STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265108	A. Building B. Wing	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beth Haven Nursing Home	2500 Pleasant Street Hannibal, MO 63401

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32899 Based on interview and record review, the facility failed to initiate cardiopulmonary resuscitation (CPR, a procedure to support and maintain breathing and circulation for a person who has stopped breathing and/or whose heart has stopped) for one resident (Resident #1) identified as having a full code status (CPR required in the event of cardiac or respiratory arrest). Staff found the resident unresponsive and without a pulse or respirations on [DATE] and failed to initiate CPR and call 911. The resident expired at the facility. The facility also failed to implement the facility policy addressing CPR requirements for staff and to monitor to ensure CPR certified staff were scheduled and present in the facility 24 hours a day, seven days a week. This failure affected 28 residents who were identified as full code status. The facility census was 76. The administrator was notified on [DATE] at 6:26 P.M., of the Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE], as confirmed by the surveyor onsite verification. Review of the facility policy, Medical Emergencies, last revised [DATE] showed it was the policy of the facility to provide treatment to consumers in the event of emergency situations. If the consumer is in an emergent situation staff should call for nearby help, assess for breathing and pulse before fully activating 911. Staff should then call 911 and immediately start CPR or alternative rescue efforts as ordered and approved by physician and guardian. After consumer is transported by emergency services staff are to notify the guardian, service coordinator, and director of homes. The charge person on duty is to call report to the emergency room nurse. Staff may then notify the physician of the transport by Emergency Medical Services (EMS) and consumer status as a courtesy call. 1. Review of Resident #1's advance directive form signed and dated on [DATE] showed the resident chose to have Life-saving Codes (CPR). Review of the resident's care plan, last revised on [DATE], did not include advanced directive information. Review of the resident's Physician Order Sheet (POS) dated ,d+[DATE] and signed by the physician showed the following: -Full code. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the resident's progress notes dated [DATE] at 6:42 A.M., showed Certified Nurse Assistant (CNA) called this nurse to the resident's room. When the nurse got to the resident's room the resident was in his/her bed and had passed away. Time of death was 4:27 A.M. Family was called and said for the facility to go ahead and call the funeral home. Funeral home phoned at 5:00 A.M. and resident was picked up by funeral home at 5:30 A.M. Physician was notified by fax. Coroner notified by phone and notification of death was faxed to the coroner's office. During interview on [DATE] at 2:45 P.M. CNA C said the following: -He/She worked with Licensed Practical Nurse (LPN) A and CNA I on the east unit on [DATE]; -He/She had last seen the resident around 2:30 to 2:45 A.M. on [DATE]; -The resident had not had any complaints on his/her shift and had been talking and eating. The resident was alert and oriented per his/her usual; -When he/she entered the room at 4:00 or 4:15 A.M. to check the resident, the resident's body was cold to touch and he/she did not move. He/She said the resident's name with no response. The resident's left eye was open; -He/She exited the room and called for the charge nurse (LPN A); -LPN A responded immediately and sent him/her to get LPN B from the [NAME] unit; -He/She did not see any staff initiate or perform CPR; -Staff did not take crash cart items into the room when they responded; -He/She was CPR certified, but the facility did not allow CNAs to perform CPR; -He/She found out (after the incident) that the resident was a full code. During interview on [DATE] at 5:55 P.M. LPN A said the following: -He/She worked as the east charge nurse from 7:00 P.M. to 7:00 A.M. on [DATE]; -He/She was the nurse for the resident; -He/She was currently CPR certified; -CNA C notified him/her that he/she thought the resident was gone (not breathing). Before this no one had reported the resident having any complaints or in any distress; -He/She responded immediately and observed the resident on his/her back, not breathing; -He/She checked for a pulse, breath sounds and a heart beat; (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-He/She ran to look at the resident's chart to find the resident's code status and according to the chart, the resident was a full code; -He/She did not initiate CPR or phone 911 as the resident was clearly gone (hands had begun to turn cold to touch, mouth open and fixed and his/her skin was yellowish (jaundice-like)). He/She did not see any mottling, purplish or blue skin, or observe stiffening of the extremities. The resident's mouth appeared stiffened and staff had to close it; -He/She had LPN B assess the resident for heart beat and breaths; -He/She was trained to initiate CPR immediately and call 911 for a resident who stopped breathing and was a full code. During interview on [DATE] at 3:12 P.M. LPN B said the following: -He/She worked as the charge nurse on west unit on the night shift on [DATE]; -CNA C arrived on his/her unit and said he/she was needed on east unit; -He/She had never seen the resident before; -LPN A asked him/her to assess the resident; -He/She auscultated for a heartbeat for one to one and a half minutes and visualized the resident for respirations. The resident did not have a heartbeat or respirations. The resident felt cold to touch, was mottled and his/her left eye and mouth were open; -Neither he/she or LPN A initiated CPR; -He/She said LPN A asked her to call it (verify death), and that it was clear the resident was deceased . 2. Review of the facility's nursing schedule dated [DATE]-[DATE] showed the facility did not have CPR certified staff in the building on the following shifts: -On [DATE] from 5:00 P.M. to 7:00 A.M.; -On [DATE] from 3:00 P.M. to 7:00 A.M.; -On [DATE] from 7:00 P.M. to 7:00 A.M.; -On [DATE] from 7:00 P.M. to 7:00 A.M.; -On [DATE] from 7:00 P.M. to 7:00 A.M.; -On [DATE] from 7:00 P.M. to 7:00 A.M.; -On [DATE] from 7:00 P.M. to 7:00 A.M.; (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-On [DATE] from 7:00 P.M. to 7:00 A.M.; -On [DATE] from 7:00 P.M. to 7:00 A.M.; -On [DATE] from 7:00 P.M. to 7:00 A.M.; -On [DATE] from 7:00 P.M. to 7:00 A.M.; -There were a total of 11 shifts from ,d+[DATE] to [DATE] with no CPR certified staff in the building where 28 full code residents resided. 