

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Sheriden Woods Health Care Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 321 Stonecrest Drive Bristol, CT 06010	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who required staff assistance with transfers and ambulating, the facility failed to review and revise the mobility care plan when there was a change with the physician's order. The findings include: Resident #1's diagnoses included osteoarthritis (the most common type of arthritis that occurs when the cartilage that lines the joints is worn down or damaged and the bones rub together when the joint is used) of the knee, rheumatoid arthritis (when the immune system attacks the tissue lining the joints causing joint inflammation and pain), and generalized anxiety disorder. A physician's order dated 3/2/25 and remained a currant order directed to provide the resident with bed mobility assistance of two (2) and transfer assistance of two (2) with a rolling walker. The annual Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of twelve (12) out of fifteen (15) indicating Resident #1 had some memory recall deficits, required partial assistance with bed mobility and transfers and utilized a wheelchair for mobility. The Resident Care Plan (RCP) initiated on 1/6/24 and last reviewed on 1/16/26 identified Resident #1 required assistance with mobility due to decreased strength. Interventions directed Resident #1 was a total lift for transfers. The care plan failed to reflect the 3/2/25 physician's order. Interview with Physical Therapist #1 and Occupational Therapist #1 on 1/30/26 at 2:02 PM identified Resident #1 had been on therapy services until 12/18/25, when he/she was then discharged as an assist of two (2) stand pivot transfers from the bed to the wheelchair and from the wheelchair to the bed. They indicated the mobility orders on discharge matched the 3/2/25 activity orders so the therapist would have notified the charge nurse on 12/18/25 Resident #1 remained at the same level of care for transfers and therapy does not update the care plans, nursing was responsible to review and revise the care plans. They identified the mobility care plan last reviewed on 1/16/26 was incorrect and Resident #1 had not required a total lift for transfers since 3/2025. Interview with the Director of Nursing (DON) on 1/30/26 at 1:29 PM identified Resident #1's mobility care plan should have matched the 3/2/25 physician's order that directed Resident #1 required transfer assistance of two (2) staff with a rolling walker. The DON identified that both the interdisciplinary team and the Minimum Data Set nurse were responsible for reviewing and revising the care plans, and they also review and revise the care plans during the resident care plan meetings, which for Resident #1 was last held on 1/16/26. Review of the Comprehensive Care Planning policy dated 9/1/22 directed, in part, that assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. The interdisciplinary team reviews and updates the care plan: when there has been a significant change in the resident's condition; when the desired outcome is not met; when the resident has been readmitted to the facility from a hospital stay; and at least quarterly, in conjunction with the required quarterly MDS</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 075350	If continuation sheet Page 1 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Sheriden Woods Health Care Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 321 Stonecrest Drive Bristol, CT 06010	

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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>assessment.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Sheriden Woods Health Care Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 321 Stonecrest Drive Bristol, CT 06010	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of Resident #1's clinical records (including Minimum Data Set assessments, care plan, admission documentation, and nursing notes), facility policies, and staff interviews, the facility failed to ensure the resident, who required two-person assistance for transfers as per the care card, was transferred per protocol on 1/16/2026. As a result, Resident #1 sustained an acute comminuted fracture of the left distal femoral shaft above the knee, confirmed by X-ray and hospital records. This constitutes a preventable accident, reflecting a breakdown in supervision and adherence to established protocols. The findings include: Resident #1's diagnoses included osteoarthritis of the knee, rheumatoid arthritis and generalized anxiety disorder. The annual Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of twelve (12) out of fifteen (15) indicating Resident #1 had some memory recall deficits, required partial assistance with bed mobility and transfers and utilized a wheelchair for mobility. The Facility Reportable Incident form dated 1/16/26 at 4:15 PM identified Resident #1 was being transferred by the 3-11PM nurse aide when a pop sound was heard. Resident #1 had an increase in left knee pain. The report indicated the provider was notified and an x-ray was ordered of the left knee which later revealed a mildly comminuted fracture of the left distal shaft of the femur. The Physician's Assistant note dated 1/16/26 identified she was notified at 10:30 PM (over six (6) hours after the incident) and a telehealth appointment occurred for consultation of acute left knee pain. The note indicated per nursing during nighttime care, a crackling sound was heard coming from Resident #1's left knee and Resident #1 reported hearing a