Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

August 24, 2022

Ms. Shannon McHale, Administrator
Crescent Manor Care Ctrs
312 Crescent Blvd
Bennington, VT 05201-0170

Dear Ms. McHale:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 27, 2022.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475033	A. BUILDING ______ B. WING ______	C 07/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESCENT MANOR CARE CTRS	312 CRESCENT BLVD BENNINGTON, VT 05201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
E 000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 7/27/2022. There were no regulatory violations identified.	E 000	**F-689: Free of Accidents Hazards/Supervision/Devices** **I. The following actions were accomplished for the residents identified in the sample:** The door on the West Wing (part of the Huntington's Unit) leading to the basement was locked by the Maintenance Director.	
F 000	INITIAL COMMENTS An unannounced, on-site re-certification survey and staff vaccination requirement review was conducted by the Division of Licensing and Protection on 7/24/22 through 7/27/22. There were regulatory violations identified during this survey:	F 000	The care plan for resident #4 was reviewed and updated. The Kardex was updated to address the need for safety monitoring and supervision related to fall risk for poor safety awareness. Staff were re-educated on the care plan.	
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and record review the facility failed to ensure the resident environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents. Findings include: 1. Per observation on 7/26/22 at 10:00 AM, a door on the West wing (part of the Huntingtons unit) leading to the basement via a stairway was	F 689	**II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:** All residents had the potential to be impacted by the deficient practice. A full-house audit of all doors was conducted immediately to identify any other safety breaches and none were identified. Safety checks were implemented once per shift to ensure the door on the West Wing (part of the Huntington's Unit) leading to the basement was locked. An audit was conducted to ensure that all Kardex's addressed the need for safety monitoring and supervision related to fall risk for poor safety awareness for those residents who were identified as a fall risk.	

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 689	Continued From page 1 unsecured, creating an accident hazard for residents. This door is marked "staff only" and leads to a stairway to the basement level which is a staff only area. The basement level has staff offices, a boiler room and a sprinkler room (unlocked) and multiple storage rooms. There is an unlocked, unalarmed marked exit door leading directly outside to staff parking area. There is a code box to the door which sets off an audible alarm when opened. 4 surveyors observed that this door can be opened without entering a code. No alarm is triggered when no code is entered. The door was continuously observed unlocked for 29 minutes. On 07/26/22 at 10:18 AM, the Unit Manager (UM) stated that every resident on the unit is a fall risk and that there is one resident that is a wander/elopement risk. On 07/26/22 at 10:26 AM, the Maintenance Director (MD) stated that the door should always be locked and only should only after entering key code. The MD stated that nursing has a master key that is able to unlock the door. The MD confirmed that door was unlocked and that the door was locked by 10:29 AM. On 07/26/22 at 10:58 AM, the Director of Nurses (DON) stated that h/she was unaware that the door could be unlocked. The DON also agreed that the unlocked door presents a risk to residents due to elopement and fall risks. 2. On 7/24/2022 at 8:15 PM Resident #4 was observed laying on a low bed with their upper body on the floor. There were interlocking wood grain floor mats around all sides of the bed. The floor mats were also fixed half way up the outer wall and on the wall at the foot of the bed. Per the licensed practical nurse (LPN) and licensed nursing assistant (LNA} who were on duty at the time of observation, the mats are there because the resident prefers to roll off the bed and onto the floor. When asked how they would identify if	F 689	**III. The following system changes will be implemented to assure continuing compliance with regulations:** A new locking mechanism was installed to the door on the West Wing (part of the Huntington's Unit) leading to the basement. The lock is no longer accessible with the Master key. A copy of the key was distributed to the Administrator, Director of Nursing, Director of Maintenance and the Emergency Panel. The alarm will be adjusted to sound whenever the door is opened without use of the key pad from the hallway to the basement corridor. A button will be installed on the basement corridor side of the door that is required to push prior to entering into the hallway. The alarm will sound if the button is not pushed. The alarm will now be tied to the fire panel. All staff will be educated on the new alarm system. **IV. The facility's compliance will be monitored utilizing the following quality assurance system:** The door on the West Wing (part of the Huntington's Unit) leading to the basement will be included on the Weekly Door Check schedule. Results of the weekly door check schedule will be reported to the QAPI committee monthly x three months. Continued reporting will be determined by the committee based on the results of the checks.	

