or 5 pounds in a week should be reported, weights daily, at the same time and in the same amount of clothing, ideally in the morning after using the bathroom and before breakfast and a fluid restriction as indicated. a The TAR dated 4/28/23 and for month of June 2023 directed to monitor left arm site every shift for thrill and bruit. The facility failed to assess the left arm site from 6/1 through 6/30/23 on 7 occasions. Additionally, the TAR dated 7/10/23 failed to indicate monitoring of left arm site. Further review of the clinical record and EMR for Resident # 33 identified the facility failed to consistently monitor the resident's weight monitoring for fluctuations within accordance to the plan of care. The TAR dated 4/28/23 and for the month of June 2023 indicated daily weights per CHF/COPD guidelines, if over 2 pounds in 24 hours or 5 pounds in 1 week, notify MD. A physician's order dated 7/10/23 indicated weigh weekly x 4, then monthly. The TAR dated 7/10/23 failed to indicate weight monitoring for the resident per plan of care. A dietitian's order dated 7/11/23 directed renal diet restriction. A physician's order dated 7/12/23 directed 1200 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	A review of the Specialized Treatment Communication forms dated 7/11, 13, 18 and 20, 23 failed to include the resident's weights. A dietitian's progress note dated 7/14/23 (late entry for 7/11/23) identified the resident had a significant weight gain associated with hospitalization , the weight gain was secondary to fluid retention, visible increase in edema, and noted that a fluid restriction was not added upon readmission and indicated written referral to APRN to assess for fluid restriction. Additionally, the dietitian indicated that laboratory work, weights, intake should be monitored. Interview and review of facility documentation on 7/20/23 at 2:22 PM with RN #1 identified monthly weights are placed in a binder at the nursing station, she was also unable to provide information how often Resident # 33's weights are to be checked. Interview and clinical record review on 7/20/23 at 2:59 PM with MDS Coordinator #1 identified Resident #33's care plan interventions indicated monitoring and reporting a weight gain of 2 pounds in 24 hours or 5 pounds in a week. Review of the Facility's Specialized Treatment- Care of the Access Site (policy review dated 2/10/23) policy directs in part residents undergoing specialized treatment will have the access device (A-V fistula, A-V graft, or A-V shunt) monitored every shift by a licensed nurse, or per physician's order. Additionally, the Procedure item #9 to observe for signs of arterial steal syndrome- caused by too little blood in the extremity. c.A review of the facility Dialysis Communication Form(s) provided by the facility located in the Communication binder included forms dated 7/11, 7/13, 7/15, 7/18 and 7/20/23, and identified the facility provided the residents vital signs, and the nurse's signature. The areas on the form completed by the Specialized Treatment Center failed to provide vital signs, pre and post treatment weights, care provided/recommendations, a provider's signature, or date of signature. Interview and review of facility documentation review with DNS identified the last weight change history in the EMR was dated 7/10, and further indicated the care plan identified weights were to be obtained daily and were to be reported if weight gain was noted of 2 pounds in a day or 5 pounds in a week. She additionally indicated that she felt it was the physician's decision and should not be because of an automatic enrollment in a program. Interview and review of facility documentation on 7/21/23 at 10:04 AM with the Regional Clinical Educator identified there should be a communication book from the Specialized Treatment Center, and that she could not identify where in the Specialized Treatment Center Communication Book for Resident #33, the pre and post dialysis weights. She further indicated that she would ask the DNS if it was in the nursing notes, the facility failed to provide this information. Interview via telephone on 7/21/23 at 10:55 AM with the RN, Specialized Treatment Center Facility Administrator identified Resident #33 attends the center. She further indicated that the nursing facility and the center communicate using pre-populated from (provided by the facility) that includes weights, vital signs, medications administered, and anything about how the visit went, and how the resident tolerated the visit. Additionally, she indicated that the center sends the communication form back along with the resident.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. 48880 Based on interviews and employee record review, the facility failed to complete annual performance evaluations for 1 of 3 sampled Nurses Aides (NA #3) reviewed. The findings include: NA #3's date of hire was 3/12/15. One performance evaluation was present in the employee record dated 3/16/23. Although requested, the facility was unable to provide annual evaluations prior to 2023 for NA #3. Interview with the Administrator on 7/20/23 at 1:30 PM indicated that administration provides the Nursing Supervisors an evaluation form to complete with the NAs being evaluated. Once completed, the form is returned to the DNS and Administrator for signatures. The Administrator was unable to indicate a reason for the absence of evaluations prior to 2023 for NA #3 and indicated that follow up to incomplete evaluations for NAs is done by the DNS. Interview with the DNS on 7/20/23 at 1:40 PM indicated that performance evaluations are completed yearly on the date of hire. The DNS was not able to indicate a reason for the absence of evaluations prior to 2023 for NA #3. The DNS identified that there is no written facility policy for performance evaluations.

