

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415066	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2022
NAME OF PROVIDER OR SUPPLIER CRA-MAR MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 575 SEVEN MILE ROAD CRANSTON, RI 02920	
(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 000	INITIAL COMMENTS A Recertification off hours survey was conducted at this nursing home from 04/03/2022 to 04/06/2022, to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. A State licensure and emergency preparedness surveys were also conducted at this facility. Deficiencies were identified. F 577 SS=B Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to-- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced	F 000	F-000 This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. However, the submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements by the State and Federal Law.	APR 28 2022 RECEIVED DEFICIENCIES REGULATION

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

TITLE

DATE

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

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F 577	Continued From page 1 by: Based on record review and staff interview, it has been determined that the facility failed to protect identifying information for 12 residents listed in the facility's survey results binder. Findings are as follows: Review of the survey results binder, displayed on a table, located in a common area of the facility, on 4/4/2022 at 11:00 AM, revealed two resident/staff roster listings for the previous annual survey, conducted in March 2021 and a complaint survey conducted in March 2022. These rosters contained the names of 5 former residents and 7 current residents. During an interview on 4/5/2022 at 11:03 AM, with the Administrator he was unable to provide evidence that the facility protected the identifying information of the 12 residents listed in the survey results binder.	F 577			
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	F 656 <i>u/r</i> <i>4/29/22</i>	F 656 • Resident ID # 24 Resident care plans immediately updated to reflect admission to Hospice Services Resident ID #10: Resident care plan updated to reflect the care of right heel wound. Resident ID # 223: Care plan updated to reflect open area	<i>4/8/22</i>	

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F 656	<p>Continued From page 2</p> <p>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)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document 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.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it has been determined that the facility failed to develop a comprehensive person-centered care plan for each resident relative to hospice services for 1 of 1 sample resident receiving hospice care and 2 of 3 sample residents with skin impairment, Resident ID #s 10, 24 and 233.</p> <p>Findings are as follows:</p>	F 656 <i>U02</i> <i>4/24/22</i>	<p>on right buttocks.</p> <ul style="list-style-type: none"> Audit completed on all resident care plan on 4/8/2022 on all residents for completeness and accuracy. DNS/MDS audit care plans weekly to ensure they are complete and updated per CMS guidelines. Audit care plans once a week for three months and reviewed at quarterly QAPI meetings. 	

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F 656	<p>Continued From page 3</p> <p>1. Record review revealed Resident ID #10 was admitted to the facility in December of 2021 and readmitted in March of 2022 with diagnoses which include, but are not limited to, non-pressure chronic ulcer of other part of left foot, peripheral vascular disease (a blood circulation disorder that causes the blood vessels outside of your heart and brain to narrow, block, or spasm), and diabetes with other skin ulcer.</p> <p>Record review revealed the following progress notes and wound consultations:</p> <ul style="list-style-type: none"> - "01/04/2022 11:05 AM Went to ...for f/u [follow up] appointment for podiatry...cleanse right heel with normal saline apply Alleevyn [type of wound dressing] change QOD [every other day]..." - "01/25/2022 2:29 PM Returned from podiatry appointment ...N.O.N. [new order noted] for right heel. Cleanse with normal saline, apply thin layer of Santyl [wound ointment] to right heel cover with DSD [dry sterile dressing]. change daily..." - Skin risk assessment dated 2/3/2022: "...vascular wound to right heel..." - Wound consultation dated 3/25/2022: "...unstageable DTI [deep tissue injury; an injury to a patients underlying tissue below the skin's surface that results from prolonged pressure in an area of the body.] of the right posterior heel..." - Wound consultation dated 4/4/2022: "...unstageable DTI of the right posterior heel..." <p>Further record review of the resident's care plan for skin impairment updated on 3/1/2022 failed to indicate that the resident has a wound to his/her right heel.</p> <p>During a surveyor interview on 4/6/2022 at 12:23</p>	F 656		

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F 656	<p>Continued From page 4</p> <p>PM with the Minimum Data Set assessment coordinator, Staff A, in the presence of the Director of Nursing Services (DNS), she acknowledged that Resident ID #10 has a wound on his/her right heel. She further acknowledged that the resident's care plan does not indicate that s/he has a wound to his/her right heel, and it should.</p> <p>2. Record review for Resident ID #24 revealed that s/he was admitted to the facility in November of 2017 and has diagnoses that include but are not limited to, unspecified dementia, legal blindness, heart disease, hypertension, nutritional anemia, and mild cognitive impairment.</p> <p>Review of the resident's progress notes revealed the following:</p> <ul style="list-style-type: none"> - 2/08/2022 12:11 PM- "Admitted to ...Hospices services this afternoon..." - 3/09/2022 11:49 AM- "Hospice care. Has been stable and at baseline..." - 3/21/2022 2:48 PM- "Hospice rec [recommendation] for prophylactic antibiotic..." - 4/04/2022 10:48 PM- "...new chair arrived from Hospice..." <p>Review of the resident's care plan failed to reveal evidence of a plan of care for the resident receiving hospice services.</p> <p>During a surveyor interview with the DNS on 4/06/2022 at approximately 1:30 PM, she acknowledged that she would expect a plan of care to be in place for hospice services and was unable to provide evidence of this plan of care.</p> <p>3. Record review for Resident ID #233 revealed</p>	F 656			