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F 689	Continued From page 2 the resident rolled [her/himself] onto the mats versus falling. The LNA stated s/he "is care planned to be on the floor." Per record review, resident #4 has diagnoses that include frontotemporal deméntia and cognitive communication deficit. A Fall Risk Assessment dated 7/22/2022 indicates that the resident is a high fall risk. A care plan focus states that the resident "likes to sit and lay on the floor related to dementia" with a goal that s/he "will remain free of complications from {her/his} choice to sit and lay on the floor." The care plan interventions include "monitor [resident] for safety." Care plan intervention dated 2/27/2022 reflects that the resident "has no safety awareness. Continue to monitor for her safety in her surroundings." The Visual/Bedside Kardex Report, used to communicate resident needs, states "Monitor/document location, size and treatment of skin injury." However, the Kardex does not address the need for safety monitoring or supervision related to fall risk for poor safety awareness. During interview with a LNA on 7/27/22 at 10:00 AM s/he stated that Resident #4 can get up off the floor and does walk around. The LNA also stated that the resident is not on safety checks at this time. "We just kind of keep an eye on [her/him] when we walk by." The LNA was not aware of any specific plan to supervise the resident. Per interview with an LNA on 7/27/2022 at 10:15 AM s/he has worked at the facility for over a year and is very familiar with Resident #4. The LNA stated that the resident "does sometimes walk by her/himself." When asked how would they know if	F 689	10 Kardex's per week will be audited x 4 weeks and monthly x 3 months to ensure that the need for safety monitoring and supervision related to fall risk for poor safety awareness is addressed for those residents identified as a fall risk. Audit results will be reported to the QAPI committee monthly x 4 months. The frequency of audits will be determined by the committee based on audit results. **Completion Date:** ____**09/05/2022**__________ **Responsibility: Director of Nursing**	

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F 689	Continued From page 3 s/he has fallen versus laying on the floor s/he stated "well if we see marks or bruises we would know that she might have had a fall." When asked about what type of safety checks are in place for her/him the LNA stated "we look in when we go by. S/He does get up and we try to get her/him up in the chair but s/he likes to be on the floor." During this interview out side the residents room, there was a loud bang. We looked to find Resident #4 laying on the floor on her/his back with her/his head by the wall. The LNA informed the Unit Manager that the resident rolled back and hit her/his head on the padded wall.	F 689	Tag F689 Poc accepted on 8/24/2022 by S.Stem/PMC	
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding	F 726	**F-726: Competent Nursing Staff** **I. The following actions were accomplished for the residents identified in the sample:** Medication review was conducted for Resident #41. All medications in the cart were inspected for expired medications. No further expired medications were identified. **II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:** All residents had the potential to be impacted by the deficient practice. Pharmacy Consultant contacted to do a full house audit of all medication rooms and medication carts to ensure all medication is within expiration limits.	

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F 726 Continued From page 4
to resident's needs.

§483.35(c) Proficiency of nurse aides.
The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
This REQUIREMENT is not met as evidenced by:
Based on interview, staff education record review, and the facility assessment, the facility failed to ensure that licensed nurses and other nursing personnel have the knowledge, competencies and skill sets to provide care and respond to each resident's individualized needs as identified in his/her assessment and care plan.

The facility assessment, last reviewed by the facility on 4/2022, states on page 11 that "All staff attend general orientation as well as departmental training and associated competencies required for their position." Included in the list of staff competencies are "Medication Administration" for nursing staff, and "Managing Residents Behaviors/Caring for those with Dementia" for all staff.

On 07/25/22 at 12:57 PM, a contracted Licensed Practical Nurse (LPN) was observed preparing insulin for Resident #41 from a vial marked "opened on 6/21/22." S/he later stated that the insulin s/he prepared should not be administered and the vial of insulin should have been discarded 28 days after opening, which would have been 7/19/22. When questioned about administering expired medication, the LPN stated s/he was not trained on facility specific medication administration policies.

F 726

An audit was conducted of all nursing staff education records, including contracted nursing staff education records to identify those contracted staff members who did not have a record of the required training and/or competencies required for their position before caring for residents.

III. The following system changes will be implemented to assure continuing compliance with regulations:

The Medication Administration policy was reviewed and revised. All licensed nurses, including contracted staff, will be re-educated on the Medication Administration Policy.

All licensed nurse new hires, including contracted licensed nurse new hires, will be educated on the Medication Administration policy during general orientation.

