STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525333	A. BUILDING _____ B. WING _____	08/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WATERTOWN HEALTH CARE CENTER	**121 HOSPITAL DR WATERTOWN, WI 53098**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility did not notify the resident representative and did not immediately notify and consult with the resident's physician when a significant change in the resident's physical, mental, or psychosocial status occurred for 1 of 4 residents reviewed (R1) of a total sample of 10 residents. On [DATE], at 6:45 AM R1 presented with a significant change in mental and physical status, the facility did not notify R1's physician until 10:00 AM, which delayed R1 in receiving EMS (Emergency Medical Services) for 3 hours. R1 was later transferred to the emergency room , for mental status changes and subsequently died on [DATE]. The facility's failure to immediately notify the physician of R1's significant change of condition on [DATE], of new onset of mental status changes and inability to respond, created a finding of IJ (Immediate Jeopardy) beginning on [DATE]. On [DATE] at 2:30 PM, NHA A (Nursing Home Administrator) and DON B (Director of Nursing) were informed of the IJ. The facility removed the jeopardy on [DATE]. The deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan. This is evidenced by: The facility's Notification of Changes Policy dated [DATE] states in part: It is the policy of this facility that changes in a resident's condition . are immediately shared with the resident and/or the resident representative . and reported to the attending physician or delegate. Nurses .are educated to identify changes in a resident's status and define changes that require notification .to ensure the best outcomes of care for the resident . 2) (i) A significant change includes deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications . Notification is provided to the physician to facilitate continuity of care and obtain input from the physician about changes . The facility stated they follow INTERACT 4.0 standard of practice for change of condition, this document guides decision making of when to report to the MD/NP/PA (Medical Doctor/ Nurse Practitioner/Physician Assistant) and notes in part: Change in Condition: Immediate Notification-Any symptoms, sign or apparent discomfort that is: Acute or Sudden in onset, and: A marked change (i.e. more severe) in relation to usual symptoms . Signs and Symptoms: Altered Mental Status: Immediate notification- Abrupt significant change in cognitive function from usual with or without altered level of consciousness .Consciousness: Immediate notification -Sudden change in level of consciousness or responsiveness . INTERACT 4.0 Care Path for symptoms of Acute Mental Status Change updated ,[DATE], states in part: New Mental Status Change . New symptoms or signs of increased confusion (e.g. disorientation, change in speech), Decreased level of consciousness (sleepy, lethargic), Inability to perform usual activities (due to mental status changes) . unresponsiveness. This Care Path includes guidance to: Take vital signs (Temperature, BP (Blood Pressure), pulse, Respirations, Oxygen saturation and to notify the MD (Medical Doctor) if any Vital Sign Criteria is met, including . Oxygen saturation below 90 percent .Resident unable to eat or drink . Findings: R1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R1 was reviewed as a closed record. R1 had an activated Power of Attorney for Health Care (APOAHC). R1's MDS (Minimum Data Set) quarterly assessment dated [DATE] noted R1 BIMS (Brief Interview for Mental Status) score of 3 of 15 indicating severe cognitive impairment. Section G of the MDS notes R1 was independent in ambulation. On [DATE] at 10:35 AM, Surveyor interviewed CNA C (Certified Nursing Assistant) about R1. CNA C stated on [DATE] at 6:45 AM, CNA C went to complete R1's morning care noting R1 was groggy, like she was drunk, would open her eyes and say yeah but did not wake up. CNA C stated R1 could not suck on a straw. CNA C explained R1 was usually alert and after staff got R1 ready for the day R1 was able to ambulate independently. CNA C stated she notified LPN E (Licensed Practical Nurse) of R1's changes right away, and said LPN E took R1's vital signs. CNA C said LPN E stated she did not know how to send someone out and was going to check with LPN G. On [DATE] at 11:44 AM, Surveyor interviewed LPN E on the phone about R1's change in condition on [DATE]. LPN E stated CNA C had reported to her at about 6:45 AM that R1 was acting different. LPN E stated she did an assessment took R1's vital signs. LPN E stated she was not 100 percent sure if R1 needed to go out to the hospital and wasn't familiar with the process of how to send residents out to the