STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135089	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cascades at Desert View	820 Sprague Avenue Buhl, ID 83316

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983 Based on record review and staff interview, it was determined the facility failed to ensure informed consent was obtained prior to initiation of psychotropic medications for 1 of 16 residents (Resident #8) reviewed for unnecessary medications. This deficient practice placed residents at risk of receiving medications without knowledge of the reason why medications were prescribed, the expected benefits, and the risks associated with the medications. Findings include: Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including surgical aftercare, Alzheimer's disease with early onset, and dementia. On 12/31/24, a physician order documented Resident #8 was to start Seroquel (an antipsychotic medication that affects brain activities associated with mental processes) 25 mg one time a day for dementia with behavioral disturbance. On 1/29/25, the Pharmacist documented It would be suggested to assess the risks versus benefits for continued use of Quetiapine (generic Seroquel) 25 mg at bedtime for dementia with behavioral disturbances secondary to the black box warning for use of antipsychotic medications for behaviors associated with dementia. On 4/2/25 at 12:15 PM, the Social Services Supervisor stated there was not a risk and benefits consent for Resident #8's use of Quetiapine. On 4/2/25 at 12:30 PM, the DON stated, she had sent the recommendations from the Pharmacist to Resident #8's attending physician, but he did not respond.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 50983 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure residents were provided with a clean, safe, homelike environment. This was true for all residents who resided in the facility whose environment were observed. This deficient practice created the potential for harm if: a) residents were embarrassed by and/or felt the disrepair in the facility was unacceptable, disrespectful, or undignified and b) residents were injured due to unsafe areas in the facility. Findings include: The facility Maintenance policy revised December 2009, documented the function of the maintenance personnel was to maintain the building in good repair and free from hazards. On 3/31/25 at 11:20 AM, observed a thick layer of dust and dirt on the ceiling air exchange vent in the North hallway. On 3/31/25 at 1:58 PM, observed the floor by the copy room with a 7-inch by 3/4- inch area missing tiles. On 4/1/25 at 1:54 PM, observed the floor in the main dining room, in front of the counter with condiments a 2-inch by 1/3-inch piece of flooring sticking up. On 4/1/25 at 5:14 PM, the Administrator stated the flooring should have been replaced. On 4/3/25 at 3:00 PM, the Maintenance Director stated the vents were cleaned annually in the Spring. 49552

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on record review and staff interview, it was determined the facility failed to ensure the MDS assessment accurately reflected resident's status. This was true for 1 of 16 residents (Resident #6) whose MDS assessments were reviewed. This deficient practice had the potential for negative outcomes if residents were not assessed and/or monitored due to inaccurate assessments. Findings include: Resident #6 was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including heart failure and diabetes. Resident #6's Physician order dated 5/29/24, documented Level of Care: Hospice. Resident #6's care plan dated 8/29/24, documented Resident #6 had a terminal prognosis and was on hospice. Resident #6's Quarterly MDS dated [DATE], documented under section O, K1. Hospice No. Resident #6's Quarterly MDS dated [DATE], documented under section O, K1. Hospice No. On 4/2/25 at 9:54 AM, the DON stated Resident #6 was on hospice and she did not know why his MDS did not reflect that. On 4/2/25 at 10:02 AM, the Regional MDS nurse stated Resident #6's MDS was not coded correctly and should have been coded as Yes for hospice services.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983 Based on record review and staff interview, it was determined the facility failed to refer residents with an exempted hospital stay and have a diagnosed mental disorder to the appropriate state-designated authority for a re-evaluation and determination. This was true for 1 of 3 residents (Resident #8), reviewed for PASRR level II evaluations. This deficient practice had the potential to cause harm if resident's specialized services for mental health needs were not evaluated by an appropriate state-designated authority. Findings include. Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including surgical aftercare, Alzheimer's disease with early onset, and Major Depressive Disorder. On 11/25/24, a BLTC Medicaid reviewer documented on Resident #8's PASRR Level II 30-day exemption rehabilitation. If the participant stays (30 days) past admission, please submit most current MDS, MD orders, social notes, and psych info to BLTC. If discharged , please notify BLTC. Review of Resident #8's medical record did not document a PASRR Level I or the requested documents were resubmitted to BLTC when her admission exceeded 30 days. On 4/2/25 at 12:15 PM, the Social Services Supervisor stated she knew Resident #8 had passed the 30-day timeframe, but had not sent her most current MDS, physician orders, social service notes, and psychiatric information as requested to BLTC.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983 Based on record review, policy review, and staff interview, it was determined the facility failed to a) ensure resident care plans were revised to reflect current needs and interventions and b) ensure residents and their representatives were encouraged to participate in care planning and attend care conferences. This was true for 4 of 16 residents (Resident #8, #11, #21, and #27) whose care plans were reviewed. This placed residents at risk for adverse outcomes if care and services were not provided due to care plans not being revised as resident's needs changed. Findings include. The facility's Care Plans, Comprehensive Person-Centered policy, revised March 2022, documented assessments of residents are ongoing, and care plans are revised as information about the resident and resident condition changes. 1. Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including surgical aftercare, Alzheimer's disease with early onset, and dementia. Resident #8's care plan revised 3/13/25, documented she had an active infection and is taking antibiotics for 10 days with a stop date of 3/23/25. Resident #8's care plan had not been updated to resolve the active infection after she completed taking the antibiotics. On 4/2/25 at 12:30 PM, the DON and the MDS Resource nurse stated the care plan should have been updated after Resident #8 finished her antibiotics. 2. Resident #11 was initially admitted to the facility on [DATE], and readmitted to the facility on [DATE], with multiple diagnoses which include acute infarction of spinal cord (stroke within the spinal cord) and diabetes. Resident #11 interviewed on 3/31/25 at 1:37 PM, stated he had not been informed or attended a care conference for some time. Resident #11's medical record documented a Resident Advocate note dated 6/26/24, and a Care Conference note dated 7/31/24. Resident #11's medical record had not documented a care conference after his readmission on 10/30/24. 3. Resident #21 was admitted on [DATE], with multiple diagnoses including osteoarthritis, anxiety disorder, and PTSD. On 4/1/25 at 10:54 AM, Resident #21 stated he had not participated in care conferences to discuss his plan of care. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/2/25 at 2:32 PM, the Social Service Supervisor stated she did not have any documentation of care conferences for Resident #21. 4. Resident #27 was admitted on [DATE], with multiple diagnoses including acute and chronic respiratory failure, hyperlipidemia (high cholesterol), and dementia. On 3/31/25 at 3:46 PM, Resident #27's medical record had not documented a care conference since 6/24/24. On 4/2/25 at 12:15 PM, the Social Service Supervisor stated she had not completed care conferences since June 2024. 52524

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on observation, record review, and staff interview, it was determined the facility failed to ensure professional standards of nursing practice were followed for 1 of 17 residents (Resident #28) reviewed for quality of care. Resident #28 was at risk for adverse outcomes when her physician order was not written correctly. This failed practice had the potential to adversely affect residents whose care and services were not followed according to accepted standards of practice. Findings include: Resident #28 was admitted to the facility on [DATE], with multiple diagnoses including peripheral vascular disease (when the arteries become narrow or blocked, reducing blood flow to the affected areas) and left leg, above the knee amputation. On 3/31/25 at 10:41 AM, observed Resident #28's right lower extremity with a Tubigrip stocking (a tubular elastic bandage used to provide tissue support and compression). Her left lower leg had been amputated. Resident #28's Physician order dated 11/19/24, documented, Tubigrip to LLE during the day for edema. Remove at night. Resident #28's TARs dated 11/20/24 through 4/2/25, documented Tubigrip had been applied to her LLE. On 4/2/25 at 10:11 AM, the Regional MDS Nurse stated Resident #28's physician order was written for the wrong leg. The order should have been written for the RLE. On 4/2/25 at 12:54 PM, the DON stated the physician order for Tubigrip should have been written for Resident #28's RLE.