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	165249	A. BUILDING _____ B. WING _____	05/20/2021

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GOOD SAMARITAN SOCIETY - NEWELL	415 WEST HIGHWAY 7 NEWELL, IA 50568

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F 000	INITIAL COMMENTS Correction Date _____ The recertification survey completed on 5/17/21 to 5/20/21 resulted in the following deficiencies. See Code of Federal Regulations (42CFR) Part 482, Subpart B-C	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the	F 550		

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

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resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, interviews, and record reviews, the facility failed to provide privacy while completing catheter care and wound care for one of two residents reviewed, (Resident #20). The facility reported a census of 25 residents.

Findings Include:

The Minimum Data Set (MDS) completed with Assessment Reference Date (ARD) of 4/27/21 showed a Brief Interview of Mental Status (BIMS) score of 14, indicating intact cognition. The MDS Resident #20 had diagnoses of pressure ulcer of the right buttock, neuromuscular dysfunction of bladder, and diabetic peripheral angiopathy. The resident had a Foley catheter in place.

During an observation on 5/17/21 at 1:13 PM Staff M Licensed Practical Nurse (LPN) and Staff E Certified Nurse Aid (CNA) went to Resident #20's room to perform wound care on the pressure ulcer located on the right buttock area. The resident was transferred to his bed, which was located parallel to the window in his room, using a Hoyer lift. Once the resident was lowered on the bed, Staff M LPN and Staff E CNA applied gloves and removed the resident's shorts and

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F 550	Continued From page 2 brief. Staff M LPN cleaned the peri area of the resident and noticed the residents brief was wet. Staff M LPN removed her gloves and obtained a new brief and applied new gloves without sanitizing or washing her hands. Staff M LPN could not tell why the brief was wet as the resident had a Foley catheter in place. Staff M LPN removed her gloves sanitized her hands and left the room to get the Director of Nursing (DON). During this time the resident was laying on his bed disrobed from the waist down with no covering in front of a large window looking out to the parking out with the blinds pulled up. Staff M LPN returned to the room at 1:25 PM and stated Oh I probably should close the blinds, and proceeded to close the blinds to the window. On 5/18/21 at 9:20 AM Surveyor was standing in the parking lot located by the resident's window and was able to see through the window into the resident s room. During interview on 5/19/21 at 12:20 PM, the Director of Nursing (DON) stated the staff should close the blinds when completing tasks that exposes the resident.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or	F 578		

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inappropriate.

§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).
(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on resident record reviews, staff interviews, and facility policies the facility failed to ensure resdient charts were updated in regards to code status for 2 out of 3 residents reviewed (Resident #19 and Resident #175). The facility reported a census of 25.

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F 578	Continued From page 4 Findings include: 1. The Minimum Data Set (MDS) assessment dated 4/25/21 for Resident #19 documented diagnoses of coronary artery disease, dementia and arthritis. The MDS showed the Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. Review of Resident #19's chart on 5/17/21 at 2:21 p.m., lacked a code status on the Face Sheet. Review of the Iowa Physician Orders for Scope of Treatment (I-Post) on 5/17/21 at 3:06 p.m., revealed Resident #19 had a Do Not Resuscitate (DNR) status signed by the physician. 2. The Care Plan dated 5/13/21 for Resident #175 documented diagnoses of heart failure, hypertension (high blood pressure), and type 2 diabetes. Review of Resident #175's chart on 5/17/21 at 2:07 p.m. revealed a DNR status on the Face Sheet. Review of the IPOST binder on 5/17/21 at 3:06 p.m., lacked documentation for Resident #175. Review of the Medication Review Report revealed a signed order for a DNR dated 5/14/21. Review of the Progress Note dated 5/13/21 at 3:48 pm., revealed the family requested to take the IPOST with them to discuss it more although they did want to follow the resident's wishes with remaining a DNR. On 05/19/21 at 9:40 a.m., interview with Staff Q,	F 578		

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Licensed Practical Nurse (LPN) revealed she would go to the IPOST book in a code situation. When asked Staff Q, LPN, where she would go if the IPOST was not in place she stated she would go to the computer as she had both of the nurse computers open at all times.

During interview on 5/19/21 at 9:50 a.m., the Minimum Data Set Coordinator (MDS) Nurse stated in a code situation it was expected nursing staff would go to the IPOST binder and it is updated every night on the night shift. The MDS Nurse further revealed the night shift nursing staff is to be running an Advanced Directive report every night.

The Order Listing Report revealed Resident #19's code status was updated on 5/19/21 and Resident #175's was updated on 5/13/21.

Review of the Policy titled Advance Care Planning and Advance Directives-Rehab Skilled, revised 1/14/21 revealed the following:
a. As necessary physicians will be contacted for orders that reflect the resident's wishes. Completed portable and enduring order forms (IPOST) will be treated as physician's orders and placed in the medical record.
b. Each day the nursing staff will print a report of all advance directive orders and keep in a three-ring binder easily accessible to the nursing staff. Any advance directive forms will also be kept in this binder.

Interview with the Director of Nursing on 5/19/21 at 2:30 p.m. revealed the expectation is for the nursing staff to go to the computer to check the resident's code status.

