

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Chateau Napoleon Caring		STREET ADDRESS, CITY, STATE, ZIP CODE 252 Hwy. 402 Napoleonville, LA 70390	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>47487</p> <p>Based on interviews and record reviews, the facility failed to ensure staff notified a physician regarding a change in a resident's skin condition for 1 (Resident #1) of 3 (Resident #1, Resident #2, Resident #3) sampled residents reviewed for notification of change.</p> <p>Findings:</p> <p>Review of Resident #1's progress note dated 02/10/2025 at 9:30AM revealed, in part, the Certified Nursing Assistant (CNA) reported a red/purple discoloration to Resident #1's right neck/chest area. Further review revealed, upon assessment, Resident #1 presented with a small red/purple discoloration to Resident #1's right neck/chest area and Resident #1's physician was made aware.</p> <p>In an interview on 02/20/2025 at 2:10PM S6Former LPN indicated she attempted to notify Resident #1's physician's nurse of Resident #1's skin alteration, but the text message was not sent successfully. S6Former LPN further indicated she had not realized the text message did not send successfully until S5StaffDevelopment Nurse called her later in the day when she (S5Staff Development Nurse) was sending Resident #1 to the emergency room .</p> <p>In an interview on 02/20/2025 at 9:05AM, S5Staff Development Nurse indicated S6Former LPN's text message to Resident #1's physician's nurse did not send successfully. S5Staff Development Nurse indicated Resident #1's physician was not notified of the bruise on Resident #1's right chest until around 7:00PM on 02/10/2024 when she sent Resident #1 to the emergency room .</p> <p>In an interview on 02/21/2025 at 11:46AM, S1Administrator indicated S6Former LPN should have notified the Resident #1's physician on 02/10/2025 when she first noticed the rash/discoloration on Resident #1's chest.</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 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>47487</p> <p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on interviews and record review, the facility failed to ensure administrative staff (S2Director of Nursing [DON]) followed the facility's abuse prevention policy and did not indicate to a staff member (S6Former Licensed Practical Nurse) that she should not have admitted to seeing Resident #1's injury of unknown origin.</p> <p>Findings:</p> <p>Review of the facility's undated DON Job Description revealed, in part, the facility's DON was responsible for ensuring the facility's nursing service personnel understood and followed departmental policies and procedures.</p> <p>Review of the facility's Freedom from Abuse, Neglect, and Exploitation-Preventing and Prohibiting Abuse policy, last revised in 03/2023 revealed, in part, a sign of abuse was a suspicious injury. Further review revealed staff would immediately report allegations or suspicions of abuse to the Administrator, state agency, adult protective services, and other required agencies.</p> <p>In an interview on 02/20/2025 at 10:32AM, S4Former Admissions Nurse indicated S8LPN had sent her a recording of a conversation between S8LPN and S2DON in which S2DON told S8LPN she should have acted like she did not see the bruise on Resident #1's chest on 02/10/2025.</p> <p>In an interview on 02/20/2025 at 2:10PM, S6Former LPN indicated the recorded conversation between her (S6Former LPN) and S2DON and had taken place on 02/11/2025. S6Former LPN further acknowledged in the recorded conversation, S2DON told her she should have acted like she did not see the bruise/injury of unknown origin on Resident #1 that she had identified on 02/10/2025.</p> <p>Review of the above mentioned recorded conversation between S6Former LPN and S2DON regarding Resident #1's bruise/injury of unknown origin, revealed, in part, S2DON stated to S6Former LPN I would have just left it alone. I'm going to be honest with you, as an LPN on the hall, I would have swear to God I didn't see it, I wouldn't do nothing about it. I'm going to be straight up, and I'm not supposed to be telling you this.</p> <p>In an interview on 02/21/2025 at 11:59AM, S2DON confirmed that it was her (S2DON) speaking to S6Former LPN in the above mentioned conversation. When asked if she had any explanation to dispute the deficient practice at this time, S2DON declined to comment.</p> <p>In an interview on 02/21/2025 at 1:58PM, S1Administrator indicated S2DON should not have told S6Former LPN to not report a bruise/injury of unknown origin.