STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505484	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTHWOODS LODGE	**2321 SCHOLD PLACE NORTHWEST SILVERDALE, WA 98383**

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

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F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to perform periodic reviews to determine whether the residents had advance directives (AD) or wished to formulate an AD, and if interested, offer assistance with the development of an AD for two of three residents (Resident #s 36 and 44) reviewed for AD. This failure placed the residents at risk to be denied the opportunity to direct their health care in the event that they become unable to make decisions or communicate their health care preferences. Findings included . ADVANCE DIRECTIVES (AD) An AD is a written instruction, such as a living will or durable power of attorney (DPOA) for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. PHYSICIAN ORDERS [REDACTED].a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST [MEDICATION NAME] form is not an AD. The regulations also showed, 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. 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. RESIDENT #36 Review of the admission Minimum Data Set (MDS, a required assessment tool), dated 02/05/20 showed that Resident #36 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS further showed the resident had limited recall and could make needs known. In interview and record review on 02/28/20 at 2:20 PM, when the AD documentation was requested, Staff C, Social Service Director (SSD), provided a copy of a document titled, Care Management/IDT (Interdisciplinary Team) Discharge Plan, dated 02/02/20. The form showed that the Patient said that son has temporary POA (Power of Attorney) who he will be living with after discharge. Called son and requested that he bring in a copy for his chart. When asked if the facility obtained a copy of the POA documentation, Staff C, SSD, stated she could not locate the AD documents. RESIDENT #44 Review of the admission MDS dated [DATE] showed Resident #44 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS further showed the resident had short-term memory loss and could make her needs known. Review of the document titled, Admission Agreement dated 02/07/20, showed that Resident #44 did not have an AD and was interested in assistance from the facility to formulate an AD. On 02/28/20 upon request for Resident #44's AD documentation from the facility, Staff C, SSD, provided a progress note dated 02/27/19 at 2:00 PM that showed, Met with pt (patient) to discuss AD. On admit she indicated that she did not have an AD but would be interested in info. Provided her with blank forms for DPOA for finances and healthcare as well as contact info for traveling notaries. She plans to discuss with her spouse. Will assist as needed. During an interview on 03/02/20 at 11:16 AM, Staff C, SSD, stated that she did not follow up with Resident #44 regarding her AD and should have. Reference WAC 388-97-0300 (3)(b-c) .
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure it had an activity program designed to meet the needs of residents based on the comprehensive assessment, interests and physical/mental/psychosocial well-being for one of one residents (Resident #149) when reviewed for activities. This failure placed the resident at risk for increased social isolation, deteriorated mood, worsening cognition and decreased quality of life. Findings included . Review of the admission Minimum Data Set (MDS, a required assessment tool), dated 02/18/20 showed that Resident #149 was admitted on [DATE] with [DIAGNOSES REDACTED]. The resident was alert, had short term memory loss, required two-person extensive assistance with bed mobility, transfers, activities of daily living (ADLs), and one-person extensive assistance with personal hygiene and walking with a front-wheeled walker. The MDS further showed that Resident #149 thought it was very important to have family involvement and somewhat important to do activities with groups of people, participate in favorite activities, to be outside on nice days, keep up to date with the news, listen to music, be around animals and participate in religious services. Review of Resident #149's care plan showed that the resident was independent with activity pursuits. The goal was for the resident to remain independent with activity pursuits. Interventions included to encourage family and friends to visit more often and spend more time out of the room daily. The resident liked watching television, listening to music, reading and loved spending time with family. The care plan further showed that staff were to provide the resident with an activity calendar and supplies as needed. The care plan wording for Resident #149 was the exact same as Resident #5, whom was also dependent on staff for ADLs and mobility. The care plan was not individualized or specific to Resident #149's needs, preferences or activity patterns. Review of Resident #149's progress notes dated 02/19/20, showed that the resident liked watching television, reading books/magazines, listening to music and spending time with family. No further activity progress notes were located. In an observation and interview on 02/26/20 at 10:01 AM, Resident #149 was in her room in bed with the television on and presented with a flat affect. When asked, the resident did not want to talk or answer any questions. No activity resources were observed at bedside, such as a music player, word games, books or magazines. In an observation and interview on 02/27/20 at 11:07 AM, Resident #149 was in bed with the television on. When asked why she was here, the resident stated that something hit her in the head, and knocked her out. Resident #149 further stated that she was having a hard time