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F 607	Continued From page 6	F 607		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on personnel file reviews, facility interviews and facility policy review, the facility failed to ensure all employees had a Single Contact Repository (SING) completed to perform the required background checks prior to working in the facility for 4 out of 5 employees reviewed (Staff D, Staff N, Staff O, Staff P). The facility reported a census of 25 residents. Findings include: Staff D, Certified Nursing Assistant (CNA), had a start date of 7/28/20. Record review revealed Staff A's personnel file lacked documentation of the SING. Staff N, CNA, had a start date of 3/24/20. Record review revealed Staff N's personnel file lacked documentation of the SING. Staff O, CNA, had a start date of 5/8/20. Record review revealed Staff O's personnel file lacked	F 607		

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F 607	Continued From page 7 documentation of the SING. Staff P, Dietary Aide, had a start date of 10/16/20. Record review revealed Staff P's personnel file lacked documentation of the SING. Review of facility policy Abuse and Neglect-Rehab/Skilled, Therapy and Rehab with a revised date of 12/23/20 revealed the facility will conduct an Iowa criminal record check and dependent adult/child abuse registry check on all perspective employees and other individuals engaged to provide sevices to residents, prior to hire, in the manner prescribed under 481 Iowa Administrative Code 50.9(3). During interview on 5/19/21 at 2:17 p.m., the Administrator revealed he knew the SING checks needed to be completed and when another company took over they took all of the background checks to their central offices.	F 607		
F 655 SS=C	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-	F 655		

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(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to ensure a summary of the baseline care plan was provided to the resident and their representative for 3 out of 7 residents reviewed, (Resident #14, #23, and #175) reviewed. The facility reports a census of 25 Residents.

Findings Include:

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1. A Minimum Data Set (MDS) assessment dated 4/6/21 for Resident #14 showed a score of 8 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident had an admission date to the facility of 3/31/21. The MDS showed the resident had a diagnoses of Alzheimer disease, dementia, need for assistance with personal care, and delirium due to known physiological condition.

Review of the residents Care Plan showed the Baseline Care Plan was initiated on 3/31/21.

The Electronic Health Record (EHR) had a Care Conference Note dated 4/14/21 at 11:50 AM that showed the resident was asked to attend but declined due to having hearing loss. The residents wife was documented as present on the phone. The Care Conference Note dated 4/14/21 lacked documentation that the Baseline Care Plan was reviewed and that a copy was given or mailed to the resident and or his representative.

During interview with the Resident #14's wife on 5/17/21 at 11:50 AM she stated she was not sure what a care plan was and nobody has discussed his plan of care or discharge planning with her.

Review of the Comprehensive Care Plan, Care Conference Policy dated 4/21/21 on page 2 stated to provide the resident and representative with a written summary of the Baseline Care Plan. The summary includes: initial goals of the resident, summary of medications, dietary restrictions, and services and treatments to be administered.

During interview with Staff I Social Worker on 5/18/21 at 12:57 PM she stated she does the

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Baseline Care Plans when she does the admission. She stated she has not been documenting that the Baseline Care Plan was given or reviewed with the Resident or the Residents representative, but will start doing it.

2. The Minimum Data Set (MDS) assessment dated 5/5/21 for Resident #23 documented diagnoses of syncope (fainting) with collapse, angina pectoris (chest pain due to decreased blood to the heart), and anemia (blood condition that blood does not have enough healthy red blood cells). The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment.

Review of the residents Care Plan showed the Baseline Care Plan was initiated on 3/31/21.

Review of Progress Notes in Resident #23's chart lacked documentation of a Baseline Care Plan being reviewed with the resident or resident's representative and that a copy was given or mailed to the resident or the resident's representative.

3. The Care Plan dated 5/13/21 for Resident #175 documented diagnoses of heart failure, hypertension (high blood pressure), and type 2 diabetes.

Review of Progress Notes in Resident #175's chart lacked documentation of a Baseline Care Plan being reviewed with the resident or resident's representative and a copy was given or mailed to the resident or the resident's representative.

Interview with the Director of Nursing on 5/19/21

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F 655	Continued From page 11 at 2:21 p.m., revealed Resident #23 and #175 do not have a Baseline Care Plan that was completed.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		

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whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on resident observations, clinical record review and staff interviews the facility failed to develop care plans to address resident's oxygen usage and pain management for 1 of 7 sampled residents, (Resident #23). The facility reported a census of 25.

Findings include:

The Minimum Data Set (MDS) assessment dated 5/5/21 for Resident #23 documented diagnoses of syncope (fainting) with collapse, angina pectoris (chest pain due to decreased blood to the heart), and anemia (blood condition that blood does not have enough healthy red blood cells). The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment.

