STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235377	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley View Care Center	1050 Four Mile NW Grand Rapids, MI 49544

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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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on observation, interview, and record review, the facility failed to provide an environment that promoted and resident dignity in 2 (Resident #60 and #71) of 3 residents reviewed for dignity, resulting in the potential of feelings of humiliation, embarrassment, and loss of self-worth, and a negative psychosocial outcome for the residents impacting their quality of life. Findings include: Resident #60: Review of current Care Plan for Resident #60, revised on [DATE], revealed the focus, .Risk of falls r/t (related to) COPD, HTN (high blood pressure), PVD (peripheral vascular disease) . with the intervention . Septic arthritis of right ankle .WBAT (weight bearing as tolerated) with RLE (right lower extremity with surgical boot .Ambulation with 1 PA (physical assist) . In an interview on [DATE] at 02:48 PM, Resident #60 reported the staff took a long time to come to assist him when he needed to use the restroom and he soiled himself and needed to have his clothes changed. Resident #60 was upset by this as he can use the bathroom and needed their help to get there because of his foot/ankle was broken. Resident #60 reported he was also receiving antibiotics by IV in his PICC line (Peripherally inserted central catheter (PICC) was a thin flexible tube that's inserted into a vein in the upper arm and threaded into a large vein near the heart). In an interview on [DATE] at 02:07 PM, Licensed Practical Nurse (LPN) T reported the call lights' were sent to pagers for the CNAs, there were screens which informed the staff of the call lights for any room in the building and could hop around the corner to assist. LPN T reported the staff try to answer the call light within 15 minutes at the most. The screens let staff know how long the call light had been activated. In an interview on [DATE] at 02:10 PM, Certified Nursing Assistant (CNA) NN reported the staff should have an immediate response to the call light sytem. CNA NN reported the call light system was for the residents to alert staff they needed assistance, it could be for several things, like water or ADL (activities of daily living) care. (continued on next page)

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 - Few	In an interview on [DATE] at 02:11 PM, Clinical Care Coordinator (CCC) F reported the expectation to answer within ,d+[DATE] minutes. The CNAs were alerted via the pager system. The call light system used to ensure patient needs were met when they arise. Resident #71: Review of an Admission Record revealed Resident #71 was a female with pertinent diagnoses which included cerebral palsy with spastic quadraplegia, depression, legal blindness, and moderate intellectual disabilities. Review of current Care Plan for Resident #71, revised on [DATE], revealed the focus, .I have a history of trauma .I have an alteration in my MOOD state r/t (related to) depression . with the intervention .Allow me to express my feelings, observe for any changes in my mood and my response to treatment, make a referrla to psych services/supportive therapy as needed .provide me reassurance when I am feeling anxious, depressed, tearful, or angry . In an interview on [DATE] at 12:04 PM, Family Member (FM) YY reported on Sunday ([DATE]) she was contacted by Licensed Practical Nurse (LPN) Q and he told me what he had said to her. LPN Q told her that he said to (Resident #71) that her sister died last night. FM YY reported she did not understand what made him randomly say that to her. Resident #71 reported, That was a cruel joke .He made me cry .Make me upset I think about it all the time .I had a hard time sleeping thinking about it This writer obseved Resident #71 attempt not to cry. FM YY reported we requested a couple months ago for her to see someone and now she had been traumatized again. In an interview on [DATE] 03:08 PM, Director of Nursing (DON) B reported she had receieved a phone call from LPN HHH informed Resident #71 was crying and upset as LPN Q had told her, her sister had passes away last night per Resident #71. DON B reported she spoke to LPN Q and he informed her they were bantering back and forth and with his odd sense of humor had told her sister had passed away, she didn't like that and told him it was not funny, she became angry and she wheeled back to her hallway. DON B informed LPN Q the allegation would need to be investigated, he asked if he should call FM YY and inform her of the incident and to apologize. DON B reported he contacted FM YY and apologized. In an interview on [DATE] at 03:39 PM, Licensed Practical Nurse (LPN) Q reported he blurted it out to Resident #71, he heard her sister passed and it was thoughtless bantered back and forth, darkest of humor blurted it out and said he reported he immediately said he was just joking, LPN Q reported (Resident #71) smiled and wheeled away. LPN Q reported shortly after he heard she was crying, upset, and prett worked up. LPN Q asked if I could give her a hug, as she was a [NAME], but she told me, No. LPN Q reported he was told later she had the brain function like a child and he did not realize that as he doesn't work with her. LPN Q reported he had crossed the line, and it was below the belt.