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
	056031	A. BUILDING _____ B. WING _____	C 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW VISTA NURSING AND REHABILITATION CENTER	8647 FENWICK STREET. SUNLAND, CA 91040

(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
F 000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the investigation of a complaint. Complaint Number: CA00908553. Representing the Department: Health Facilities Evaluator Nurse(s): 42275. The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Four deficiencies were identified for the Complaint Number: CA00908553 (Refer to F656, F732, F806, and F842).	F 000	New Vista Nursing & Rehabilitation Center submits this response and plan of correction as part of the requirements under the State and Federal Law. The plan of correction is submitted in accordance with the specific regulatory requirements. It shall not be construed as admission of any alleged deficiency cited or any liability. The provider submits this plan of correction with the intention that it is inadmissible by any third party in any civil, criminal action or proceedings against the provider of its employees, agents, officers, directors or shareholders. The provider reserves the right to challenge the cited findings if at any time the provider determines that the disputed finding are relied upon in a manner adverse to the interest of the provider either by the governmental agencies or third parties. Any changes to provider policy or procedures should be subsequent remedial measures as that concept is employed in Rule 407of the federal rules of evidence code section 1151 and should be in any proceeding on that basis.	8/2/24
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rose Narcisse | TITLE: Administrator | (X6) DATE: 8/2/24

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 656	Continued From page 1 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop a person-centered care plan (a document a designed to facilitate communication among members of the care team that the summarizes a resident's health conditions, specific care needs, and current treatments) and implement care plan interventions for two of seven sampled residents (Resident 2 and 3) by failing to:	F 656	F656: Develop/Implement Comprehensive Care Plan Corrective Action: On 7/11/24 and 7/12/24 the RD and dietary supervisor did a sweep of the facility to check if care plans for dietary preferences were carried out for residents. Identification of other residents having the potential to be affected: On 7/11/24 the RD & Dietary supervisor did an audit on all current residents regarding dietary preferences. No other residents were identified for this deficient practice. Measures Adopted for Systematic Changes: On 7/11/24 the RD and Dietary supervisor did an audit on current residents regarding dietary preferences. The dietary supervisor will do a weekly audit for 3 months on current residents to accommodate residents' food preferences. Monitoring Performance & Intergration Into QA System: Audit findings will be reviewed and summarized monthly by the dietary supervisor or designee. The Administrator or designee will then present the findings during the QAPI meeting to QA Committee for further review and recommendations until compliance has been achieved for 3 consecutive months.	8/2/24

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F 656	Continued From page 2 1. Ensure a comprehensive person-centered care plan to accommodate Resident 3's food preference was developed and implemented. 2. Ensure a comprehensive person-centered care plan to address Registered Dietician 1 (RD 1) nutritional care planning recommendation to promote Resident 2's wound healing was developed and implemented. These deficient practices had the potential to result in a delay or lack of delivery of care and services and miscommunication among the care team regarding the resident's needs. Findings: 1. A review of Resident 3's Admission Record indicated the facility admitted the resident on 3/10/2024 with diagnoses that included type two diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and hypertension (high blood pressure). A review of Resident 3's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 6/15/2024, indicated Resident 3's cognition (the mental action or process of acquiring knowledge and understanding) was intact. The MDS indicated Resident 3 required setup or clean-up assistance for eating and required maximum assistance for bed mobility. A review of Resident 3's Physician Orders ordered 3/10/2024, indicated no pork, no dairy or dairy products, no spicy food or chiles pepper, and no cold or hot cereal.	F 656	F732: Posted Nurse Staffing Information: Corrective Action: On 7/10/24 it was identified that there was a failure to post the actual hours worked by license, unlicensed nurses and unlicensed nursing staff directly responsible for resident care per shift. It was identified that it had a date crossed out of 6/8/24, 7/4/24 & 7/10/24 without the total hours. The facility immediately removed the posting and correctly posted the total number & the actual hours worked by licensed, unlicensed nurses and unlicensed nursing staff directly responsible for resident care per shift. Identification of other residents having the potential to be Affected: No other residents or visitors were affected by this deficient practice. Measures Adopted for Systematic Changes: The Administrator, DSD, DON & payroll staff will meet daily during the week to correctly calculate and post the total number & actual hours worked by certified nursing staff, licensed nurses and unlicensed nursing staff directly responsible for resident care per shift. for residents and visitor' s visibility. During the weekends the RN Supervisor will calculate & post the total number & actual hours worked by certified nursing staff, licensed nurses and unlicensed nursing staff directly responsible for resident care per shift.	8/2/24