On 5/17/21 at 11:13 a.m., interview with Resident #23 revealed he was having back pain and wanted to lay down. Facial grimacing noted with movement in his wheelchair. Resident #23 stated he had received Tylenol but that was not helping. Staff A, Certified Nursing Assistant (CNA) and Staff B, CNA, entered the room to assist the resident with removing his jacket and laying him down in bed. Resident #23 asked Staff B, CNA, to stop removing his jacket due to pain. Staff B,

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CNA, stopped removing his jacket. Staff A, CNA and Staff B, CNA attached straps to E-Z Stand and assisted Resident #23 to bed. Noted facial grimacing and moans during transfer. After Resident #23 was in bed, Staff A, CNA turned on the oxygen concentrator and assisted him with placing his nasal cannula into his nostrils. Interview with Staff B, CNA, revealed the resident is to wear his oxygen whenever he is in his room. Observation of the oxygen concentrator showed a rate of 2 liters (L) of oxygen.

During observation 5/18/21 at 9:19 a.m., Staff D, CNA and Staff E, CNA, arrived to room to assist Resident #23 to lay down. Staff D, CNA, and Staff E, CNA hooked straps up on the E-Z stand to transfer Resident #23. Noted facial grimacing, moaning, shortness of breath, squeezing eyes closed and pursed lip breathing by Resident #23 while transferring him from wheelchair to his bed. Resident #23 asked Staff D, CNA, and Staff E, CNA, to please wait to lay him down. Resident stated, "God it hurts" while sitting on the edge of the bed. Staff D, CNA, and Staff E, CNA, assisted Resident #23 to lay down when he was ready and repositioned for comfort. Staff D, CNA, asked Resident #23 if he had received anything for pain yet and Resident #23 replied that he had not. After Resident #23 was in bed, Staff E, CNA, assisted him with placing the nasal cannula back in his nostrils. Staff D, CNA, stated that he should have oxygen 24 hours a day 7 days a week. Observation of the oxygen concentrator showed a rate of 2L of oxygen.

The revised Care Plan dated 5/6/21 lacked information regarding Resident #23's oxygen usage and pain management.

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F 656	Continued From page 14 Interview with the Director of Nursing on 5/19/21 at 2:30 p.m. revealed the Care Plan lacked information for oxygen usage and pain management interventions.	F 656		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks,	F 676		

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§483.24(b)(5) Communication, including
(i) Speech,
(ii) Language,
(iii) Other functional communication systems.
This REQUIREMENT is not met as evidenced by:
Based on interviews and record reviews the facility failed to provide the necessary care and services to ensure the resident's abilities to participate in activities of daily living does not diminish for 2 out of 2 residents reviewed, (Resident # 8 and #22). The facility reported a census of 25 Residents.

Findings Include:

The Minimum Data Set (MDS) completed with an Assessment Reference Date (ARD) of 3/25/21 for Resident #8 showed a Brief Interview of Mental Status (BIMS) score of 15, indicating intact cognition. The MDS showed the resident had diagnoses of diabetes, history of falling, and osteoarthritis. The resident required limited assistance with transfers and ambulation.

Review of the MDS with ARD of 12/29/21 showed the resident needed extensive assistance with two staff members for transfers and ambulation.

Review of the Physical Therapist (PT) Progress and Discharge Summary dated 4/21/21 stated the residents prior level as of 3/31/21 for knee strength was 3+/5 fair full range of motion (ROM) against gravity and takes minimal resistance but then breaks suddenly. The end goal was met on 4/21/21 and the resident's knee strength was 4/5 good with full ROM against gravity. Transfer goals were met on 4/21/21 and the resident was able to

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F 676	Continued From page 16	F 676		

perform sit to stand and bed to chair with modified independence using assistive devices. PT Discharge Plan recommendations were discussed with the care coordinator included returning to Restorative Nursing Program and to include seated lower extremities and Nustep.

Review of Progress Note dated 4/7/2021 at 2:53 PM from therapy stated, discussed the resident during Medicare meeting today; looking at probably discharging resident from therapies next week. Resident was able to get on nu-step yesterday and that was one of her goals. States transfers are going better; continue to work on strengthening et endurance. Resident continues to be very particular on which therapist she sees, when she wants to be seen, and which tasks she wants to complete. Will attempt at getting resident to ambulate longer distances and see how receptive she is.

Review of the Care Plan showed the Resident needed a functional maintenance program (FMP) due to self-care performance deficit with an initiation date of 10/7/14 and revised on 1/24/17. Interventions were active range of motion for lower extremities 3 times a week and active range of motion on Nu-Step for 5- 10 minutes 3 times a week as tolerates.

During interview on 5/17/21 at 12:40 PM Resident #8 stated she would like to use the Nu-Step but there is not enough staff to allow her to use it. Resident #8 stated she is afraid she is going to decline again and she worked very hard in therapy to get where she is now.

