STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155758	A. BUILDING 00 B. WING	11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASBURY TOWERS HEALTH CARE CENTER	102 W POPLAR ST GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: November 15, 16, 17, 18, 21, and 22, 2022 Facility Number: 001120 Provider Number: 155758 AIM Number: 200525120 Census Bed Type: SNF/NF: 18 Residential: 48 Total: 66 Census Payor Type: Medicare: 5 Medicaid: 7 Other: 6 Total: 18 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on December 1, 2022.	F 0000		
F 0770 SS=A Bldg. 00	483.50(a)(1)(i) Laboratory Services §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the			

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

Audra Rose | RN, DON | 12/25/2022

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	applicable requirements for laboratories specified in part 493 of this chapter. Based on record review and interview, the facility failed to ensure a pharmacy recommendation to have a resident's laboratory fasting lipid panel (blood test) completed for 1 of 5 residents reviewed for unnecessary medications (Resident 1). Finding includes: Resident 1's record was reviewed on 11/17/22 at 10:45 a.m. Diagnoses included but was not limited to mixed hyperlipidemia (an inherited condition in which levels of certain lipids in the blood are higher than they should be). An active physician's order, started 8/31/21, indicated pravastatin sodium (medication used to lower the amount of lipids in the blood) tablet 20 milligrams (mg), give one tablet by mouth at bedtime for hyperlipidemia. A pharmacy consultation report, dated 1/12/22, indicated Resident 1 received Pravastatin Sodium and did not have a fasting lipid panel (blood test) documented in the medical record in the previous 12 months and recommended to monitor a fasting lipid panel on the resident's next scheduled lab day on 1/28/22 and every 12 months thereafter. The physician agreed with the recommendation and indicated to check the fasting lipid panel with the next laboratory blood draw for the resident. The medical record lacked documentation the fasting lipid panel had been completed for Resident 1. On 11/21/22 at 9:42 a.m., the Director of Nursing	F 0770	F-770 1. A laboratory tracking binder will be created by 12/19/22 to ensure labs are completed and results are uploaded to PCC. 2. The DON or designee will update the laboratory binder daily with new orders and checked weekly for lab completion. 3. All nurses now have log ins to review and order labs through Putnam County Hospital to ensure results are no longer missed. 4. Laboratory techs will begin leaving a report of labs drawn with resident name and what labs with the nurse at each station. These reports will be given to the DON to track with laboratory binder.	12/19/2022

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	(DON) indicated she had looked for the February 2022 lab results and had contacted lab company and the physician. The lab company could not find the February fasting lipid panel test. The physician indicated he had not received nor reviewed the February lab results for Resident 1. The fasting lipid panel lab test for Resident 1 had just gotten missed. The DON, on 11/18/22 at 2:00 p.m., provided and identified a document as a current facility policy, titled "Medication Regimen Review," dated 5/20/21. The policy indicated, "...Policy: The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart ...Policy Explanation and Compliance Guidelines: ...7. Timelines and responsibilities for Medication Regimen Review: ...f. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities...." 3.1-49(a) 3.1-49(b)			
F 0812 SS=D Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent			

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	facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, interview, and record review, the facility failed to ensure pureed food items were prepared in a sanitary manner during 1 of 1 observation of pureed food preparation. Findings include: Cook 9 was observed preparing pureed food, on 11/21/22 at 10:37 a.m. After washing his hands thoroughly and donning gloves, the Cook was observed to touch and adjust his facemask and immediately pick up rolls and place them in the blender, with his gloved hands. At one time, the handle from the lid of the blender came loose and fell to the floor. The Cook picked up the handle from the floor, placed it on the counter next to the blender, touched and adjusted his facemask with his gloved hand, removed the lid from the blender, and reached in and adjusted the blender blade, with the same gloved hand, without changing his gloves and performing hand hygiene. Throughout the entire procedure, the Cook was observed to touch and adjusted his facemask a total of 5 times, without ever changing his gloves and performing hand hygiene. During an interview, on 11/21/22 at 10:43 a.m., Cook 9 indicated he was not aware that he had	F 0812	F812 Food Procurement, Store/Prepare/Serve-Sanitary 1. All Dietary staff will be educated on proper hand hygiene and sanitation techniques and appropriate times to perform them. 2. By December 31, 2022, all dietary staff will be educated on proper Food procurement procedures, or they will be removed from the schedule until it is completed. 3. Dining Service Director or designee will perform regular audits to ensure staff are performing proper food procurement procedures. These audits will be performed monthly for 6 months and until compliance is maintained. 4. Audits will be reviewed by QAPI monthly until compliance is maintained to identify any trends and adjust POC if needed.	12/31/2022