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F 656	<p>Continued From page 5</p> <p>that s/he was admitted to the facility in May of 2018 and has diagnoses that include but are not limited to, Alzheimer's disease, unspecified fracture of the T11 - T12 (Thoracic) vertebra, subsequent encounter for fracture with routine healing, and difficulty in walking.</p> <p>Record review of the resident's progress notes revealed the following:</p> <ul style="list-style-type: none"> - 3/16/2022 10:57 AM- "CNA[Certified Nursing Assistant] called this writer into Mrs. [name extracted] room. Mrs. [name extracted] has an open area on [his/her] right buttocks measures 0.6 CM [centimeters] in diameter...NP [nurse practitioner] notified..." <p>Review of a skin assessment dated 3/24/2022 revealed in part, "...Area to right buttocks remains, measures 0.5 CM in diameter. Resident often refuses to get OOB [out of bed]...Treatment in place..."</p> <p>Review of a skin assessment dated 3/31/2022 revealed in part, "...Open area on right buttocks measures 0.2 CM in diameter..."</p> <p>Further record review revealed a care plan initiated 5/25/2018 and last revised on 10/26/2021 indicating the resident was at risk for pressure. Additional review of the care plan failed to reveal evidence it was reviewed and/or revised after the above noted skin impairment was identified on the resident's right buttocks on 3/16/2022.</p> <p>During a surveyor interview with the Director of Nursing Services on 4/6/2022 at approximately 1:30 PM, she acknowledged that the care plan was not updated for Resident ID #233.</p>	F 656		

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F 656	Continued From page 6 Additionally, she indicated that the care plan should be updated when a new skin impairment is identified on a resident.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that the facility failed to revise the resident's plan of care following identification	F 657 <i>WR</i> <i>4/12/22</i>	F 657 <ul style="list-style-type: none"> Resident ID #24: Resident's care plan immediately updated to reflect fall Audit completed on all resident care plan on 4/8/2022 on all residents for completeness and accuracy. DNS/MDS audit care plans weekly to ensure they are complete and updated per CMS guidelines. Audit care plans once a week for three months and reviewed at quarterly QAPI meetings. 	<i>4/8/22</i>

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F 657	<p>Continued From page 7</p> <p>of changes in the resident's condition for 1 of 11 residents reviewed for care plans, Resident ID #24.</p> <p>Findings are as follows:</p> <p>Record review for Resident ID #24 revealed that s/he was admitted to the facility in November of 2017 and has diagnoses that include but are not limited to, unspecified dementia, legal blindness, history of vertigo (a sudden internal or external spinning sensation often triggered by moving your head too quickly), abnormal posture, and mild cognitive impairment.</p> <p>Record review of the resident's progress notes revealed a progress note dated 3/27/2022 at 9:10 AM, "Resident was found on the floor in [his/her] room at 6:50 AM by CNA [certified nursing assistant]. [S/he] was found on [his/her] right side. Prior to fall [s/he] was sitting in wheelchair in [his/her] room. CNA stated Mrs. [name extracted] was scooting [her/himself] forward in the w/c [wheelchair] prior to fall and was repositioned at that time. Red make [sic] on forehead at hairline. No hematoma noted. Small bruise noted to [his/her] right shoulder. Denies any pain..."</p> <p>Further record review revealed a care plan initiated on 11/30/2017 and last revised on 10/26/2021, which indicated the resident was at risk for falls. Additionally, the care plan failed to reveal evidence that it had been reviewed and/or revised after the resident had experienced an actual fall on 3/27/2022.</p> <p>During a surveyor interview with the Director of Nursing Services on 4/06/2022 at approximately 1:30 PM, she acknowledged that the care plan</p>	F 657			

