STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055199	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Horizon Health & Subacute Center	3034 E Herndon Fresno, CA 93720

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on interviews, observations, and record review, the facility failed to follow their Policy and Procedure (P&P) and provide professional standards of care when:1. The facility did not provide behavioral health training for Activity Aides per policy.2. The facility did not review and update 1 of 4 sampled P&Ps at least annually per policy.3. The facility did not create a multidisciplinary plan for ventilator (respiratory ventilator (a machine that helps a person breathe when they cannot breathe well enough on their own) weaning for one of one sampled resident (Resident 1) per policy. This had the potential to result in poor care, unsafe conditions, and injury to residents and staff. 1. During a phone interview on 3/18/26 at 11:02 am with Complainant 1, Complainant 1 stated the Activity Assistants were being sent into the behavioral health Special Treatment Program (STP) to assess the resident's activity needs without the required behavioral health training.During an interview on 3/20/26 At 9:20 AM with Special Treatment Program (STP) Director (STPD), the STPD stated all employees working in the STP are required to have behavioral health training for their safety and the safety of their residents.During a concurrent interview and record review on 3/20/26 at 11:31 am with Director Staff Development (DSD), the facility record of employee behavioral health training was reviewed. DSD stated activity assistant (AA) 1 and 3 we're not on the list. DSD stated this indicated AA 1 and AA 3 had not received the facility behavioral health training. DSD stated he was not sure if the activity assistants were required to have the training.During an interview on 3/20/26 at 1:35 pm with AA1, 2, and 3, behavioral health training was discussed. AA 1 stated she had been working at the facility for about one year. AA 2 stated she had been working at the facility for 5 months. AA 3 stated she had been working at the facility for over 2 years. AA 1, AA 2, and AA 3 stated they had all been required to go into the STP unit to do activity assessments and revise resident's activity plan of care. AA 1 and AA 3 stated they had both requested behavioral health training because they were afraid for their safety in the STP but they had not been provided with the training.During a concurrent interview and record review on 3/20/26 at 3:10 PM with Director of Nursing (DON) and Administrator (ADM), the facility behavioral health training log, undated, was reviewed. ADM stated all staff in the behavioral health unit were required to have the facility behavioral health training. Neither DON or ADM could state if the AAs were required to have the behavioral health training. ADM confirmed only AA 2 was listed on the log as having any of the behavioral health training.During a concurrent interview and record review on 3/24/26, at 2 pm, certificates of completion for the facility's behavioral health training documentation provided by the facility were reviewed. The document indicated AA 1 and AA 2 had completed day 1 (of 2) of the behavioral health training. ADM confirmed that the facility had no documentation of training completion for day 2 for AA 1 and AA 2 and no documentation of any behavioral health training for AA 3 and AA 4. 2. During a concurrent interview and record review on 3/20/26 at 3:10 PM with DON and ADM, the facility policy and procedure (P&P) titled Ventilation, Weaning a Patient from Mechanical, dated 7/31/2017, was reviewed. ADM confirmed last date of review documented on the P&P was 7/31/2017. ADM stated P&Ps should be reviewed annually. Review of the Facility P&P titled Facility Policy and Procedures - Annual Reviews, dated (last revision) 10/2018, indicated .Policies and procedures are reviewed as needed and at least annually. Revisions to policies and procedures are made as necessary to reflect current facility operations, (continued on next page)