adjusting to the facility. When asked her what helped her get through the day and at times of stress, the resident stated, I don't know. When asked what she does in her spare time, Resident #149 stated that she went out and did things with her husband and friends. In addition, the resident stated she found herself bored and felt down frequently during her stay in the facility. In an interview on 03/04/20 at 11:42 AM, Staff F, Activity Assistant (AA), stated she visited residents daily and invited them to groups. When asked how she was aware residents were meeting or not meeting their goals, Staff F, AA, stated, It was documented. When asked where they kept track of each resident's activity participation and refusals, Staff F, AA, stated it was documented in the progress notes. In addition, Staff F, AA, stated she performed one to one (1:1) visits, but did not keep a list as to who required/requested the intervention. When asked about Resident #149 and her specific activity needs, Staff F, AA, stated that the resident had difficulty adjusting to the facility placement and just wanted to be home. She did not always seem very happy. Staff F, AA, further stated that the resident did not want activity supplies or come to groups, did not know why she refused, and did not spend much time out of her room. When asked how often she visited Resident #149, Staff F, AA,

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 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) stated she visited her almost daily, did not always document the visits, the resident's response to the 1:1 visits or interventions. When asked what kind of music and books/magazines Resident #149 liked, Staff F, AA, stated she would have documented that in the care plan. Staff F, AA, further stated that she had difficulty getting residents to participate in group activities as they typically did not want to participate in activities like bingo as they focused on therapy and getting better. In an interview on 03/04/20 at 12:54 PM, Staff E, Resident Care Manager/Registered Nurse (RCM/RN), stated that Resident #149, was probably not happy with being here. She perked up when her family was here. In addition, Staff E, CM/RN, stated that Resident #149 refused therapy at times, In fact the husband came in more regularly so that she would participate in therapy. Staff E, CM/RN, further stated that she believed the resident had some cognitive issues, and made her needs/wants known. In an observation on 03/04/20 at 1:18 PM, Staff F, AA, sat at a table in the dining room with three residents playing bingo. In an interview on 03/05/20 at 9:30 AM, Staff M, Activity Director (AD), stated that she oversees the department, was available for Staff F, Activity AA, when she had questions, and worked in the facility eight hours a month. Staff M, AD, further stated that the Activity Assistant worked from 10:00 AM to 3:00 PM during the week. No activity staff were available for evenings or weekends. Staff M, AD, stated that the resident population was different from a typical nursing facility, as it was a short stay placement. In addition, Staff M, AD, stated that her goal for activity department was to make the activities individualized to each resident's needs. When asked about care plans to describe the definition of what independent with leisure activities meant for a resident, Staff M, AD, stated that it was someone who was independent with their ADLs, mobility, and made their own decisions. When asked about Resident #149's goals, Staff M, AD, stated that since Resident #149 had impaired cognition, dependent on staff for assistance, and had mood concerns, the resident should not have been independent and the activity care plan should have been more individualized. Staff M, AD, further stated that she should have ensured residents' activity participation was documented including those that refused to participate and why, as well as revising the care plans when the interventions were not effective or individualized. In an interview on 03/04/20 01:42 PM, Staff A, Administrator (ADM), stated that the facility was not a typical skilled nursing facility and that the population tended to be higher functioning and short stay for rehabilitation. Staff A, ADM., further stated that it sounded like the program needed to be revised. Reference WAC 388-97-0940(1) .
F 0680 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure the activities program is directed by a qualified professional.** Based on interview and record review, the facility failed to ensure the qualified activity professional provided direct oversight to the activity program to see that it met the needs of the residents, implement individualized programs, monitor the responses and provide consistent documentation. This failure placed the residents at risk for boredom, decreased mood, cognitive decline, isolation and decreased quality of life. Findings included . Refer to F679 for additional information regarding the activity program In an interview on 03/05/20 at 9:30 AM, Staff M, Activity Director (AD), stated she worked eight hours a month in the facility supervising the activity program/department and the activity assistant as she mostly worked in the assisted living portion of the community. Staff M, AD, further stated that she was not aware Staff F, Activity Assistant (AA), did not document all activity interventions, participation record, appropriate goal setting and revising care plans when they were no longer effective. In addition, Staff M, AD, stated that she needed to work more directly with Staff F, AA, to ensure activities were individualized, met the residents' needs and preferences in conjunction with therapy goals. In an interview on 03/04/20 at 1:42 PM, Staff A, Administrator, stated that it sounded like the program needed to be revised and include more oversight. Reference WAC 388-97-0940(3)(a-c) .