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F 657	Continued From page 8 had not been updated for Resident ID #24 after s/he had an actual fall. Additionally, she revealed that she would expect that a care plan would be updated after a resident has an actual fall.	F 657		
F 658 SS=D	<p>Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)</p> <p>§483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it has been determined that services provided by the facility failed to meet professional standards of quality for 1 of 12 sample residents reviewed relative to medication administration, Resident ID# 132.</p> <p>Findings are as follows:</p> <p>Potter and Perry, Fundamentals of Nursing, Eighth Edition, page 305 states in part, "...nurses follow health care providers' orders unless they believe the orders are in error or harm patients..."</p> <p>Record review revealed the resident was admitted to the facility in April of 2022 with a diagnosis of but not limited to, acute on chronic diastolic (congestive) heart failure (a heart condition that causes your heart pumps less blood to your body than normal).</p> <p>Review of the resident's hospital discharge summary dated 4/1/2022 revealed an order stating "carvedilol (COREG) 3.125 MG tablet -</p>	F 658 <i>WR</i> <i>4/21/22</i>	<p>F 658</p> <ul style="list-style-type: none"> Resident ID # (not identified in report): Physician informed of held medication. All Nursing and Certified Medication Aids were in serviced regarding medication administration, parameters, and when to call physician. Medication Administration compliance report run for the month of April. No other residents affected. Medication audit reports analyzed once a week. Medication audit reports analyzed once a week, results discussed at risk meetings once a week and reviewed quarterly. 	<i>4/26/22</i>

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F 658	Continued From page 9 Take 1 (one) tablet (3.125 mg total) by mouth 2 (two) times a day. [a medication used to treat high blood pressure and heart failure]." Additional review of the discharge summary revealed a handwritten notation, indicating this order had "no parameters". Review of the resident's physician's orders, revealed the following order dated, 4/1/2022, "Coreg (carvedilol) tablet; 3.125 mg; amt: One tablet; oral Twice A Day...". Review of the resident's Medical Administration Record (MAR) revealed the above medication was not given on 4/3/2022. Further review of the MAR revealed a "reasons/comment" dated 4/3/2022 at 10:06 AM stating "Not Administered: On Hold Comment: Low BP [blood pressure]" Record review of the resident's progress notes failed to reveal evidence that the physician was notified of the resident's blood pressure or that the medication was held on 4/3/2022. During a surveyor interview on 4/6/2022 at approximately 9:30 AM with the Director of Nursing Services, she acknowledged that the above medication did not have a parameter in place and should not have been held. Additionally, she was unable to provide evidence that the physician was notified when the medication was not administered as ordered.	F 658		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880	F 880 • Annual Review of IPCP was	

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F 880	<p>Continued From page 10</p> <p>§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.</p> <p>§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:</p> <p>§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 accepted national standards;</p> <p>§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,</p>	F 880	<p>completed on 4/8/2022 by the Administrator, Director of Nursing and the Medical Director. Policies and procedures were reviewed and updated.</p> <ul style="list-style-type: none"> 4/15/2022-4/19/2022 All facility staff completed in-servicing on the updated IPCP policies and Procedures that were implemented. Staff were also in-serviced on the location of the binder, and the system for recording incidents and corrective actions Director of Nursing, the Administrator and the facility Medical Director will review and update Policies to ensure compliance with CMS guidelines Q 2 weeks and as needed. This will be tracked per attached schedule IPCP binder will be reviewed and updated quarterly to ensure that all Policies and procedures are up to date 	4/19/22	

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NAME OF PROVIDER OR SUPPLIER CRA-MAR MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 575 SEVEN MILE ROAD CRANSTON, RI 02920		
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F 880	<p>Continued From page 11</p> <p>depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§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 and staff interview it has been determined that the facility failed to conduct at least an annual review of its Infection Prevention and Control Program (IPCP). Additionally, the facility failed to utilize a system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. The facility further failed to ensure that all staff were provided education and competency assessments demonstrating their knowledge and skills pertaining to IPCP standards, policies, and procedures.</p>	F 880	<p>F 880</p> <ul style="list-style-type: none"> • Audit to ensure those residents with active infection were documented in infection tracker software and discussed at weekly risk meeting. • Audit on residents to ensure infections have been identified, documented, and treated per physician orders. • All facility infections tracked once a week and discussed/reviewed at risk meetings once a week. • MDS RN implemented a detailed computerized infection tracking system for recording and review of facility's infections. <ul style="list-style-type: none"> ○ All facility infections will be tracked weekly and reviewed at weekly risk meeting and quarterly QAPI meeting. 	

