

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055206	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/07/2025
NAME OF PROVIDER OR SUPPLIER  Plaza Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1209 Hemlock Way Santa Ana, CA 92707	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and facility document review, the facility failed to provide the reasonable accommodations to meet the care needs for three of three sampled residents (Residents 9, 10, and 11) observed for call lights. * The facility failed to ensure Resident 9 had a urinal to use when he needed to urinate. In addition, the facility failed to respond timely when Resident 9 pressed his call light to ask for assistance which resulted in Resident 9 soiling his pull ups. * The facility failed to ensure the call light was within Resident 10 and 11's reach. These failures posed a risk for residents' care needs not being met and could negatively impact the residents' health and well-being. Findings: 1. On 8/6/25 at 1135 hours, the call light outside Resident 9's room was observed activated. Resident 9 was observed in bed, visibly upset. Resident 9 stated he activated his call light at around 1110 hours for the staff to bring his urinal. Resident 9 stated the staff had not answered his call light, which resulted soiling his pull ups. Review of the facility's document titled Nursing Assignment and Sign-In sheets for 8/6/25, showed CNA 9 was assigned to Resident 9 and was scheduled to go on lunch break from 1130 to 1200 hours. The document also showed CNA 8 was assigned to one of Resident 9's roommates and was scheduled to go to lunch from 1100 to 1130 hours. On 8/6/25 at 1145 hours, an interview was conducted with CNA 9. CNA 9 verified he was Resident 9's assigned CNA on 8/6/25. When asked about answering Resident 9's call light, CNA 9 stated he was on his lunch break. On 8/6/25 at 1430 hours, an interview was conducted with CNA 8. When asked about answering the call light for Resident 9's room, CNA 8 stated he went to his lunch break late. When asked about the lunch break coverage for the residents as per the nursing assignment, CNA 8 acknowledged he was supposed to cover for CNA 9 when CNA 9 went to lunch. CNA 8 stated he cared for a resident that took a long time, so he went to lunch 30 minutes later than his scheduled time. When asked if he had informed any staff when he went to lunch later than his scheduled time, CNA 8 stated he did not inform any staff about going to lunch late. Medical record review for Resident 9 was initiated on 8/6/25. Resident 9 was readmitted to the facility on [DATE]. Review of Resident 9's Care Plan Report showed a care plan problem initiated on 11/15/24, addressing Resident 9 was at risk for impaired bladder/bowel incontinence. The interventions included to check the resident every shift and assist with toileting as needed. Review of Resident 9's H&amp;P examination dated 7/23/25, showed Resident 9 was readmitted to the facility with diagnoses including post status stroke, Parkinson's disease, and high blood pressure. Review of Resident 9's Bowel and Bladder Program Screener dated 7/23/25, showed Resident 9 always voids appropriately without incontinence and independently, with reasonable speed, had the ability to get to the BR (bathroom)/transfer to toilet/commode/urinal, adjust clothing and wipe. Review of Resident 9's MDS assessment dated [DATE], showed Resident 9 had a BIMS score of 15 (no cognitive impairment). 2. On 8/1/25 at 1050 hours, an observation and concurrent interview was conducted with Resident 11. Resident 11 stated she was hungry. When asked to activate her call light, Resident 11's call light was observed hanging over towards the back of Resident 11's headboard, not within reach of the resident. Resident 11 was observed with a sling to her left upper extremity. Resident 11 was observed unable to reach her call light. When surveyor asked for Resident 11's CNA, the staff overhead paged the CNA for Resident 11. CNA 9 came and verified Resident 11's call light was not within reach of the resident. Medical record review for Resident 11 was initiated on 8/1/25. Resident 11 was readmitted to the facility on [DATE] Review of Resident 11's H&amp;P examination dated 5/15/25, showed Resident 11 had the capacity to make decisions. Review of Resident 11's annual MDS assessment dated [DATE], showed Resident 11 had an impairment to her extremities and needed substantial assistance with her ADLs care. 3. On 8/1/25 at 1130 hours, an observation and concurrent interview was conducted with Resident 10. Resident 10 stated she wanted to have iced water. When asked to activate the call light, Resident 10's call light was observed on the floor, and not within reach of the resident. CNA 8 came and verified Resident 10's call light was not within reach of the resident. Medical record review for Resident 10 was initiated on 8/1/25. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's H&amp;P examination dated 5/2/25, showed Resident 10 had the capacity to make decisions. Resident 10 was admitted to the facility with diagnoses including schizoaffective disorder, mood disorder, and anxiety.</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>(continued on next page)</p>