popping sound. The note identified Resident #1 was non-ambulatory at baseline. Resident #1 reported pain with attempted movement of the left leg and swelling of the left knee was noted. The note indicated APRN #1 ordered a STAT (immediate) left knee x-ray, directed to continue Tylenol administration as needed for pain and staff to apply ice to the knee. The 3-11 PM nursing supervisor's note dated 1/16/26 at 11:50 PM identified a call was placed to the on-call provider to report Resident #1 had an increase in pain to the left knee with noted edema after a cracking sound was heard during care. The note indicated an order was obtained for a STAT x-ray of the left knee, ice to be applied to the left knee for fifteen (15) to twenty (20) minutes every two (2) to three (3) hours as tolerated and to monitor for an increase in swelling, pain, new bruising or numbness. The Radiology Report dated 1/17/26 at 6:27 AM identified Resident #1 had sustained an acute comminuted fracture in the distal shaft of the left femur. The nurse's note dated 1/17/26 at 8:02 AM identified the provider was notified of the results of the left knee x-ray and Resident #1 was transferred to the hospital for further workup. The hospital Discharge summary dated [DATE] identified Resident #1 had been admitted for an acute comminuted fracture in the distal shaft of the left femur with surgical intervention, open reduction internal fixation. The nurse's note dated 1/22/26 at 11:04 PM identified Resident #1 had been readmitted to the facility. Interview with Resident #1 on 1/20/26 at 11:24 AM identified on 1/16/26 he/she was very tired, falling asleep in the wheelchair and his/her left foot had been bothering him/her, so a nurse aide, Nurse Aide (NA) #1, said she was going to put him/her into bed. Resident #1 explained he/she had not attempted to stand on his/her own without staff and although two (2) staff would always help him/her transfer from the wheelchair to the bed, NA #1 was alone that evening and without another staff present. Resident #1 identified NA #1 helped him/her stand without the use of the walker and told him/her to grab onto the side rail and then turn his/her bottom towards the bed. Resident #1 identified he/she started to turn but could barely move the left foot so NA #1 told him/her to step slowly and do it a little at a time and as he/she started to pivot the left</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Sheriden Woods Health Care Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 321 Stonecrest Drive Bristol, CT 06010	
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>knee he/she felt grinding in the left knee and immediate pain. Resident #1 identified NA #1 also heard the sound and the resident reported his/her left leg was touching the mattress, so NA #1 was able to pull him/her onto the edge of the bed and get him/her into bed without a fall occurring. Resident #1 indicated the transfer was very difficult and NA #1 did not utilize a gait belt. Interview with NA #1 on 1/30/26 at 1:17 PM identified as she was walking by Resident #1's room on 1/16/26, she observed Resident #1 leaning forward in the wheelchair with his/her hands on the side rail and it appeared Resident #1 was trying to stand. NA #1 indicated Resident #1 had been incontinent and although she knew Resident #1 was an assist of two (2) stand pivot with the walker for transfers, she did not call out or use the call bell to request assistance. NA #1 identified she did not place a gait belt around Resident #1 and did not utilize the walker to assist in the transfer. NA #1 explained she assisted Resident #1 in standing while Resident #1 held onto the side rail and as Resident #1 started to pivot, she heard a pop sound and Resident #1 yelled out in pain. NA #1 identified Resident #1 was close enough to the bed so she was able to get Resident #1 on the edge of the bed and lay Resident #1 into the bed and then left the room immediately to notify the nursing supervisor. NA #1 reported looking back, she should have yelled for assistance, waited so Resident #1 could safely be transferred to the bed, should have put the gait belt on and utilized the walker prior to transferring Resident #1 to bed. Interview with the 3-11PM nursing supervisor, Registered Nurse (RN) #1, on 1/30/26 at 12:18 PM identified on 1/16/26 the 3-11 PM nurse aide, Nurse Aide (NA) #1, came to her around 4:15 PM to report the incident. RN #1 indicated NA #1 reported she went to provide care to Resident #1 because Resident #1 had been incontinent and the incident occurred when she transferred Resident #1 into bed. RN #1 identified she assessed Resident #1 and although Resident #1 complained of pain with movement of the left leg and knee, she did not observe any redness or swelling so she did not report the incident to the provider immediately. RN #1 identified the 3-11PM charge nurse, Licensed Practical Nurse (LPN) #2, came to her just after 10:30 PM and reported Resident #1 had swelling to the left knee and continued to complain of pain with any movement of the left leg. RN #1 explained she assessed Resident #1 and then called the provider to report the initial incident and the subsequent swelling and pain. RN #1 reported NA #1 should not have transferred Resident #1 without a second staff member present and identified Resident #1 had significant lymphedema to both lower legs. Interview with Physical Therapist #1 and Occupational Therapist #1 on 1/30/26 at 2:02 PM identified Resident #1 had been on therapy services until 12/18/25, when Resident #1 was then discharged as an assist of two (2) for stand pivot transfers from the bed