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on observations, record review, and staff interview, the facility failed to ensure interventions were put in place and followed to prevent additional falls for 2 of 16 residents (#1 and #6) reviewed for falls. This failure increased the potential for additional falls and potential injury for residents with a history of falls. Findings include: 1. Resident #1 was initially admitted to the facility on [DATE], and readmitted [DATE], with multiple diagnoses including cerebral infarction (when blood flow to the brain is blocked, causing tissue death to the brain) and traumatic brain injury. Review of the facility's Incident and Accident reports dated 6/22/24, documented the staff were transferring Resident #1 to the bed when his knees buckled, and he was lowered to the ground. Review of the facility's Incident and Accident reports dated 2/10/25, documented NA #1 was transferring Resident #1 to the bed, when his legs buckled, and she lowered him to the ground. Review of Resident #1's care plan did not document new fall prevention interventions for the falls. On 4/2/25 at 12:56 PM, the DON stated Resident #1's falls were due to a behavioral issues and there were no new behavioral interventions put in his care plan after his falls and there should have been. 2. Resident #6's was initially admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including heart failure and dementia. Review of the facility's Incident and Accident reports dated 8/31/24, documented Resident #6 fell out of his bed. Review of Resident #6's care plan did not document a new intervention for his fall. On 4/2/25 at 12:44 PM, the Regional MDS Nurse stated there were no new fall prevention interventions documented in Resident #6's care plan. On 4/2/25 at 1:06 PM, the DON stated there were no new fall prevention intervention for Resident #6 and there should have been.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 52524 Based on record review and staff interview, it was determined the facility failed to ensure controlled medications were tracked and kept secure from potential theft and/or diversion. This was true for 1 of 2 medication carts reviewed. This failure created the potential for undetected misuse and/or diversion of controlled medications and had the potential to affect all residents who received controlled medication in the facility. Findings include: On 4/1/25 at 1:55 PM, during North hall medication cart audit, observed the narcotic accountability record, dated 3/2/25 to 4/1/25, with one licensed nurse signature not documented. On 4/1/25 at 1:57 PM, LPN #1 stated the nurses should have signed the narcotic accountability sheet when they accepted the medication cart or released the medication cart.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983 Based on policy review, record review, and staff interview, it was determined the facility failed to ensure the attending physician acted upon Pharmacy recommendations for 1 of 16 residents, (Resident #8) whose medication regimens were reviewed for psychotropic medication. This deficient practice placed residents with dementia at an increased risk of death. Findings include: The facility's Medication Regimen Review Policy dated April 2024, documented the attending physician is to document in the medical record any medication irregularity and what, (if any) action was taken to address it. Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including surgical aftercare, Alzheimer's disease with early onset, and dementia. On 12/31/24, a physician order documented Resident #8 was to start Seroquel (a medication that affects brain activities associated with mental processes) 25 mg one time a day for dementia with behavioral disturbances. On 1/29/25, the Pharmacist documented on the MRR report to the prescribing physician the following, It would be suggested to assess the risks versus benefits for continued use of Quetiapine (generic Seroquel) 25 mg at bedtime for dementia with behavioral disturbances. On 2/28/25, the Pharmacist documented on the MRR report to the prescribing physician the following, Consider discontinuing Quetiapine 25 mg at bedtime currently prescribed for dementia with behavioral disturbances. Resident #8's medical record did not document a response from the attending physician for the Pharmacists recommendation on 1/29/25 or 2/28/25. On 4/2/25 at 12:15 PM, the Social Services Supervisor stated there was no documentation in Resident #8's medical record assessing risk versus benefits for the use of Quetiapine. On 4/2/25 at 12:30 PM, the DON stated, she had sent the recommendations from the Pharmacist to Resident #8's attending physician, but he had not responded.