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, medical record review, and facility P&amp;P review, the facility failed to ensure the resident was free from unnecessary psychotropic medication for one of four residents (Resident 4) reviewed for the psychotropic medication use. * The facility failed to ensure Resident 4 had the mental capacity to give consent for the administration of the clonazepam (anti-anxiety) medication. In addition, the facility failed to ensure the lorazepam informed consent included the reason and duration for Resident 4's use of lorazepam (anti-anxiety) medication and the Surrogate IDT Proposal of Medical Intervention was completed. These failures had the potential for the resident to have adverse effects from the psychotropic medications. Findings: Review of the facility's P&amp;P titled Psychotropic Medication Use effective 6/2021 showed a psychotropic drug is any medication that affects brain activities associated with mental processes and behavior, which includes but is not limited to antipsychotics, anxiolytics, hypnotics and antidepressants. It is the responsibility of the attending health care practitioner to inform the resident and/or resident representative of the initiation, reason for use, and the risks associated with the use of the psychotropic medications, per facility policy or applicable state regulation. The informed consent will be obtained by the Prescriber prior to initiation of the psychotropic medication. The facility shall verify informed consent prior to the administration of a psychotropic medication for a resident. Review of the facility's P&amp;P titled Informed Consent revised on 6/27/24, showed the initial determination of the resident's capacity and identification of a decision maker includes:- The resident's physician will determine the resident's capacity to make decisions.- If the resident lacks the capacity to provide informed consent, the surrogate decision-maker will provide informed consent.- If the resident lacks capacity to provide informed consent and does not have a surrogate decision-maker, the facility will convene a Surrogate interdisciplinary team. Medical record review for Resident 4 was initiated on 8/6/25. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's H&amp;P examination dated 5/19/25, showed Resident 4 had no mental capacity to make decisions. Review of Resident 4's Order Summary Report showed the following physician's order:- dated 7/2/25, clonazepam oral tablet 1 mg one tablet by mouth two times a day for anxiety disorder manifested by throwing herself on bed, and- dated 7/8/25, lorazepam oral tablet 1 mg give one tablet by mouth every six hours as needed for anxiety manifested by inability to relax for 30 days. a. Review of Resident 4's Informed Consent showed the consent for the use of clonazepam 1 mg one tablet by mouth two times a day for anxiety was obtained by the medical provider from Resident 4. The consent form was signed and dated by the medical provider on 7/2/25. Review of Resident 4's Verification of Informed Consent for the clonazepam 1 mg one tablet by mouth two times a day for anxiety dated 7/2/25, the section for the person who verified that the physician spoke to them regarding the informed consent indicated Resident, and the verification was obtained via telephone. The verification of the informed consent further showed two nurses had signed the form. b. Review of Resident 4's Informed Consent for the lorazepam 1mg by mouth every six hours as needed dated 7/8/25, showed the medical practitioner had obtained the consent for the use of the lorazepam medication. The form failed to show the reason and duration of the lorazepam medication. Review of Resident Verification of Informed Consent dated 7/8/25, failed to show the name of the psychotropic medication, dosage, and frequency. In addition, the form showed the medical intervention was approved by the Surrogate Interdisciplinary Team (IDT), if the Surrogate Interdisciplinary Team (IDT) approved the medical intervention, the completion of the verification form is not necessary. Completion of the Surrogate IDT Proposal of Medical Intervention will serve as the verification of Informed Consent. Further review of Resident 4's medical record did not show documentation if the Surrogate IDT Proposal of Medical Intervention was completed. On 8/7/25 at 1113 hours, an interview and concurrent medical record review for Resident 4 was conducted with the DON. The DON stated Resident 4 could not decide for herself and the family was not involved with the resident's care. The DON confirmed the surrogate IDT proposal of the medication intervention was not completed for Resident 4. The DON also verified the Informed Consent should also include the reason and duration of the medication prior to use. On 8/7/25 at 1550 hours, the Administrator was made aware and acknowledged the above findings</p>		