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>34608</p> <p>Based on interviews and record reviews, the facility failed to revise a plan of care with an intervention after a fall for 1 (Resident #2) of 3 (Resident #1, Resident #2, Resident #3) sampled residents investigated for resident centered care plans.</p> <p>Findings:</p> <p>Review of the facility's incident/accident log dated 11/2024 to 02/2025 revealed, in part, Resident #2 had unwitnessed falls on 11/24/2024 12/18/2024, and 02/13/2025.</p> <p>Review of Resident #2's Minimum Data Set with an Assessment Reference Date of 12/10/2025 revealed, in part, Resident #2 had a Brief Interview for Mental Status assessment score of 9, which indicated moderate cognitive impairment. Further review revealed Resident #2 had one fall with no injury since Resident #2's last assessment.</p> <p>Review of Resident #2's nursing progress note dated 02/13/2025 at 9:10PM revealed, in part, a Certified Nursing Assistant (CNA) reported to the nurse Resident #2 was found lying on the floor near Resident #2's bed.</p> <p>Review of Resident #2's Plan of Care with a target date of 03/11/2025 revealed, in part, Resident #2 was at risk for falls related to gait/balance problems and had unwitnessed falls on 11/20/2024, 12/18/2024, and 02/13/2025. Further review of Resident #2's Plan of Care revealed no new intervention was implemented after Resident #2's fall on 02/13/2025.</p> <p>In an interview on 02/20/2025 at 10:08AM, S2DON confirmed a new intervention was not developed for Resident #2's Plan of Care following Resident #2's fall on 02/13/2025. S2DON indicated Resident #2's Plan of Care should have been updated with an intervention to decrease risk of falls on 02/13/2025.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>47487</p> <p>Based on interviews and record reviews, the facility failed to ensure a licensed nurse (S7Licensed Practical Nurse [LPN]) did not leave the facility without ensuring another nurse assumed responsibility of her resident assignment.</p> <p>This deficient practice had the potential to affect all 28 residents (Resident #1, Resident #R4, Resident #R5, Resident #R8, Resident #R9, Resident #R10, Resident #R11, Resident #R12, Resident #R13, Resident #R14, Resident #R15, Resident #R16, Resident #R17, Resident #R18, Resident #R19, Resident #20, Resident #21, Resident #22, Resident #23, Resident #24, Resident #25, Resident #26, Resident #27, Resident #28, Resident #29, Resident #30, Resident #31, Resident #32) who resided on the facility's Hall y and Hall z on 02/09/2025.</p> <p>Findings:</p> <p>Review of the facility's LPN schedule dated 02/09/2025 revealed, in part, S7LPN was the scheduled nurse for Hall y and Hall z on the 6:00AM to 6:00PM shift and S18Agency LPN was the scheduled nurse for Hall y and Hall z on the 6:00PM to 6:00AM shift.</p> <p>Review of the facility's time sheets dated 02/09/2025 revealed, in part, S7LPN clocked out of her shift at 6:15PM on 02/09/2025. Further review revealed S18Agency LPN clocked in for her shift at 9:36PM on 02/09/2025.</p> <p>In an interview on 02/20/2025 at 9:05AM, S5Staff Development Nurse indicated on 02/09/2025 between 6:00PM and 10:00PM the residents on Hall y and Hall z did not have a scheduled nurse because S7LPN left without ensuring another nurse assumed her resident assignment. S5Staff Development Nurse further indicated she was notified that no nurse was taking care of the residents on Hall y and Hall z by S17Agency LPN and S18Agency LPN's nurse staffing agency. S5Staff Development further indicated she sent a text message to S7LPN to figure out why she had left without ensuring a nurse would be taking her assignment. S5Staff Development Nurse further indicated S7LPN had sent her a text message indicated that she had just left a written report sheet because she was not going to argue with S17Agency LPN.</p> <p>Review of the text exchange between S5Staff Development Nurse and S7LPN on 02/09/2025 at 8:18PM revealed, in part, S5Staff Development Nurse sent three text messages in a row that asked S7LPN to call her as soon as possible, asked S7LPN if she had left report for Hall y and Hall z and indicated to S7LPN, the nurses are at a standstill and ready to walk out due to you not giving a report! Further review revealed S7LPN replied back with a text message that indicated the other nurse did not want to get off of Hall w, so she left a written report sheet because she was not about to argue with her.