2. The Minimum Data Set (MDS) completed with an Assessment Reference Date (ARD) of 4/26/21

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F 676	Continued From page 17 for Resident # 22 showed a Brief Interview of Mental Status (BIMS) score of 15, indicating intact cognition. The MDS showed the resident had diagnoses of diabetes, heart disease, and chronic obstructive pulmonary disease. The MDS showed the resident needed extensive assistance with bed mobility and total dependence with transfers. During interview on 5/17/21 at 11:12 AM Resident #22 stated somebody comes in once in a while when they have the time to do exercises with her arms. She stated they don't come in very often. Resident #22's current Care Plan showed the resident needed a FMP due to self-care performance deficit. The resident would complete active range of motion 3 times a week with active assisted ROM with blue theraband. The resident has own exercise program in her room to complete, staff to follow up with resident and prompt her to complete. During interview with the Director of Nursing (DON) on 5/18/21 at 1:37 PM, the DON stated restorative should be documented in the Electronic Health Record. The DON stated they currently have a QAPI plan in place for restorative as it is not being completed. During interview on 5/19/21 at 12:20 PM the DON stated due to Covid and staff cuts there is not enough staff to get restorative completed sometimes. The DON stated she is aware the Resident #8 wants to use the Nu-Step and they will try to get something in place.	F 676		
F 684 SS=D	Quality of Care	F 684		

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F 684	Continued From page 18 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure that a resident received treatment and care by failing to give insulin at scheduled time for 1 out of 2 residents reviewed, (Resident #8).. The facility reported a census of 25 residents. Findings include: The Minimum Data Set (MDS) completed with Assessment Reference Date (ARD) of 3/25/21 for Resident #8 showed a Brief Interview of Mental Status (BIMS) score of 15, indicating intact cognition. The MDS showed the resident had diagnoses of diabetes, history of falling, and osteoarthritis. The resident required limited assistance with transfers and ambulation. Review of Progress Notes dated 3/12/21 at 6:45 PM stated Resident #8's noon Novolog insulin dose of 6 units was not given. Director of Nursing (DON), family and the physician was notified. No signs of hypoglycemia or hyperglycemia. Blood sugar checked at 5:15 PM and was 197. Evening insulin given plus 1 unit per sliding scale.	F 684		

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Review of the Medication Error Incident report dated 3/12/21 at 12:00 PM stated the resident's noon insulin was missed through omission by Staff M LPN.

Review of the Orders tab in the Electronic Health Record showed the resident had an order for Novolog Solution Insulin Aspart to give 2 units in the AM, give 6 units at noon, and 6 units at PM.

Review of the Medication Administration Report for the month of March 2021 showed that for 3/12/21 the noon dose of Novolog 6 units was listed as an 8. Review of the chart codes showed 8 equals other and see Nurses Note.

Review of the Medication Administration Report for the month of March 2021 showed the PM dose of Novolog 6 units on 3/15/21 lacked documentation that it was given.

Review of the Medication Administration Report for the month of April 2021 showed the PM dose of Novolog 6 units on 4/18/21 lacked documentation that it was given.

Review of the Medication Administration Report for the month of May 2021 showed the noon dose of Novolog 6 units on 5/13/21 lacked documentation that it was given.

Review of the Progress Note dated 5/17/2021 at 5:03 PM the resident woke up confused and struggling to find her words when talking to staff, face was pale and clammy stated she didn't feel well, felt dizzy. Resident's blood sugar was 224 nurse administered scheduled 6 units of Novolog plus 2 units for sliding scale.

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F 684	Continued From page 20 During interview with Resident #8 on 5/18/21 at 9:40 AM she stated she cannot say for sure if she missed an insulin injection or not but sometimes it is hard to get her insulin on time by one of the nurses. The resident would not reveal the name of the nurse. During interview on 5/19/21 at 12:20 PM the DON stated she was aware of the missed insulin in March, but was not aware of the other three missing doses. She expects the insulin to be given as ordered. During interview on 5/19/21 at 2:45 PM the DON stated it was the same nurse who has missed all the insulins and that she is going to pull that nurse off the floor and put her back into orientation. Review of the Medication Errors policy dated 2/10/21 stated omission of medication as ordered but not administered at least once is a medication error.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff	F 695		

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interviews and policy reviews, the facility failed to have a current physician order for oxygen, change and label oxygen tubing, provide outside signage of room with oxygen in use for 1 of 1 residents reviewed (Resident # 23). The facility reported a census of 25.

Findings include:

The Minimum Data Set (MDS) assessment dated 5/5/21 for Resident # 23 documented diagnoses of syncope (fainting) with collapse, angina pectoris (chest pain due to decreased blood to the heart), and anemia (blood condition that blood does not have enough healthy red blood cells). The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment.

Observation on 5/17/21 at 11:03 a.m., revealed Resident #23's oxygen concentrator tubing was not labeled and there was not an oxygen in use sign outside of the room door.

Observation on 5/17/21 at 11:13 a.m., revealed Resident #23 returned to his room from an appointment outside of the facility. Staff A, Certified Nursing Assistant (CNA) and Staff B, CNA transferred him to his bed with the E-Z Stand. After he was in bed Staff A, CNA turned on the oxygen concentrator and assisted him with placing his nasal cannula into his nostrils. Interview with Staff B, CNA revealed resident is to wear his oxygen whenever he is in his room. Observation of the oxygen concentrator showed a rate of 2 liters (L) of oxygen.

Review of the Medication Administration Record (MAR) and Treatment Administration Record

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(TAR) on 5/18/21 at 11:07 a.m., revealed no order for oxygen or orders for changing oxygen tubing.

