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	495105	A. BUILDING _____ B. WING _____	C 07/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNCHBURG HEALTH & REHABILITATION CENTER	5615 SEMINOLE AVENUE LYNCHBURG, VA 24502

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 7/5/2022 through 7/6/2022. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Three complaints were investigated during the survey: VA00055537 substantiated with deficient practice. VA00054712 substantiated with deficient practice. VA00054713 substantiated with deficient practice. The census in this 180 certified bed facility was 144 at the time of the survey. The survey sample consisted of three current resident reviews and two closed record reviews.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review, facility document review and during a complaint investigation, the facility staff failed to follow physician orders for 2 of 5 residents in the survey sample, Resident #1 and Resident #5. 1. Resident #1 did not receive the medication	F 684	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or	8/9/22

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

Electronically Signed | 07/20/2022

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F 684	Continued From page 1 Levothyroxine Sodium Table 137 MCG (Synthroid) as ordered by the physician. 2. Resident #5 did not receive the TED hose as ordered by the physician. The findings include: 1. Resident #1 was admitted to the facility with diagnoses that included cellulitis, collapsed fractured vertebra, hypo-osmolality, hyponatremia, right breast cancer, hypothyroidism, hypertension, type 2 diabetes, and COPD. The nursing admission assessment dated 02/21/22 assessed Resident #1 as cognitively intact, alert and oriented x4 (person, place, time and situation). The admission assessment documented Resident #1 as incontinent of bladder related to impaired immobility and incontinent of bowels. Resident #1 was assessed as rarely having pain within the last 5 days prior to admission to the facility and rated the pain as a 2 out of 10. Resident #1 was assessed as requiring setup/clean up assistance for eating and oral hygiene; partial/moderate assistance for toileting, transfers, bed mobility, and ambulation. Resident #1's closed clinical record was reviewed on 07/05/22. Observed on the order summary report was the following order "Levothyroxine Sodium Tablet 137 MCG (Synthroid). Give 1 tablet by mouth everyday. Start Date: 02/23/22 at 0600 (6:00 a.m.)." Resident #1's medication administration record (MAR) for February 2022 was reviewed and did not document that Resident #1 received the Synthroid medication. Resident #1's clinical record included the hospital	F 684	will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F-684 Resident # 1 is no longer in the facility. Resident # 5 is currently having his TED stockings applied as per physician orders. Residents with orders for TED stockings have the potential to be affected, as well as current residents in the center who receive medications. Licensed nurses will be educated by the SDC/ Designee on ensuring MD orders are entered accurately in the EHR on new admissions/readmissions and on following MD orders for applying TED HOSE. The DON/ Designee will monitor residents with orders for TED stockings via direct observation 5x weekly to ensure residents have TED stockings applied as ordered. In addition, orders for new admissions/readmissions will be reviewed to ensure orders have been entered correctly into the EHR. Results of the monitoring will be presented to the QAPI Committee for review and discussion, once the committee determined the problem no longer exist then random monitoring will be conducted. Date of completion: August 9, 2022	

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discharge summary dated 02/21/2022. A review of the hospital's discharge instructions, orders, and medications documented the following, "Levothyroxine 137 Micrograms Oral (given by mouth) every day. Last dose 02/21 7:39 a.m. Next Dose: 02/22 6:00 a.m."

On 07/06/2022 at 7:50 a.m., the registered nurse (RN #3) who was identified as the nurse who entered Resident #1's orders into the electronic system was interviewed regarding the missed dose of the Synthroid medication. RN #3 stated she reviewed Resident #1's clinical record and determined the order was either entered incorrectly or the system switched the medication to start on the next day (2/23/22) at 6:00 a.m. instead of 2/22/22 at 6:00 a.m. RN #3 continued and stated the system may have switched the date because the order was entered after midnight on 02/22/2022. RN #3 stated this is why Resident #1 may not have received Synthroid medication.