hospital. LPN E stated she went to talk to LPN G who was working on another unit. LPN G texted DON B, who said RN D was coming into the facility and to have RN D assess R1. LPN E stated that she continued to check on R1, took R1's vital signs, and monitored R1. LPN E stated all R1 said was yeah which was not normal for her. LPN E stated she held R1's medication that morning as she didn't feel comfortable attempting to give her medication. Of note, LPN E did not immediately notify a physician when R1 presented with a change of condition of decreased level in consciousness and inability to swallow at 6:45 AM. Review of R1's Progress Notes for [DATE] notes: On [DATE] Late Entry at 10:15 AM, CNA informed writer that res (resident) was not acting like her normal self. Upon assessment, res appeared sleepy, not able to respond verbally, and not able to follow commands. Vitals were obtained. MD was notified about residents change in condition and instructed writer to send res to ER. Ambulance arrived around 10:00. This entry was signed by LPN E (Licensed Practical Nurse). Of note there is no evidence that R1's physician was notified when R1 presented with a significant change of condition at 6:45 AM. Review of EMS report for R1 dated [DATE], notes that EMS was notified at 10:11 AM and arrived at facility at 10:17 AM for change in mental status duration: 3 hours. Review of R1 hospital record notes state in part; on [DATE], R1 presented in the emergency room with altered mental status changes and unable to ambulate which was not normal for R1. R1 oxygen saturation was 73% on room air. It was noted that R1's drug screen was positive for opioids and R1 had no orders for opioids. R1 had hypoventilation and pinpoint pupils and [MEDICATION NAME] was given for possible opioid ingestion, which R1 responded to, but R1's condition continued to decline. R1 was placed on comfort care on [DATE] in the hospital and R1 expired on [DATE]. R1 hospital Discharge Summary notes includes in part; final Diagnoses: [REDACTED]. Of note it is unclear at this time, if R1 had an opioid overdose. The facility investigated and completed a self -report incident and was unable to determine how or if R1 received opioids. Subsequent testing was performed at the hospital and was inconclusive. On [DATE] at 11:00 AM, Surveyor interviewed RN D (Registered Nurse) about R1's change of condition on [DATE]. RN D stated she had received a text at about 8:15 AM from LPN G asking when RN D would be coming into work, because R1 was not acting herself and DON B (Director of Nursing) was off duty. RN D stated she got to the facility at 9:30 AM and went to LPN E to get updated on R1's condition, LPN E told RN D that R1 was acting like she was drunk that her blood pressure was low and her oxygen saturations were in the ,[DATE] % range. RN D said she assessed R1 noting R1 was unable to speak, had tremors and could not squeeze RN D's hands, RN D thought R1 had a stroke. RN D stated she obtained vital signs and got oxygen started for R1. RN D said she told LPN E to call the doctor to get orders, call EMS (Emergency Medical Services), to call ER (emergency room) with a report and to call R1's POA (Power of Attorney). RN D stated later that day ([DATE]) we found out LPN E did not call R1's POA. Surveyor asked how long it took the facility to notify R1's POA of R1 change of condition and transport to ER, RN D stated about 7 hours, RN D stated that was unacceptable. On [DATE] at 12:15 PM, Surveyor interview DON B and CD F (Clinical Director) about R1's change of condition on [DATE]. DON B stated she was off duty on [DATE]. DON B stated at about 7:45 AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) 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 0580 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) she received a text message from LPN G saying they noticed a change in R1, they were monitoring R1, R1's oxygen saturation was in the 80 percent range but now up to 93 percent, LPN G said R1 was acting differently, DON B stated she attributed that to R1's lower oxygen level. Surveyor asked DON B what she would expect staff to do for a resident with a significant change in condition. DON B stated she would want the doctor updated staff were monitoring R1. DON B stated she did not tell staff to update the doctor. DON B stated she did not know LPN G had not looked at R1 on [DATE]. DON B stated she told LPN G that RN D would be in later and to have RN D assess R1. DON B stated she had been educating nurses to monitor resident more versus sending residents to the emergency room and transferring them quickly. DON B stated she had been training nurses to use their assessment skills to monitor residents. DON B stated she would expect the doctor to be notified as soon as possible with a critical change in condition. It