to the wheelchair and from the wheelchair to the bed. They indicated Resident #1 was not capable of pulling or pushing him/herself up out of the wheelchair unassisted. Interview with the Director of Nursing (DON) on 1/30/26 at 1:29 PM identified at the time of the 1/16/26 incident, Resident #1 was an assist of two (2) stand pivot transfer with the walker per the resident care card and physician's order. Review of the Use of Care Cards policy dated 3/12/25 directed, in part, that the facility utilizes Care Cards as a supplement tool to communicate essential, resident-specific care information to staff that highlights key care needs to support safe, consistent daily care and that they may include the following minimum necessary information to include mobility/transfer status. Noncompliance will be addressed through re-education and corrective action as needed. Review of the Gait Belt policy dated 9/1/22 directed, in part, that gait belts must be used for any residents who requires assistance with transfers or ambulation. A gait belt is required unless the resident is independently mobile or its use is contraindicated.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Sheriden Woods Health Care Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 321 Stonecrest Drive Bristol, CT 06010	
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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who had sustained an injury, the facility failed to administer pain medication following observations of pain to keep the resident comfortable. The findings include: Resident #1's diagnoses included osteoarthritis (the most common type of arthritis that occurs when the cartilage that lines the joints is worn down or damaged and the bones rub together when the joint is used) of the knee, rheumatoid arthritis (when the immune system attacks the tissue lining the joints causing joint inflammation and pain), and generalized anxiety disorder. A monthly physician's order that was initially ordered on 1/26/24 directed to administer acetaminophen 325 milligrams (mg), give three (3) tablets by mouth every six (6) hours as needed for pain. The annual Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of twelve (12) out of fifteen (15) indicating Resident #1 had some memory recall deficits, required partial assistance with bed mobility and transfers and utilized a wheelchair for mobility. The Resident Care Plan dated 1/16/26 identified Resident #1 has a diagnosis of rheumatoid arthritis and osteoarthritis with the potential for pain and decreased mobility. Interventions included administering medications as prescribed, observing for effectiveness and side effects and reporting to the provider as needed. The Facility Reportable Incident form dated 1/16/26 at 4:15 PM identified Resident #1 was being transferred by the 3-11PM nurse aide when a pop sound was heard, and Resident #1 had an increase in left knee pain. The report indicated the provider was notified and an x-ray was ordered of the left knee which later revealed a mildly comminuted fracture (when a bone breaks into three (3) or more pieces caused by high impact trauma) of the left distal shaft of the femur (thighbone fracture that occurs just above the knee joint). The report identified the acetaminophen had been administered to Resident #1 on 1/16/26 at 4:15 PM for a level of six (6) out of ten (10) pain and was noted to be effective. The Physician's Assistant note dated 1/16/26 identified she was notified at 10:30 PM (over six (6) hours after the incident) and a telehealth appointment occurred for consultation of acute left knee pain. The note indicated per nursing during nighttime care, a crackling sound was heard coming from Resident #1's left knee and Resident #1 reported hearing a popping sound. The note identified Resident #1 was non-ambulatory at baseline, since the event Resident #1 reported pain with attempted movement of the left leg and swelling of the left knee was noted. The note indicated APRN #1 ordered a STAT (immediate) x-ray of the left knee, directed to continue Tylenol administration as needed for pain and staff to apply ice to the knee. Review of the January 2026 Medication Administration Record (MAR) identified the acetaminophen (Tylenol) had been administered to Resident #1 on 1/17/26 at 5:12 AM for a pain level of ten (10) out of ten (10) pain and was noted to be ineffective. The nurse's note dated 1/17/26 at 8:02 AM identified the provider was notified of the results of the left knee x-ray and Resident #1 was transferred to the hospital for further workup. The note failed to reflect documentation that Resident #1's pain level was addressed, or an order was obtained to administer additional pain medication prior to Resident #1's transfer to the hospital. The hospital Discharge summary dated [DATE] identified Resident #1 had been admitted for an acute comminuted fracture in the distal shaft of the left femur with surgical intervention, open reduction internal fixation. Interview with Resident #1 on 1/20/26 at 11:24 AM identified following the 1/16/26 injury, he/she had severe pain to the left knee following any movement until arrival at the hospital. Interview with the 3-11PM nursing supervisor, Registered Nurse (RN) #1, on 1/30/26 at 12:18 PM identified on 1/16/26 the 3-11PM nurse aide, Nurse Aide (NA) #1, came to her around 4:15 PM to report the incident. RN #1 identified</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Sheriden Woods Health Care Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 321 Stonecrest Drive Bristol, CT 06010	