On 07/06/2022 at 8:55 a.m., during a meeting with the administrator, the director of nursing (DON) and corporate consultant, the facility's administration team were interviewed regarding how orders were received, verified and entered into the clinical record. The corporate consultant stated the orders were reviewed on the hospital's discharge summary and then entered into the electronic record. The DON & corporate consultant were advised the hospital discharge summary documented the Synthroid medication was to start on 02/22/22 at 6:00 a.m., however Resident #1's clinical record documented the medication was to start on 02/23/22 at 6:00 a.m.

No additional information was received by the

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survey time prior to exit on 07/06/2022 at 12:00 noon.

This is a complaint deficiency.

2. Resident #5 was admitted to the facility with diagnoses that included cerebral infarction with hemiplegia/hemiparesis, edema, hypertension, atrial fibrillation, glaucoma, major depressive disorder, hyperlipidemia and gastroesophageal reflux disease. The minimum data set (MDS) dated 5/6/22 assessed Resident #5 as cognitively intact.

On 7/5/22 at 5:00 p.m., Resident #5 requested if the survey team could check on the status of his TED (support) hose. Resident #5 stated he had swelling in both feet and lower legs and was supposed to wear TED hose during the day. Resident #5 stated he had asked nurses about the TED hose several times and was told they were checking on them. Resident #5 stated it had been months since he had worn TED hose. Resident #5 was observed at this time with socks and sneakers on without TED or any type of support hose in use. The resident's ankles were swollen with the left ankle larger than the right.

On 7/6/22 at 8:30 a.m., Resident #5 was observed in a wheelchair in the courtyard area. The resident was wearing sock/shoes with no TED hose. Resident #5 stated he took medication that helped with the swelling but wanted the TED hose to help support his swollen feet/ankles.

Resident #5's clinical record documented a physician's order dated 6/9/20 for "Ted hose on in

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F 684	Continued From page 4 AM [morning] and off HS [bedtime] every day and evening shift for edema." Resident #5's treatment administration record (TAR) for 7/1/22 through 7/5/22 documented the TED hose were on/off each day as ordered. Nursing notes for 7/1/22 through 7/5/22 made no mention of the resident's TED hose. On 7/6/22 at 8:32 a.m., the licensed practical nurse (LPN #4) caring for Resident #5 was interviewed about the TED hose. LPN #4 stated she was not aware of the TED hose order but had not cared for Resident #5 recently. On 7/6/22 at 8:40 a.m., the registered nurse unit manager (RN #1) was interviewed about Resident #5's TED hose. RN #1 stated the resident had not approached her about getting TED hose and she was not aware he did not have the hose. RN #1 stated, "He's [Resident #5] supposed to have them [TED hose]." RN #1 stated the floor nurses were supposed to verify the resident's use of the TED hose each day and evening shift. RN #1 did not know why nurses signed off the TED hose were in use if the resident did not have them. This finding was reviewed with the administrator, director of nursing and corporate nursing consultant during a meeting on 7/6/22 at 10:40 a.m.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		8/9/22

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F 689	Continued From page 5 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to ensure safety while providing incontinence care for one of five residents in the survey sample. Resident #2, dependent upon staff for all mobility and personal care needs, fell from the bed when turned by a staff member during provision of incontinence care. Staff failed to follow the resident's plan of care for two-person assistance and failed to safely turn the resident in bed when the fall occurred. The resident experienced a "goose egg" and a bleeding abrasion/laceration to the forehead from the fall. Resident #2 became unresponsive on the way to the hospital and was pronounced dead upon arrival at the emergency department. The findings include: Resident #2 was admitted to the facility with diagnoses that included cerebral infarction, right hand contracture, diverticulosis with gastrostomy, dysphagia, adult failure to thrive, Alzheimer's disease, diabetes, major depressive disorder, hypertension, hyperlipidemia, dysarthria and constipation. The minimum data set (MDS) dated 5/30/22 assessed Resident #2 with short and long-term memory problems and moderately impaired cognitive skills. This MDS listed the resident as non-verbal with impaired range of motion in both upper extremities and was assessed as totally dependent upon staff for	F 689	F-689 Resident # 2 is no longer in the facility. Current residents who required assistance with bed mobility during incontinence care have the potential to be affected. The DON/SDC will educate clinical staff on using the Mosby Manual for LTC Nursing Assistants as per the policy on bed mobility for residents requiring incontinence care. The DON/ Designee will observe via direct observation 5 residents weekly during incontinence care to ensure the proper bed mobility/assistance is used. Results of the monitoring will be presented to the QAPI Committee for review and discussion, once the committee determined the problem no longer exist then random monitoring will be conducted. Date of Completion: August 9, 2022	

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hygiene and requiring the extensive assistance of one person for bed mobility.