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	touched his facemask during the pureed preparation. It had become such an automatic reflex to keep his mask up over his nose, since facemasks had become required. He understood that he should have not continued to prepare food, after touching his facemask with his gloves, without first washing his hands and putting on new gloves. During an interview, on 11/21/22 at 11:54 a.m., the Dining Services Supervisor indicated the Cook should have performed hand hygiene and changed his gloves when he touched his mask and when he had picked something up from the floor. On 11/21/22 at 10:53 a.m., the Dining Services Director provided an document, dated 3/13/22, titled, "Hand Hygiene," and indicated it was the policy currently being used by the facility. The policy indicated, "Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors...Policy Explanation and Compliance Guidelines...6. Additional considerations: a. The use of gloves does not replace hand hygiene...." 3.1-21(3)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control			

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	program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin			

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	lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based observation, interview, and record review, the facility failed to ensure staff wore personal protective equipment (PPE) of a face shield when administering medication and providing care to a COVID-19 positive resident in transmission-based precautions (TBP) droplet isolation (used to prevent the spread of pathogens that are passed through respiratory secretions) for 1 of 1 random observation during medication administration (Resident 16). Finding includes: During a random observation of medication administration, on 11/21/22 at 11:18 a.m., a sign was observed posted on Resident 16's door which indicated, transmission-based precautions (TBP) contact droplet isolation room and to don (put on)	F 0880	F-880 1. A root cause analysis and a LTC infection control self-assessment was completed on 12/12/22. 2. All staff will be educated on how and when to don and doff PPE with a return demonstration, including, but not limited to, mask, N95, gloves, gown, and eye protection. See Exhibit A (Personal Protective Equipment policy) and Exhibit B (Validation Checkoff for Donning/Doffing PPE). 3. By December 31, 2022, all staff will be educated on the Personal Protective Equipment policy and complete the validation checkoff	12/31/2022

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	personal protective equipment (PPE) of an N-95 face mask, a face shield or goggles, a gown, and gloves required to enter the isolation room. Registered Nurse (RN) 8 was observed to don an isolation gown, N-95 face mask, and gloves, then entered Resident 16's TBP droplet isolation room for the medication administration. RN 8 administered to Resident 16 a medication capsule and applied a medicated ointment to the resident's neck. On 11/21/22 at 11:31 a.m., RN 8 indicated she had forgotten to don a face shield prior to entering the droplet isolation room but should have put eye protection on before entering the isolation room. The Director of Nursing (DON), on 11/21/22 at 11:51 a.m., indicated on 11/19/22 Resident 16 had complained of a sore throat, headache, and runny nose, and tested positive for COVID-19. Resident 16 was placed on TBP droplet isolation in his private room. Staff should have worn a gown, gloves, N95 face mask, and a face shield or goggles when they entered the TBP droplet precautions isolation room. On 11/21/22 at 1:30 p.m., the DON provided and identified a document as a current facility policy titled, "Transmission-Based Precautions," dated 3/13/22. The policy indicated, "...Policy: it is our policy to take appropriate precautions to prevent transmission of infectious agents, based on the agents' modes of transmission...3. Contact Precautions...d. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination (e.g. VRE, C. difficile, noroviruses and other intestinal tract pathogens, RSV)...4.		for Donning/Doffing PPE, or they will be removed from the schedule until completed. 4. Bi-annual infection control education/in-services will be preformed for all staff. 5. The DON, IP, or designee will complete a visual rounds audit to ensure staff are practicing appropriate infection control protocols related to donning and doffing PPE. This audit will be daily x 6 weeks and until compliance is maintained. 6. Audits will be reviewed by QAPI monthly for 6 months and until compliance is maintained to identify any trends and to adjust the POC as warranted.	

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	Droplet precautions...d. Healthcare personnel wear a mask for close contact with infectious resident...." 3.1-18(b)(1) 3.1-18(b)(2)			
F 0943 SS=E Bldg. 00	483.95(c)(1)-(3) Abuse, Neglect, and Exploitation Training §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. Based on record review and interview, the facility failed to provide annual education for abuse prevention, and ensure employees had also completed dementia and resident rights training for 3 of 5 randomly selected Healthcare facility employees who had been employed at the facility for greater than one year. This deficient practice had the potential to effect 18 of 18 residents who resided in the facility. Findings include: On 11/21/22 at 1:00 p.m. 10 randomly selected employee files were reviewed, 5 new hires and 5	F 0943	F-943 1. An audit of staff education was completed to determine how many staff did not have required education/in-services for Abuse, neglect, and exploitation, Dementia, and Resident Rights completed within the year. 2. By December 31, 2022, all staff who are not caught up on required education for Abuse, neglect, and exploitation, Dementia, and Residents Rights will be removed from the schedule until completed.	12/31/2022