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	regulatory requirements and accepted standards of care. The quality assurance and performance improvement committee reviews policies and procedures and makes revisions as necessary. c. at least annually. Final revisions are posted for staff with a summary of changes and effective date. 3. During a phone interview on 3/19/26 at 4:24 pm with Complainant 2, Complainant 2 reported that Resident 1 was admitted to the facility nine months ago for ventilator weaning but has not been weaned. He expressed concern that weaning trials have stopped and stated that neither he nor Resident 1 could obtain information on the facility's ventilator weaning policy from any Respiratory Therapists (RT). During a record review of Resident 1's physician order for vent weaning, dated 10/2/25 and respiratory therapy notes dated 9/30/2025, 10/3/25, 2/11/26, 2/14/26, and 2/15/26, were reviewed. the physician ordered ventilator weaning as Wean Orders: May start mode:. Document Tolerance: TOL: 1 = Tolerated; 0 = Not Tolerated. Document number of hours (HRS); use 0 if tolerated less than one hour. RT must stay with resident when weaning on this mode. every shift for Shortness of Breath until 10/06/2025 09:53 Start of Wean as tolerated. Physician order dated 10/2/25 indicated Please continue weaning with.try not to change it. In knowing that he will be harder to wean off due to Guillain Barre Syndrome, we should be very patient. During a concurrent interview and record review with RT 1, Resident 1's RT notes dated 2/11/26 were reviewed. The notes indicated .Pause cool mist to wean off ventilator until next week to reevaluate. RT 1 stated he could not find the reassessment that was supposed to be completed the following week. RT 1 could not locate the follow-up assessment for Resident 1. RT 1 could not state the facility's current ventilator weaning policy and did not know how to access it. RT 1 reported that he relied on his own experience for ventilator weaning procedures. During a concurrent interview and record review on 3/25/26 at 11:05 am with RT 2, the facility Policy and Procedure titled, Ventilation, Weaning a Patient from Mechanical, dated 7/31/2017, was reviewed. The P&P indicated . It is the policy of this facility to wean patients from the mechanical ventilator when ordered by the physician . Assessment findings should be reviewed by the physician and respiratory therapist to determine the patient's suitability to wean. Develop a multidisciplinary weaning plan that includes: a. Time to start weaning during the day shift, b. The mode, (SIMV) C. Duration of a weaning trial (off ventilator 5, 10 and 15 minutes to 1/2 hour, then double the time if tolerated well, and d. Method of monitoring the patient and periods of rest.RT 2 stated she was unfamiliar with the multidisciplinary plan was and had not used one. RT 2 stated the RTs entered the weaning parameters as an order. orders after consulting other staff but did not document participants. RT 2 provided Resident 1's multidiscipline order for ventilator weaning dated 1/2/26, the order indicated, weaning trial per [MD].daily as tolerated up to 12 hours. The order was entered by RT 1. There were no details listed for time to start weaning during the day shift, day to start weaning, the duration of the weaning trial, or the method of monitoring the patient and periods of rest.and it did not include time to start weaning during the day shift or the method of monitoring the patient and periods of rest.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure sufficient nursing staffing to meet residents' needs for 3 of 4 sampled residents (Residents 1, 2, and 3) when: 1.The facility failed to adjust staffing levels to account for a high-acuity resident (Resident 5) who required extensive staff time, further contributing to delays in care for other residents. 2.The facility decided to reduce PM shift staffing in the sub-acute (is a designated area within the facility that provides a higher level of skilled nursing care services than a regular nursing home unit) from two certified nursing assistant (CNA) to one, without conducting an assessment of resident's acuity or monitoring the impact of these changes. These failures resulted in delayed care and unmet needs, as evidence by Resident 1 expressing feelings of hopelessness, Resident 2 expressing delayed bedtime until 10 pm, and Resident 3 waiting approximately 30 minutes on the commode, placing residents at potential risk for discomfort, pain, and injury. 1. During a record review on 3/24/26 at 8:37 am, Resident 5's Face Sheet (front page of the chart that contains a summary of basic information about the resident), undated, MDS (MDS - a federally mandated resident assessment tool) dated 12/31/25, and Behavioral Symptoms/problem care plans, dated 9/14/18, 3/4/19, 1/25/20, 12/1/24, 12/27/24, and 3/12/25 were reviewed. Resident 5's Face Sheet indicated Resident 5 was a [AGE] year-old female admitted to the facility on [DATE]. Resident 5's MDS section C indicated Resident 5 had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 indicating no cognitive impairment. Resident 5's Behavioral Symptoms/problem care plans indicated the facility had been attempting to work with Resident 5 and her