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50983 Based on review of the FDA Black Box Warning, record review, and staff interview, the facility failed to ensure the medical necessity for psychotropic medication administration. This was true for 1 of 16 residents (Resident #8) reviewed for unnecessary medications. This failure created an increased risk of mortality when residents diagnosed with dementia were prescribed antipsychotic medications. Findings include: The FDA documented elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Seroquel (an antipsychotic drug) is not approved for elderly patients with dementia related psychosis. Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including surgical aftercare, Alzheimer's disease with early onset, and dementia. On 12/31/24, a physician order documented Resident #8 was to start Seroquel 25 mg one time a day for dementia with behavioral disturbance. On 2/28/25, the Pharmacist documented on the MRR report to the attending physician to consider discontinuing Seroquel 25 mg. Resident #8's medical record had not documented a response from the attending physician for the Pharmacists recommendation on 2/28/25. On 4/2/25 at 12:30 PM, the DON stated she had sent the recommendation from the Pharmacist to discontinue Resident #8's Seroquel to Resident #8's attending physician, but he had not responded.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 52524 Based on observation and staff interview, it was determined the facility failed to ensure the medication error rate was less than 5%. This was true for 2 medications (5.41% error rate) which affected 1 of 3 residents (Resident #142) whose medication administrations were observed. This failed practice placed residents at risk of not receiving their prescribed medication or dosage of their medication. Findings include: The following was observed during the medication pass: Resident #142's physician order documented insulin sliding scale; administer Lantus insulin, 10 Units subcutaneously and Lispro insulin, 2 Units subcutaneously. On 4/2/25 at 7:35 AM, observed LPN #1 remove Lantus insulin pen from the medication cart and dial the Lantus insulin pen to 1 Unit to prime and then dialed to 10 Units as ordered. On 4/2/25 at 7:36 AM, observed LPN #1 remove Lispro insulin pen from the medication cart and dial the Lispro insulin pen to 1 Unit to prime then dialed to 2 Units as ordered. LPN #1 did not prime the insulin pens with the required 2 Units of insulin before dialing the ordered dose. LPN #1 then administered the Lantus insulin and Lispro insulin to Resident #142. On 4/2/25 at 7:48 AM, LPN #1 stated she primed each insulin pen with 1 Unit of insulin before dialing the pen to the ordered dose.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 52524 Based on observation and staff interview, it was determined the facility failed to ensure controlled medications were stored and kept secure from potential theft and/or diversion. This failure created the potential for undetected misuse and/or diversion of controlled medications and had the potential to affect all residents who received controlled medication in the facility. Findings include: On 4/1/25 at 1:37 PM, observed bottle of lorazepam liquid (Schedule IV controlled medication) stored in the medication refrigerator door rack. On 4/1/25 at 1:48 PM, RN #1 stated the medication refrigerator and the medication room door is locked. She stated there is no other locked, permanently affixed, compartment inside the medication refrigerator for controlled medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49552 Based on observation, interviews, and review of the Idaho Food Code, it was determined the facility failed to ensure food was stored properly, dated when opened, equipment was stored in a sanitary condition, and ensure infection control protocol was followed during meal tray delivery. This deficient practice had the potential to affect all 39 residents who received meals prepared in the facility's kitchen. Findings include: The Idaho Food Code, revised February 2021, stated, 3-501.17 Ready-to-eat, Time/Temperature Control for Safety Food, Date Marking . held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded . The NSF Machine Operational Requirements for the dishwasher documented: Wash temperature recommended 120 degrees Fahrenheit, minimum 120 degrees Fahrenheit. Rinse temperature recommended 140 degrees Fahrenheit, minimum 120 degrees Fahrenheit. Required 50 PPM Available Chlorine. 1. The following were related to labeling and storage of food products: During the initial kitchen tour on 3/31/25 at 9:50 AM, with the dietary manager present, the following observations were made: In the walk-in refrigerator: -1 bottle of lime juice with use by date of 1/7/25. -1 bottles of lime juice with use by date of 2/2/25. -1 half empty, opened, carton of liquid whole eggs with no open date or use by date. On 3/31/25 at 9:53 AM, the DM stated the juices should have been discarded and the carton of liquid eggs should have been closed and dated. 2. The following was observed for sanitary conditions: During the initial kitchen tour on 3/31/25 at 9:55 AM, with the dietary manager present, the following observations were made: - the edge of the walk-in refrigerator door had a black, dry substance on the edge of the door, by the handle. - the toaster and air fryer had a dry, white substance on it. - on the back wall of the steam table observed a dry, red substance. (continued on next page)