Observation on 5/18/21 at 9:15 a.m., revealed Resident #23's oxygen concentration tubing was not labeled and there was not an oxygen in use sign outside of the room door.

During observation on 5/18/21 at 9:19 a.m., staff took off Resident #23's oxygen tubing and lay on his bed. Staff D, CNA and Staff E, CNA transferred him into bed with the E-Z Stand. After he was in bed Staff E, CNA assisted him with placing the nasal cannula back in his nostrils. Staff D, CNA stated he should have oxygen on 24 hours a day 7 days a week. Observation of the oxygen concentrator showed a rate of 2L of oxygen.

The revised Care Plan dated 5/6/21 at 11:09 a.m., lacked information regarding Resident #23's oxygen usage.

Review of Progress Notes on 5/19/21 at 12:36 p.m., revealed the following entries:
a. 5/18/21 at 2:01 p.m., asking for an order for oxygen.
b. 5/18/21 at 2:47 p.m., order for oxygen 2-5 L per nasal cannula as needed for comfort or air hunger.

Review of the Medication Review Report signed by the Nurse Practitioner on 5/5/21 lacked an oxygen order or orders to change oxygen tubing.

Review of the policy named Oxygen Administration, Safety, Mask Types-Rehab/Skilled Therapy and Rehab revised 5/10/21 revealed the following:

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F 695	Continued From page 23 a. Equipment needed included signage for door-oxygen precaution/in use if appropriate. b. Oxygen administration is carried out only with a medical provider order. c. Disposable equipment should be changed weekly or according to manufacturer's instruction and marked with date and initials. On 5/18/21 at 11:06 a.m., interview with the MDS coordinator revealed the MAR is where staff find the schedule to change oxygen tubing.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on resident observations, resident record reviews and interviews the facility failed to provide proper pain management for 1 out of 1 resident reviewed, (Resident #23). The facility reported a census of 25 residents. Findings include: The Minimum Data Set (MDS) assessment dated 5/5/21 for Resident # 23 documented diagnoses of pain, fracture of lower end of left femur and laceration of the scalp. The MDS showed the Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment. On 5/17/21 at 11:13 a.m., interview with Resident	F 697		

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#23 revealed he was having back pain and wanted to lay down with facial grimacing noted with movement in his wheelchair. Resident #23 stated he had received Tylenol but it was not helping. Staff A, Certified Nursing Assistant (CNA) and Staff B, CNA, entered the room to assist the resident with removing his jacket and laying down in bed. Resident #23 asked Staff B, CNA to stop removing his jacket due to pain. Staff B, CNA stopped removing his jacket. Staff A, CNA, and Staff B, CNA, attached straps to E-Z Stand and assisted Resident #23 to bed and facial grimacing and moans were noted with transfer.

On 5/17/21 at 2:55 p.m., interview with Resident #23's family member revealed they felt the pain was now being controlled due to him receiving hospice services. Family member stated before Resident #23 was on hospice, his pain was not well controlled. The family member stated they felt the facility did not know what to do or how to properly address the pain.

Observation on 5/18/21 at 8:50 a.m., revealed Resident #23 sitting in his wheelchair after finishing his breakfast in his room. Resident #23 stated he was not feeling too good and was having pain in his back. He stated he did not know when the last time he had pain medication.

Observation on 5/18/21 at 9:00 a.m., Resident #23 pushed his call light to go back to bed. Facial grimacing and moaning with independent body movement was noted.

Observation on 5/18/21 at 9:02 a.m., Staff E, CNA, answered his call light. Resident #23 requested to go to bed. Staff E, CNA told him the other staff were giving a bath and it would be a

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few minutes. Staff E exited room.

Observation on 5/18/21 at 9:05 a.m., Resident #23 was still sitting in a wheelchair in his room with facial grimacing and moaning noted with independent body movements while in his wheelchair.

Observation on 5/18/21 at 9:15 a.m., Staff E, CNA came to Resident #23's room and told him they had not forgotten him and the other CNA was finishing up a shower and it would be another 5 minutes or so until they could get him into bed. Resident #23 noted to continue to have facial grimacing and moaning with independent body movements while in the wheelchair.

Observation on 5/18/21 at 9:19 a.m., Staff D, CNA and Staff E, CNA arrived to Resident #23's room to assist him to lay down. Staff D, CNA, and Staff E, CNA, hooked straps up on the E-Z stand to transfer Resident #23. Noted facial grimacing, moaning, shortness of breath, squeezing eyes closed and, pursed lip breathing with transferring him from wheelchair to his bed. Resident #23 asked Staff D, CNA, and Staff E, CNA, to please wait to lay him down. Resident stated, "God it hurts" while sitting on the edge of the bed. Staff D, CNA, and Staff E, CNA, assisted Resident #23 to lay down when he was ready and repositioned for comfort. Staff D, CNA asked if Resident #23 had received anything for pain yet and Resident #23 replied that he had not.