is important to note, there is no evidence a doctor was notified of R1's change in condition until 10:00 AM, 3 hours and 15 minutes after R1's change in condition was first noted. R1's Progress Note continues: On [DATE] at 2:52 PM, Call placed to POA (name). Updated on transfer to hospital. Of note, R1's POA was not notified for almost ,[DATE] hours after R1 presented with a change in status. Surveyor asked about the delay in R1's POA being notified. CD F stated that on [DATE] at 2:45 PM, LPN E had come to her to report LPN E had not notified R1's POA that morning of R1's change in condition and transfer to the hospital, as LPN E was not comfortable notifying R1's POA. CD F stated that she notified R1's POA at that time with LPN E present so that LPN E could learn. On [DATE] at 3:41 PM, Surveyor interviewed R1's POA, FM I (Family Member) who stated that she had not been notified of R1's change in condition by the facility on [DATE], and had not been notified that R1 was sent to the hospital until 2:49 PM on [DATE]. FM I stated that she thought the facility did not take R1's change of condition seriously. On [DATE] at 7:55 PM Surveyor interviewed R1's physician, MD H (Medical Doctor),who stated he would have expected to have been notified of R1's, change in condition, unresponsiveness within 30 minutes of noting R1's change. The facility was aware of R1's significant change of condition including alteration in mental status, significant decrease in responsiveness and inability to swallow at 6:45 AM. The facility did not immediately notify the physician of R1's changes until 10:00 AM, 3 hours and 15 minutes after R1 change was first noted, which delayed R1 in receiving needed emergency medical services. The facility's failure to provide care consistent with current standards of practice for staff notifying a physician for a resident with a significant change in condition created a finding of IJ that began on [DATE]. The facility developed and began implementing a removal plan on [DATE]. The facility's plan indicated it would: -Immediately conduct a sweep of facility 24 boards and review all documentation to ensure all Primary Care Providers (PCP) and responsible parties were notified of changes of condition. Nurses were interviewed to ensure no changes of condition were missed. -Disciplinary action was taken with licensed nurse who was aware of significant change but did not report it to the physician timely. -Immediately revised Notification Policy to reflect INTERACT Tool used and Standard of Practice. -Immediately educated for nursing staff regarding PCP, RN, and responsible party notification of changes using the INTERACT Version 4.0 Tool as to when to notify. Staff will be educated before the start of their next scheduled work day. -A Performance Improvement Project was implemented with a focus on physician notification, RN notification, and Responsible party notification. -DON or designee will monitor all documentation daily for change of condition and PCP and responsible party notification time for 2 weeks, the 3 residents weekly for 4 weeks, the 2 residents weekly for 2 weeks the 2 residents a month for 2 months and ongoing as needed. -Immediately complete competencies for all nursing on recognition and response to change of condition, MD/family notification. -Random Competency Check for change of condition, notification of physician/responsible party, and RN completed at least weekly for 12 weeks and ongoing as need or directed by QAPI. -Results of all audits and competencies will be reported to the QAPI team at least monthly
F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not provide care and treatment in accordance with professional standards of practice related to assessment and monitoring for change in condition for 1 resident (R1) of 4 residents reviewed for change of condition of a total of 10 sampled residents. On [DATE] at 6:45 AM, when R1 presented with a significant change in mental and physical status. the facility failed to immediately complete a full nursing assessment of R1's condition, or consult with a physician, which delayed R1 in receiving needed emergency medical services. R1 was later transferred to the emergency room for change in mental status and subsequently died on [DATE]. The facility's failure to assess R1 when R1 was noted to be experiencing a change in condition, exhibiting symptoms of new onset of mental status changes and inability to respond, created a finding of IJ (Immediate Jeopardy) beginning on [DATE]. On [DATE] at 2:30 PM, NHA A (Nursing Home Administrator) and DON B (Director of Nursing) were informed of the IJ. The facility removed the jeopardy on [DATE]. The deficient practice continues at a scope/severity of D (potential for more than minimal harm/isolated) as the facility continues to implement