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<p>F 0805</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>Based on observation, interview, and facility P&amp;P review, the facility failed to ensure the residents' meal was served according to their diet order for all the residents receiving meal from the kitchen as per the facility P&amp;P. * The facility failed to ensure prior to serving the meal trays, the licensed nurse checked the foods served to the residents were according to the physician's order. This failure posed the risk for the residents to not receive the correct diet as ordered by the residents' physicians. Findings: Review of the facility's P&amp;P titled Dining Program revised 1/30/25, under the section for Staff Assignments - Licensed Nurses, showed to check the meals against the attending physician's order. On 8/1/25 at 1209 hours, a dining room meal observation was conducted. LVN 5 was observed looking at the diet cards and lifting the lids of the resident's meal trays. When asked about the list of the residents' diet orders to verify the residents were receiving the correct diets as ordered by their physicians, LVN 5 stated the list was at the nurses' station. On 8/1/25 at 1215 hours, an observation and concurrent interview was conducted with LVN 2 at the nurse station. When asked for the list of the residents' diet orders, LVN 2 verified the list of residents' diet orders was not at the nurse station. LVN 2 acknowledged the list should have been printed prior to the residents' meal time for LVN 5 to check the resident's meal tray against their current diet as ordered by the physician.</p>		

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<p>F 0807</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and medical record review, the facility failed to ensure sufficient fluids was provided for two of three sampled residents (Residents 9 and 10) observed for hydration. * The facility failed to ensure Resident 10 had a water pitcher inside her room. * The facility failed to ensure Resident 9's water pitcher was refilled with water. These failures posed the risk for the residents to not receive an appropriate hydration. Findings: 1. On 8/1/25, at 1130 hours, concurrent observation and interview was conducted with Resident 10. Resident 10 verbalized wanting to have iced water. Resident 10 was observed with dryness to her mouth. Resident 10 was observed without a water pitcher in place. CNA 8 verified Resident 10 had no water pitcher for her use. Medical record review for Resident 10 was initiated on 8/1/25. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's H&amp;P examination dated 5/2/25, showed Resident 10 had the capacity to make decisions. Resident 10 was admitted to the facility with diagnoses including schizoaffective disorder, mood disorder, and anxiety. Review of the facility's August 2025 Diet Type Report showed Resident 10 did not have any fluid restrictions. 2. On 8/6/25 at 1135 hours, a concurrent observation and interview was conducted with Resident 9. When asked about having water in his water pitcher, Resident 9 verbalized the staff did not refill his water pitcher. Resident 9 stated his water pitcher was empty and no water in it. On 8/6/25 at 1140 hours, a concurrent observation and interview was conducted with LVN 6 inside Resident 9's room. LVN 6 verified Resident 9's water pitcher was empty, there was no water inside it. On 8/6/25 at 1145 hours, an interview was conducted with CNA 9. When asked about refilling Resident 9's water pitcher, CNA 9 stated he would refill the water pitcher when he could. Medical record review for Resident 9 was initiated on 8/6/25. Resident 9 was readmitted to the facility on [DATE]. Review of Resident 9's H&amp;P examination dated 7/23/25, showed Resident 9 was readmitted to the facility with diagnoses including post status stroke, Parkinson's disease, and high blood pressure. Review of Resident 9's MDS assessment dated [DATE], showed Resident 9 did not have a cognitive impairment. Review of the facility's August 2025 Diet Type Report showed Resident 9 did not have any fluid restrictions.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and facility P&amp;P review, the facility failed to ensure the sanitary/safe conditions, and food services were maintained as evidenced by: * The facility failed to ensure the bag of pepperoni slices and pizza crust were dated and the expired gallon of milk was removed from the storage area. * The facility failed to ensure there was no leak under the sink and water was not pooling on the floor near the trayline area and stove. * The facility failed to ensure [NAME] 1 performed hand hygiene after picking up a food item from the floor and before touching a clean utensil. * The facility failed to ensure the staff wore or properly wore the hair restraint while inside the kitchen, These failures posed the risk of food borne illness to the residents receiving food from the kitchen. Findings: Review of the facility's P&amp;P titled Dietary Department - Infection Control revised 2/29/24, showed personal cleanliness is required in sanitary food preparation. Cover hair, beard, and mustache with an effective hair restraint, such as hats, hair coverings, or nets while in any kitchen and food storage areas. The section for proper hand washing included the following:- during food preparation, as often as necessary to remove soil and contamination, and to prevent cross-contamination when changing task, - before dispensing or serving food and handling clean tableware and serving utensils in the food service area, and- after engaging in any other activities that contaminate the hands. 