KLR
4/29/22

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F 880	<p>Continued From page 12</p> <p>Findings are as follows:</p> <p>1. Review of the facility's Infection Control Policies and Procedures provided by the Director of Nursing Services (DNS) revealed a binder with documents last updated in 2020.</p> <p>During a surveyor interview with the DNS on 4/5/2022 at approximately 11:05 AM, she indicated that she just received the updated guidelines via email but that they have not been reviewed or signed. Additionally, she was unable to provide evidence the IPCP had been reviewed since 2020.</p> <p>During a surveyor interview with Staff B, Certified Medication Technician, on 4/06/2022 at approximately 1:32 PM, she revealed that she is unaware of where the Infection Control policies and procedures are kept.</p> <p>During a surveyor interview with Staff C, Certified Nursing Assistant on 4/06/2022 at approximately 1:35 PM, she revealed that she thinks the Infection Control policies and procedures are kept in the employee break room.</p> <p>2. Record review of a binder labeled "Infection Control" revealed monthly infection tracking for January 2021 through May 2021, the remaining months of 2021 were blank.</p> <p>During a surveyor interview with Staff A on 4/5/2022 at approximately 11:15 AM, she revealed an analyzed detailed spreadsheet on her laptop of monthly infection tracking for January 2022 through March 2022. She failed to provide evidence of monthly Infection tracking for</p>	F 880	<p>F 880</p> <ul style="list-style-type: none"> On 4/15/2022-4/18/2022 Facility Wide Hand Hygiene, Donning and Doffing, PPE and standard and transmission-based precautions in-service. Audit completed on all staff infection control in servicing/completion. Starting 4/15/2022 and continued Quarterly for the remainder of this year Inservice's will be broken up into quarters and presented over a 4-day event to ensure that all staff are meeting the requirements for CMS guidelines. All new hires are required to have scheduled orientation to complete all of the required in-services upon hire to ensure that they are in compliance. The Quarterly In-Service Calendar has been posted so that all the staff are aware. 	

MR
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F 880	<p>Continued From page 13 June, July, August, September, October, November, and December 2021. Additionally, she pulled up a report from the facility's electronic medical record which indicated that there were residents with active infections in the facility from June 2021 through December 2021 that were not tracked in the facility's Infection Control binder.</p> <p>During a surveyor interview with the DNS on 4/06/2022 at approximately 12:00 PM, she was unable to provide evidence that the facility was tracking infections for the months of June 2021 through December 2021.</p> <p>3. Review of the employee list provided by the facility included 49 employees.</p> <p>Review of all the Infection Control education and competencies performed with the staff by the facility from April 2021 through March 2022, reveals the following:</p> <ul style="list-style-type: none"> - November 2021- "Hand hygiene" Inservice was performed, lists 1 employee in attendance. - December 2021- "Donning and Doffing" Inservice was performed, lists 6 employees in attendance. - January 2022- "Protective Personal Equipment" (PPE) Inservice was performed, lists 10 employees in attendance. - January 6-17, 2022- "Standard precaution/transmission precaution" Inservice was performed, lists 16 employees in attendance. <p>During a surveyor interview with the DNS on 4/6/2022 at approximately 12:10 PM, she acknowledged that the facility did not provide education to all staff in Infection Control from April 2021 through March 2022.</p>	F 880	<ul style="list-style-type: none"> • Audit and monitor by business office manager upon hire and at quarterly QAPI meetings. 	

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F 943 SS=E	<p>Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3)</p> <p>§483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on-</p> <p>§483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.</p> <p>§483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property</p> <p>§483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview it has been determined that the facility failed to provide training to their staff, that at a minimum includes abuse, neglect, exploitation, and misappropriation of resident property and dementia management.</p> <p>Findings are as follows: Record review of a listing of current staff revealed that the facility has 42 staff members. Record review of the facility's line listing of staff in-services for dementia management, abuse, and neglect, in the presence of the Director of Nursing Services on 4/5/2022 at 12:58 PM failed to reveal evidence that 12 of 42 staff members had received the required training in abuse, neglect, and dementia management.</p>	F 943	<p>F 943</p> <ul style="list-style-type: none"> On 4/15/2022-4/19/2022 Facility Wide completion of abuse, neglect, and residents' rights in-service. <ul style="list-style-type: none"> An audit was completed on all staff abuse, neglect, dementia, and residents' rights in servicing/completion Starting 4/15/2022 and continued Quarterly for the remainder of this year Inservice's will be broken up into quarters and presented over a 4-day event to ensure that all staff are meeting the requirements for CMS guidelines. All new hires are required to have scheduled orientation to complete all of the required in-services upon hire to ensure that they are in compliance. The Quarterly In-Service Calendar has been posted so that all the staff are aware. 	4/22/22	

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F 943	Continued From page 15 During a surveyor interview on 4/6/2022 at 9:59 AM with the Director of Nursing Services, she was unable to provide evidence that the in-service training for dementia management, abuse, and neglect was provided to all the facility's staff, as required.	F 943 <i>kr</i> <i>4/27/22</i>	<ul style="list-style-type: none"> • 4/22 Dementia training for staff began and scheduled throughout the rest of the year. • Audit and monitor by business office manager upon hire and at quarterly QAPI meetings. <ul style="list-style-type: none"> ○ Auditing in servicing schedule quarterly and reviewed at QAPI meetings every quarter. 	