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 interview and record review, the facility failed to ensure all nursing assistants (NA's) had performance reviews conducted annually and received their mandatory 12 hour annual training for five of five NA Staff (Staff G, H, K, F and J). This placed residents at risk for receiving substandard quality of care and decreased quality of life. Findings included . All employee record reviews were conducted on 03/06/20 unless otherwise specified. Review of Staff G, Nursing Assistant Certified (NAC), personnel file, showed that the staff member was hired on 03/28/97. The personnel file also showed that the last performance review was conducted on October 2011. Review of Staff H, NAC, personnel file, showed that the staff member was hired on 08/15/12, had 5.5 hours of required annual training since 01/01/19, and no performance reviews were included in the file. Review of Staff K, NAC, personnel file, showed that the staff member was hired on 07/15/14, had 5.5 hours of required annual training since 01/01/19, and no performance reviews were included in the file. Review of Staff F, NAC, personnel file, showed that the staff member was hired on 03/01/07, had 8 hours of required annual training since 01/01/19, and no performance reviews were included in the file. Review of Staff J, NAC, personnel file, showed that the staff member was hired on 10/07/02, had one hour of required training since 01/01/19 and no performance reviews were on file. In an interview on 03/06/20 at 9:30 AM, Staff A, Administrator, stated that the facility tracked the annual training from January to January, but did not ensure all staff had the training completed. Staff A, Administrator, stated, This is a system that we need to work on. Reference WAC 388-97-1680(1)(2)(a-c) .
F 0732 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Post nurse staffing information every day.** Based on interview and record review, the facility failed to consistently post actual hours worked by licensed and unlicensed nursing staff each shift, daily, to residents and visitors. This failure prevented residents, family members and visitors from knowing the facility's actual number of available nursing staff maintained by the facility. Findings included . Review of the forms titled, Staffing Pattern, and the daily staff postings for the dates of 01/27/20 through 02/25/20, showed the following days had discrepancies of actual hours worked between Registered Nursing and/or Nursing Assistant hours on at least one shift: 01/28/20, 01/29/20, 01/30/20, 01/31/30, 02/02/20, 02/03/20, 02/05/20, 02/06/20, 02/07/20, 02/08/20, 02/10/20, 02/14/20, 02/15/20, 02/17/20, 02/19/20, 02/22/20, 02/23/20 and 0[DATE]. In an interview on 03/09/20 at 8:29 AM, Staff A, Administrator (ADM), stated that she was not aware that there were discrepancies between two forms and that she needed to review and change the system how to calculate and report to ensure that the actual hours posted were accurate. No Reference WAC .
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure proper monitoring and appropriate administration of a medication which affected blood pressure and abnormal involuntary movements was in place, for one of five residents (Resident #5), reviewed for unnecessary medications. This failure placed the resident at risk for adverse medication side effects, discomfort, and medical complications. Findings included . Review of the admission Minimum Data Set (MDS, a required assessment tool), dated 12/22/19 showed that Resident #5 was admitted on [DATE] with [DIAGNOSES REDACTED]. The MDS further showed that the resident was alert and oriented, required extensive two-person assistance with bed mobility, transfers, toileting, hygiene and extensive one-person assistance with dressing. Resident #5 was able to make all his needs known. BLOOD PRESSURE MONITORING Review of the February 2020 Medication Administration Record [REDACTED]. In addition, the order included licensed staff to hold for SBP (systolic blood pressure) less than 100. The MAR further showed that on 02/22/20 and 02/23/20, the SBP was 92. Both days the medication was administered. In an interview on 03/09/20 at 11:01 AM, Staff E, Care Manager/Registered Nurse (CM/RN), stated that it appeared that the licensed nurse administered the medication both days and should not have. ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS) Review of the February 2020 Medication Administration Record [REDACTED]. Review of Resident #5's health record on 03/04/20, showed that an AIMS could not be located. In an interview on 03/05/20 at 11:33 AM, Staff E, CM/RN, stated that the AIMS were located in the Evaluation section in the electronic health record. Staff E, CM/RN, further stated that she could not locate Resident #5's AIMS. Reference WAC 388-97-1060(3)(k)(i) .