Resident #2's closed clinical record documented a nursing note dated 6/11/22 stating, "This writer entered room and observed resident lying supine on the floor mat in between the two beds, writer observed raised area roughly the size of a quarter on the left side of forehead near eyebrow, and abrasion to left side of forehead. Resident was calm, no s/s [signs/symptoms] of distress or pain...chest rise ready and regular. CNA [certified nurses' aide] instructed to hold pressure to abrasion that was bleeding while writer call the on call MD [physician] and nursing manager. At 1850 [6:30 p.m.] new order to send resident to ER [emergency room] was obtained...EMS [emergency medical services] arrived at 1855 [6:35 p.m.] and assumed care of resident..." (Sic)

A change in condition communication form dated 6/11/22 documented Resident #2's vital signs after the fall were: blood pressure 142/81; pulse rate 104; respiration rate 20; temperature 97.2; blood glucose 140 and pulse oximetry 95.0%. A transfer form dated 6/11/22 documented the resident as a high fall risk with wounds listed as, "...bleeding coming from her head and a goose egg."

Resident #2 became unresponsive on the way to the hospital and was pronounced dead upon arrival at the emergency department. The emergency room physician's note dated 6/11/22 documented, "...pt [patient] arrived from [facility] via EMS after a witnessed fall. Per EMS the pt was responsive on arrival, but became unresponsive and pulseless during transport..." The ER physician's note documented, "...The

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patient presents with a heart rate of 40 with pulseless electrical activity. There were no palpable pulses and no organized cardiac activity on bedside ultrasound...We decided to terminate the resuscitation...Patient was pronounced dead at 1944 [7:44 p.m.]..." The ER report listed the resident was assessed with an unspecified fall, unspecified head injury and cardiac arrest upon arrival. The report documented no cause of death.

A facility reported incident form dated 6/12/22 documented Resident #2 rolled from the bed while CNA #2 was providing incontinence care on the evening of 6/11/22. The facility's investigation dated 6/17/22 documented, "...Primary CNA was interviewed and stated the following: resident turned over onto left side while in bed due to bowel movement that needed to be addressed, resident was noted to hold onto the grab bar with right hand. When CNA went to reach for wipes to clean resident, [Resident #2] adjusted her grip on the bar and momentum carried her forward and over the side of the bed. A fall mat was present on the floor in between resident's bed, resident was observed supine on the floor, a raised area to the left forehead and a laceration with a moderate amount of bleeding was present to forehead as well..."

The facility's investigation included written statements from staff members caring for the resident and/or working on the resident's unit at the time of the fall.

A written statement dated 6/11/22 by CNA #2 who was providing care for Resident #2 at the time of the incident documented, "...CNA assisted Resident onto her left side to be cleaned.

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Resident grabbed the left railing and gripped it tightly. When resident grabbed railing she rolled over the left side of the bed onto the floor mat. CNA was on the right side of the bed and was placing brief under resident until fall. CNA called for help and checked on resident..."

A written statement dated 6/11/22 by licensed practical nurse (LPN) #5 working on Resident #2's unit at the time of the fall documented, "...I heard the CNA [#2] ...yell and I saw another CNA run down the hall...I came out and went into [Resident #2's] room and saw her lying on the floor mat in between both beds...resident was alert and awake...I noticed blood coming from her head and a goose egg showing up on her forehead...I called 911 and they got here fast..."