During interview on 5/18/21 at 9:43 a.m., the Minimum Data Set (MDS) Coordinator reported she had not had any reports of pain from staff regarding Resident #23. The MDS Coordinator stated she was not aware Resident #23 was in

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pain. The MDS Coordinator revealed Resident #23 is to be getting scheduled Tylenol. The MDS Coordinator walked down to Resident #23's room and asked him to rate his pain on a scale of 0-10. Resident #23 stated his pain level was at an 8. The MDS Coordinator revealed she was going to give Resident #23 a Hydrocodone due to the rating of his pain level. The MDS Coordinator returned to Resident #23's room and gave pain medication and a drink of water with medications.

Review of the Medication Administration Record (MAR) on 5/28/21 at 11:06 a.m., revealed there was no active order for scheduled Tylenol.

During interview on 5/18/21 at 11:16 a.m., The MDS Coordinator stated Resident #23's pain level has decreased and thanked the surveyor for bringing it to her attention.

On 5/18/21 at 11:51 a.m., interview with Resident #23's family member revealed they arrived at the facility last Thursday (5/13/21) at approximately 10:20 a.m.. Resident #23 told the family member he was feeling lousy and had asked for an ice pack for his back and the ice pack had not arrived yet. Family member requested an ice pack again from staff. Family member stated someone came down to Resident #23's room to ask what they needed again. Family member stated Resident #23 was waiting for an ice pack. Family member revealed the ice pack had arrived for Resident #23 around noon. Family member stated Resident #23 sighed with relief once the ice pack was applied.

Communication with the Physician dated 4/15/21 at 7:28 p.m., revealed a note to the doctor asking to discontinue Tramadol order since Resident #23

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had not utilized it since admission.

Review of the March 2021 MAR revealed the resident took as needed Tramadol on 3/31/21 for pain rated at a 8.

Review of Progress Note dated 3/31/21 at 9:28 a.m., for follow up Tramadol pain level rated at 5 and was effective.

Review of Progress Note dated 5/18/21 at 2:01 p.m., revealed discussion with hospice for further options of pain control for the resident.

The revised Care Plan dated 5/6/21 lacked information regarding Resident #23's pain management.

Review of the facility policy titled Pain Management- Rehab/ Skilled Reviews dated 11/2/20 revealed the nurses working directly with residents must continually monitor and observe the resident for success of the pain management plan and report to the nurse manager and prescriber as necessary to keep the resident comfortable. Non-pharmacological interventions should be attempted first; however in the event they are not successful, they may be combined with a pharmacological regimen. Be sure to ask the resident what has worked for him or her in the past. Any time a resident is in pain, the nursing assistant should make the resident as comfortable as possible and verbally communicate with the nurse on duty, as well as send a new alert from PCC using the eINTERACT Stop and Watch Alert for pain.

Interview with the Director of Nursing (DON) on 5/20/21 at 10:16 a.m., revealed she expected

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F 697	Continued From page 28 staff to observe for pain every time that they are in the room and the CNA's are trained to report anything abnormal to the nurse on duty. The DON further revealed if the nurse is busy they can use Stop and Watch in Point Click Care(PCC) and it will alert the nurses that there is a report from the CNA.	F 697		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to develop and implement a person- centered care plan that includes and supports the dementia care needs identified in the comprehensive assessment and to develop and include individualized interventions related to the resident's symptoms related to dementia for 1 of 1 resident reviewed, (Resident #14). The facility reports a census of 25 Residents. Findings Include: A Minimum Data Set (MDS) assessment dated 4/6/21 for Resident #14 had a score of 8 on the Brief Interview for Mental Status (BIMS) indicating moderate cognitive impairment. The resident had an admission date to the facility of 3/31/21. The MDS showed the resident had diagnoses of Alzheimer disease, dementia, need for assistance with personal care, and delirium due	F 744		

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to known physiological condition. Review of the MDS assessment section I dated 4/6/21 showed the resident to have a diagnosis of Alzheimer's, and the diagnosis of Non- Alzheimer's Dementia. Review of the MDS assessment section E dated 4/6/21 showed the resident to have hallucinations and delusions. The resident had verbal behavioral symptom such as; threating others, cursing and screaming at others and behavioral physical symptoms such as; hitting and scratching self. The MDS was marked yes for did any of the identified symptoms put the resident at significant risk for physical illness, interfere with residents care, and interfere with participation in activities or social interactions.

Review of the Progress Note dated 4/5/21 at 8:30 PM stated Resident #14 was yelling out and trying to get out of bed and tried to self- transfer. Emergency Room was called and a one-time order was received for 0.5 mg Ativan.

Review of the Order Summary with active orders as of 5/19/21 showed the resident had orders for telecare to evaluate and treat for psychiatric and psychological health. The order summary showed the resident had an order of Donepezil for depressive disorder and delirium due to known physiological condition. Resident #14 had an order for Duloxetine for depressive disorder and for Seroquel for delirium due to known physiological condition.

Review of the Care Plan with a print date of 5/18/21 lacked any information related to caring for dementia symptoms, dementia interventions, or dementia support.