</p> <p>In an interview on 02/21/2025 at 9:21AM, S3Former Assistant Director of Nursing (ADON) indicated on 02/09/2025, S7LPN left the keys to Medication Cart c on the counter and did not ensure S8LPN and/or S17Agency LPN accepted the Hall y and Hall z resident assignment before she left the facility.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the text exchange between S3Former Assistant Director and S7LPN on 02/09/2025 at 7:45PM revealed, in part, S3Former ADON sent a text message that asked S7CNA if she could call S8LPN and give her a report on Hall y and Hall z, as S8LPN was refusing to take the keys to Medication Cart c for Hall y and Hall z without report from S7LPN. Further review revealed S7LPN replied back with a text message that indicated the other nurse did not want to get off of Hall w, so she left a written report sheet because she was not about to argue with her</p> <p>In an interview on 02/20/2025 at 11:45AM, S17Agency LPN indicated she never took responsibility/report for the residents on Hall y and Hall z from S7LPN on 02/09/2025.</p> <p>In an interview on 02/21/2025 at 10:15AM, S8LPN indicated that she did not get report from S7LPN or take responsibility of the residents on Hall y and Hall z when S7LPN left the facility. S8LPN further indicated she did not accept the Hall y and Hall z resident assignment until after 8:00PM on 02/09/2025.</p> <p>In an interview on 02/24/2025 at 9:50AM, S7LPN confirmed she did not ensure another nurse took the Hall y and Hall z assignment before she left on 02/09/2025 because she did not want to deal with S17Agency LPN.</p> <p>There was no documented evidence, and the facility did not present any documented evidence, the resident's that resided on Hall y and Hall z had an assigned nurse between S7LPN's departure from the facility at 6:15PM on 02/09/2025 until 8:37PM on 02/09/2025 when S8LPN took Medication Cart c and accepted the Hall y and Hall z resident assignment.</p> <p>In an interview on 02/21/2025 at 11:59AM, S2Director of Nursing indicated S7LPN should not have left the facility without ensuring another nurse assumed the resident assignment for Hall y and Hall z. S2DON further indicated she would consider S7LPNs above actions as resident abandonment.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>47487</p> <p>Based on interviews and records reviews, the facility failed to ensure wound care was completed as ordered for 8 (Resident #R10, Resident #R11, Resident #R12, Resident #R13, Resident #R14, Resident #R17, Resident #R28, Resident #R29) of 10 (Resident #R8 and Resident #R9, Resident #R10, Resident #R11, Resident #R12, Resident #R13, Resident #R14, Resident #R17, Resident #R28, Resident #R29) residents reviewed for completed wound care.</p> <p>Findings:</p> <p>Review of the facility's time sheet for 02/09/2025 revealed, S19Wound Care Nurse (WCN) worked on 02/09/2025 from 6:27AM to 2:15PM.</p> <p>Further review of the facility's time sheet for 02/09/2025 revealed, in part, there was no documented evidence S20WC Nurse worked on 02/09/2025.</p> <p>In an interview on 02/20/2025 at 11:52AM, S19WC Nurse indicated she did not perform the resident's wound care on 02/09/2025 because she was still in training.</p> <p>Review of Resident #R10's February 2025 electronic Treatment Administration Report (eTAR) revealed, in part, documentation S20WCN cleaned Resident #R10's right shin non-pressure ulcer with wound cleanser/normal saline, applied calcium alginate (a dressing that absorbs excess moisture to promote wound healing), Santyl (a medication used to remove damaged tissue from chronic skin ulcers), and collagen (a substances used to promote wound healing) to the wound bed, covered the wound with gauze, an abdominal (ABD) pad, and secured the dressing with an ACE wrap (elastic bandage wrap).</p> <p>Review of Resident #R11's February 2025 eTAR revealed, in part, documentation S20WCN cleaned Resident #R11's lower back surgical site with Betadine (an antiseptic that was used to disinfect wounds, applied an ABD pad, and secured the dressing with tape.</p> <p>Review of Resident #R12's February 2025 eTAR revealed, in part, documentation S20WCN cleaned Resident #R12's right medial ankle venous ulcer with wound cleanser, patted the wound dry, applied collagen and alginate (and absorbent wound dressing) to the wound, and covered the wound with a border foam dressing. Further review revealed documentation S20WCN had applied skin preparation (prep) to the skin surrounding Resident #R12's left lower leg venous ulcer, applied collagen and alginate to the wound, and secured the dressing with a border foam dressing.