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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. 46046 Based on observation and staff interview for 2 of 2 units, the facility failed to ensure staff ensure that treatment carts were secure. The findings included. 1. Observations on 7/17/23 6:15 AM on the first floor, noted the treatment cart located on left side of hall across from the nursing station was unlocked and unattended Interview with the charge nurse, LPN # 8 indicated the treatment cart should have been locked and proceeded to immediately lock the cart. LPN #8 further indicated a staff member had just been in it a few minutes ago. Observation further identified no other staff member or resident in the vicinity of the unsecured treatment cart. 2. Observations on 7/17/2023 at 6: 25 AM on the second floor identified the treatment cart was found unlocked and unattended to the right side of the nurse's station in the hall leading to resident rooms. The charge nurse LPN# 7 was noted sitting at the opposite side of the nurse's station using the computer. LPN # 7 indicated the treatment cart should have been locked and s/he did not know who left the cart unlocked and proceeded to get up walk over the location of the treatment cart and immediately locked it. On 7/17/2023 at 8:30 AM the DNS was made aware that the treatment carts were found unlocked and unattended. The DNS indicated staff should have locked the treatment carts.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 47491 Based on observation, review of the facility infection control program and interviews, the facility failed to perform hand hygiene following glove removal and failed to properly label, cover, and store a bedpan to prevent the spread of infection. The findings included: 1. Observation and interview with RN #4 on 7/17/23 at 11:42 identified failure to perform hand hygiene after removing his/her gloves following a blood glucose test. RN#4 indicated she did not perform hand hygiene after removing her gloves, policy directed to perform hand hygiene following glove removal, and she forgot to perform hand hygiene following glove removal. Interview with the Director of Education and the Director of Nursing Services on 7/20/23 at 2:48 PM indicated the nurse should perform hand hygiene following the removal of his/her gloves. Review of the Hand Hygiene Policy directed to utilize hand sanitizer after removing gloves. 2. Observation and interview with Nurse Aid (NA) #8 on 7/20/23 at 7:45 AM identified an unlabeled and uncovered bedpan in Resident # 15, 47, 70, 102, and 117's shared bathroom between the grab rail and the wall on the right side of the toilet, with the bedpan opening facing the wall. Interview with NA#8 identified h/she was unsure why the bedpan was in the shared bathroom and staff were responsible for cleaning, drying, covering, and storing labeled bedpan. NA #8 also indicated the Residents # 15, 47, 70, 102, and 117 were independent with bathroom use. Interview with the Director of Nursing Services (DNS) on 7/21/23 at 8:48 AM identified a used bedpan that should be cleaned, covered, and stored. Furthermore, the DNS indicated the bathroom was shared by residents who used the facilities and would not use bedpans.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48336 Based on observations, review of facility documentation, and staff interviews, the facility failed to maintain resident equipment in a safe operating condition. The findings include: Observations on 7/21/23 at 1:04 PM through 1:45 PM with the Administrator, Director of Operations, Director of Maintenance and the Regional Director of Housekeeping identified resident beds in room [ROOM NUMBER] B, room [ROOM NUMBER] A and room [ROOM NUMBER] B had all four bed wheels propped on top of wooden blocks, which rendered the bed incapable of moving. Interview with the Director of Operations on 7/19/23 at 1:00 PM identified that he was unaware beds were risen on blocks, and would inquire with the Director of Maintenance. Interview with the Director of Operations on 7/19/23 at 2:30 PM identified the Director of Maintenance placed the beds on wooden blocks in order to prevent them from moving because the wheel locks did not function well. Subsequently, he directed the Director of Maintenance to order new beds. Interview with Director of Maintenance on 7/21/23 at 1:15 PM indicated that the beds were put on wooden blocks because the wheels did not lock, and in order to move the bed, the frame would need to be lifted and the blocks kicked out. Additionally, the Director of Maintenance identified the facility had purchased 10 new beds and planned to replace all the beds that were on blocks with the new beds.