A written statement dated 6/11/22 by TNA [temporary nurses' aide] #3 who was working on Resident #2's unit at the time of the fall documented, "...CNA called my name asking for help looking frantic so I ran down the hallway and enter room...CNA was holding the end of the bed looking red in the face. Then the nurse came in asking what happened and that's when CNA [#2] said that [Resident #2] had fell off the bed so I went around and seen... that her body was on the floor mat while her head was under her roommate's bed. Then I went toward [Resident #2] and removed her head from under the bed and seen a pool of blood so I asked the CNA to give me a washcloth so the injury could be compressed to stop further bleeding..." (Sic)

Resident #2's clinical record documented the resident was at risk of falls due impaired mobility and cognitive impairment. A fall risk assessment dated 2/27/22 documented the resident's fall risk

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factors included impaired vision, inability to stand or ambulate, inability to perform range of motion, incontinence, improper positioning while in a chair (slouching, leaning), requirement for two-person assistance with transfers and use of a Geri (reclining) chair when out of bed.

Occupational therapy (OT) evaluated and treated Resident #2 from 5/24/22 through 6/3/22 due to impaired upper extremity mobility. The OT evaluation dated 5/24/22 documented the resident as "...Non-verbal, cooperative at times, moderately resistive to RUE PROM (right upper extremity passive range of motion), significantly resistive to LUE PROM (left upper extremity passive range of motion) exercises, unable to follow one-step commands..." The OT evaluation listed the resident had a contracture of the right hand, was dependent upon staff for oral hygiene, toileting, bathing and upper and lower body dressing with severely impaired decision-making and impaired safety awareness.

Resident #2's plan of care (reviewed/revised 6/8/22) documented the resident had ADL self-care deficit due to history of stroke and Alzheimer's dementia. Interventions to maintain ADLs documented a requirement for two-person assistance for bed mobility and two-person assistance with transfers using a mechanical lift. The care plan documented the resident was always incontinent of bowel/bladder and required total assistance for dressing and hygiene. The care plan listed the resident was non-verbal and "likes to chew on her fingers..." Interventions to meet basic needs were listed as, "Anticipate and meet needs." The care plan documented the resident was at risk of falls and was unaware of safety needs. Interventions to prevent falls

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included, "Anticipate and meet The resident's needs...Assist bars & Geri-chair... Be sure The resident's call light is within reach and encourage the resident to use it...Fall Education...Keep environment free of trip hazards..." (Sic) The requirement for two-person assistance with bed mobility listed under ADL care had been in place and was last revised on 6/3/19.

On 7/5/22 at 12:40 p.m., CNA #2 that was with Resident #2 at the time of the fall on 6/11/22 was interviewed. CNA #2 stated around 6:30 p.m. on 6/11/22, she rolled Resident #2 onto her left side to provide a brief change. CNA #2 stated the resident was only able to move her hands and described the resident's body as "very stiff." CNA #2 stated after she positioned the resident onto her side, with her hand on the resident's hip, she reached back 180 degrees to get the wipes. CNA #2 stated the resident then gripped the bed rail and this moved the resident toward the rail. CNA #2 stated the resident continued in motion and rolled off the bed onto the floor mat. CNA #2 stated she was on the opposite side of the bed facing the resident's backside and stated concerning the fall, "I could not stop her." CNA #2 stated after the fall, the resident's forehead had a "goose egg" and was bleeding. CNA #2 stated there were no other staff members in the room at the time of the fall and TNA #3 and LPN #5 came to the room after she called for help. When asked what assistance was required when turning Resident #2 in bed, CNA #2 stated she mostly changed the resident by herself. CNA #2 stated the resident was "very stiff" and if a staff person was not familiar with the resident or not strong enough, two people would be needed to provide safe care. CNA #2 stated again, "I usually do her by myself." CNA #2 stated she

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was familiar with Resident #2 and that her trainer told her she could provide care for Resident #2 with one person. CNA #2 did not remember the name of her CNA trainer. CNA #2 stated she used two people for transfers because the resident required a mechanical lift. CNA #2 described the resident as non-verbal and as dependent upon staff for moving and turning in bed. CNA #2 stated the resident was "total care" and "did nothing for herself." CNA #2 stated the resident's right hand was contracted and she sometimes put a washcloth in the hand to help with moisture.