3. During interview on [DATE] at 12:54 P.M., CNA F said CNAs were not supposed to perform CPR at the facility, only the nurses could initiate CPR. During interview on [DATE] at 7:49 P.M., the Director of Nursing (DON) said the following: -She would expect staff to initiate CPR and call 911 if they found a non-breathing, full code resident; -She would expect CPR certified staff to be available on all shifts if full code residents resided in the building; -Her CPR certification was expired upon hire and he/she had informed the previous DON who said they taught classes in the facility. During interview on [DATE] at 6:30 P.M., the administrator said the following: -She was currently responsible for the nursing schedule; -She did not have a complete list of CPR certified staff; -All of the licensed nurses should be CPR certified; -She did not know the reason, but CNAs were not able to do CPR in the facility; -She would expect staff to start CPR and call 911 if a full code resident was found unresponsive. During interview on [DATE] at 11:30 A.M. the physician said the following: -He/She would expect staff to initiate CPR on a full code resident when found unresponsive; -Calling 911 should be routine with CPR; -He/She would expect the facility to have CPR certified staff coverage on all shifts given that they had 28 full code residents in house. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level K. Based on observation, interview, and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the E level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violations(s). MO#00193035

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30813 38016 Based on interview and record review, the facility failed to provide adequate supervision and oversight to prevent falls for one resident (Resident #3) in a review of 32 sampled residents including Resident #3's closed record. Staff failed to implement fall prevention interventions as indicated on the resident's care plan and failed to provide safe transfers as directed by the resident's plan of care and physician's orders. The resident had multiple falls with injuries including a fractured right leg. The facility census was 73. Review of the facility Fall Management Program policy, dated 9/17/21, showed the following: -A fall referred to any unintentional downward motion that the resident was unable to recover from without assistance, whether they came to rest on the floor, ground, or other lower lever. An episode where a resident lost his/her balance and would have fallen, if not for staff intervention was considered a fall. When a resident was found on the floor, unless there was suggestion otherwise, a fall was considered to have occurred; -The facility would systematically assess resident and evaluate fall situation and potential situation with the goal of identifying common fall risk factors and develop care plan interventions to mitigate potential harm; -A fall risk evaluation of preadmission information concerning lift style factors, fall history and medical information would be reviewed when available. The admission team would determine upon review of the information if the facility could safely provide appropriate care for the resident; -All resident's would be assessed by a licensed nurse on admission, quarterly, and/or upon a significant change in the resident's condition; -An interdisciplinary team would meet on a regular basis to discuss individuals who had a history or at a high risk of falling and develop a plan to lower the risk potential for future falls; -All staff members were responsible for seeking out, removing, and reporting potential fall hazards; -A fall prevention checklist included, in part, knowing the residents mobility status and follow the resident care plan for proper transfers and ambulation. Utilize fall risk assessments on admission, quarterly, and as needed. For most residents, keep bed in the lowest position, except during care, being careful to insure bed was in the low position before exiting the room after care. Dress the resident with easy to manage clothing when possible. Do visual checks often on all residents; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Equipment use checklist included, in part, to check wheelchairs, bed, walkers, and canes often and report any non-working brakes and broken equipment. Use all seating items ordered for each resident. Report to the charge nurse, any resident who leaned over, slid down, or leaned to one side while seated in a wheelchair. Use gait belts for all transfers and ambulation with those resident who needed assistance. Mechanical lifts were to be used with two staff members for resident safety; -Post fall management section included assessment of the resident immediately at the time of fall, evaluate resident vital signs, mental status change, and physical injury, keep resident immobile until assessment completed. Note any injury or complaints of pain. If a fracture was suspected or obvious obtain an x-ray and/or medical evaluation. Place the resident on alert charting list and document every shift for three days. Report all falls to the physician and family and provide neurological assessments as indicated. Complete the incident report form and initiate an investigation to determine the cause of the fall at the time of first assessment following the fall. The care plan team would discuss the falls on a regular basis and would develop a care plan about potential fall prevention measures and measures to minimize injury related to falls. 1. Review of Resident #3's undated face sheet (no date) showed the resident had diagnoses of stroke, kidney disease, history of falling, dementia, anxiety disorder, muscle weakness, arthritis, difficulty walking, unsteadiness on feet, abnormal gait and mobility, and altered mental status. Review of the resident's Fall Risk Assessment, dated 4/17/20, showed staff documented the resident had a history of one to two or more falls in the past month, was confused, and had a history of stroke and arthritis. He/She had decreased vision and hearing, incontinence of bladder, used a wheelchair or walker assistive device, had transfer difficulties, and unsteady gait. He/She took two medications that increased his/her risk of falls. Staff scored the resident at 17 indicating the resident was a high risk for falls (8 points or more indicated high fall risk). Review of the resident's care plan, updated 2/26/21, showed the resident was at high risk for falls related to multiple disease processes. Staff should not push the resident in the wheelchair without feet positioned on foot pedals. Staff should keep the bed against the wall and locked at all times, keep the call light within reach, glasses clean and free from scratches, and never leave the resident unattended while restless. Staff should keep items the resident might want within reach, staff should ensure the resident wore non-skid socks when legs were edematous instead of shoes, and keep the mechanical pad under the resident while in the recliner and wheelchair. Two staff members should transfer the resident until therapy deemed safe to change transfer status. Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 4/16/21, showed the following: -Short and long term memory problems; -Required extensive assistance of one staff member with bed mobility, dressing, and personal hygiene; -Required extensive assistance of two staff members with transfers and toileting; -Walking in room and corridor did not occur; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Not steady, only able to stabilize with staff assistance when moving from seated to standing position, moving on and off the toilet, and surface-to-surface transfers between bed and chair or wheelchair; -Impairment in functional range of motion on one side of the lower extremity; -Frequently incontinent of bowel and bladder; -No falls since admission or readmission. Review of the resident's care plan, updated 5/17/21, showed staff discontinued two staff member transfer intervention and implemented staff should transfer the resident with the mechanical lift (a mechanical device used for transfers that required a sling and hoist to raise and lower the resident from one surface to another) for all transfers. Review of the resident's nurses' note, dated 6/4/21 at 6:30 P.M., showed staff documented the following: -At 12:40 P.M. the resident was on the floor on his/her back with feet near the bed and head by his/her roommate's bed. The resident had external rotation to his/her left leg (leg turned out away from the body) and complained of pain when touched or rolled. A V-shaped skin tear to the left elbow was noted and a laceration on the bridge of the resident's nose. The resident had multiple bruises on his/her forehead, nose, and under the eyes. Bruising was noted on the resident's finger, hands, arms, and legs. The physician was notified and physician orders received to send the resident to the emergency room . The resident's family member was notified and the resident left the facility at 1:20 P.M. Staff asked the resident what happened and the resident said, I fell and cannot get up. Certified Nurse Assistant (CNA) staff said the resident had one leg behind the other and was trying to move in his/her wheelchair. The CNA staff turned around and saw the resident lean forward and before staff could get to the resident, the resident fell face first out of the wheelchair. The resident wore a gown and slippers. The resident returned from the hospital at 5:00 P.M. and sat in his/her recliner for supper; -At 6:44 P.M. the resident had returned with no fractures of nose, hip, or knees. Review of the resident's care plan showed no updated fall prevention interventions following the 6/4/21 documented fall. During interview on 11/10/21 at 8:10 A.M., Nursing Assistant (NA) J said the following: -On 6/4/21 he/she and CNA K were attempting to transfer the resident from the bed to the wheelchair with a two person assist and a gait belt. They could not get the resident to stand up. CNA K told him/her to go get the sit to stand mechanical lift. NA J left the resident's room and when he/she returned with the mechanical lift the resident was on the floor and bleeding from his/her elbow and had hit his/her face on the floor. CNA K said he/she transferred the resident by him/herself, the resident's feet got crossed during the transfer and the resident tried to reposition his/herself in the wheelchair. The resident fell out of the wheelchair onto the floor; (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-The resident usually had bruising on his/her arms, legs and to his/her rib areas. He/She thought the bruising was from staff trying to transfer the resident with a gait belt and staff pulling and lifting on the resident's arms and under the resident's arms. The resident previously could stand and hold his/her own weight, but the resident's balance was poor. The resident had poor eyesight and poor hearing. He/She required a bariatric bed (wider bed and mattress than a standard bed), a fall mat on the floor, and the bed in the lowest position near the floor. During interview on 11/10/21 at 12:55 P.M., CNA K said the following: -On 6/4/21 the resident was in bed and he/she transferred the resident from the bed to the wheelchair by him/herself with a gait belt. The resident's legs crossed during the transfer and he/she did not notice at the time the resident's legs were crossed. He/She lowered the resident into the wheelchair, turned around to place the gait belt in a chair and when he/she turned back around the resident tried to lift him/herself up and uncross his/her legs. The resident fell out of the wheelchair on his/her face and was transferred to the hospital by ambulance; -The resident sometimes required more assistance than other times during transfers; -He/She could transfer the resident by him/herself, because the resident trusted him/her; -Staff should keep the resident's bed close to the floor in the lowest position when the resident was in bed and place a fall mat on the floor; -He/She should follow the resident's care plan and transfer the resident with two person assist and a mechanical lift. During interview on 11/10/21 at 12:20 P.M., Licensed Practical Nurse (LPN) M said the following: -The resident's history included a stroke with inability to walk, but on admission could bear weight and pivot during a transfer to and from the chair. The resident should be a two person transfer and required staff to hold onto him/her at all times. The resident's balance was not good. The sit to stand lift caused bruising under the resident's arms and the mechanical lift caused bruising under the resident's legs. Staff obtained and started using a larger mechanical lift pad and staff could not find the larger lift pad on 6/4/21; -LPN M was the charge nurse on 6/4/21. NA J came out of the resident's room and said he/she was going to get the sit to stand lift. While NA J was out of the resident's room CNA K transferred the resident by him/herself. CNA K should not have transferred the resident by him/herself. The resident fell because staff transferred the resident inappropriately. The resident required a two person transfer at that time; -The resident's bed was supposed to be against the wall and in the lowest position with a mat on the floor. The mat was taken out of the room at some point and not brought back into the room. No mat was in the room on 6/4/21. Review of the resident's nurses' note, dated 6/14/21, showed LPN M documented the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-At 1:17 P.M. LPN M assisted a CNA to get the resident