chronic behaviors such as raising voice, verbally abusing staff when things are not done exactly the way I want, being chronically unhappy, not easy to please, fired many certified nurse assistants (CNA) and licensed vocational nurses (LVN), using racial slurs, throwing items, being verbally aggressive with staff and residents, attention seeking, drug seeking, makes false accusations, has manipulative behaviors, and prefers to have a bed bath on assigned shower days and wash her hair I the sink in the bathroom instead of going to the shower room. Intervention on the care plan included intervene as necessary to protect the rights and safety of others. and Inform resident that her verbally abusive behaviors are effecting other resident's indicating the facility had knowledge that Resident 5's behaviors were adversely affecting other residents. During a concurrent observation and interview on 3/20/26 at 10:55 AM with Resident 2, Resident 2 shared that Resident 5's nighttime bed baths often required the CNAs to spend 1-3 hours, causing other residents, including herself, to wait. Resident 2 mentioned sometimes not going to bed until 10:00 PM instead of her preferred 8:30 PM and expressed feeling it was unfair for Resident 5 to take up so much of the CNAs' time. During an interview on 3/20/26 at 11 AM with CNA 7, CNA 7 stated resident 5 needed a lot of attention, often keeping CNAs in her room for one to three hours. During a concurrent interview and observation with Resident 6, Resident 6 stated Resident 5 was out of control and demanded the attention of facility staff almost constantly. Resident 6 stated there was an outing delay yesterday because staff were busy setting up transportation for Resident 5's hair appointment. Resident 6 stated Resident 5 plays her music very loud at times and other residents cannot even hear their televisions. Resident 6 stated when residents make complaints about Resident 5, the facility talks to Resident 5 but nothing ever changed. During a concurrent interview and observation with Resident 3, Resident 3 stated all the residents had to wait for CNAs because they were always busy with Resident 5. Resident 3 stated she had to wait 20 to 30 minutes for CNAs to answer her bathroom light when she was on the commode and needed assistance to get off. Resident 3 stated she was in resident council and had brought this up many times and stated, everyone has. Resident 3 stated SSD attended resident council meetings, but nothing had been done to improve the amount of time CNAs (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had for other residents or decrease the amount of time CNAs had to spend with Resident 5. During a concurrent interview and observation on 3/20/26 at 2:25 pm with Resident 5 in her room, Resident 5 stated the facility CNAs did not give her enough time to meet all her needs. Resident 5 stated she could not take showers because of her pain so requested bed baths. Resident 5 stated she tried to get her bed baths done in one hour or less because other residents needed help. Resident 5 stated sometimes her bed bath took much longer if the CNA didn't know what they were doing. Resident 5 stated there were not enough CNAs staffed to meet her needs and the needs of other residents. During an interview on 3/20/26 at 2:30 PM, with Minimum Data Set Coordinator (MDSC) and medical records director (MRD), both stated they had heard residents complain of the amount of time the CNAs had to spend on Resident 5. The MDSC stated she had told the Director of Nursing (DON) multiple times and Resident 5 had been told multiple times not to take up so much of the CNAs' time. The MRD stated she had heard many residents complain that their needs were not met because of Resident 5. During an interview on 3/20/26 at 2:52 PM with Social Service Director (SSD), the SSD stated he had heard residents were unhappy with Resident 5 due to her loud music and the amount of attention she demanded from CNAs. The SSD stated to address concerns about the noise, the SSD offered earplugs to affected residents and instructed CNAs to limit their time with Resident 5. The SSD stated he brought these complaints to the Interdisciplinary Team (IDT) meetings but could not recall what was decided. The SSD stated he did not follow up because the issue was reported as a complaint, not a formal grievance, and his responsibility was only to follow up on grievances. The SSD stated that the Activity Director (AD) usually led Resident Council and handled complaints. During an interview on 3/20/26 at 3:10 PM with the DON and administrator (ADM), the ADM stated staffing met minimum requirements and adjusted for resident acuity to ensure adequate coverage. The