All current nursing staff, including contracted nursing staff, who are assigned to the Dementia Unit, will attend 8 hours of classroom Dementia training.

All newly hired nursing personnel, including contracted nursing personnel, who will be assigned to the Demential Unit, will attend 8 hours of classroom Dementia training going forward.

All contracted nursing staff will undergo the required training and competencies required for their position.

All newly hired contracted nursing staff will undergo the required training and competencies required for their position going forward.

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F 726	Continued From page 5 Per review of 5 sampled employee education records, 2 contracted LPNs did not have documentation of training or onboarding competencies to demonstrate that they had the skills necessary to perform resident care. Per interview on 7/27/22 at 1:13 PM with the Director of Nursing (DON) and the Nurse Educator, the Nurse Educator stated that contracted staff do not receive training or review of competencies required for their position before caring for residents. The DON and Nurse Educator both confirmed that training and competencies should be completed for all staff upon hire.	F 726	**IV. The facility's compliance will be monitored utilizing the following quality assurance system:** Files for new hires, including contracted staff, will be reviewed weekly x 4 weeks and monthly x 3 months to ensure all staff receive the required training and competencies required for their position prior to caring for residents. Audit results will be reported to the QAPI committee monthly x 4 months. The frequency of audits will be determined by the committee based on audit results. **Completion Date:** _09/05/2022______ **Responsibility:** __Director of Nursing_______ Tag F726 Poc accepted on 8/24/2022 by S.Stem/PMC	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761	**F-761: Label/Store Drugs and Biologicals** **I. The following actions were accomplished for the residents identified in the sample:** Medication review was conducted for Resident #41. All medications in the cart were inspected for expired medications. No further expired medications were identified. **II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:** All residents had the potential to be impacted by the deficient practice. Pharmacy Consultant conducted a full house audit of all medication rooms and medication carts to ensure all medication was within expiration limits. No further expired medications were identified.	

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F 761	Continued From page 6 the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Per observation, staff interview, and facility policy, the facility failed to ensure that medications were stored, labeled properly, and removed from use when expired for 1 of 7 residents (Resident #41) observed for medication administration. Findings include: Facility policy titled "Medications with Special Expiration Date Requirements, Section 9.11," states that Humulin-R expires 28 days after opening. On 07/25/22 at 12:57 PM during an observation of medication administration for Resident #41, a Licensed Practical Nurse (LPN) prepared 9 units of Humulin R [insulin], per physician's orders, from a vial marked "opened on 6/21/22." Before administering this medication to Resident #41, this surveyor asked the LPN if s/he was aware of when this medication expired. This LPN stated that s/he didn't know the expiration date and would have to look it up. This LPN said s/he was not trained about the facility medication administration policy, and she was not sure who was responsible for removing expired medications from the cart, but that any nurse that sees an expired medication can dispose of it. S/he then confirmed that the insulin s/he prepared should not be administered and the vial of insulin should have been discarded 28 days after opening, which would have been 7/19/22.	F 761	The policy titled "Medications with Special Expiration Date Requirements" was reviewed and updated. The Medication Administration Policy was reviewed and updated. **III. The following system changes will be implemented to assure continuing compliance with regulations:** All licensed nurses, including contracted staff, will be re-educated on the Medications with Special Expiration Date Requirements and the Medication Administration Policy. All licensed nurse new hires, including contracted licensed nurse new hires, will be educated on the Medications with Special Expiration Date Requirements and the Medication Administration policy during general orientation. **IV. The facility's compliance will be monitored utilizing the following quality assurance system:** Files for newly hired licensed nurses, including contracted licensed nurses, will be reviewed weekly x 4 weeks and monthly x 3 months to ensure all staff receive the required education on the Medications with Special Expiration Date Requirements and the Medication Administration policy. Audit results will be reported to the QAPI committee monthly x 4 months. The frequency of audits will be determined by the committee based on audit results. The medication carts and the medication rooms will be audited reviewed weekly x 4 weeks and monthly x 3 months to ensure expired medications are discarded timely. Audit results will be reported to the QAPI committee monthly x 4 months. The frequency of audits will be determined by the committee based on audit results.	

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F 761 Continued From page 7

Per interview on 7/27/22 at 1:13 PM with the Director of Nursing (DON) and the Nurse Educator, the DON confirmed that expired medications should not be administered. S/he stated the "pharmacist looks for expired medications once a month and the Unit Managers should also be removing all expired medications from use and discarding them."