its action plan. This is evidenced by: Upon request, the facility was not able to provide a policy for completing an RN (Registered Nurse) assessment of residents with change of condition. The facility stated they follow INTERACT 4.0 tools for change of condition. INTERACT 4.0 Care Path for symptoms of Acute Mental Status Change updated ,[DATE], states in part: New Mental Status Change . New symptoms or signs of increased confusion (e.g. disorientation, change in speech), Decreased level of consciousness (sleepy, lethargic), Inability to perform usual activities (due to mental status changes) . unresponsiveness. This Care Path includes guidance to: Take vital signs (Temperature, BP (Blood Pressure), pulse, Respirations, Oxygen saturation and to notify the MD (Medical Doctor) if any Vital Sign Criteria is met, including . Oxygen saturation below 90 percent .Resident unable to eat or drink . Findings: R1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R1 was reviewed as a closed record. R1's MDS (Minimum Data Set) quarterly assessment dated [DATE] noted R1 BIMS (Brief Interview for Mental Status) score of 3 of 15 indicating severe cognitive impairment. Section G of the MDS notes R1 was independent in ambulation. Review of R1's Progress Notes for [DATE] notes documented entry: Late Entry at 10:15 AM, CNA informed writer that res (resident) was not acting like her normal self. Upon assessment, res appeared sleepy, not able to respond verbally, and not able to follow commands. Vitals were obtained. MD was notified about residents change in condition and instructed writer to send res to ER. Ambulance arrived around 10:00. This entry was signed by LPN E. Of note: there is no documentation of any data gathered (e.g. vital sign, responsiveness) of R1's status change when it was reported to LPN E at 6:45 AM. Additionally, there is no documentation of an RN assessment for R1's significant change of condition on [DATE]. On [DATE] at 10:00 AM R1's vital signs were documented: Temperature- 97.3, BP: ,[DATE], Pulse: 99, Respirations: 14, Oxygen saturation: 88%. Review of EMS report for R1 dated [DATE], notes that EMS was notified at 10:11 AM and arrived at facility at 10:17 AM for R1's condition of altered mental status, duration 3 hours. R1's vital signs per EMS at 10:37 AM were BP ,[DATE], P90, R16 and oxygen sturation 90%. Review of R1's hospital record notes in part: On [DATE], R1 presented in the emergency room with altered mental status changes and unable to ambulate which was not normal for R1. R1's oxygen saturation was 73% on room air. It was noted that R1's drug screen was positive for opioids and R1 had no orders for opioids. R1 had hypoventilation and pinpoint pupils and [MEDICATION NAME] was given for possible opioid ingestion, which R1 responded to, but R1's condition continued to decline. R1 was placed on comfort care on [DATE] in the hospital and R1 expired on [DATE]. R1's hospital Discharge Summary notes includes in part, final Diagnoses: [REDACTED]. Of note it is unclear at this time, if R1 had an opioid overdose. The facility investigated and completed a self -report incident and was unable to determine how or if R1 received opioids. Subsequent lab orders were inconclusive. On [DATE] at 10:35 AM, Surveyor interviewed CNA C (Certified Nursing Assistant) about R1. CNA C stated on [DATE] at 6:45 AM, CNA C went to complete R1's morning cares noting R1 was groggy, like she was drunk, R1 would open her eyes and say yeah but did not wake up. CNA C stated R1 could not suck on a straw. CNA C explained R1 was usually was alert and after staff got R1 ready for the day R1 was able to ambulate independently. CNA C stated she notified LPN E (Licensed Practical Nurse) of R1's changes right away, and said LPN E took R1's vital signs. CNA C said LPN E stated she did not know how to send someone out and was going to check with LPN G. CNA C stated she checked on R1 about every ,[DATE] minutes that morning and R1 stayed the same not really responding much. CNA C stated RN D (Registered Nurse) came to check on R1 about 9:30 AM. On [DATE] at 11:44 AM Surveyor interviewed LPN E on the phone about R1's change in condition on [DATE]. LPN E stated CNA C had reported to her at about 6:45 AM that R1 was acting different. LPN E stated she took R1's vital signs. LPN E stated she was not 100 percent sure if R1 needed to go out to the hospital and wasn't familiar with the process of how to send residents out to the hospital. LPN E stated she went to talk to LPN G who was working on another unit. LPN G texted DON B, who said RN D was coming into the facility and to have RN D