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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>although Resident #1 complained of pain with movement to the left leg and knee, she did not observe any redness or swelling so she asked the charge nurse to take Resident's vital signs and administer Tylenol for pain relief. Interview with the 3-11PM charge nurse, Licensed Practical Nurse (LPN) #2, on 1/30/26 at 12:40 PM identified the nursing supervisor, RN #1, came to her requesting she take Resident #1's vital signs and administer Tylenol for pain relief just before 4:15 PM on 1/16/26. LPN #1 reported she administered Tylenol and then went to check on Resident #1 again a little after 5:00 PM, Resident #1 was comfortable and the Tylenol had been effective. LPN #2 identified when she went to check on Resident #1 again around 10:40 PM, she lifted Resident #1's left leg, and Resident #1 yelled out in pain, the left knee was noted to be swollen so she immediately notified the nursing supervisor who called the provider. LPN #2 identified she should have administered the Tylenol again to Resident #1 when she discovered the pain around 10:40 PM. Interview with the 11PM-7AM charge nurse, LPN #3, on 1/30/26 at 12:29 PM identified both LPN #2 and the 11PM-7AM nursing supervisor, RN #2, reported to her Resident #1 had been in pain at the end of the 3-11PM shift, and although Resident #1 appeared to be uncomfortable when she checked on Resident #1 throughout the night, she did not medicate Resident #1 with Tylenol prior to 5:12 AM because she assumed LPN #2 had administered it since Resident #1 had just been assessed at the end of the 3-11PM shift. LPN #3 identified she did not verify on the Medication Administration Record when the Tylenol was last given and around 5:00 AM, the nurse aides reported to her they were going to do care, so she administered Tylenol at 5:12 AM in preparation for care. LPN #3 reported she stayed to assist throughout the care, Resident #1 appeared to be very uncomfortable with movement and when she checked on Resident #1 again after 6:00 AM, Resident still appeared to be restless and uncomfortable, so she notified the nursing supervisor. LPN #3 indicated because she notified RN #2 of the unrelieved pain, she assumed RN #2 would notify the provider with the pain concerns as well as the x-ray results. Interview with Advanced Practice Registered Nurse (APRN) #1 on 1/30/26 at 2:27 PM identified if the acetaminophen was not effective in managing Resident #1's pain following the 5:12 AM administration, this should have been reported to the provider so additional pain relief could have been ordered. Interview with the Director of Nursing (DON) on 1/30/26 at 1:29 PM identified the 3-11PM charge nurse, LPN #2, should have administered Tylenol upon observing Resident #1 to be in pain with movement to the left knee/leg around 10:40 PM and the provider should have been notified Resident #1 had unrelieved pain after the 5:12 AM dose so that an alternative pain medication could have been ordered and Resident #1 kept comfortable, especially with the transport to the hospital. Review of the Pain Assessment and Management policy (undated) directed, in part, that acute pain should be assessed every thirty (30) to sixty (60) minutes after the onset and reassessed as indicated until relief is obtained. Review the medication administration record to determine how often the individual requests and receives as needed pain medication, and to what extent the administered medications relieve the resident's pain. If pain has not been adequately controlled, the multidisciplinary team, including the physician, shall reconsider approaches and make adjustments as indicated. Report the following information to the physician or practitioner: significant changes in the level of the resident's pain and prolonged, unrelieved pain despite care plan interventions.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Sheriden Woods Health Care Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 321 Stonecrest Drive Bristol, CT 06010	
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 0730</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>Based on review of facility documentation, review of facility policy, and interviews for one (1) of three (3) nurse aides, the facility failed to complete an annual performance evaluation. The findings include: Review of a 3-11PM nurse aide's, Nurse Aide (NA) #1, personnel file identified a hire date of 11/26/12 and the last performance evaluation was completed on 12/18/22. The facility failed to identify a yearly performance evaluation was completed in 2023, 2024, and 2025. Interview with the Administrator on 1/20/2026 at 2:45 PM identified each employee was required to have a performance evaluation completed annually based on their date of hire, yearly anniversary. The Administrator identified although the facility does not currently have a Human Resources (HR) staff member, HR was expected to make the notification of when the performance evaluation was due, and the annual evaluation was then distributed to the nursing supervisor to complete, HR was then responsible for ensuring the annual performance evaluations were completed and in the employee's record. The How to Complete the Performance Evaluation policy identified that the facility reviews and summarizes the employee counseling session to identify a trend and pattern. The facility also reviews the job description performance rating with the employee to ensure the employee understands the performance rating for the function of their position and the performance evaluation is filed in accordance with facility policy.</p>		