1. On 8/1/25, at 1015 hours, an initial tour of the facility's kitchen was conducted with the Food Services Director. A see-through plastic bag of pepperoni slices and pizza crust were observed undated inside the meat freezer. Also, a gallon of milk with an expiration date of 7/29/25, was observed inside the walk in freezer. Review of a sign posted on the vegetable freezer door showed the staff were to label and date all the food items. The findings were verified by the Food Services Director and acknowledged the food items should have not been stored in the freezers. 2. On 8/5/25 at 1112 hours, an observation and concurrent interview was conducted with [NAME] 1. [NAME] 1 verbalized a concern about the water pooling under a sink located next to the kitchen stove. Water was observed leaking from a pipe underneath the sink and then pooling onto the floor in the trayline area and kitchen stove. [NAME] 1 stated she had previously reported this ongoing problem to staff. An interview was conducted then with the Food Services Director who was also present in the kitchen. When asked about the water leakage and water pooling near the kitchen stove, the Food Services Director stated she was not aware. 3. On 8/5/25, at 1100 hours, during the trayline service observation, [NAME] 1 was observed picking up a food item from the kitchen floor with gloved hands and threw the food item into the kitchen barrel. [NAME] 1 was observed returning to the steam table and about to touch a clean utensil used for the trayline service, without performing hand hygiene in between. When asked regarding hand hygiene, [NAME] 1 acknowledged she did not perform hand hygiene after picking up a food item from the kitchen floor. 4. On 8/5/25, at 1202 hours, the following was observed inside the kitchen:- CNA 7 was observed entering the kitchen without a hair restraint;- the Food Services Director was observed with her hairnet partially restraining her hair. The front part of her hair was not restrained; and- the Dietary Aide was observed without a hair restraint inside the kitchen. All of the above findings were verified with the Food Services Director.</p>		

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<p>F 0838</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>Based on interview and facility document review, the facility failed to ensure the facility assessment showed a resident centered staffing plan to meet the needs of the residents. * The facility failed to ensure the assessment specified the staff members' competencies to care for residents with psychiatric disorders. This failure posed the risk for staff members not being able to provide the appropriate care when the residents had escalating behavior episodes. Findings: Review of the Facility's Assessment Tool dated 8/1/24, showed the facility was licensed for a total of 145 beds. The tool showed the number of residents with behavioral symptoms and cognitive performance was 120. Further review of the Facility's Assessment Tool failed to show the staffing plan included the specific staff competencies in placed to care for the residents with psychiatric disorders. On 8/6/25, at 0845 hours, an interview and concurrent facility assessment review tool was conducted with the Administrator. The Administrator stated he used the facility tool as a general outlook of acuity for residents and how to proceed. The Administrator stated all the staff received behavioral training. The Administrator was informed the facility assessment tool did not specify the behavioral training the staff would receive in the staffing plan to address the residents with psychiatric disorders. On 8/6/25 at 1515 hours, an interview was conducted with CNA 5. When asked about caring for residents with mental health behaviors during escalating episodes, CNA 5 stated she did the best she could and used her instinct, including yelling for help when needed. When asked if she had received any formal training about how to care for the residents during escalating behaviors, CNA 5 stated she did not receive any formal training from the facility. Review of CNA 5's employee file failed to show CNA 5 had received resident behavioral training from the facility. On 8/7/25, at 1200 hours, the Administrator and DON were informed CNA 5 file did not include resident behavioral training from the facility. The Administrator stated he would provide course completion history. Review of the facility's Course Completion History failed to show CNA 5 had received resident behavioral training from the facility.</p>		