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F 656	Continued From page 3 A review of Resident 3's Care Plan titled "Nutritional Status" dated 3/12/2024, last revised on 6/18/2024, indicated Resident 3 is on a therapeutic diet (a meal plan that controls the intake of certain foods or nutrients). The goal was for Resident 3's nutritional needs to be adequately met. The interventions included to provide diet as ordered and to respect food preferences. Further review of Resident 3's Care Plan titled "Nutritional Status" dated 3/12/2024, last revised on 6/18/2024, did not reflect Resident 3's food preference such as no pork, no dairy or dairy products, no spicy food or chiles pepper, and no cold or hot cereal as ordered by Resident 3's physician on 3/10/2024. During an interview with Resident 3 on 7/10/2024 at 8:44 a.m., inside Resident 3's room, Resident 3 stated that he (Resident 3) does not want any milk in his food tray including soy milk or dairy products because it can cause him to experience stomach upset. Resident 3 further stated that he was served with an ice cream a week ago (unable to recall specific date) and had to remind facility staff of his food preference and not to provide dairy products with his meals. During a concurrent interview and record review with the MDS Coordinator (MDSC) on 7/10/2024 at 10:40 a.m., the MDSC reviewed Resident 3's Physician Orders dated 3/10/2024 and Resident 3's "Nutritional Status" care plan dated 3/12/2024, last revised on 6/18/2024. The MDSC stated Resident 3's "Nutritional Status" care plan did not reflect Resident 3's food preferences and instead a "none stated" was entered and documented under food dislike. During a concurrent interview and record review	F 656	Monitoring Performance & Intergration Into QA System: Audit findings will be reviewed and summarized monthly by the Administrator or designee. The Administrator or designee will then present the findings during the QAPI meeting to QA Committee for further review and recommendations until compliance has been achieved for 3 consecutive months. F806: Resident Allergies, Preferences, Substitutes Corrective Action: On 7/9/24 it was identified that the milk on the diet card was checked when the resident was intolerant to milk. The RD and Dietary Supervisor stated that the resident was provided non-dairy milk. The card was immediately corrected, and an in-service as given by the dietary supervisor on 7/9/24 on having accurate dietary cards according to the residents' dietary preferences. The dietary supervisor will do a weekly audit on dietary cards and updating as needed. Identification of other residents having the potential to be Affected: No other residents were affected by this deficient practice.	8/2/24

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F 656	Continued From page 4 with the Director of Nursing (DON) on 7/10/2024 at 3:27 p.m., the DON reviewed Resident 3's "Nutritional Status" care plan and stated that the facility did not implement a person-centered care plan to accommodate Resident 3's food preferences. The DON stated Resident 3's food preferences of no pork, no dairy or dairy products, no spicy food or chiles pepper, and no cold or hot cereal should have been included and documented in Resident 3's care plans. The DON further stated that changes in resident's preferences and goals should be reflected in the care plan. The DON stated the purpose of the person-centered comprehensive care plan was to meet the resident's preferences, choices, and goals and to implement the care and services to be provided to a resident. 2. A review of Resident 2's Admission Record indicated the facility admitted the resident on 4/19/2024 and re-admitted on 4/25/2024 with diagnoses that included including fracture (broken bone) of pelvis (wide curved set of bones at the bottom of the body that the legs and spine are connected to) and multiple fracture of ribs (the bony framework of the chest area). A review of Resident 2's Dietary Assessment dated 5/2/2024 indicated Resident 2 had stage III (full thickness tissue loss) pressure ulcer (PU - injury to skin and underlying tissue resulting from prolonged pressure on the skin) on the right hip. Further review of Resident 2's Dietary Assessment under Care Planning Decisions section indicated to proceed to nutritional care planning (compromised status, risk factors and or complications were identified requiring a need for intervention). Resident 2's Dietary Assessment indicated to add activated liquid protein (a	F 656	Measures Adopted for Systematic Changes: The dietary supervisor will do a weekly audit on diet cards to make sure the dietary cards & references are accommodated & update as needed. Monitoring Performance & Intergration Into QA System: Audit findings will be reviewed and summarized monthly by the Administrator or designee. The Administrator or designee will then present the findings during the QAPI meeting to QA Committee for further review and recommendations until compliance has been achieved for 3 consecutive months.	8/2/24