On 7/5/22 at 1:09 p.m., TNA #3 working on Resident #2's unit at the time of the fall was interviewed. TNA #3 stated on the evening of 6/11/22, CNA #2 came in the hall and asked for help. TNA #3 stated she and LPN #5 went to Resident #2's room and found her on the floor on her back beside the bed. TNA #3 stated the resident's forehead was bleeding and she put pressure on the wound with a cloth to stop the bleeding. TNA #3 stated she had worked in the facility about three months and had previously cared for Resident #2. TNA #3 stated the resident was totally dependent for care and required two people for bed mobility and transfers. TNA #3 stated Resident #2 "did not move" and was non-verbal. TNA #3 stated she previously cared for Resident #2 and stated, "I used two persons always with her."

On 7/5/22 at 2:50 p.m., the physical therapy assistant (PTA)/assistant rehab manager (other staff #3) was interviewed about Resident #2. The PTA stated the resident was evaluated and treated in May 2022 for impaired range of motion focusing on the right shoulder and elbow. The

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	495105	A. BUILDING _____ B. WING _____	C 07/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYNCHBURG HEALTH & REHABILITATION CENTER	5615 SEMINOLE AVENUE LYNCHBURG, VA 24502

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PTA stated Resident #2 was unable to straighten her right arm even after therapy.

On 7/5/22 at 4:25 p.m., the director of nursing (DON), administrator and corporate nursing consultant (administration staff #3) met with the survey team about Resident #2's fall of 6/11/22. The nursing consultant stated they had reviewed the incident and the only issue identified was that the care plan had not been updated to indicate the resident required one-person assistance for bed mobility. The nursing consultant stated the reason the care plan needed updating was so the required bed mobility assistance would match the MDS. The survey team asked for a rationale of why the required amount of assistance for Resident #2 would be decreased and if there had been an improvement in her condition that changed her needs. There were no reasons provided by the nursing consultant or DON about why the resident's mobility assistance needed to change from two-person to one-person other than to match the MDS.

On 7/5/22 at 4:45 p.m., CNA #4 that routinely cared for Resident #2 was interviewed. CNA #4 described Resident #2 as "non-verbal and non-moving." CNA #4 stated two people were always required when performing incontinence care or transferring Resident #2. CNA #4 stated she got information about resident needs at shift change from other CNAs. CNA #4 stated she always changed Resident #2's brief with one person on one side of the bed and another staff person on the opposite side of the bed.

On 7/5/22 at 4:55 p.m., LPN #3 that routinely cared for Resident #2 was interviewed. LPN #3 described Resident #2 as "total care." LPN #3

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stated the resident required a mechanical lift for transfers and required two people for bed mobility during incontinence care. LPN #3 stated the resident's body frequently "stiffens up" when moved making it more difficult to turn her in bed.

On 7/6/22 at 8:38 a.m., LPN #4 that routinely cared for Resident #2 was interviewed. LPN #4 stated she had cared for Resident #2 for years and was familiar with her needs. LPN #4 stated the resident was "total care" and a high fall risk. LPN #4 stated the resident could sometimes grab the bed rail but required assistance from staff for turning and was transferred with a mechanical lift. LPN #4 stated if one person provided incontinence care "you would have to use good body mechanics." When asked to explain, LPN #4 stated that meant pulling the resident toward you and not away from you. LPN #4 stated if the resident's foot, leg or upper body went over the bedside the resident was not able to hold herself or stop herself for falling. LPN #4 stated she always pulled the resident toward her when turning to prevent the resident from rolling or falling from bed.