Review of the Comprehensive Care Plan and

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F 744	Continued From page 30 Care Conferences policy dated 4/21/21 stated on page 4, to formulate the care plan it is driven by identified resident issues, to focus on what the problem is related to which is usually a diagnosis. Interview with Staff C RN/ MDS stated she knows the Care Plan should contain information on dementia and behaviors and have interventions in place for staff to use. During interview with the Director of Nursing (DON) on 5/19/21 at 12:20 PM she stated she expects for the Care Plan to be complete and contain dementia information.	F 744		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		

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F 880	Continued From page 31 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on record review, observations and staff interviews, the facility failed to ensure appropriate infection control practices. The facility reported a census of 25 residents.

Findings Include:

1. The Minimum Data Set (MDS) completed with Assessment Reference Date (ARD) of 4/27/21 for Resident #20 showed a Brief Interview of Mental Status (BIMS) score of 14, indicating intact cognition. The MDS showed the resident had diagnoses of pressure ulcer of the right buttock, neuromuscular dysfunction of bladder, and diabetic peripheral angiopathy. Resident #20 had a Foley catheter in place.

During an observation on 5/17/21 at 1:13 PM Staff M Licensed Practical Nurse (LPN) and Staff E Certified Nurse Aid (CNA) went to Resident #20's room to perform wound care on the pressure ulcer located on the right buttock area. The resident was transferred to his bed which was located parallel to the window in his room using a Hoyer lift. Once the resident was lowered on the bed, Staff M LPN and Staff E CNA applied gloves and removed the resident's shorts and brief. Staff M LPN cleaned the peri area of the resident and noticed the residents brief was wet. Staff M LPN removed her gloves and obtained a new brief and applied new gloves without sanitizing or washing her hands. Staff M LPN could not tell why the brief was wet as the

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resident had a Foley catheter in place. Staff M LPN removed her gloves sanitized her hands and left the room to get the Director of Nursing (DON) to access the catheter. On 5/17/21 at 1:38 PM Staff M LPN applied gloves and rolled the resident to his left side to access wound on the right buttock. Staff M LPN removed the dirty dressing and discarded. Staff M did not remove dirty gloves. Staff M LPN proceeded to clean the area around the wound with saline, Staff M LPN then proceeded to apply skin prep to the outer edges of the wound, then packed the wound with medihoney and covered with a new dressing. Dressing was dated and initialed. Staff M LPN then removed gloves and applied new gloves without sanitizing and finished adjusting the resident's brief.

Review of the Electronic Health Record showed Resident #20 had an order to cleanse pressure injury to right ischium with normal saline, pat dry, apply a thin layer of medical honey to wound bed, apply skin prep to peri wound skin and cover with a border foam.

Review of the Centers for Disease hand hygiene guidance for Healthcare workers at https://www.cdc.gov/handhygiene/providers/index.html with a reviewed date of 1/8/21 on page 2 stated alcohol based sanitizer should be used before moving from work on a soiled body site to a clean body site on the same patient. On page 3 it stated alcohol based sanitizer should be used immediately after glove removal. Gloves are not a substitute for hand hygiene and hand hygiene should be done immediately after removing gloves and gloves should be removed when moving from work on a soiled body site to a clean body site on the same patient

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During interview on 5/19/21 at 12:20 PM with the Director of Nursing (DON) she stated gloves should be changed between removing a dirty dressing and placing a clean dressing on. The DON stated staff are expected to sanitize or wash their hands between glove changes and staff were given a bottle of sanitizer to keep in their pockets and sanitize station were placed in halls to allow easy access.
2. Observation on 5/17/21 at 12:04 p.m. revealed Staff H, Dietary Aide, in the dining room serving meal trays to residents with her mask under her nose. Staff H, Dietary Aide walked into the kitchen, walked back out of the kitchen and then served a resident a drink off of the drink cart.

3. During observation on 5/17/21 at 12:08 p.m., Staff A, Certified Nurse Aide (CNA) took a meal tray to Resident #23's room. Staff A, CNA, set the meal tray on the bedside table next to his bed and performed hand hygiene. Staff A, CNA, attempted to wake Resident #23 and was unable to wake him. Staff A, CNA, took the meal tray back to the dining room serving window and set the tray on the counter. Staff A, CNA, asked Staff G, Cook, to save the meal for Resident #23. Neither Staff A, CNA or Staff G, Cook, changed the tray after the tray came back to the kitchen. Staff G, Cook, took the tray and set it in the kitchen on the counter next to the steam table. Staff G, Cook, took a piece of tape and marked the tray with Resident #23's name. Staff G, Cook, stated she was going to keep the tray in the refrigerator until supper and if he didn't eat it she would get rid of it. Staff G, Cook, took the tray and placed the tray into the kitchen refrigerator next to a gallon of milk.