out of bed and the resident required both staff to physically lift him/her during the transfer. (Review of the care plan showed the resident required a mechanical lift for all transfers). The CNA took the resident to the shower and called for assistance to transfer the resident back to the chair. The resident would not take initiative to pull up on the grab bar on his/her own. The two staff members had to physically lift the resident into a standing position. Once standing the resident held onto the grab bar while his/her buttocks were dried. The resident could not stand long enough for proper drying and his/her clothing applied. LPN M spoke with therapy about interventions to try. The resident was changed from the sit to stand mechanical lift (mechanical device used for transfers that required an upper body sling wrapped around the resident's back and under the arms, attached to a machine that raised the resident to a standing position and allowed staff to roll the resident while standing on the lift platform from one surface to another and then lowered onto the alternate surface such as the toilet) due to bruising on the resident's back, flanks and upper arms from a mechanical lift. The resident was changed from the mechanical lift back to a two person assist due to the bruising left on the backs of the resident's mid-thigh. Staff planned to try a larger mechanical lift pad to see if it would work without bruising the resident; -At 7:06 P.M. the resident was now a mechanical lift transfer with his/her own lift pad with the resident's name on the pad. The lift pad was a larger size. Review of the resident's nurses' notes, dated 6/15/21 at 4:07 P.M., showed the resident's transfer status had changed to a mechanical lift with his/her own lift pad labeled with the resident's name. If the first pad became soiled another pad would be provided. Review of the resident's care plan showed no updated interventions directing staff on the resident's current transfer assistance requirements on 6/15/21. Review of the resident's Fall Risk Assessment, dated 7/9/21, showed staff documented the resident was incontinent of bowel and bladder, no longer required a walker, but continued to require a wheelchair assistive device. Staff scored the resident at 17 indicating the resident remained a high risk for falls (8 points or more indicated high fall risk). Review of the resident's quarterly MDS, dated [DATE], showed the following: -Short and long term memory problems; -Required total assistance of two staff members with transfers; -Always incontinent of bowel and bladder; -One fall with injury since admission or readmission. Review of the resident's physician's order sheet, dated 7/20/21, showed the resident could be up to the chair with two staff member assistance and a mechanical lift transfer. Review of the resident's nurses' notes showed staff documented the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-On 8/17/21 at 5:00 A.M. the resident was on the floor beside his/her own bed lying on his/her back. The resident was unable to rotate his/her left leg. Bruising and deformity noted to the right leg. The resident's pupils were not equal and would not dilate (not respond to light), the right pupil was pin sized. The resident complained of head pain and right leg pain. Upon observation the resident's call light was not within reach, appropriate footwear was not in place, the head of bed was elevated and in the highest position, and the room was dim. The resident was incontinent of bowel and bladder. The resident reported he/she attempted to transfer and walk to make breakfast. The resident was increasingly confused at this time and alert to self. Skin was warm/dry with edema (swelling), lungs diminished and wheezing noted (irregular lung sounds), heart rate irregular. Three staff assisted with the mechanical lift and transferred the resident to bed. The resident was transferred by ambulance to the hospital; -On 8/17/21 at 11:46 A.M. the resident returned to the facility at 10:30 A.M. with tibia and fibula fractures (both bones in the lower leg). The resident's family said they decided not to go with surgery as they did not want to put the resident through this. Review of the resident's x-ray report, dated 8/17/21, showed right thigh and leg pain. Fall at the facility that morning with previous history of hip and knee replacement. Findings of acute right proximal tibia and fibula fractures (both bones broken in the leg near the knee located in the lower leg). Review of the resident's care plan, updated 8/17/21, showed staff should keep the resident's bed in the low position when not providing the resident's care and place a mattress on the floor beside the resident's bed while the resident was in bed. During interview on 11/10/21 at 12:00 P.M., LPN L said the following: -He/She was the charge nurse on 8/17/21 when the resident fell out of bed. He/She was pretty sure the resident's leg was broken and he/she was worried both legs were injured as well as the resident's arm; -The resident was found on the floor. His/Her bed was against the wall in the high position and no fall mat or mattress was on the floor; -The resident's bed should have been in the lowest position with a mat or mattress on the floor; -The resident required a mechanical lift transfer and the bed in the lowest position while the resident was in bed; -The resident could not follow commands and other staff said the resident did not get up on his/her own. Review of the resident's Fall Risk Assessment, dated 10/8/21, showed staff documented the resident had history of two or more falls in the past month, and took three medications that increased his/her risk for falls. Staff scored the resident at 17 indicating the resident remained a high risk for falls (8 points or more indicated high fall risk). Review of the resident's annual MDS, dated [DATE], showed the following: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beth Haven Nursing Home	2500 Pleasant Street Hannibal, MO 63401