F 761

Completion Date: ___09/05/2022___________

Responsibility: __Director of Nursing___________

Tag F761 Poc Accepted on 8/24/2022 S. Stem / PMC

F 773 SS=D

Lab Srvcs Physician Order/Notify of Results
CFR(s): 483.50(a)(2)(i)(ii)

§483.50(a)(2) The facility must-
(i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.
(ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders.
This REQUIREMENT is not met as evidenced by:
Based on observations, interviews and record review the facility failed to promptly notify the ordering provider of laboratory results that fell outside of clinical reference ranges. Findings include:

The facility did not notify the provider of abnormal results in a timely manner for 1 sampled resident (#53).

Per record review Resident #53 was admitted to

F 773

F-773: Lab Srvcs Physician Order/Notify of Results

I. The following actions were accomplished for the residents identified in the sample:

The MD was consulted regarding the omission of lab results and for assessment of condition of Resident #53. No new orders were received.

II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:

All residents had the potential to be impacted by the deficient practice.

An audit was conducted of labs ordered between 06/01/2022 to date to ensure appropriate follow up. No further issues were identified.

The Change in Resident Condition Policy & Procedure was reviewed and revised.

III. The following system changes will be implemented to assure continuing compliance with regulations:

All licensed nurses will be re-educated on the Change in Resident Condition Policy & Procedure.

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F 773	Continued From page 8 the facility on June 3, 2022, with end-stage liver disease, cirrhosis and portal hypertension, chronic kidney disease stage 3, recurrent ascites/general body swelling. On June 7, 2022, the provider placed an order for the following laboratory tests: complete blood count (CBC), vitamin B12 level, folate, INR (a test to determine speed of blood clotting), reticulocyte count, iron, ferritin, ammonia, one time only for cirrhosis and anemia. A laboratory report dated June 8, 2022, with numerous abnormal results with text in the comments section "ammonia ordered but did not send correct tube, called CMNH (Crescent Manor Nursing Home) they are going to bring dark green and gold top for Vit B 12". The report contained a notation indicating it was faxed (no destination identified) on June 8, 2022. Two additional hand written items on the lab slip included "noted 6/10/22 see orders for f/u" and a second notation "in hospital 6/28/22". These items contained initials that were identified as the Nurse Practitioner and the Physician respectively. On June 25, 2022 resident #53 was transferred to the hospital and admitted to the Intensive Care Unit with a diagnosis of encephalopathy and required the transfusion of two units of packed red blood cells. The Director of Nursing was interviewed on July 26 at 1pm and confirmed that the facility has a problem with receiving laboratory results and notifying providers of abnormal results. On July 26, 2022 at 3:30pm interviewed the ordering physician to ascertain the process of notification of abnormal lab results, he/she noted the process isn't clear "sometimes I get lab	F 773	**IV. The facility's compliance will be monitored utilizing the following quality assurance system:** All lab orders will be audited weekly x 4 weeks and monthly x 3 months to ensure timely physician notification and follow up documentation. Audit results will be reported to the QAPI committee monthly x 4 months. The frequency of audits will be determined by the committee based on audit results. **Completion Date: __09/05/2022__________** **Responsibility: ___Director of Nursing__________**	

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F 773	Continued From page 9 results from the facility, sometimes from the hospital lab and sometimes I check the hospital portal myself". The physician admitted the order to obtain the ammonia level and Vitamin B 12 had not been cancelled but no results had been received. Upon further discussion of the resident requiring hospitalization the physician denied correlation between not having lab results from the ammonia or Vit B 12 levels and pointed to the residents liver and kidney failure as precursers to the hospitalization. On July 27, 2022 at 9:30 am interviewed nurse practitioner who described the laboratory notification process as "muddled" and stated, "I would have expected the labs that were ordered but not obtained would have been collected" and confirmed neither the ammonia nor the Vitamin B 12 had been obtained per her knowledge.	F 773	TAG F 773 Poc accepted on 8/24/22 S. Stem/PMC	

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475033	A. BUILDING: ____ B. WING ____	C 07/27/2022