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 35981 Based on observation, interview and record review, the facility failed to implement a comprehensive, person-centered care plan for 1 (Resident #11) of 3 residents reviewed for pressure ulcer prevention, resulting in an incomplete reflection of the resident's care and monitoring needs for pressure ulcer preventative Findings include: Review of an Admission Record revealed Resident #11 was originally admitted to the facility on [DATE] with pertinent diagnoses which pressure ulcers stage 4. Review of Resident #11's Kardex (individualized-personalized resident care guide for staff use) with no date revealed: (Resident#11) I need my soft heel offloading boots on both of my feet at all times, remove for morning and evening care and for skin inspection . During an observation on 10/08/24 at 4:55 PM., on 0/09/24 at 12:30 PM., and on 10/09/24 at 2:10 PM Resident #11 was laying in his bed. It was noted Resident #11 was not wearing any sort of soft boot, nor were any soft boots noted in and or around Resident #11's room. Review of Physicians Orders dated 5/30/24 revealed: Order Summary: (Resident #11) Wound care to right heel: Cleanse site NS (normal saline), pat dry, apply foam border dressing to site. Ensure PRAFO (name brand-soft boots) boots are applied when in and out of bed During an observation on 10/10/24 at 9:19 AM., on 10/10/24 at 9:55 AM, and on 10/10/24 at 10:30 AM, Resident #11 was laying in his bed. It was noted Resident #11 was not wearing any sort of soft boot, nor were any soft boots noted in and or around Resident #11's room. During an observation on 10/10/24 at 10:50 AM., Registered Nurse (RN) V was completing wound dressing change for Resident #11's right heel. It was noted no offloading boots were on Resident #11. It was noted no soft boots around Resident #11's bed, or areas visible in his room. In an interview on 10/10/24 at 11:20 AM., RN V reported he was unsure where Resident #11's soft boots were. RN V looked around Resident #11's room, closet and drawers. No soft boots were found in Resident #11's room. RN V reported

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 47659 This citation pertains to intake MI00146660. Based on observation, interview, and record review, the facility failed to provide sufficient staff to meet resident needs for 6 (Resident #19, Resident #20, Resident #71, Resident #333, Resident #51, and Resident #60) of 3 residents and residents from the confidential group interview reviewed for staffing, from a total sample of 27 residents, resulting in long call light wait times and resident care needs not being consistently met with the potential for unmet care needs for all residents residing in the facility. Findings include: During an interview on 10/10/24 at 1:00 PM, Scheduler RR reported that she was responsible for scheduling nurses and certified nursing assistants (CNA's) in the facility based on the acuity and needs of the residents. Scheduler RR reported that she had received workload concerns from the facility staff all the time. Scheduler RR reported that she had received the most complaints about staffing on the facility's 200 and 500 hall, which seemed to have the heaviest workload for staff. This writer informed Scheduler RR of the observations of residents on the 200 hall that had not received any morning care by 12:30 PM. Scheduler RR reported that she felt that the residents needs not being met timely on the 200 hall was not a staffing issue, but an issue with one particular CNA. Scheduler RR reported that there was one CNA that was very precise with care, and did everything the right way and took more time with each resident than she should. This writer queried on how much time Scheduler RR felt was appropriate for a CNA to spend with each resident, and Scheduler RR reported that she was not able to report how much time she felt was appropriate. Scheduler RR reported that she was not a clinical staff member, so she did not know what kind of care assistance each resident on the 200 hall required, or an estimated time that should be