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F 0684 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	(continued... from page 2) assess R1. LPN E stated she continued to check on R1, took R1's vital signs, and monitored R1. LPN E stated all R1 said was yeah which was not normal for her. LPN E stated she held R1's medication that morning as she didn't feel comfortable attempting to give her medication. Later Surveyor asked LPN E about the one set of vital signs recorded for R1 on [DATE] at 10:00 AM. LPN E could not explain why she had not documented the vital signs she had taken for R1 before 10:00 AM. Of note, an LPN by law and training cannot assess. On [DATE] at 11:20 AM, Surveyor interviewed LPN G about R1's change of condition on [DATE]. LPN G stated that LPN E came down to her unit at 7:45 AM reporting R1 was not acting herself and moving around like she was drunk. LPN G said she asked LPN E if R1 needed to be sent to the hospital, LPN E said R1 seems better, and it did not seem urgent. Surveyor ask LPN G if she had gone to see R1, she stated she did not and LPN E did not ask her to. LPN G said there wasn't an RN on duty at the time so she texted DON B who said to wait until RN D came into the facility and have her assess R1. On [DATE] at 11:00 AM, Surveyor interviewed RN D (Registered Nurse) about R1's significant change of condition on [DATE]. RN D stated she had received a text at about 8:15 AM from LPN G asking when RN D would be coming into work, because R1 was not acting herself and DON B (Director of Nursing) was off duty. RN D stated she got to the facility at 9:30 AM and went to LPN E to get updated on R1's condition, LPN E told RN D that R1 was acting like she was drunk that her blood pressure was low and her oxygen saturations were in the ,[DATE] % range. RN D said she assessed R1 noting that R1 was unable to speak, had tremors and could not squeeze RN D's hands, RN D thought R1 had a stroke. RN D stated she obtained vital signs and got oxygen started for R1. RN D said she told LPN E to call the doctor to get orders, call EMS (Emergency Medical Services), to call ER (emergency room) with a report and to call R1's POA (Power of Attorney). Surveyor asked how long did R1 had to wait for an RN assessment, RN D stated 2 hours, and stated this was unacceptable. Later, the facility provided Surveyor with a timeline document from [DATE] signed by RN D and dated [DATE] which notes in part: Received text message at 8:15 AM from (name-LPN G) asking when I was coming in because (name -DON B) was off and (initials-R1) was not acting herself and wanted me to assess her when I got into work. Replied at 8:45 AM stating I would be at work in 30 minutes (R1) was acting like she was drunk BP was low and 02 (oxygen was low). (R1) was lying in bed with her eyes closed and opened her eyes when RN D said her name, (R1) did not say anything, (R1) tried to say something, but could not get the words out . RN D obtained vitals: BP ,[DATE] R: 14 P: 99 O2 88% T: 97.3. Lung sounds were clear. (R1) would respond to verbal and touch stimuli . (R1) was unable to squeeze RN D's hands, (R1) was unable to follow any directions. (R1) had some tremors when asking to squeeze hands. CNA went and got oxygen .applied oxygen. Sat (R1) up in bed. O2 rechecked and was at 90% . Told (LPN E) . to call MD to give update. (LPN E) called MD and got order to send out to ER to be evaluated . On [DATE], Surveyor interviewed RN D about the timeline document RN D signed on [DATE] related to RN D's assessment of R1 on [DATE]. Surveyor asked RN D if she should have documented her findings into R1's medical record, RN D said she should have but forgot to do this and should have made a late entry. It is important to note that there is no documentation in R1's record of an RN assessment being completed on [DATE] when R1 presented with a significant change in condition. On [DATE] at 12:15 PM, Surveyor interviewed DON B about R1's significant change of condition on [DATE]. DON B stated she was off duty on [DATE]. DON B reported that at about 7:45 AM she received a text message from LPN G saying they noticed a change in R1, they were monitoring R1, that her oxygen saturation was in the 80 percent's but now up to 93 percent, LPN G said R1 was acting differently, DON B stated she attributed that to R1's lower oxygen level. Surveyor asked DON B what she would expect staff to do for a resident with a significant change in condition. DON B stated she would want the doctor updated that staff were monitoring R1. DON B stated she did not tell staff to update the doctor. DON B stated she did not know that LPN G had not looked at R1 on [DATE]. DON B stated she told LPN G that RN D would be in later and to have RN D assess R1. DON B stated she had been educating nurses to monitor residents more versus sending residents to the emergency room and transferring them quickly. DON B stated she had been training nurses to use their assessment skills to monitor residents. DON B stated she would expect the