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4. During observation on 5/17/21 at 12:23 p.m., Staff H, Dietary Aide took a room tray down to Resident #175's room who was in contact isolation. Staff H, Dietary Aide, put gown on and goggles and entered Resident #175's room and performed hand hygiene after leaving the room. Staff H, Dietary Aide, then began pushing the serving cart down the hallway approximately 20 feet. Staff H, Dietary Aide, realized she still had the isolation gown on and walked back to the isolation garbage outside of Resident #175's room, removed the gown and threw it away. Staff H, Dietary Aide, did not perform hand hygiene after removing the gown. Staff H, Dietary Aide, did not change their surgical mask after leaving the isolation room. Staff H, Dietary Aide, took the goggles off and laid them down on the serving cart while walking down the hallway. Staff H, Dietary Aide, picked the goggles back up and put them back on before exiting the hallway. Staff H, Dietary Aide, walked to the cabinet in the dining room, opened the door, placed goggles back into the cabinet and closed the door of the cabinet without disinfecting the goggles. Staff H, Dietary Aide, did not perform hand hygiene after taking off the goggles. Staff H, Dietary Aide, left the serving cart in the dining room and then took the drink cart from the dining room and pulled it over to the kitchen moving the serving cart out of the way while walking by. Staff H, Dietary Aide, put in the kitchen door code and opened the kitchen door and pulled the drink cart into the kitchen. Staff H, Dietary Aide closed the door behind them.

Interview on 5/19/21 at 12:50 p.m., with Dietary Manager (DM) revealed the following:
a. Expects staff to be wearing their mask over their noses at all times.

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b. Expects staff to throw away any food that has been brought to a resident's room and they do not eat. The Dietary Manager revealed she expected her staff to serve a new tray or offer the resident something else to eat.
c. Expects staff to wear whatever Personal Protective Equipment (PPE) is posted outside the resident's door and staff should not be bringing any of the PPE back to the kitchen. The DM further revealed Staff H had been trained on the proper usage of PPE.

Review of Staff H, Dietary Aide revealed training on the following:
a. Putting On and Taking Off PPE clinical skill checklist completed on 3/9/20.
b. Hand Hygiene and Handwashing clinical skill checklist completed on 4/9/20.

Review of facility policy titled Hand Hygiene and Handwashing- Rehab/Skilled, Senior Living revised 4/6/21 revealed the following:
a. During service of meals, nursing and all other employees wash hands before meal service begins, when visibly soiled and whenever hands are contaminated by touching a resident, self or any other surface.

Centers for Disease Control and Prevention website titled, Recommendations for Healthcare Personnel during the Coronavirus Disease 2019 (COVID-19) Pandemic, visited 5/20/21 and updated 2/23/21, revealed Healthcare Personnel (HCP) should wear well-fitting source control (use of well-fitting face masks to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing) at all times while they are in the healthcare facility. The website further

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F 880	Continued From page 37 revealed, if worn properly a facemask helps block respiratory secretions produced by the wearer from contaminating other persons and surfaces. 5. Observation on 5/19/21 at 11:20 AM, revealed Staff F, Activity's Assistant (AA), in the facility Activity Room with her face mask placed below her chin not covering her mouth or nose while participating in an activity involving 8 unmasked residents throwing a ball and the residents hitting the ball with a foam noodles. Observed Staff F, AA, come within 6 feet of the residents with her face mask remaining below her mouth and chin to pick up the ball during the activity. Observed Staff F, AA, pull her mask up over her nose and mouth at 11:30 AM and proceeded to push a resident that had been in a wheelchair out of the Activity Room. During an interview on 5/20/21 at 9:30 A.M., the Director of Nursing (DON) revealed it is an expectation staff wear their face masks at all times while working unless they are on break in the breakroom or if they are outside.	F 880		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training.	F 947		

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§483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.

§483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.
This REQUIREMENT is not met as evidenced by:
Based on personnel file review and staff interview, the facility failed to assure 2 of 5 staff met the requirements for completing mandatory dependent adult abuse training (Staff D and Staff K). The facility reported a census of 25 residents.

Findings include:

Staff D, Certified Nursing Assistant (CNA), had a start date of 7/28/20. Record review revealed Staff A had not completed the 2 hour mandatory dependent adult abuse training until 2/8/21.

Review of time sheet for worker hours revealed Staff D, CNA, worked:
a. On 2/2/21 for 11.48 hours.
b. On 2/8/21 for 5.87 hours.

Staff K, Activities Assistant had a start date of 2/5/20. Record review revealed Staff B had not completed the 2 hour mandatory dependent adult abuse mandatory training until 8/12/20.

Review of facility's Kronos Timekeeper revealed Staff K, Activity Assistant worked:
a. On 8/8/20 for 4.75 hours.
b. On 8/9/20 for 6 hours.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - NEWELL	415 WEST HIGHWAY 7 NEWELL, IA 50568

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 947	Continued From page 39 Review of facility policy Abuse and Neglect-Rehab/Skilled, Therapy and Rehab revised 12/23/20 revealed each employee shall be required to complete two hours of training related to the identification and reporting of dependent adult abuse within six month of initial employment. Interview with Activity Director on 5/18/21 on 3:04 p.m., revealed the facility was aware the staff had been missed in regards to completing their mandatory dependent adult abuse training and the facility is now completing the training with new employees during initial orientation. Interview with Administrator on 5/19/21 at 2:17 p.m. revealed it is an expectation for staff to complete the mandatory 2 hour dependent adult abuse training within 6 months of employment.	F 947		