ADM and the DON indicated residents' needs were being met, and the DON regularly communicated with residents through various channels. Resident 5 was described as challenging, and while some residents expressed concern about CNAs frequently assisting Resident 5, no specific outcomes were reported. Complaints were discussed in morning meetings, but ADM was not informed of any outcomes. During an interview on 3/25/26 at 1:56 pm with ADM, the ADM stated no Resident Council Meeting occurred in February 2026 due to the resignation of the Activity Director. The ADM stated two replacements were hired, one left after two weeks and the other is on leave until 3/27/26. During a review of the facility's Resident Council Meeting minutes, minutes were requested for the last 3 months of Resident Council Meetings. The Resident Council Meeting minutes for 3/4/26 were provided. The minutes indicated Resident 2 and 3 attended the meeting. Under New Issues/Compliments/Notes: was listed (15772)- Complaints of another peer resident taking too much time of the CNA staff and peer resident's volume to the TV. 2. During a record review on 3/24/26 at 8:37 am, Resident 1's Face Sheet undated, and MDS dated [DATE], were reviewed. Resident 1's Face Sheet indicted Resident 1 was a [AGE] year old male, admitted on [DATE], with a history of Gullain-Barre Syndrome (a rare condition where the body's immune system mistakenly attacks the nerves leading to paralysis starting with the feet and moving upward), chronic respiratory failure (longˆterm illnesses that affect the lungs and airways, making it difficult to breathe over an extended period of time), tracheostomy (a surgical procedure where a small hole is made in the front of the neck into the windpipe so a person can breathe more easily), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a medical condition where a person experiences excessive, persistent worry or fear that is strong enough to interfere with daily life), and dependence on respiratory ventilator (a machine that helps a person breathe when they cannot breathe well enough on their own). Review of Resident 1's MDS indicated in Section C, Resident 1 had a BIMS score of 15 indicating no cognitive impairments. Section D - Mood, indicated Resident 1 felt down, depressed, or hopeless several days a week. Section E - Behavior, indicated Resident 1 did not have the behavior of rejecting care. Section GG - Functional abilities, indicated Resident 1 was completely dependent on others for all activities of daily living. During a (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	phone interview on 3/19/26 at 4:24 pm with Complainant 2, Complainant 2 stated Resident 1 waited three hours for a CNA to change his brief on 3/16/26. Complainant 2 stated the facility had notified residents that PM shift staffing would be reduced from two CNAs to one. Complainant 2 stated Resident 1 was worried about receiving adequate care with fewer staff and expressed concerns to the facility. During a concurrent interview and observation on 3/20/26 at 9:26 am with Resident 1, Resident 1 was reclined in bed with a visitor. Resident 1 stated he put his call light on at 7 pm because he needed his soiled brief changed. Resident 1 stated the CNA on PM shift didn't answer his call light until around 10 pm. Resident 1 stated when the CNA came in, she apologized and told him she had been busy in rooms with other residents. Resident 1 stated having to wait for three hours in a soiled brief made him feel hopeless and helpless. Resident 1 stated on 3/20/26 at 9:26 am, he waited three hours for a CNA to respond to his call light to change a soiled brief, from 7 pm to 10 pm. Resident 1 stated the CNA apologized, saying other resident needs took long. Resident 1 described feeling hopeless and helpless during the delay. During a concurrent interview and record review on 3/20/26 at 9:44 am with Unit Manager (UM) 1, UM 1 stated it was the facility's third day with only one CNA covering the PM shift. Resident 1, who requires two-person assistance, raised concerns about this. UM 1 stated on 3/17/26, Resident 1 waited three hours for a brief change due to the CNA being occupied with other residents. UM 1 stated she verbally reported the incident to the Director of Nursing. During an interview on 3/20/26 at 10:26 AM with CNA 3, CNA 3 stated the facility had recently reduced staffing in the sub-acute unit to just one CNA per PM shift, starting on 3/16/26. CNA 3 stated most residents there required two staff members to assist with their care. CNA 3 stated while nurses occasionally helped out, they were often occupied with their own responsibilities. CNA 3 stated Resident 1 had complained to her on