doctor to be notified as soon as possible with a critical change in condition. Surveyor asked what standard of practice the facility follows regarding change of condition. On [DATE] at 7:45 PM CD F (Clinical Director) reported to Surveyor the facility uses INTERACT 4.0 tools for resident change of condition which includes: Stop and Watch, SBAR (Situation, Background, Assessment and Recommendations), and Care Pathways. CD F stated, I know this is not what was followed regarding change of condition for R1. On [DATE] at 7:55 PM Surveyor interviewed R1's physician, MD H (Medical Doctor), who stated he would have expected to have been notified of R1 change in condition of unresponsiveness within 30 minutes of noting R1's change. (Cross reference F580.) The facility was aware of R1's significant change of condition including alteration in mental status, significant decrease in responsiveness and inability to swallow at 6:45 AM. The facility did not ensure R1 received a thorough RN assessment until 9:30 AM, which delayed R1 in receiving needed emergency medical services. The facility's failure to provide care consistent with current standards of practice for completing an RN assessment for a resident with a significant change in condition created a finding of IJ that began on [DATE]. The facility developed and began implementing a removal plan on [DATE]. The facility's plan indicated it would: -Immediately conduct a sweep of facility 24 hour boards and interview of nurses to ensure all changes of condition were assessed. -Revise the Change of Condition policy using AMDA (American Medical Director Association) clinical practice guidelines for Acute Change of Condition in the Long Term Setting 2003. -Immediately initiate education for nursing staff regarding change of condition documentation and assessment. All staff will be educated prior to starting their next scheduled work day. -Assessment education includes vital sign and assessment of the affected system. -Implement a Performance Improvement Project with a focus on assessment and documentation of significant change. -DON will complete chart audits for health assessment documentation and monitor all documentation daily for change of condition, SBAR INTERACT assessments for 2 weeks, and then 3 residents weekly for 4 weeks, 2 residents for 2 weeks the 2 residents a month for 2 months. -Results of all audits will be reported at least monthly to the QAPI team. -Complete competencies for all nursing on recognition and response to change of condition, Resident Assessment.
F 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Observe each nurse aide's job performance and give regular training.** Based on record review and staff interviews, the facility did not provide evidence that CNAs (Certified Nursing Assistant) had 12 hours of in-service training per year for 5 of 5 CNA's reviewed for in-service training. The survey team randomly selected 5 facility CNAs who have been employed at the facility for longer than 1 year. CNA C, CNA J, CNA K, CNA L, and CNA M did not have 12 hours of in-service training. Findings include: On 8/6/20, at 9:00 AM, Surveyor provided DON B (Director of Nursing) with a list of five CNA names the Surveyor had randomly selected and requested their in-service records. DON B provided in-service records. On 8/6/20, Surveyor reviewed the in-service records and noted the following: Example 1: Surveyor reviewed CNA C's in-service records from 7/31/19 to 7/31/20. During this time, CNA C completed 2 hours of in-service for the year 7/31/19 to 7/31/20. CNA C did not complete 12 hours of in-service as required. Example 2: Surveyor reviewed CNA J's in-service records from 7/31/19 to 7/31/20. During this time, CNA J completed 1 hour of in-service for the year 7/31/19 to 7/31/20. CNA J did not complete 12 hours of in-service as required. Example 3: Surveyor reviewed CNA K's in-service records from 7/31/19 to 7/31/20. During this time, CNA K completed 2 hours of in-service for the year 7/31/19 to 7/31/20. CNA K did not complete 12 hours of in-service as required. Example 4: Surveyor reviewed CNA L's in-service records from 7/31/19 to 7/31/20. During this time, CNA L completed 2 hours of in-service for the year 7/31/19 to 7/31/20. CNA L did not complete 12 hours of in-service as required. Example 5: Surveyor reviewed CNA M's in-service records from 7/31/19 to 7/31/20. During this time, CNA M completed 2 hours of in-service for the year 7/31/19 to 7/31/20. CNA M did not complete 12 hours of in-service as required. On 8/6/20 at 1:00 PM Surveyor interviewed DON B asking about CNA in-service records not meeting the requirements of 12 hours annually, DON B stated that a new company took over in October of 2019 and that the facility had no other in-service hours tracked for the 5 CNA's and there should have been.