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F 656	Continued From page 5 nutritional supplement that provides a concentrated source of protein) 30 milliliters (ml - unit of measure) twice a day and Zinc Sulfate (ZnSO4 - a supplement that helps in the immune system function and for growth, for the development and health of body tissues) for 14 days. During a concurrent interview and record review on 7/10/2024 at 10:18 a.m. with MDSC, Resident 2's Dietary Assessment dated 5/2/2024 was reviewed. The MDSC stated that there was no documented evidence found in Resident 2's medical record from 5/2/2024 until discharged (on 7/3/2024) that RD 1's nutritional recommendations were reflected and implemented in Resident 2's care plans. A review of the facility policy and procedures (P&P) titled "Care Plans, Comprehensive Person-Centered", dated 11/28/2018, last reviewed on 2/29/2024, indicated, "A comprehensive, person-centered care plan that includes measurable objectives and the timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .... Assessment of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change." A review of the facility P&P titled "Nutritional Screening/Assessments/Resident Care Planning", last reviewed on 2/29/2024, indicated, "A nutritional program specific to the resident's needs will be planned and implemented, and then reassessed periodically for progress."	F 656	F842: Resident Records-Identifiable Information Corrective Action: On 7/10/24 it was identified that C.N.A charting flow sheet was not completed. On 7/11/24, 7/12/24 7/14/24 & 7/15/24 an in-service was given to C.N.A and nursing staff for timely and completion of charting. Identification of other residents having the potential to be Affected: No other residents were affected by this deficient practice. Measures Adopted for Systematic Changes: The DSD or designee will do a random audit 3 X a week for compliance for C.N.A flow sheet charting. Monitoring Performance & Intergration into QA System: Audit findings will be reviewed and summarized monthly by the Administrator or designee. The Administrator or designee will then present the findings during the QAPI meeting to QA Committee for further review and recommendations until compliance has been achieved for 3 consecutive months.	
F 732 SS=E	Posted Nurse Staffing Information	F 732	Completion: 08/2/24	

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F 732	Continued From page 6 CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 732		8/2/24

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F 732	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staffing information of the actual hours worked by licensed and unlicensed nursing staffing directly responsible for resident care per shift was posted daily as indicated in the facility's policy and procedure (P&P) on "Posting Direct Care Daily Staffing Numbers". This deficient practice resulted in the residents and visitors being unaware of the total number of staff and the actual hours worked by the staff in the facility. Findings: During an observation on 7/10/2024 at 9:30 a.m., observed in Nursing Station 1 (NS 1), a facility document (untitled) initially dated 6/8/2024 then was crossed with a line and was changed to 7/4/2024. The same facility document (untitled) with a now date of 7/4/2024 was again crossed with a line and was changed to 7/10/2024. The untitled facility document posted indicated the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: a. For Day Shift 1. Registered Nurses (RNs) 2. Licensed Vocational Nurses (LVNs) 3. Certified Nurse Assistants (CNAs) 4. Restorative Nursing Assistants (RNAs) 5. Treatment Nurses (TX) 6. Minimum Data Set Nurse (MDS) b. For Evening Shift	F 732		8/2/24