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Cascades at Desert View	820 Sprague Avenue Buhl, ID 83316

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- the Dish Machine temperature log documented 100 degrees Fahrenheit under the Rinse temperature and sanitation was not documented. On 4/2/25 at 11:04 AM, observed the following in the kitchen: - plate warmer base had a light brown, fuzzy substance on it. - the front of the plate warmer had a dry, white substance on it. - the steam table handle had a white, dry substance on it. - the vent and 2-fire alarms had a thick, black substance on and around them. -the pipes under the dish washing area had a black substance on them. On 4/2/25 at 12:33 PM, the DM stated the staff were to follow the daily cleaning schedule and there were items she needed to add to the list to be cleaned. She also stated that they had not been checking the rinse cycle temperature on the dishwasher and now realized they should have been. 3. The following was observed for proper meal delivery: On 3/31/25 at 11:50 AM, observed RN #1 delivering meal trays to room [ROOM NUMBER], #11, and #4. RN #1 walked from the Behavioral Health lunchroom to the resident's rooms without the salad and the hot spiced apples covered. On 3/31/25 at 11:52 AM, RN #1 stated she was not sure if the salad and apples had to be covered when it was walked down the hall to a resident's room. On 4/2/25 at 11:43 AM, the DM stated the food should be covered if it is being delivered a long distance to a resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135089	A. Building B. Wing	04/03/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49552 Based on observation, policy review, and staff interview, it was determined the facility failed to ensure infection control and prevention practices were maintained to provide a safe and sanitary environment when staff did not perform proper hand hygiene. These failures had the potential to impact all residents in the facility by placing them at risk for cross contamination and infection. Findings include: The following was observed for hand hygiene: On 3/31/25 at 11:55 AM, observed 12 residents served their meal in the dining room. Hand hygiene was not offered or performed for the residents prior to receiving their meal. On 3/31/25 at 12: 06 PM, observed RN #1 serve 3 residents their meal to them in their room. Hand hygiene was not offered or performed for the residents. On 3/31/25 at 12:36 PM, CNA #1 stated they usually wash the resident's hands with wash clothes before and after they eat but today, they did not, and they should have. On 4/3/25 at 12:11 PM, IP stated the residents should be offered hand hygiene before meals, in the dining room and in their rooms.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 49552 Based on record review and staff interview, the facility failed to provide a minimum of 12 hours of in-service education per year for 2 of 2 CNAs (#2 and #3) reviewed for sufficient and competent CNA staffing. This failure placed residents at risk of receiving care from staff who are not adequately trained to meet residents' needs. Findings include: 1. On 4/3/25 at 12:46 PM, review of CNA #2's employee file documented her hire date was 3/22/19. Review of CNA #2's Employee In-service Hours form documented she had 9.5-hours of in-service time for 2024. Review of CNA #2's Employee In-service Hours form documented she had completed two in-services for 2025. No time was documented for the two in-services. CNA #2's employee file did not document that she had completed 12-hours of in-services for the 2024/2025 evaluation period. 2. On 4/3/25 at 1:50 PM, review of CNA #3's employee file documented her hire date was 1/13/10. Review of CNA #3's Employee In-service Hours form documented she had 4 hours of in-service time documented for 2024. CNA #3's Employee In-service Hours form documented 1.5-hours of in-service time for 2025. CNA #3's employee file did not document that she had completed 12-hours of in-services for the 2024/2025 evaluation period. On 4/3/25 at 2:13 PM, the Administrator stated she knew the CNAs had to have 12-hours of in-service time, but she did not know it was based on hire date. On 4/3/25 at 3:12 PM, the DON stated CNA #2 and CNA #3 did not have the required 12-hours of in-service and they should have had it.