allotted for staff assignments. Scheduler RR reported that she had never gone to the hall to observe cares and assignments for staff, and that this would be something that nursing management would need to do. Scheduler RR reported that she would never consider moving the CNA to another hall with residents that required less care because the residents on the 200 hall loved her because she did a good job. Scheduler RR confirmed that the CNA that she felt took too long had also voiced concerns to her about not being able to manage the workload on the hall. Scheduler RR reported that she did not have the pull to adjust the schedule to accommodate the halls that had a heavier work load with more staff, and that was up to nursing management. 41027 Resident #19 Review of a Minimum Data Set (MDS) assessment for Resident #19, with a reference date of 8/8/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #19 was cognitively intact. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #19's Care Plan revealed, Focus: .At risk for urinary/bowel incontinence r/t (related to) parkinson's .I have actual ADL (activities of daily living) deficit r/t parkinson's (a disorder of the central nervous system (brain and spinal cord) that causes difficulty with movement.) .Interventions: .non ambulatory, bed bath/shower: Monday & Thursday 1st shift, Transfer 1 PA (person assist) .Bed mobility 1 PA . During an observation and interview on 10/08/24 at 11:55 AM in Resident #19's room, the resident was lying flat in his bed, his pants were visibly wet and there was a strong odor of urine. Resident #19 reported that when he asks staff for assistance, they tell him that they will be right back, but they never do. Resident #19 reported that he wasn't going to ask for assistance anymore, unless it was an emergency because all the good staff don't work in the facility anymore, and there's not enough of the other staff. Resident #19 reported that he would not be getting out of bed either, because there was never anyone available when he wanted to lay back down. During an observation and interview on 10/10/24 at 11:36 AM in Resident #19's room, the resident was lying flat in his bed, with a sheet wrapped around the bottom half of his body, and there was a strong odor of urine in the room. Resident #19 reported that he preferred a shower vs. bed bath, but had not gotten a shower yet this week, and that he likely would not get it that day either. In an interview on 10/10/24 at 12:03 PM, Certified Nursing Assistant (CNA) AA reported that at times Resident #19 would decline assistance, but that she had not gotten a chance to check in with him yet that day. CNA AA reported that she started her shift at 6:30 AM and tried to get into Resident #19's room before noon, but that she had no time that day. CNA AA reported that Resident #19 was supposed to have gotten a shower that morning. During a subsequent observation and interview on 10/10/24 at 01:42 PM in Resident #19's room, the resident was lying in bed and there was still a strong odor of urine. Resident #19 reported that he had not received any assistance yet that day and stated, .my requests have been put in, and that's usually all that happens .it would be nice to get some attention and get cleaned up. Review of Resident #19's Shower Task indicated that he had received 3 showers since 9/12/24. Resident #20 Review of a Minimum Data Set (MDS) assessment for Resident #20, with a reference date of 8/29/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #20 was cognitively intact. Review of Resident #20's Care Plan revealed, Focus: Skin Management - At risk for additional skin breakdown .hx (history) of Stage 4 sacral ulcer, hx of Stage 4 pressure ulcer right medial foot .MASD (moisture associated skin damage) buttocks to my intergluteal cleft .Interventions: .assist me with floating my heels .Please help me get turned and repositioned while in bed or in my wheelchair as needed .Focus: I have actual ADL deficit .Interventions: .non-ambulatory .bed mobility 2 PA . (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 10/08/24 at 12:01 PM in Resident #20's room, the resident was lying in his bed. Resident #20 reported that he would like to get up into his chair everyday, but that there is not enough staff to help him. Resident #20 reported that when he presses his call light, the staff shut it off and say that they will be right back, but don't come back. Resident #20 reported that staff talk about being short handed, and that he hears them talking in the hall about who has enough time to do things, or which resident's that they still need get to. Resident #20 reported that occasionally staff will offer him to get out of bed, but then make it sound like its going to be a difficult task, so he doesn't always ask. Resident #20 