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview and record review, the facility failed to perform proper serve food in a sanitary manner in one of two kitchen observations. The facility failed to perform hand hygiene when changing gloves and handling ready to eat foods after touching multiple surfaces. This failure placed residents at risk for cross contamination, food-borne illness

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) and decreased quality of life. Findings included . FOOD PREPARATION In an observation on 03/05/20 at 12:35 PM, Staff N, Cook, was prepping grilled cheese sandwiches. Staff N, Cook, wore gloves, grabbed the bread and Ziploc bag of cheese and put it on a parchment by the stove. Staff N, Cook, opened the bread bag, pulled out a stack of bread with her gloved hands and laid them out on the paper. Staff N, Cook, opened the Ziploc bag of cheese, pulled out a small stack with her gloved hands (same gloves), and placed two slices on each slice of bread. Staff N, Cook, took her gloves off, threw them away, picked up the Ziploc bag of cheese, closed it and put it back in the refrigerator. Staff N, Cook, walked back to the counter, grabbed a spatula and frying pan, put on new gloves, picked up the bread in her left gloves hand and buttered it with her right with a paint brush, and put two sandwiches in the pan. In a continued observation on 03/05/20 at 12:38 PM, Staff N, Cook, took off her gloves, grabbed the spatula, looked at the underside of the grilled cheese sandwich in the pan, put the spatula down on the parchment paper, put a glove on her left hand, flipped the sandwiches in the pan while holding the spatula with the right hand and the sandwich with the left gloved hand. Staff N, Cook then took off her glove, adjusted the temperature on the stove top, got out the thermometer and checked the side of the sandwich, put a new glove on her left hand and grabbed a spatula in the right and flipped the two sandwiches and put them in the steam table at 12:41 PM. Staff N, Cook, continued to use the same method of buttering the cheese sandwiches while holding it with a gloved hand, touched the cheese sandwich in the frying pan with the same gloved hand and changed gloves multiple times without performing hand hygiene in between taking the gloves off and putting new ones on. Staff N, Cook touched multiple surfaces and the ready to eat foods without clean utensils or performing proper hand hygiene. TRAY LINE In an observation on 03/05/20 at 12:51 PM, Staff N, Cook, washed her hands, put on gloves and started tray line. Staff N, Cook, moved the lids from the pans on the steam table, took off her gloves, and threw them away. At 12:52 PM, Staff N, Cook, picked up a thermometer and temped the various foods before serving. Staff N, Cook, then put a glove on the left hand, grabbed a utensils with the right hand and put it in the pans on the steam table. In a continued observation on 03/05/20 at 12:58 PM, Staff N, Cook, took her gloves off and put new ones on. At 12:59 PM, Staff N, Cook, grabbed two plates, a hamburger bun and laid it in half on the plate, picked up the tongs, picked up the burger and put it on the bun, and touched the bread with the gloved hand. In an observation on 03/05/20 at 12:59 PM, Staff N, Cook, took her gloves off, threw them away, put new ones on and continued tray line. At 03/05/20 at 1:06 PM, Staff N, Cook, reached in the mashed potato pan with her gloved hands, picked up a smaller pan that sat in the mashed potatoes and moved them to another location in that same pan of mashed potatoes. Staff N, Cook, touched plates, plate warmers, and serving utensils. In a continued observation on 03/05/20 at 1:09 PM, Staff N, Cook, with the same gloved hands, grabbed tongs and picked up lettuce and tomato for the burger. Her gloved right hand touched a piece of lettuce. Staff N, Cook, donned and doffed gloves several times throughout tray line and did not perform hand hygiene in between. In addition, Staff N, Cook, touched multiple surfaces with her gloved hands and touched ready to eat foods. In an interview on 03/09/20 at 2:19 PM, Staff D, Culinary Services Director (CSD), stated that it was her expectation that when touching ready to eat foods that staff use clean utensils. Staff D, CSD, further stated that she expected staff to wash their hands with soap and water after taking off soiled gloves and before putting on new ones. Staff D, CSD, stated that Staff N, Cook, should have utilized both procedures to prevent cross contamination. Reference WAC 388-97-1100(3) & -2980 .