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	-Short and long term memory problems; -Required total assistance of two staff members with transfers; -Required total assistance of one staff member with toileting and personal hygiene; -One fall with major injury since admission or readmission. Review of the resident's x-ray report, dated 10/18/21, showed no evidence of union (healing) at the proximal tibia fibular fractures. Review of the resident's nurses' note, dated 10/18/21 at 4:09 P.M., showed staff documented the resident's x-ray showed the tibia and fibula were not healing, repeat x-ray monthly for four months. Review of the resident's nurses' note, dated 10/19/21 at 6:37 A.M., showed staff documented the resident was found sitting on the floor next to his/her bed at 5:10 A.M. The resident said he/she was trying to get to the recliner and slid off the bed onto the floor. During interview on 11/10/21 at 8:05 A.M., LPN N said the resident fell on [DATE]. CNA staff found the resident on the floor and the resident's roommate said the resident wiggled out on to the floor. The resident's bed was in the low position, but no fall mat was on the floor. Review of the resident's nurses' note, dated 10/23/21 at 6:30 P.M., showed staff documented the resident continued to try to climb out of bed and said he/she had to use the bathroom. Staff redirected the resident and a mattress was put by the bedside. Record review showed no documentation new interventions were put in place when the resident fell out of bed on 10/19/21 or when the resident continued to try to climb out of bed. During interview on 11/9/21 at 4:45 P.M., the MDS coordinator said he/she was in charge of completing residents' MDS' and care plans. A comprehensive care plan was completed as the admission MDS was completed. All residents care plans were posted in binders at the nurses' desk and all CNA staff had access to the residents care plans in the binders. Staff should assess the resident following a fall for injuries and provide care. Staff should then complete the fall investigation report. The Interdisciplinary Team (IDT) met weekly and updated resident care plans following the meeting with new fall prevention interventions or changes in the residents' care plans. The new interventions were reviewed at the change of shift team report and CNA staff signed the new care plan acknowledging they were aware of the changes or new interventions. During interview on 11/9/21 at 1:45 P.M., the Director of Nursing (DON) said staff should assess residents after every fall for injuries, complete a fall investigation report, figure out why the fall occurred and update the resident's care plan with new or changed interventions. The charge nurses should inform the CNA staff of any new fall interventions during the change of shift report. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During interview on 11/10/21 at 2:00 P.M., the DON said staff should follow the resident's care plan and transfer residents with the specified transfer equipment. If the care plan indicated a mechanical lift for all transfers, staff should not transfer the resident with a gait belt. Staff should ensure the residents are safe on all surfaces and during all transfers. Staff should place fall mats on the floor and place beds in the lowest position as directed. Staff should lower the resident's bed following cares before leaving the room. Staff should not leave the resident alone in the bed without placing the bed to the lowest position near the floor. The resident was a fall risk for a long time and required a fall mat and the bed in the lowest position at all times when not providing care. These interventions should have been in place prior to the 8/17/21 fall. During interview on 11/9/21 at 1:50 P.M., the administrator said staff should follow the fall policy and implement interventions to prevent falls. MO#192366 MO#191123 MO#186569 MO#186584 MO#185021

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30813 38016 Based on observation, interview, and record review, the facility failed to follow the facility's weight loss policy for weekly weights, re-evaluate the care plan and interventions with continued weight loss, and to acquire dental services for ill-fitting dentures for one sampled resident (Resident #22) of 32 sampled residents and three closed records. The resident had a total weight loss of 39 pounds (lbs) (26% weight loss) over the course of eight months, the most significant weight loss occurred after the resident's diet was changed from a mechanical soft diet to a pureed diet when the resident lost 24 lbs in two months (18%, severe weight loss) and expressed he/she did not like his/her food pureed. The facility census was 73. Review of the facility's policy Weight Gain and Loss, revised [DATE], showed the following: -Inform physician and family of resident weight gain and weight losses; -Obtain all resident weights monthly no later than the 8th of the month; -Notify primary physician of resident weight gain or loss when at least 5% in a month, 7.5 % in three months or 10% in six months; -Discuss at care plan meeting with the interdisciplinary team; -Report weight loss or gains to the dietary manager, dietary manager is to report to the dietitian; -Document per guidelines; -Complete dietary assessment form until weight is stable; -Obtain weight weekly on significant loss/gain until weight is stable; -Make referral to speech therapy for weight loss. Review of the facility's policy Modifying Diet Consistency, undated, showed the following: -Each resident is admitted with the written recommendation of a physician regarding their diet; -Each resident remains under the care of a physician at all times; -The resident's diet is supervised by a physician who participates in the resident's assessments and care planning; -Each resident's ability to tolerate a specific dietary consistency may change over time due to changing medical conditions and/or temporary health conditions; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-Nursing staff should respond if a resident has difficulty with the consistency of their current diet to maintain their optimal nutritional status; -Nursing staff may down-grade dietary consistency to see if the new consistency is tolerated for a period no longer than one week without getting a change in diet orders from the physician; -While attempting the diet modification the resident is to be placed on the dietary monitoring list; The results are to be reported to the physician at the end of the trial period for possible change in physician order sheet, the results should include body weight at the beginning and the end of the week and estimated daily intake on the previous diet consistency and on the new trial consistency. 