reported that he would like to get out and/or see what they have going on in activities, but its such a big ordeal to get him in and out of bed, that he rather not even try. During an observation on 10/08/24 at 02:49 PM Resident #20 was observed in his wheelchair in his room. During an observation and interview on 10/10/24 at 11:47 AM Resident #20 was lying in his bed, positioned on his left side with a pillow tucked under his right side, wearing a facility gown. Resident #20 reported that he was up in his chair the day before for a couple of hours, and when he wanted to lay back down, there was no one available, but that eventually staff from another hall came to help. Resident #20 reported that he had not had any cares provided yet that day, and that he had been in the same position since the day before. Resident #20 reported that his room is always the last room that staff come to when they do their rounds, and sometimes they don't come at all. In an interview on 10/10/24 at 12:03 PM, CNA AA reported that she had not gotten a chance to check on Resident #20 yet that day. CNA AA reported that there were 3 aides on the hall that day, and she still did not have time to get to every resident, every 2 hours. In an interview on 10/10/24 at 12:11 PM, Clinical Care Coordinator (CCC) G reported that there was sufficient staff that day, and that Resident #19 and #20 both should have been rounded on and provided cares 2-3 times since 6:30 AM that day. During an observation on 10/10/24 at 01:02 PM in Resident #20's room, CNA AA was preparing to provide cares and get the resident out of bed and into his wheelchair. At 1:16 PM Licensed Practical Nurse (LPN) P entered the room to assist with turning and incontinence care. There was a foul odor when Resident #20 was rolled onto his side. Resident #20's soaker pad, underneath him was observed soiled with brown and red liquid substance, the bottom sheet was soiled, and his incontinence brief had blue lines, indicating that it was wet. 41424 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In a confidential interview for resident council on 10/10/24 at 11:08 AM, Thirteen residents reported the call light wait times were long, and the facility was short staffed especially on nights and weekends. Nurses were having to cover two hallways and report they can't get to the resident's requests for assistance. Medications were being delivered late because of the staffing issue. Four residents reported they had to wait for someone to take them to the restroom and were concerned about soiling themselves. Residents reported they were told to go to the bathroom in their briefs. One resident reported that was degrading to soil their brief on purpose and they were not a child. It was reported there were times the call light wasn't answered for approximately an hour. Multiple residents reported the staff shut off the call light and say they will come back and then they don't come back to assist the resident. Resident #71: Review of an Admission Record revealed Resident #71 was a female with pertinent diagnoses which included cerebral palsy with spastic quadriplegia, depression, legal blindness, and moderate intellectual disabilities. In an interview on 10/9/24 at 12:12 PM, Family Member (FM) YY reported the staff were not doing rounds every two hours as they were supposed to do, Resident #71 had redness and a rash due to not being taken to the restroom and not being changed. Resident #71 reported second shift was not very good at toileting or changing her every two hours. Resident #333: During an observation on 10/08/24 at 11:52 AM, Resident #333 was observed seated in her wheelchair. In an interview, Resident #333 reported she required staff assistance to get into bed and she had to wait until 12:30 -1:00 AM before staff came and assisted her to bed. She reported she had turned on her call light and was told that she didn't need to turn it on again. Resident #333 reported she thought her call light had been turned off or it was not working since no one had come to assist her to bed. Resident #51: Review of an Admission Record revealed Resident #51 was a female with pertinent diagnoses which included ulcer of right lower extremity, lymphedema, kidney disease, chronic pain, deep vein thrombosis (blood clot) and migraine. In an interview on 10/09/24 at 08:50 AM, Resident #51 reported the facility did have short staffing, sad that staff had to work by themselves on this unit. Resident #51 reported on the weekends the facility was short staffed all three shifts. Resident #51 reported she had an injury to her ankle one Sunday as the CNA was rushing to get me ready for church and she was the only one, that should never happen that she had to be by herself. We were rushing and she was helping me get dressed for church and get out of here on time to go to church. My ride was here and we were rushing to get the entrance and my foot got caught in the wheelchair and my ankle was hurt. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Physician's Note dated 9/30/24 at 1:37 PM, revealed, .ASSESSMENT/PLAN: Right ankle pain -patient noted injury one week ago where ankle was caught in her wheelchair. Suspected to be sprain at that time. Patient noting continued pain with ambulation and movement. Will order x-ray to r/o (rule out) acute process or occult fracture -encourage supportive care, rest and elevation .-continue pain regimen as seen below .-monitor for improvement . Resident #60: Review of an Admission Record revealed Resident #60 was a male with pertinent diagnoses which included stroke, cognitive communication deficit, pain in right ankle and joints of right foot, cellulitis of right lower limb, and muscle weakness. Review of current Care Plan for Resident #60, revised on 9/5/24, revealed the focus, .Risk of falls r/t (related to) COPD, HTN (high blood pressure), PVD (peripheral vascular disease) . with the intervention .Septic arthritis of right ankle .WBAT (weight bearing as tolerated) with RLE (right lower extremity with surgical boot . Ambulation with 1 PA (physical assist) . Review of Physician's Note dated 10/8/24 at 3:28 PM, .Continue to assist with ADLs as needed and provide a safe environment . In an interview on 10/08/24 at 02:48 PM, Resident #60 reported the staff took a long time to come to assist him when he needed to use the restroom and he soiled himself and needed to have his clothes changed. Resident #60 was upset by this as he can use the bathroom and needed their help to get there because of his foot/ankle was broken. Resident #60 reported he was also receiving antibiotics by IV in his PICC line (Peripherally inserted central catheter (PICC) was a thin flexible tube that's inserted into a vein in the upper arm and threaded into a large vein near the heart). In an interview on 10/10/24 at 02:07 PM, Licensed Practical Nurse (LPN) T reported the call lights' were sent to pagers for the CNAs, there were screens which informed the staff of the call lights for any room in the building and could hop around the corner to assist. LPN T reported the staff try to answer the call light within 15 minutes at the most. The screens let staff know how long the call light had been activated. In an interview on 10/10/24 at 02:10 PM, Certified Nursing Assistant (CNA) NN reported the staff should have an immediate response to the call light system. CNA NN reported the call light system was for the residents to alert staff they needed assistance, it could be for several things, like water or ADL (activities of daily living) care. In an interview on 10/10/24 at 02:11 PM, Clinical Care Coordinator (CCC) F reported the expectation to answer within 10-15 minutes. The CNAs were alerted via the pager system. The call light system used to ensure patient needs were met when they arise.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 This citation pertains to intake MI00146660. Based on interview and record review, the failed to ensure documentation of resident medical records were completed for 2 (Resident #17 and #43) residents, of total sample of 27, reviewed for comprehensive and accurate medical records, resulting in an inaccurate reflection of the resident's medical treatments administered resulting in the potential for providers to not have an accurate picture of resident status and condition. Findings include: Resident #17 Review of an Admission Record revealed Resident #17 was originally admitted to the facility on [DATE] with pertinent diagnoses which included hypertension (high blood pressure). Review of Residents Treatment Administration Record (TAR) revealed, Orders: Cleanse right heel with normal saline, pat dry, apply foam dressing. Change every 3 days and PRN (as needed). One time a day every 3 day(s). Start Date: [DATE]. It was noted that on [DATE], and [DATE] and [DATE], there was missing documentation that the treatment had been completed or missed. Order: Cleanse sacral wound with soap and water, pat dry, fill wound with iodosorb (gel used to treat pressure ulcers) and cover with dry dressing. Change daily and PRN. In the morning. Start date [DATE]. It was noted that on [DATE] there was missing documentation to indicate that the treatment had been completed or missed. Order: Left shin cleanse with soap and water, pat dry, apply foam dressing. Change every 3 days and PRN. in the morning every 3 day(s) for wound care. Start date: [DATE]. It was noted that on [DATE] there was missing documentation to indicate that the treatment had been completed or missed. During an interview on [DATE] at 10:57 AM, Clinical Care Coordinator (CCC) G reported