</p> <p>Review of Resident #R13's February 2025 eTAR revealed, in part, documentation S20WCN cleaned Resident #R13's moisture associated dermatitis (MASD) to her sacrum with wound cleanser, patted the wound dry, applied Medihoney (a medical grade honey that assist with wound healing) and alginate to the wound, and covered the wound with a dry dressing.</p> <p>Review of Resident #R14's February 2025 eTAR revealed, in part, documentation S20WCN applied Betadine soaked gauze to Resident #R14 ruptured right heel blister and covered the wound with a dry dressing.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #R17's February 2025 eTAR revealed, in part, documentation S20WCN cleaned Resident #R17's mid chest surgical site with wound cleanser, patted the surgical site dry, and left the surgical site open to air.</p> <p>Review of Resident #R28's February 2025 eTAR revealed, in part, documentation S20WCN cleaned Resident #R28's left inner thigh wound with Dakin's solution(a diluted bleach solution used to treat and prevent infections in wounds), patted the wound dry, applied Santyl to the wound, then applied a Dakin's solution moistened gauze, and covered the wound with a dry dressing. Further review revealed documentation S20WCN had cleaned Resident #R28's right inner thigh wound with quarter-strength Dakin's solution, patted the wound dry, applied Santyl to the wound bed, then packed the wound with Dakin's solution moistened gauze, and covered the wound with a dry dressing. Further review revealed documentation S20WCN had cleaned Resident #R28's left medial hip open lesion with quarter-strength Dakin's solution, patted the wound dry, applied metronidazole (a medication used to treat infections) gel then Santyl to the wound bed, applied Dakin's solution moistened gauze to the wound, and covered the wound with a dry dressing.</p> <p>Review of Resident #R29's February 2025 eTAR revealed, in part, documentation S20WCN cleaned Resident #R29's sacrum wound with wound cleanser, patted the wound dry, applied Santyl and collagen to the wound, covered the wound with a Dakin's solution moistened gauze, and secured the dressing with a border foam dressing.</p> <p>In an interview on 02/25/2025 at 11:17AM, S20WCN indicated she did not work on 02/09/2025 and had not performed wound care for residents on that day. S20WCN further indicated she must have documented she performed the above mentioned resident's wound care in error.</p> <p>There was no documented evidence, and the provider did not present any documented evidence the above mentioned wound care was completed on 02/09/2025 for Resident #R10, Resident #R11, Resident #R12, Resident #R13, Resident #R14, Resident #R17, Resident #R28, Resident #R29.</p> <p>In an interview on 02/20/2025 at 1:50PM, S16Medical Director indicated it was not acceptable that resident's required wound care was not completed as per the physicians orders.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for 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>47487</p> <p>Based on interviews and record reviews, the facility failed to ensure a resident's assistive device was available for a resident's use to decrease the risk of falls for 1 (Resident #1) of 4 (Resident #1, Resident #2, Resident #3, Resident #R4) residents reviewed for accident/hazards.</p> <p>Findings:</p> <p>Review of Resident #1's Electronic Medical Record revealed, in part, Resident #1 had diagnoses, which included, unspecified dementia, abnormal posture, difficulty in walking, muscle weakness, and lack of coordination.</p> <p>Review of S9Former Certified Nursing Assistant (CNA) witness statement dated 02/13/2025 revealed, in part, on 2/8/2025 S9Former CNA indicated she found Resident #1 lying in the bed with Resident #1's upper half of his body in the bed and the lower half of Resident #1's body in his wheelchair. Further review of S9Former CNA witness statement revealed S9Former CNA placed Resident #1 back in the bed and removed Resident #1's wheelchair from the bedside. Resident #1 was upset S9Former CNA removed his wheelchair.</p> <p>In an interview on 02/21/2025 at 11:46AM, S1Administrator indicated S9Former CNA should not have taken Resident #1's wheelchair from his bedside and away from Resident #1.</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>47487</p> <p>Based on interview and record reviews, the provider failed to ensure a Registered Nurse (RN) worked at least 8 hours for 1 (02/09/2025) of 14 (02/02/2025, 02/03/2025, 02/04/2025, 02/05/2025, 02/06/2025, 02/07/2025, 02/08/2025, 02/09/2025, 02/10/2025, 02/11/2025, 02/12/2025, 02/13/2025, 02/14/2025, 02/15/2025) days reviewed for staffing requirements.