the morning of 3/17/26 about waiting three hours to be changed by a CNA on 3/16/26. CNA 3 said she informed a nurse but could not recall which one. During an interview on 3/20/26 at 3 PM with CNA 6, CNA 6 stated this was her first time working as the only CNA scheduled for the PM shift on the subacute wing. CNA 6 stated she expressed feeling nervous and noted the previous CNAs had found it challenging to meet all residents' needs alone. CNA 6 stated the facility had added an LVN to the PM shift after reducing the number of CNAs, but the LVN also had their own nursing duties. During an interview on 3/20/26 at 3:10 PM with DON and ADM, the ADM stated the facility had recently reduced the number of CNAs assigned to the subacute wing during the PM shift from two to one. The ADM stated this adjustment was made following a decrease in census from 23 to 17 residents. The ADM stated the facility determined it had previously exceeded the required CNA hours while being slightly below the necessary nursing hours for the PM shift over two consecutive Sundays, prompting this staffing change. The ADM stated, if overstaffing were to occur, preference would be given to higher-skilled staff members. The ADM noted the additional LVN scheduled during PM shifts was intended solely to assist CNAs with Activities of Daily Living and documentation and was not assigned any direct nursing responsibilities. During a concurrent observation and interview with LVN 2, LVN 2 reported he was assigned as the extra LVN for the PM shift today and yesterday. LVN 2 state he assisted CNAs with patient care, toileting, nurse charting, assessments, and helped nurses catch up when needed. LVN 2 stated he was not instructed to perform only CNA duties while serving as the extra nurse on PM shift. During a review of the facility document titled Facility Assessment 2026, the document indicated, The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility assessment must address or include: The care required by resident population. All residents are assessed prior to admission to assure that the facility can provide adequate care for the acuity of the Resident. The need for the number of nursing staff/therapy staff is assessed by the Medical Director, the Director of Nursing and the Director of Rehabilitation on an ongoing basis.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure safe and competent nursing care when:3 of 4 sampled Activity Assistants (AA) (AA 1, 2, and 3) lacked required behavioral health training.7 out of 8 sampled staff members (Certified Nurse Assistant (CNA) 3, CNA 4, CNA 5, CNA 7, Licensed Vocational Nurse (LVN) 2, LVN 3, Respiratory Therapist (RT) 1, Unit Manager (UM) 1, and UM 2 could not locate key policies and procedures.This failure had the potential to result in substandard care and injury to residents and staff.1. During a phone interview on 3/18/26 at 11:02 am with Complainant 1, Complainant 1 reported that AAs were required to entered the Special Treatment Program (STP), the facility's behavioral health unit, to assess residents' activity needs without having the required behavioral health training. During an interview on 3/20/26 at 9:20 AM with STP Director (STPD), the STPD stated all employees who worked in the STP were required to complete behavioral health training to ensure staff and resident safety. During a concurrent interview and record review on 3/20/26 at 11:31 am, with Director of Staff Development (DSD), the facility's employee behavioral health training record, which was untitled and undated, was examined. The DSD indicated that AA 1 and AA 3 were not listed among staff who had completed training, while AA 2 had participated in the first day of a two-day behavioral health training program. The DSD further clarified that AA 1 and AA 3 had not received the facility's behavioral health training and expressed uncertainty regarding whether this training was required for the AAs. During an interview on 3/20/26 at 1:35 pm with AAs 1, 2, and 3, behavioral health training was discussed. All three reported they had been required to enter the Special Treatment Program (STP) unit for activity assessments and care plan revisions. Although AA 1 and AA 3 requested behavioral health training due to safety concerns in the STP, but they had not receive it. AA 1 stated she had worked at the facility for one year, AA 2 for five months, and AA 3 for over two years. During a concurrent interview and record review on 3/20/26 at 3:10 PM with Director Of Nursing (DON) and administrator (ADM), the facility's employee behavioral health training record, which was untitled and undated, was reviewed. ADM confirmed that all behavioral health unit staff required