On 7/6/22 at 8:40 a.m., the registered nurse unit manager (RN #1) was interviewed about Resident #2 and the fall on 6/11/22. RN #1 stated the resident's care plan required for two-person assistance with bed mobility and transfers and that requirement had been in place since 2019. RN #1 stated staff members including CNAs were expected to follow the plan of care for all residents. RN #1 stated, "The care plan states how we are supposed to care for residents." RN #1 stated Resident #2 at times nodded her head but had no upper body control or ability to manage movements in bed. RN #1 stated it was

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a standard of care to roll patients toward you and not away from you when rolling/turning in bed to ensure safety and prevent falls. RN #1 stated she did not know why CNA #2 turned the resident toward the opposite side of the bed on 6/11/22. RN #1 stated if unfamiliar with Resident #2, two staff persons were required to safely turn the resident for incontinence care.

On 7/6/22 at 8:50 a.m., the facility's TNA instructor (RN #2) was interviewed about the proper protocol for turning residents in the bed with one-person assistance. The TNA instructor stated if one person was providing care for a dependent resident, they should pull the patient toward them so that the patient's body movement could be controlled and falls prevented. The TNA instructor stated the resident was also supposed to be in the center of the bed and not near the edge when positioned laterally for care. The TNA instructor stated the only time it would be appropriate to roll a resident away from your body was with a staff person on each side of the bed to ensure safety. The TNA instructor stated this technique for turning residents safely was part of her instruction manual for nurse aides and was included on the examination for nurse aide certification.

On 7/6/22 at 9:08 a.m., the TNA instructor provided a copy of procedure 5-6 from her CNA instruction manual titled "Turning a Resident from Supine to Side-Lying for Personal Care" (undated). The procedure documented steps for turning a resident to their side with one staff person as, "...Help the resident bend their knees and place their feet flat on the bed...Place one hand on the resident's shoulder that is farthest from you...Place you other hand on the hip

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farthest from you...On the count of three, help the resident roll toward you...Some residents may be more comfortable guiding the turn by holding on to the side rails..."

On 7/6/22 at 9:17 a.m., the DON and corporate nursing consultant met with the survey team regarding Resident #2's fall of 6/11/22. The nursing consultant stated CNA #2 "did nothing wrong" when Resident #2 fell from the bed on 6/11/22. The nursing consultant stated the resident was a one-person assist for bed mobility according to the MDS but the care plan had not been updated to reflect the one-person requirement. When asked if staff members were expected to follow the plan of care for residents, the nursing consultant stated CNAs went by the reports from nurses, reports from other CNAs, nursing assessments, shift reports, current status of resident and care given last. The nursing consultant stated, "Things change rapidly." When asked if there was anything identified as needing correction and/or improvement based on investigation of Resident #2's fall, the nursing consultant stated, "Everything was done right." The nursing consultant stated if a resident had plenty of room and could hold the bed rail, he had no problem rolling/pushing the resident away from him during care as long as the legs and arms were secured. When asked who was supposed to ensure safety for Resident #2 when she was turned in bed, the nursing consultant stated it was the responsibility of all staff members in the facility to keep residents safe. The nursing consultant stated nothing was identified that should have been done differently and described the incident as "an unfortunate accident."

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On 7/6/22 at 10:35 a.m., the survey team met with the administrator, DON and corporate nursing consultant. During this meeting the survey team reviewed the additional interviews obtained with the unit manager (RN #1), TNA instructor (RN #2) and other staff members (CNA #4, LPN #3, LPN #4) that routinely cared for Resident #2. The nursing consultant stated these interviews were staff members "just talking to a surveyor." The nursing consultant stated the unit manager's (RN #1's) response that two people were required with Resident #2 and that residents should be pulled toward you and not away when turned was "speculating". The nursing consultant stated, "This was just her (RN #1) talking to a surveyor." The nursing consultant stated he did not know where the information about how to turn a resident to side-lying position presented by the TNA instructor came from. The administrator and DON offered no further information or comment about Resident #2's fall on 6/11/22.

CNA #2's most recent in-service education was dated 4/6/22 and included requirements for mandated reporting related to abuse/neglect, protocols for standard precautions/blood borne pathogens, a fall prevention in-service quiz, a test about use of positioning devices and a fall facts quiz.

These findings were reviewed with the administrator, DON and corporate nursing consultant during a meeting on 7/6/22 at 10:40 a.m.

This is a complaint deficiency.