</p> <p>Findings:</p> <p>Review of the Nursing/Ancillary Personnel Staffing Pattern Report Form submitted by the facility revealed, in part, there was no documented evidence an RN worked on 02/09/2025.</p> <p>Review of the facility's time sheets dated 02/09/2025 revealed, in part, there was no documented evidence an RN worked on 02/09/2025.</p> <p>There was no documented evidence, and the provider was unable to present any documented evidence, an RN worked at least 8 hours as required on 02/09/2025.</p> <p>In an interview on 02/20/2025 at 1:50PM, S16Medical Director indicated an RN should have worked on 02/09/2025 as required.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>47487</p> <p>Based on interviews and record reviews, the facility failed to maintain a system to reconcile controlled drugs for 1 (Medication Cart c) of 3 (Medication Cart a, Medication Cart b, Medication Cart c) medication carts reviewed for the reconciliation of controlled substances.</p> <p>Findings:</p> <p>Review of the facility's surveillance footage on 02/09/2025 from 6:00PM until 8:37PM revealed, in part, Medication Cart c (the medication cart that held the controlled drugs for the residents that resided on Hall y and Hall z) was in view of the surveillance camera. Further review revealed no evidence S7LPN reconciled Medication Cart c's controlled drugs with any nurse before she left the facility at 6:15PM on 02/09/2025.</p> <p>In an interview on 02/24/2025 at 9:50AM, S7LPN indicated she did not reconcile the controlled drugs in Medication Cart c with another nurse before leaving the facility.</p> <p>In an interview on 02/25/2025 at 9:15AM, S2Director of Nursing acknowledged the facility's off going and oncoming nurses should reconcile controlled drugs at shift change.</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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>47487</p> <p>Based on interview and record review, the facility failed to ensure the facility assessment included active involvement from direct care staff, a governing body member, residents, and residents' representatives in its development.</p> <p>Findings:</p> <p>Review of the facility's facility assessment, last updated on 08/26/2024 revealed, in part, there was no documented evidence the facility assessment included a Registered Nurse (RN), a Licensed Practical Nurse (LPN), a Certified Nursing Assistant (CNA), and a resident and/or a resident's representative was involved in the development of the facility's facility assessment. Further review revealed there was no documented evidence a member of the facility's governing body was involved in the development of the facility's facility assessment.</p> <p>The facility was unable to present documented evidence the above mentioned staff, a resident and/or a resident's representative, and a member of the facility's governing body were involved in the development of the facility's assessment.</p> <p>In an interview on 02/21/2025 at 11:46AM, S1Administrator indicated he was unaware RNs, LPNs, CNAs, resident and/or a resident's representative, and a member of the facility's governing body had to be involved in the development of the facility's facility assessment.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195498	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/25/2025
NAME OF PROVIDER OR SUPPLIER Chateau Napoleon Caring		STREET ADDRESS, CITY, STATE, ZIP CODE 252 Hwy. 402 Napoleonville, LA 70390	
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 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>34608</p> <p>Based on interview and record review, the facility failed to ensure a Certified Nursing Assistant (CNA) received 12 hours of in-service training annually for 1 (S12CNA) of 5 (S11CNA, S12CNA, S13CNA, S14CNA and S15CNA) CNAs' personnel files reviewed for in-service trainings.</p> <p>Findings:</p> <p>Review of S12CNA's personnel file revealed, in part, a date of hire of 07/17/2014. Further review of S12CNA's personnel file revealed no documented evidence, and the facility was unable to present any documented evidence S12CNA completed 12 hours of in-service trainings annually as required.</p> <p>In an interview on 02/21/2025 at 9:17AM, S2DON indicated the facility did not have any documented evidence S12CNA completed 12 hours of in-service trainings annually as required.</p>		