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F 732	Continued From page 8 1. RNs 2. LVNs 3. CNAs c. For Night Shift 1. RNs 2. LVNs 3. CNAs However, the total actual hours worked by each category of licensed and unlicensed nursing staff directly responsible for resident care per shift was blank. During an observation on 7/10/2024 at 9:32 a.m. observed in NS 1, a document titled "Census and Direct Care Service Hours Per Patient Day (DHPPD)" dated 7/9/2024 posted beside the facility document (untitled). The DHPPD form dated 7/9/2024 indicated actual total direct care service hours for 7/9/2024 and actual total CNA direct care service hours for 7/9/2024. During a concurrent observation and interview on 7/10/2024 at 10:10 a.m., with the Vice President of Operations (VPO), the VPO reviewed the untitled facility document initially dated 6/8/2024, currently dated 7/10/2024 and the DHPPD document dated 7/9/2024 posted in NS 1. The VPO stated that the information posted currently did not indicate the total actual hours worked by each category of licensed and unlicensed nursing staff directly responsible for resident care per shift for 7/10/2024. The VPO further stated that the untitled facility document had been posted since 6/8/2024 and was only updated twice (7/4/2024 and 7/10/2024) utilizing the same document. During an interview with the Director of Nursing	F 732		8/2/24

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F 732	Continued From page 9 (DON) on 7/10/2024 at 12:39 p.m., the DON stated that the facility should post the nursing staffing information on a daily basis and should reflect the total actual hours worked by each category of licensed and unlicensed nursing staff directly responsible for resident care per shift daily. The DON stated the total actual hours worked by each category of licensed and unlicensed nursing staff directly responsible for resident care per shift were not posted since 6/8/2024. A review of the facility's policy and procedure titled "Posting Direct Care Daily Staffing Numbers" dated 11/20/2022, last reviewed on 2/29/2024, indicated, "Our facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents .... Within two (2) hours of the beginning of each shift, the number of Licensed Nurses (RNs and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format ... The actual time worked during that shift for each category and type of nursing staff."	F 732		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat	F 806		

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F 806	Continued From page 10	F 806		8/2/24

food that is initially served or who request a different meal choice;
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to accommodate a resident's food preference of no milk or dairy products with meals for one of two sampled residents (Resident 3).

This deficient practice had the potential to result in decreased meal intake which can then lead to weight loss.

Findings:

A review of Resident 3's Admission Record indicated the facility admitted the resident on 3/10/2024 with diagnoses that included type two diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and hypertension (high blood pressure).

A review of Resident 3's Minimum Data Set (MDS- a standardized assessment and screening tool) dated 6/15/2024, indicated Resident 3's cognition (the mental action or process of acquiring knowledge and understanding) was intact. The MDS indicated Resident 3 required setup or clean-up assistance for eating and required maximum assistance for bed mobility.

A review of Resident 3's Physician Orders ordered 3/10/2024, indicated no pork, no dairy or dairy products, no spicy food or chiles pepper, and no cold or hot cereal.

During a concurrent observation and interview

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	056031	A. BUILDING _____ B. WING _____	C 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW VISTA NURSING AND REHABILITATION CENTER	8647 FENWICK STREET. SUNLAND, CA 91040

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with the Dietary Supervisor (DS), in the kitchen, on 7/9/2024 at 4:33 p.m., the DS stated that Resident 3's diet card indicated no milk, no cereal, no pork, no dairy, and no fish however Resident 3's diet card was marked checked for milk during breakfast, lunch, and dinner. When the DS was asked if the kitchen staff provided milk for Resident 3, the DS stated that they provided non-dairy milk for Resident 3.

During an interview with Resident 3 on 7/10/2024 at 8:44 a.m., inside Resident 3's room, Resident 3 stated that he (Resident 3) does not want any milk in his food tray including soy milk or dairy products because it can cause him to experience stomach upset. Resident 3 further stated that he was served with an ice cream a week ago (unable to recall specific date) and had to remind facility staff of his food preference and not to provide dairy products with his meals.

During a concurrent observation and interview with the Dietary Aide 2 (DA 2), in the kitchen, on 7/10/2024 at 11:56 a.m., DA 2 reviewed Resident 3's diet card. DA 2 stated Resident 3's diet card was marked checked to provide milk during breakfast, lunch, and dinner and there was no entry of "no milk" under the dislike section. DA 2 stated that Resident 3's food preference should be honored, and that Resident 3 should not be provided with any milk or dairy products.