1. Review of Resident #22 face sheet showed the resident admitted to the facility on [DATE]. Review of the resident's Weight Record, dated [DATE], showed the resident's weight as 149 lbs. Review of the resident's admission Minimum Data Set (MDS), a federally required assessment, dated [DATE], showed the following: -Moderate cognitive impairment, Brief Interview for Mental Status (BIMS) 12 (score of 0 being most severe cognitive impairment, and 15 being cognitively intact); -Diagnosis of anemia, atrial fibrillation (rapid heart beat), coronary artery disease, hypertension, peripheral vascular disease, diabetes mellitus, hyperlipidemia (high cholesterol), arthritis, other fractures, chronic pain syndrome, non-pressure ulcer of the ankle, and presence of pacemaker; -Weight 149 lbs; -No weight loss; -Not on mechanically altered diet; -Did not have loosely fitting dentures, and was not edentulous (no teeth); -Did not have a condition or chronic disease that may result in a life expectancy of less than six months; -Did not have a diagnosis of Alzheimer's disease or dementia. Review of the resident's Care Plan, dated [DATE], showed the following: -Nutritional risk related to vascular wounds, history of diabetes, ill-fitting dentures with chewing problems, and decreased vision and hearing; -Monitor labs as ordered and refer to physician as needed; -Monitor wounds and edema; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-Provide no added salt, regular consistency diet; -Record intake at each meal; -Provide set up help at meals; -Weigh as ordered and record, monitor for significant change and refer to physician as needed. Review of the resident's Registered Dietitian note, dated [DATE], showed the resident denied swallowing problems, but reports chewing issues due to ill-fitting upper and lower dentures and wanted soft meats. Review of the resident's medical record showed no documentation staff requested or communicated the need for a referral to a dentist for ill-fitting dentures. Review of the resident's record showed he/she was sent to the hospital on [DATE]. Review of the resident's Admission Assessment, dated [DATE], showed staff documented the resident's dentures fit. Review of the resident's Weight Record, dated [DATE], showed the resident's weight at 138.4 lbs, (down 10. 6 lbs.) a 7% weight loss in 30 days. Review of the resident's Care Plan, updated [DATE], showed house supplement two times daily and monitor acceptance of supplement. Review of the resident's Dietitian Note, dated [DATE], showed the following: -Diet Mechanical soft, no added salt, house supplements two times a day; -Height is 67 inches, Weight 146 lbs; -2+ edema (swelling of tissue in arms or legs); -Goals: weight stability, adequate intake, and wound healing; -Recommend: Add multivitamin with minerals, monitor weights. Review of the resident's Weight Record, dated [DATE], showed the resident's weight at 134 lbs. (a loss of 4. 4 additional lbs. for a total of 15 lbs., a 10% weight loss since [DATE], less than 60 days). Review of the resident's medical record showed no evidence staff reviewed the resident's care plan. There were no additional interventions to prevent further weight loss. Review of the resident's Dietitian Note, dated [DATE], showed the following: -Referral from nursing due to weight; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-Most recent weight 134 lbs, shows significant 9% weight loss in one month; -May be some fluid loss, and resident had decrease appetite with a urinary tract infection; -Hopefully appetite will improve with antibiotics; -No new recommendations. Review of the resident's Nurses Notes, dated [DATE], showed staff documented the resident complained about pain in his/her mouth and tongue. The resident said his/her dentures and gums had build on them and needed them cleaned. After his/her dentures were brushed he/she said it felt like there was something under them and he/she couldn't wear them. Review of the resident's Dietitian Note, dated [DATE], showed the following: -Resident's weight was 134 lbs (no new weight was taken, same weight recorded on [DATE]); -Weight was down significantly over one month mostly due to diuresis (increased or excessive production of urine), but there was also some decline in appetite; -Diet was mechanical soft, no added salt, house supplement two times per day; -Will monitor weights; -No new recommendations. Review of the resident's Weight Record, dated [DATE], showed the resident's weight at 128.5 lbs. Review of the resident's Nurses Notes, dated [DATE], showed the resident complained about his/her dentures, he/she does not want Fixodent. The staff documented they would recommend a denture consult to the resident's durable power of attorney. Review of the resident's Weight Record, dated [DATE], showed the resident's weight at 122.1 lbs. During an interview on [DATE] at 1:08 P.M., the resident's durable power of attorney/family member said the facility never approached him/her about the resident needing to be seen for ill-fitting dentures. He/She would have taken the resident to a dental appointment and paid for new dentures if the resident needed them. In [DATE] he/she met the resident at an audiology appointment. During the audiology appointment, the resident told the clinic that the facility lost his/her dentures and he/she had not had them for a while, and staff told the resident he/she would be okay. The facility told him/her they had found the resident's dentures and they fit better. Review of the resident's Weight Record, dated [DATE], showed the resident's weight at 124.7 lbs. Review of the resident's Nurses Note, dated [DATE], showed the following: -Resident's DPOA notified about the resident not wanting to use Fixodent; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-Resident not wearing his/her dentures during the day; -Discussed resident may need a dental consult since his/her dentures do not fit properly, DPOA to discuss with resident. The resident's medical record did not contain any follow up documentation about a dental consult. Review of the resident's Dietitian Note, dated [DATE], showed the following: -Resident's weight is 125 lbs; -Weight was down over three months; -Recommendation for the resident's house supplement to increase to three times a day due to continued weight loss; -Will monitor weights and labs. Review of the resident's nurses notes, physician orders, and care plan showed no evidence the resident's house supplement was increased to three times a day. Review of the resident's Dietitian note, dated [DATE], showed the following: -Most recent weight of 124.7 lbs showed weight loss appears to be stabilizing; -Appetite more consistent since urinary tract infection resolved and intake of supplements better with nursing supervision; -Resident with a history of not wearing dentures during meals and on mechanically altered diet with no swallowing problems reported; -Supplements are twice a day; -Continue weekly weights to more closely monitor. Review of the resident's Weight Record, dated [DATE], showed the resident's weight at 129.8 lbs. Review showed staff did not document weights from [DATE]-[DATE]. Review of the resident's Weight Record, dated [DATE], showed the resident's weight at 136.8 lbs. Review showed staff did not document weights from [DATE]-[DATE]. Review of the resident's Dietitian Note, dated [DATE], showed the resident's weight was up to 137 lbs., fluctuates, continue regimen and will monitor weight trends. Review of the resident's Weight Record, dated [DATE], showed the resident's weight at 134.6 lbs. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's Weight Record, dated [DATE], showed the resident's weight at 134.6 lbs. Review showed staff did not document weights from [DATE]-[DATE]. Review of the resident's Weight Record, dated [DATE], showed the resident's weight at 128.3 lbs down another 6.3 lbs in one month, another 0.5 from the previous month with no review or addition of interventions documented. Review of the resident's medical record showed no evidence staff reviewed the resident's care plan and did not add any interventions to prevent further weight loss. Review of the resident's Weight Record, dated [DATE], showed the resident's weight at 130.9 down 12% in five months since admission. Review of the resident's Physician's Orders, dated [DATE], showed the resident's diet order changed to mechanical soft. Review of the resident's Dietitian Note, dated [DATE], showed the resident's weight as 128 lbs and was down slightly. Continue regimen to help promote weight stability and healing. Review showed staff did not document weights from [DATE]-[DATE]. Review of the resident's Weight Record, dated [DATE], showed the resident's weight at 125 lbs. Review of the resident's medical record showed no evidence staff reviewed the resident's care plan, or added any interventions to prevent further weight loss. Review of the resident's quarterly MDS, dated [DATE], showed the following: -Moderate cognitive impairment, BIMS 11; -Weight 125 lbs.; -Significant weight loss; -Dental section left blank; -Mechanically altered diet; -The resident did not have a condition or chronic disease that may result in a life expectancy of less than six months; -The resident did not have a diagnosis of Alzheimer's disease or dementia. Review of the resident's Physician's Orders, dated [DATE], showed the resident's diet order was changed to pureed. Review of the resident's Weight Record, dated [DATE], showed the resident's weight at 134.8 lbs. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's Weight Record, dated [DATE], showed the resident's weight at 132 lbs. Review of the resident's Weight Record, dated [DATE], showed the resident's weight at 128.5 lbs. Review of the resident's Physician's Note, dated [DATE], showed the resident complained he/she did not like his/her food. Review of the resident's Weight Record, dated [DATE], showed the resident's weight at 125 lbs. Review of the resident's medical record showed no evidence staff reviewed the resident's care plan, or added any interventions to prevent further weight loss. Review of the resident's Weight Record, dated [DATE], showed the resident's weight at 117 lbs. Review of the resident's medical record showed no evidence staff reviewed the resident's care plan, or added any interventions to prevent further weight loss. There were no weights recorded from [DATE]-[DATE]. Review of the resident's Weight record, dated [DATE], showed the resident's weight at 112.6 lbs. Review of the resident's Physician's Order, dated [DATE], showed an order for supplement of choice bid (same as before) and Paxil 20 milligrams daily for depression and appetite. Review of the resident's Weight Record, dated [DATE], showed the resident's weight as 114.4 lbs down 23%, 34.6 lbs since admit in May. Review of the resident's Physician's Orders, dated [DATE], showed an order for mechanical soft diet for pleasure feedings. Review of the resident's Weight Record, dated [DATE], showed the resident's weight at 110.2 lbs. During an interview on [DATE] at 12:15 P.M., CNA O said the following: -The resident had dentures when he/she first came, but they went missing; -He/She doesn't know if they were found or not but the resident stopped wearing them; -The resident liked chicken noodle soup, peppermints, and 7-Up soda; -The resident complained about being nauseated all the time, and he/she would often get sick after he/she ate. During an interview on [DATE] at 1:08 P.M., the resident's durable power of attorney, a family member, said the following: -The facility did not notify him/her of any weight loss until January and only said the resident lost 8 lbs.; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-He/She was not notified the resident's dentures weren't fitting, there was only one conversation about him/her not liking Fixodent; -The resident did not have a dental appointment while at the facility; -The resident told him/her the facility would give the resident food he/she could not chew like pork chops; -The resident said he/she did not like the food, and after they started grinding up his/her food he/she complained that he/she did not like the food and did not want his/her food ground up; -The resident complained that he/she did not get the snacks his/her family brought him/her. During an interview on [DATE] at 2:20 P.M., the hospice Family Nurse Practitioner said the following: -The resident's hospice admission diagnosis was late onset Alzheimer's, dysphagia (difficulty swallowing), failure to thrive, and the resident lost 22 lbs in two months; -Admission note said the resident was edentulous; -The resident was referred to hospice on [DATE], admitted to hospice on [DATE], and expired on [DATE]. During an interview on [DATE], the resident's physician said the following: -The resident was put on a mechanical soft diet in [DATE]; -He would expect the facility to make dental appointments for ill-fitting dentures, but during COVID we were not sending people to the dentist; -You can eat without teeth; -He did not know if the resident was on a pureed diet or not- but he/she stopped eating; -He tried to feed the resident chocolate pudding once, the resident said he/she didn't like chocolate, and complained about getting the same meat every day; -The facility could try different interventions, but they probably wouldn't have worked. During an interview on [DATE] at 1:30 P.M., LPN R said the following: -He/She monitored the weights during the time this resident had weight issues; -The resident did have problems with his/her dentures, but he/she doesn't know if the resident got a dental appointment; (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-The Dietitian would make recommendations, but the DON at that time (not the current DON) would cancel them, so the Dietitian felt uncomfortable documenting his/her recommendations and then they would not be put into place; -He/She would notify the physician about significant weight changes, but he would not respond to faxes about weight loss; -He/She faxed the physician with all weight loss findings and reviewed with the physician when he/she made rounds; -He/She would put out which weekly weights needed to be completed and the CNA's would not do them, the previous DON would not help with the issue; -The resident's family member tried to help the resident and would bring him/her his/her favorite home cooked meals, and it helped for a while; -The resident did