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	employees who had worked at the faccility greater than one year. The Director of Nursing (DON), hired on 9/13/16, did not have documentation of abuse training in the past 12 months (one year). Qualified Medication Aid (QMA) 17, hired on 11/1/21, did not have documentation abuse, dementia, or resident rights training in her employee file for the past 12 months (one year). On 11/21/22 at 2:30 p.m., during an interview, the Business Office Manager (BOM) indicated QMA 17 did not have any records of having completed any annual training in her file or the electronic system. Licensed Practical Nurse (LPN) 18, hired on 1/7/21 did not have documentation of abuse training in the past 12 months (one year). On 11/21/22 at 2:50 p.m., during an interview, the DON indicated the facility did not have annual trainings completed for abuse. She started doing annual in-services but has only gotten a few employees done. She was not aware she had to be trained by someone else (not herself). On 11/22/21 at 1:47 p.m., the DON provided a current policy, dated 10/17/22, titled, "Continuing Education." This policy indicated "Compliance with the facility's standards, policies, and procedures is a condition of employment. This includes compliance with the policies and procedures of this facility's training programs...." 3.1-13(2)		3. Education for Abuse, neglect, and exploitation will be added to the list of annual training on Relias to ensure it is no longer missed. 4. Starting 1/12/22 with our next QAPI meeting policies for Abuse, neglect, and exploitation, Dementia, and Residents rights will be reviewed at least bi-annually and given to staff.	

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F 9999 Bldg. 00	3.1-14 PERSONNEL (a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Specific inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure new hired employees had a completed and clear criminal record review from the Indiana State Police before starting work in the facility for 2 of 5 randomly selected new hire employees. This deficient practice had the potential to effect 18 of 18 residents who resided in the facility. Findings include: On 11/21/22 at 1:00 p.m. Five randomly selected new hire employee files were reviewed. Maintenance Employee (ME) 12 was hired on 9/22/22. The Indiana State Police criminal background report, dated November 1, 2022, indicated "...Your request is being returned for the following reason(s): Incorrect year for date of birth. Please resubmit the corrected Limited History check...." A handwritten note on the report indicated "resubmitted 11/8/22 *report not yet received...."	F 9999	F9999 Final Observations 3.1-14 Personnel 1. Specific procedures written and implemented for the screening of all prospective employees shall be managed with a check off sheet. This is to be used every time with all new employees, the check-off sheet must be attached and signed before any employee is allowed to begin working on the floor. 2. Staff who are in a role who can on board prospective staff members must be trained by Human resources in the hiring process and must follow the policy for guidelines. 4. Background investigations will include - licensure verification, criminal conviction record, all completed by proper authorities before being allowed to work on the floor. 3. By December 18, 2022 staff who are in a role to hire personnel will be trained on the check off list to make sure all info is correct and has the proper dates.	12/18/2022

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R 0000 Bldg. 00	Certified Nurse Aid (CNA) 15 was hired on 10/11/22. The Indiana State Police criminal background report, dated 10/14/22, indicated "RECOMMENDED FOR FINGERPRINTS Your Limited Criminal History Request Report cannot be delivered...." A handwritten note on the report indicated "CC to [name of employee] 10/28/22." On 11/21/22 at 2:30 p.m., during an interview, the Business Office Manager (BOM) indicated ME 12 and CNA 15 were both working in the facility and their completed background checks had not been received. On 11/22/22 at 1:51 p.m., during an interview, the Director of Nursing (DON) indicated Criminal History reports should have been completed and cleared before new hires started work. On 11/22/22 at 1:47 p.m., the DON provided a current policy, dated 9/1/22, titled, "Background Investigation." This policy indicated, "Job reference checks, drug screenings, licensure verifications and criminal conviction record checks are conducted on all personal making application for employment with this company...If the background investigation(s) disclose any material misrepresentation or omissions by the applicant or employee on the application form or reveal information indicating that the individual may not be appropriate for hire, the company will investigate the matter further...."	R 0000		

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	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: November 15, 16, 17, 18, 21, and 22, 2022 Facility number: 001120 Residential Census: 48 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 1, 2022.			
R 0030 Bldg. 00	410 IAC 16.2-5-1.2(e)(1-6) Residents' Rights - Noncompliance (e) Residents have the right to be provided, at the time of admission to the facility, the following: (1) A copy of his or her admission agreement. (2) A written notice of the facility ' s basic daily or monthly rates. (3) A written statement of all facility services (including those offered on an as needed basis). (4) Information on related charges, admission, readmission, and discharge policies of the facility. (5) The facility ' s policy on voluntary termination of the admission agreement by the resident, including the disposition of any entrance fees or deposits paid on admission. The admission agreement shall include at least those items provided for in IC 12-10-15-9. (6) If the facility is required to submit an Alzheimer ' s and dementia special care unit			