that he was responsible for reviewing documentation of Nursing staff and ensuring they completed documentation. CCC G reported that he checked the electronic health record (EHR) system daily for reports of missing documentation, and would follow up with staff that had not completed the documentation. This writer reviewed Resident #17's TAR with CCC G and queried about the missing documentation of Resident #17's treatments in September and [DATE]. CCC G reported that he was unaware that Resident #17 had multiple missing documentation for treatments in September and October. CCC G confirmed that he had not reached out to the staff members responsible for the missing documentation of Resident #17's treatments in September and [DATE]. Resident #43 Review of an Admission Record revealed Resident #43 was originally admitted to the facility on [DATE] with pertinent diagnoses which included alzheimer's disease. Review of Resident #43's EHR revealed no documentation of care tasks completed by CNA's from 11:30 PM- 6:00 AM on [DATE] through [DATE]. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 8:56 AM, CNA GG reported that CNA's were required to document care tasks for every resident each shift. CNA GG reported that some of the required documentation for every resident included the resident's toileting status and if the resident had a bowel movement on their shift. During an interview on [DATE] at 8:48 AM, CCC D reported that the facility's CCC's would monitor the facility's EHR daily to ensure that staff were completing all required documentation on residents. CCC D showed this writer the outstanding charting report in the EHR that was utilized for the CCC's to monitor outstanding documentation. It was noted that toilet use was a required task monitored in this report. This writer queried about Resident #43's toilet use documentation, and why there was not any documentation available from 11:30 PM through 6:00 AM on [DATE] to [DATE]. CCC D reported that the charting for the toilet use task was to be completed by exception. CCC D could not report why the toilet use task order was noted to be completed every shift if the facility only required this task to be charted by exception. CCC D could not explain why the facility would receive outstanding reports for this task if it was not required to be documented for each shift. CCC D reported that she was not able to explain why Resident #43 did not have any CNA tasks documentation in her EHR from 11:30 PM through 6:00 AM on [DATE] to [DATE]. During an interview on [DATE] at 10:57 AM, CCC G reported that the CCC's were responsible for reviewing the outstanding documentation of CNA tasks. CCC G reviewed Resident #43's toilet use task with this writer and reported that CNA's were expected to document under the toilet use task every shift. CCC G was not able to report why Resident #43 did not have any CNA tasks documentation in her EHR from 11:30 PM through 6:00 AM on [DATE] to [DATE]. During an interview on [DATE] at 12:43 PM, CNA LL reported that she was the CNA responsible for caring for Resident #43 from 11:30 PM through 6:00 AM on [DATE] to [DATE]. CNA LL reported that she had not completed any documentation on Resident #43 because she did not have access to the facility's EHR system, so she was not able to document on any residents that she had provided care for that night. CNA LL reported that she had reached out to scheduler RR to gain access to the EHR. During an interview on [DATE] at 1:00 PM, Scheduler RR confirmed that she was notified by CNA LL on [DATE] that she did not have access to the facility's EHR to document resident cares. Scheduler RR reported that CNA LL had not worked since July, so her password had expired. Scheduler RR reported that she had to contact another facility staff member to assist CNA LL with gaining access to the EHR, which she got on [DATE]. Scheduler RR confirmed that CNA LL worked on [DATE], [DATE], and [DATE] without access to the facility's EHR to document on all of the residents that she had cared for. During an interview on [DATE] at 2:09 PM, CCC G reported that he was not aware that CNA LL had worked three shifts without access to document on any of the residents that she had cared for. During an interview on [DATE] at 3:05 PM, CCC D reported that she was not aware that that CNA LL had worked three shifts without access to document on any of the residents that she had cared for. Review of the Facility's Medical Record Documentation dated [DATE] revealed, PURPOSE: To assure care provided is accurately described in the medical record. POLICY: Licensed staff will document care provided in the medical record which shall include the name and credentials of additional licensed personal when dual signatures are not available in the electronic medical record .