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S203 SS=E	2.7 (d) and (d)(1) SPECIAL CARE UNITS - DEMENTIA UNITS 2.7 (d) Dementia units shall meet the following staffing and staff training requirements: 2.7(d)(1) Dementia units must provide initial training in addition to general nursing home training to include eight hours of classroom orientation for all employees assigned to the unit and an additional eight hours of clinical orientation to all nursing employees assigned to the unit. The eight hours of classroom work must include: i. A general overview of Alzheimer's disease and related dementia; ii. Communication basics; iii. Creating a therapeutic environment; iv. Activity focused care; v. Dealing with difficult behaviors; and vi. Family issues. This REQUIREMENT is not met as evidenced by: Based on staff interview and staff record review, the facility failed to provide 8 hours of initial dementia unit specific training for employees working on the licensed dementia unit. 1. Per observation and interview on the dementia unit on 7/25/2022 at 11:07 AM, Resident #35, who is diagnosed with dementia with behavioral disturbances, was seen grabbing the arm of a contracted Licensed Practical Nurse (LPN). The resident was using both hands to pull this staff member down part of the unit hallway for over a minute while the LPN struggled to become released from the resident's grip. This LPN later stated that s/he had dementia training through her agency but not from this facility.	S203	**S-203: Special Care Units – Dementia Units** **I. The following actions were accomplished for the residents identified in the sample:** The care plan for Resident #35 was reviewed and updated. Kardex was updated. Staff were re-educated on the updated plan of care. The care plan for Resident #45 was reviewed and updated. Kardex was updated. Staff were re-educated on the updated plan of care. **II. The following corrective actions will be implemented to identify other residents who may be affected by the same practice:** All residents had the potential to be impacted by the deficient practice.	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S203	Continued From page 1 2. Resident #45 who resides on the special care unit was admitted with the diagnoses of dementia with behavioral disturbance. On 7/26/2022 at 11:46 AM Resident # 45 was observed in a common area sitting at a table in a Geri-chair. A Licensed Nursing Assistant (LNA) approached the Geri-chair from behind, unlocked the wheels, and without acknowledging the resident or explaining what was happening the LNA, pulled the chair backward from the table, and began pulling it backwards out of the room and down the hall to the other common area. Per interview with the LNA on 7/26/2022 at 11:50 AM s/he is a contracted employee. S/he was asked to describe the training that the facility had provided prior to her/him being assigned to care for the residents on the dementia care unit. The LNA stated that her/his training consisted of "being put with another LNA and shown what to do with the specific residents." The LNA was asked if the facility had provided any type of classroom instruction related to dementia care, resident specific dementia needs, and how to handle difficult behaviors, s/he replied "no, not here." 3. Per interview with an LNA on 7/27/2022 at 10:15 AM s/he has worked at the facility for over a year. When asked to describe the training s/he had related to dementia care s/he stated "we have tests and things we read. The [nurse educator] is there if we have questions." Per the LNA the nurse educator does not provide instruction related to the information or tests unless help is needed. Per review of 5 sampled employee education records, 2 contracted LPNs and 1 LNA did not	S203	An audit was conducted of all staff education records, including contracted staff, to identify those staff members assigned to the Dementia Unit who did not have a record of the required 8 hours of classroom Dementia training. **III. The following system changes will be implemented to assure continuing compliance with regulations:** All current staff, including contracted staff that are assigned to the Dementia Unit will attend 8 hours of classroom Dementia training. All new hires, including contracted new hires, who will be assigned to the Dementia Unit will attend 8 hours of classroom Dementia training prior to working on the Dementia Unit.	

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S203	Continued From page 2 have documentation of training to demonstrate that they had the skills necessary to perform care for dementia residents. Per interview on 7/27/22 at 1:13 PM with the Director of Nursing (DON) and the Nurse Educator, the Nurse Educator stated the facility provides 8 hours of special care unit classroom training required is not specific to the dementia unit; the 8 hours also includes Huntington's training. S/he also stated that contracted staff do not receive the 8 hours of required dementia training from the facility. The DON and Nurse Educator both confirmed that dementia training and competency should be completed for all staff upon hire.	S203	**IV. The facility's compliance will be monitored utilizing the following quality assurance system:** Files for new hires who will be assigned to the Dementia Unit will be reviewed weekly x 4 weeks and monthly x 3 months to ensure all staff receive the required 8 hours of classroom Dementia training. Audit results will be reported to the QAPI committee monthly x 4 months. The frequency of audits will be determined by the committee based on audit results. **Completion Date: ____09/05/2022___________** **Responsibility: ____Director of Nursing___________** Poc accepted on 8/24/22 by S. Stem/PMC	