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	155758	A. BUILDING 00 B. WING	11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASBURY TOWERS HEALTH CARE CENTER	102 W POPLAR ST GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	disclosure form under IC 12-10-5.5, a copy of the completed Alzheimer ' s and dementia special care unit disclosure form. Based on interview and record review, the facility failed to complete and submit a Dementia Care Disclosure form, State Form 48896, to the Indiana Department of Health. This deficient practice had the potential to effect 11 of 11 residents who resided in the Memory Care Unit. Finding includes: On 11/21/22 at 8:55 a.m., during the entrance conference with the Director of Nursing (DON), a copy of the Dementia Care Discloser form was requested. During an interview, on 11/21/22 10:27 a.m., Administrative Assistant (AA) 19 indicated she could not recall completing the form for the closed dementia unit. On 11/21/22 at 2:47 p.m., AA 19 indicated the facility had not completed and submitted a Dementia Care Disclosure form, State Form 48896 for the closed dementia unit.	R 0030	R-0030 Surveyors educated Administrative Assistant of need to complete Dementia Care Disclosure Form. After getting access to the site, Admin Asst completed form on November 22, 2022. Will put on calendar alert for completion each year by the administrative assistant. Monitoring will be ongoing by Executive Director.	11/22/2022
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid			

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	certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to provide a minimum of one First Aid trained employee on each shift for 7 of 7 days reviewed. This deficient practice had the potential to effect 48 of 48 residents who resided on the Assisted Living Facility. Findings include: On 11/21/22 at 2:00 p.m., the Assisted Living staff schedules for one week, November 13 through 19 were reviewed. There were no employees identified as First Aid Certified. A review of the provided licensure book for all licensed employees contained no First Aid Certification documents. On 11/22/22 at 2:02 p.m., the DON provided a current policy, dated 8/18/17 and reviewed 11/22/22, titled "Cardiopulmonary Resuscitation (CPR)." This policy did not address First Aid. On 11/21/22 at 2:50 p.m., during an interview, the	R 0117	R-117 1. A licensed instructor will provide courses in house to certify AL staff for first aid. 2. Due to holidays conflicting with scheduling. Courses will be scheduled to begin in January 2023. 3. Staff who provide services in Assisted Living will be certified with first aid by 1/31/23. 4. An audit will be completed every 6 months indefinitely, to ensure staff on Assisted Living are certified for first aid.	01/31/2023

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	Director of Nursing (DON) indicated they did not have first aid certificates for any of their employees. They thought the CPR (Cardiopulmonary Resuscitation) classes included first aid but they found out the classes their employees had taken for CPR did not include First Aid training. Their policies did not include a policy for First Aid training. They had not been aware it was required. They would need to update the policies.			
R 0120 Bldg. 00	410 IAC 16.2-5-1.4(e)(1-3) Personnel - Noncompliance (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with			

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	dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge attendance by written signature. Based on record review and interview, the facility failed to ensure employees received annual abuse training for 4 of 5 randomly selected Assisted Living facility employees. Findings include: On 11/21/22 at 1:00 p.m. five randomly selected Assisted Living employee files were reviewed. The Director of Nursing (DON) was identified as the Dementia Care Director, she did not have documentation of abuse training in the past year. Licensed Practical Nurse (LPN) 13, hired on 2/28/17, did not have documentation of abuse training in the past year. Qualified Medication Aid (QMA) 14, hired on 7/10/17, did not have documentation of abuse training in the past year. QMA 16, hired on 3/27/13, did not have documentation of abuse training in the past year. On 11/21/22 at 2:50 p.m., during an interview, the DON indicated The facility did not have annual trainings completed for abuse. She started doing annual in-services but has only gotten a few employees done. She was not aware she had to be	R 0120	R-120 1. An audit of staff education was completed to determine how many staff did not have required education/in-services for Abuse, neglect, and exploitation completed within the year. 2. By December 31, 2022, all staff who are not caught up on required education for Abuse, neglect, and exploitation will be removed from the schedule until completed. 3. Education for Abuse, neglect, and exploitation will be added to the list of annual training on Relias to ensure it is no longer missed. 4. Starting 1/12/22 with our next QAPI meeting policies for Abuse, neglect, and exploitation will be reviewed at least bi-annually and given to staff.	12/31/2022

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	trained by someone else (not herself). On 11/22/21 at 1:47 p.m., the DON provided a current policy, dated 10/17/22, titled "Continuing Education." This policy indicated "Compliance with the facility's standards, policies, and procedures is a condition of employment. This includes compliance with the policies and procedures of this facility's training programs...."			