F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Implement a program that monitors antibiotic use.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement policies or practice appropriate use of antibiotics for five of seven residents (Resident #s 21, 23, 31, 106 and 156) when reviewed for antibiotic stewardship. In addition, the facility failed to regularly report on antibiotic use and resistance to relevant staff such as prescribing clinicians and nursing staff, develop protocols and systems to educate residents/families and providers about antibiotic stewardship. This failure placed the residents at risk to develop infections with bacterial organisms resistive to certain antibiotics, adverse outcomes associated with the inappropriate/unnecessary use of antibiotics. Findings included . Review of the November 2019 through February 2020 Antibiotic Surveillance Log, showed that each month there were residents identified that were prescribed antibiotics that did not meet McGeer's criteria, and no further documentation was provided. JANUARY 2020 Review of the January 2020 Antibiotic Surveillance Log showed that Resident #21 was admitted on [DATE] with urinary symptoms of dysuria, urinary frequency and urgency, suprapubic pain. According to the urinalysis (UA) results, the urine sample was contaminated, so the organism was not identified. The resident was started on [MEDICATION NAME] (antibiotic) on 01/28/20. The status of the infection because it does not meet criteria, due to a contaminated UA. It was unclear if the antibiotics were sensitive and actually treating the organism. In further review of the log, Resident #21 was changed to [MED] (antibiotic) on 02/02/20 through 02/05/20 due to complaints of nausea and vomiting. It was unclear if the nausea and vomiting was related to the antibiotic or worsening symptoms as no other notes were documented. FEBRUARY 2020 Review of the Review of the February 2020 Antibiotic Surveillance Log showed the following residents did not meet McGeer's criteria for antibiotic use: Resident #s 23, 31 and 106. In further review of the log, Resident #23 was admitted on [DATE], showing urinary symptoms including dark urine, which alone, did not meet criteria for a UA. The culture was performed on 02/13/20, two antibiotics ([MEDICATION NAME] and [MEDICATION NAME]) started on 02/22/20 and stopped on 02/28/20. Review of the log showed that Resident #31 was admitted on [DATE] with unknown urinary symptoms. A urine culture was obtained on 02/03/20, showing that it had urogenital flora (bacteria naturally occurring in the body) Review of Resident #106 showed that the resident was admitted on [DATE] with urinary symptom of urinary urgency and already started on [MEDICATION NAME] (antibiotic) with a stop date of 02/15/20. According to McGeer's it did not meet criteria for the use of antibiotics or obtaining a UA. No culture was located/obtained to verify the sensitivity of the antibiotic to the organism. NOVEMBER 2019 Review of the November 2019 Antibiotic Surveillance Log showed that Resident #156 did not meet McGeer's criteria for the use of an antibiotic. The resident was admitted on [DATE]. On 11/06/19, Resident #156 had a UA completed without any documented symptoms, which did meet criteria. Antibiotics were started and changed ([MEDICATION NAME] to [MED]) on 11/08/19 and discontinued on 11/17/20. In an interview on 03/04/20 at 1:13 PM, Staff L, Assistant Director of Nursing Services/Infection Control Preventionist (ADNS/ICP), stated that the facility identified infection control trends and discussed in monthly in the Quality Assurance meetings, identify any concerns and training needed. The analyses were included in the Quality Assurance (QA) Committee Meeting reviews, not in the logs. Staff L, ADNS/ICP, further stated that she was not aware of a program to educate residents, families or visitors on the Antibiotic Stewardship Program. Review of the Infection Control QA summaries, showed that antibiotic stewardship, trends and training were not discussed. In an interview and record review on 03/04/20 at 1:05 PM, Staff L, ADNS/ICP, stated that she did not recall any formal discussions regarding antibiotics and that they did not have any documentation regarding antibiotic stewardship trends, discussions or trainings. Staff L, ADNS/ICP provided additional follow-up documentation regarding physician's rationale for antibiotic use when McGeer's Criteria was not met, to include specific residents, Resident #s 21, 23, 31, 106 and 156. Staff L, ADNS, ICP, further stated that there were physicians identified that prescribed antibiotics when it was not indicated, but unsure if the medical director was included in training/educating those physicians. In addition, the follow-up information reviewed on specific residents included sooner stop dates of antibiotics and responses from physicians if they were or were not in agreement with the discontinuance of the antibiotic when the criteria was not met. All the follow-ups were not updated in the log or discussed in QA. In an interview on 03/04/20 at 1:42 PM, Staff A, Administrator, stated that she received the data and reports from the infection control log and analyzed it monthly in the Quality Assurance committee. Staff A, ADM, further stated that they discussed antibiotic stewardship in QA meetings, but did not document the analysis. In addition, Staff A, ADM stated that the analysis did not include if there were physicians identified that trended to prescribe antibiotics unnecessarily or ensure a program was implemented for residents and family members to educate them on antibiotic stewardship. No Reference WAC. .
F 0947 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.** Based on interview and record review, the facility failed to ensure nursing assistants (NAs) had the required abuse prohibition and/or dementia management trainings annually for five of five staff (Staff #s G, H, K, F and J). This placed the residents at risk for unmet care needs. Findings included . All record review of personnel files occurred on 03/06/20 unless otherwise specified. Review of facility training records showed that Staff G, Nursing Assistant Certified (NAC), did

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