not like his/her pureed diet, he/she would give the resident foods he/she specifically asked for but no one changed his/her diet back. During an interview on [DATE] at 11:09 A.M., the Registered Dietitian said the following: -He/She expected residents with weight loss to have weekly weights; -When a resident had weight loss the resident was evaluated to find the cause of their weight loss, and interventions are individualized based on the findings; -Interventions were evaluated with continued weight loss to ensure the interventions are effective; -Residents are evaluated to see if there are issues with chewing, swallowing, acceptance of their diet, depression, dentition, etc.; -During the time the resident experienced weight loss there were process issue in getting the weekly weights, follow up with the weight losses, and follow up with recommendations for weight loss; -He/She was not able follow the resident during the whole course of his/her weight loss; -Review of the notes showed there was some weight loss from edema and diuretic use from [DATE] to [DATE], there is no documentation of edema from [DATE] to [DATE]. MO00173981 MO00180281

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 30813 38016 Based on observation, interview, and record review, the facility failed to ensure staff served the appropriate prepared food items according to the residents dietary tickets for four residents (Residents #9, #10, #12, and #33) on physician-ordered pureed diets. The facility census was 73. 1. Review of Resident #10's meal ticket on 11/9/21 at the lunch meal showed the resident should be served the following: -Pureed turkey with gravy; -Pureed stuffing; -Pureed green bean casserole; -Pureed roll; -Cranberry sauce; -Pureed pumpkin pie; -Handled cups with straws. Observation on 11/9/21 at 12:05 P.M., showed staff served the resident pureed turkey with gravy, pureed stuffing, pureed green bean casserole, pureed pumpkin pie, and two handled cups with straws, one containing tea and the other with water. The staff did not serve the resident cranberry sauce or a pureed roll. During an interview on 11/9/21 at 12:20 P.M., the resident said he/she would love some cranberry sauce. Observation on 11/9/21 at 12:35 P.M., showed staff brought the resident cranberry sauce and he/she consumed 100% of the cranberry sauce. Staff did not ask the resident if he/she wanted the pureed roll. 2. Review of Resident #9's meal ticket on 11/9/21 at the lunch meal showed the resident should be served the following: -Pureed turkey with gravy; -Pureed stuffing; -Pureed green bean casserole; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265108	A. Building B. Wing	11/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beth Haven Nursing Home	2500 Pleasant Street Hannibal, MO 63401

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Pureed roll; -Cranberry sauce; -Pureed pumpkin pie; -Drinks with straws. Observation on 11/9/21 at 12:11 P.M., showed staff served the resident pureed turkey with gravy, pureed stuffing, pureed green bean casserole, pureed pumpkin pie, and drinks with straws. Staff did not serve the resident cranberry sauce or a pureed roll. Continued observation through 12:45 P.M. showed staff did not offer the resident cranberry sauce or a pureed roll. 3. Review of Resident #33's meal ticket on 11/9/21 at the lunch meal showed the resident should be served the following: -Pureed turkey with gravy; -Pureed stuffing; -Pureed green bean casserole; -Pureed roll; -Cranberry sauce; -Pureed pumpkin pie; -Drinks. Observation on 11/9/21 at 12:25 P.M., showed staff served the resident pureed turkey with gravy, pureed stuffing, pureed green bean casserole, and drinks. Staff did not serve the resident cranberry sauce, pureed pumpkin pie, or a pureed roll. At 12:30 P.M. the resident said, where is dessert? At 12:40 staff served the resident pureed pumpkin pie. Continued observation through 12:45 P.M. showed staff did not offer the resident cranberry sauce or a pureed roll. During an interview on 11/9/21 at 12:31 P.M., Certified Nurse Aide (CNA) R said they never knew what the residents on pureed diets would get. 4. Review of Resident #12's meal ticket on 11/9/21 at the lunch meal showed the resident should be served the following: -Pureed turkey with gravy; -Pureed stuffing; -Pureed green bean casserole; (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Pureed roll; -Cranberry sauce; -Pureed pumpkin pie; -Handled cups with straws. Observation on 11/9/21, at 12:05 P.M., showed staff served the resident pureed turkey with gravy, pureed stuffing, pureed green bean casserole, pureed pumpkin pie, and drinks. Staff did not serve the resident cranberry sauce or a pureed roll. Continued observation through 12:45 P.M. showed staff did not offer the resident cranberry sauce or a pureed roll. 5. During an interview on 11/9/21 at 12:15 P.M., CNA O said the following: -Residents with pureed trays do not always get all of the items shown on their meal ticket; -Sometimes dietary does not send them the bread or rolls, or they forget the dessert and the little things like the cranberry sauce. During an interview on 12/1/21 at 11:35 A.M., the dietary manager said the following: -Pureed diets should have every food item that a regular diet receives; -The spreadsheet usually had the exact same menu, just the pureed portions and recipes were different; -If there was a food that could not be pureed, the spreadsheet will have an alternate item; -Dietary staff plate the food and should put all items on the meal ticket on the resident's tray; -On 11/9/21, they had a new employee that forgot to put items on the pureed resident trays; -Staff are expected to ensure all items on the meal tickets are served.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 30813 Based on interview and record review, facility staff failed to conduct and document a facility-wide assessment to determine what resources were necessary to care for residents competently during both day-to-day operations and emergencies. The facility census was 73. Review of the facility's Daily Census Report, dated 10/9/21, showed the facility census was 73. Review of the facility's assessment showed the assessment was last updated in 2019 and was not fully completed. Review showed the facility had not assessed the following: -The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; -The staff competencies that are necessary to provide the level and types of care needed for the resident population; -Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services; -All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; -Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. During an interview on 11/9/21 at 3:00 P.M., the administrator said she had been working on the facility assessment, but had not gotten it completed.