behavioral health training but could not confirm if AAs need training before working on the STP unit. ADM and DON confirmed only AA 2 appeared on the training list. After consulting, ADM learned that AA 1 and AA 2 had completed day 1 of the behavioral health training; there was no evidence that AA 3 or AA 4 received any behavioral health training. During a concurrent interview and record review on 3/24/26, at 2 pm, with ADM, certificates of completion for day one of the facility's behavioral health training were reviewed. ADM stated AA 1 and AA 2 had attended day one of training, but there was no documentation of their completion of day two or any behavioral health training records for AA 3 and AA 4. During a review of the facility's Policy and Procedure titled, ProACT Training & Certification, dated 8/28/2025, indicated Generations Healthcare provides Professional Assault Crisis Training(C) (ProACT) all staff that are involved in direct patient care within Behavioral Health buildings/ units and is used to provide crisis deescalation education. this policy applies to all Program Staff, Nursing Staff (R.N., L.V.N., C.N.A.), Behavioral Health/Special Treatment Program (STP) Staff (Program Counselors, Mental Health Workers), and ancillary staff who are responsible for daily job duties on Behavioral Health units where they may interact with BH residents. All applicable staff providing direct patient care or completing daily job duties on Behavioral Health units must complete the ProACT De-escalation and Restraint training within 90 days of their initial date of hire. 2. During a concurrent interview and record review on 3/20/26 at 10:26 am with Unit Manager (UM) 1, the facility policy and procedures (P&P) were reviewed. When asked for the P&P for ventilator weaning UM 1 stated the P&Ps could be found on the computer. UM 1 searched the P&Ps and stated she could not find a P&P for ventilator weaning. During an interview on 3/20/26 at 10:15 am with Respiratory Therapist (RT) 1, RT 1 stated he did not know where to locate facility P&P. RT 1 stated the P&Ps used to be stored in a binder but he did not know where it was. RT 1 was unable to (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	state the current policy for ventilator weaning and indicated he relied on personal experience and knowledge to perform the procedure. During an interview on 3/20/26 at 10:26 AM with CNA 3, CNA 3 stated she did not know where the facility P&P were kept but she could ask someone to find out. During an interview on 3/20/26 at 11 AM with CNA 7, CNA 7 sated she did not know where facility P&P were stored but she could ask a nurse if she had any questions. During a concurrent observation and interview with LVN 2, LVN 2 was asked to retrieve the policy and procedure on vent weaning. LVN 2 stated he did not know where the policies and procedures were kept but he could ask the unit manager where they were. During a concurrent observation and interview on 3/20/26 at 1:16 PM with CNA 5, CNA 5 stated he had been working at the facility since 9/2025. CNA 5 stated he did not know where the facility Policy and Procedures were kept but he could ask a nurse. During a concurrent observation and interview on 3/20/26 at 1:20 PM with LVN 3, LVN 3 looked for the policy and procedure on resident showers. LVN 3 searched multiple locations for the resident shower policy but was unable to locate it. During a concurrent interview and observation with CNA 4 and unit manager 2, CNA 4 and UM 2 were unable to state where facility P&Ps were kept. UM 2 stated she could ask medical records for policy and procedures. During a professional reference review retrieved from: https://www.aapacn.org/solution-providers/writing-effective-policies-for-long-term-care-ensuring-regulatory-cor the American Association of Post-Acute Care Nursing indicated: .Annual reviews of policies should be conducted. If regulatory information or guidance changes, policies should be reviewed and revised as necessary. Have documentation in place and available that demonstrates review dates and revision histories. Consider methods of storing old policies that have been removed or revised should the case arise that it may need to be brought back up for legal or regulatory review reasons. Policies ensure that regulatory expectations are met, resident rights are protected, and staff actions are guided with clarity and consistency. policy development must be a collaborative, informed and ongoing process. LTC providers must stay ahead of the ever evolving and changing regulatory landscape, adapting their policies to new realities while preserving their core mission: providing compassionate and competent care for every resident.