A review of the facility policy and procedures titled "Food Preferences", last reviewed on 2/29/2024, indicated, "Resident's food preferences will be adhered to within reason .... Food preferences can be obtained from the resident, family, or staff members. Updating of food preferences will be done as the resident's needs change and/or

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F 806	Continued From page 12 during the quarterly review."	F 806		8/2/24
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation	F 842		

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purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to maintain medical records that are complete and accurately documented for one of seven sampled residents (Resident 1).

This deficient practice resulted in incomplete and inaccurate resident medical care information for Resident 1 and had the potential to result in

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confusion with the care and services for Resident 1 which could place the resident at risk for not receiving appropriate care.

Findings:

A review of Resident 1's Admission Record indicated the facility admitted the resident on 7/1/2024 with diagnoses that included osteoporosis (a condition in which the bones become brittle and fragile) and major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in daily activities).

A review of Resident 1's Physician Order dated 7/5/2024 at 10:30 a.m. indicated to transfer Resident 1 to General Acute Care Hospital 1 (GACH 1) for generalized weakness and poor appetite.

During a review of Resident 1's CNA Flowsheet for July 2024, there were no documented entries (blank) from 7/1/2024 to 7/5/2024 for the 11:00 p.m. to 7:00 a.m. to indicate the care and services were provided or refused by Resident 1 on the following self-care areas and mobility areas:

a. Eating
b. Oral Hygiene
c. Toilet Hygiene
d. Shower or Bathe Self
e. Upper Body Dressing
f. Lower Body Dressing
g. Putting on/taking off footwear
h. Personal Hygiene
i. Roll left and right
j. Lying to sitting on side of the bed

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F 842	Continued From page 15 k. Sit to Stand l. Chair/bed to chair transfer m. Toilet transfer n. Tub/Shower transfer o. Car transfer p. Walking q. Turning and Repositioning During a concurrent interview and record review with Treatment Nurse 1 (TN 1) on 7/9/2024 at 4:10 p.m., TN 1 reviewed Resident 1's CNA flowsheet and stated that there were gaps and blanks including the section for turning/repositioning. TN 1 stated that CNAs must document after delivering care services to provide relevant information accurately, correctly, and completely. During a concurrent interview and record review with Certified Nursing Assistant 1 (CNA 1) on 7/10/2024 at 7:03 a.m., CNA 1 reviewed Resident 1's CNA flowsheet from 7/1/2024 to 7/5/2024. CNA 1 confirmed the finding and stated Resident 1's CNA flowsheet was noted with blanks. CNA 1 stated if any residents refused care and be turned and repositioned, CNAs then should document "R" (means refused) and notify the charge nurses of the refusal. CNA 1 stated for care areas and mobility areas not applicable during the night shift (11:00 p.m. to 7:00 a.m.) such as walking, dressing, or showering, then CNAs should document "9" (means not applicable). During a concurrent interview and record review with the Director of Nursing (DON) on 7/10/2024 at 1:46 p.m., the DON reviewed Resident 1's CNA flowsheet from 7/1/2024 to 7/5/2024. The DON confirmed the findings and stated that there were gaps and blanks in Resident 1's CNA flowsheet	F 842		8/2/24

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F 842	Continued From page 16 and that the assigned CNAs did not document to reflect what care services were provided to Resident 1. The DON stated that the assigned CNA's from 11:00 p.m. to 7:00 a.m. should have documented the care services provided or refusals in Resident 1's CNA Flowsheet. A review of the facility policy and procedures (P&P) titled "General Documentation", dated 11/27/2019, last reviewed on 2/29/2024, indicated, "Completing and Correcting Clinical Records .... Individuals must be trained and competent in the fundamental documentation practices of the facility and the legal documentation standards .... Any person(s) making observations or rendering direct services to the resident shall document in the record .... Do not leave blank spaces on forms designed for chronological, sequential notes." A review of the facility P&P titled "Activities of Daily Living Training", dated 11/30/2018, last reviewed on 2/29/2024, indicated that if a patient refuse to participate, CNA should document in the CNA flow sheet, and CNA to document activity on the CNA flow sheet.	F 842		8/2/24