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 46046 Based on observations and interviews the facility failed to ensure the resident lounge on the second-floor unit was clean and odor free. The findings include: Observations on 7/17/2023 at 6:02 AM while walking up the staircase to the second floor identified strong odor of urine. Upon entering the locked unit, the smell of urine was present a short distance across the hall from the staircase doorway to the resident lounge where two residents were noted: one lying down on the couch and the other sitting on another small couch. The strong odor of urine was noted in the lounge and neither resident was noted to have soiled clothing, no trash cans that contained any trash would account for the smell. Additionally, there were a few food wrappers under the couch but without smell. Observation and interview with the Administrator on 7/17/2023 at 7:30 AM of the second-floor lounge area indicated the lounge needed a deep cleaning. The Administrator further indicated that cleaning of the lounge was done as needed. However, the Administrator could not provide a date when the deep cleaning was done. Subsequent to inquiry, the Administrator indicated a cleaning of the area would occur today. The Administrator further indicated he would look further into the revision of the cleaning schedule. The Administrator also indicated that his requested plan for some redecorating of the resident rooms and lounge areas include flooring, which may help with the odor but had no date when the improvements should begin. Observation on 7/17/2023 at 11:30 AM of the second-floor lounge identified a cleaned area with reduced odor of urine.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075314	A. Building B. Wing	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Touchpoints at Manchester	333 Bidwell St Box 1296 Manchester, CT 06040

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on review of facility documentation and interviews, the facility failed to ensure the therapy department staff received mandatory annual training that included in part abuse and dementia training. The findings included: The Facility assessment dated [DATE] indicated in part the facility training plan upon on hire and annually staff training which included: Effective Communication, Resident Rights, Abuse, Neglect, and Exploitation (part of the annual in-service and a test is completed), Infection Control, Compliance with Ethics, Nurse Aide Competency, Behavioral Health, and Non-pharmacological Interventions. Interview with the Director of Rehabilitation PT#1, on 7/18/2023 at 8:30 AM identified the therapy department staff has 53 licensed staff who follows, the facility in servicing schedule of mandatory in-service training that is provided by the facility for staff in all other departments. Review of the in-service binders and signature sheets for 2021, 2022, and 2023 with the staff development nurse, LPN #2 indicated that the Director of Rehabilitation, PT #1's signature was the only therapy department signature found and no other therapy department staff members who attended the mandatory in servicing were noted. An interview on 7/21/23 at 12:05 PM with the Corporate Nurse RN #6, the Director of Operations and the facility Administrator identified they were unable to find any annual in-servicing material for the therapy department, the staff indicated they completed the in-services, but the signature sheets have not been found. RN#6 further indicated the in-servicing for the therapy staff is the responsibility of the facility and that staff members in-service attendance and is placed with the in-service material binders in the Staff Development office which could not t be found at this time.