STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195610	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Helena Parish Nursing Home	32 North 2nd Street Greensburg, LA 70441

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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

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

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews and interviews, the facility failed to ensure notifications of changes in residents' conditions were made for 2 (#1 and #2) of 4 (#1, #2, #3, and #R6) residents reviewed for behavioral services. The facility failed to ensure:1. S12NP was notified Resident #2 had an increase in inappropriate sexual behaviors; and 2. S12NP was notified Resident #2 sexually and psychosocially abused Resident #1.1. Review of Resident #2's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Bipolar Disorder and Depression. Further review revealed Resident #2 was a convicted sex offender. Review of Resident #2's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/23/2025 revealed a Brief Interview for Mental Status (BIMS) of 14, which indicated Resident #2 was cognitively intact. Review of Resident #2's Nurse's Notes revealed the following, in part:03/04/2025 at 2:34 p.m. - Resident #2 constantly pulls off all of his clothing after the Certified Nursing Assistants (CNAs) have dressed him. He doesn't call for help with changing his brief. This morning and this afternoon, I knocked on the door to give Resident #2 his medications, he told me to come in and he was lying in bed with no brief or clothing on. I had to tell him to cover up so I could come in and give him his medication. Signed, S19LPN04/27/2025 at 6:07 a.m. - CNA reported to me that while she was changing Resident #2, he made some very crude comments to her. CNA stated Resident #2 said he wanted to touch her all over and continued making sexual comments to her. CNA told Resident #2 he was being very disrespectful and inappropriate. CNA finished up with Resident #2 as soon as possible and reported to S8LPN. Signed, S8LPN Review of Resident #2's current Care Plan revealed the following, in part:Created 02/26/2025Problem: The resident has a behavior problem: excessive masturbating and staying completely naked at all times when in room/makes sexual comments towards staff at times. Interventions: Explain/reinforce why behavior is inappropriate and/or unacceptable to the resident; intervene as necessary to protect the rights and safety of others; 05/15/2025: Intensive Outpatient Program (IOP) to be notified of increase in inappropriate sexual behavior. Review of an email dated 05/16/2025 at 10:34 a.m. from S4CP to S6SW revealed the following, in part:I couldn't remember if you were in the meeting when S2DON said it or not, but S2DON said she wants S12NP to look at Resident #2 because the CNAs are saying he's progressively getting worse and worse about making inappropriate sexual comments towards them. Review of Resident #2's Psychiatric Evaluation Notes revealed the last time he was evaluated by S12NP was on 01/16/2025. On 08/26/2025 at 1:10 p.m., an interview was conducted with S4CP. She stated the intervention initiated on Resident #2's care plan on 05/15/2025 for IOP to be notified of his increased inappropriate sexual behaviors was S6SW's responsibility to arrange. S4CP stated she did not know if it was done. On 08/26/2025 at 1:11 p.m., an interview was conducted with S1ADM. He stated S6SW was on vacation and unable to be reached. 2.Review of Resident #1's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Alzheimer's Disease, Mood (Affective) Disorder, and Major Depressive Disorder. Review of Resident #1's admission MDS with an ARD of 07/12/2025 revealed a BIMS of 2, which indicated Resident #1 was severely cognitively impaired. Review of the facility's Incident Log revealed, Resident #1 was involved in a Physical Aggression Received incident. Resident #1's Incident Report revealed the following, in part:Date: 08/01/2025 at 8:43 p.m. Person Preparing Report: S7LPNNursing Description: When S7LPN was walking up with S11CNA, S11CNA got her attention and pointed toward two residents in the front lobby in front of the nurse's station. S7LPN noticed Resident #2 had his hand between Resident #1's legs. S7LPN removed Resident #2's hand and separated the two residents. When S7LPN was speaking with Resident #1, she informed her Resident #2 said, Don't let no one see this. When Resident #1 was asked if she told Resident #2 no, she said, yes. S7LPN talked further with Resident #1, she asked if she could check her out and make sure that everything was ok. Resident #1 refused and put her right fist in the air saying she can handle anything that needs to be handled. At 10:12 p.m., local police arrived at the facility and spoke to Resident #1 and #2 regarding the incident. Information regarding both residents, as well as a typed statement, was given to the officers by S7LPN. Resident #1 remained at the nurse's station until she was ready to go to bed and at that time, she was assisted to the room and assisted to bed. S1ADM was notified. S2DON was made aware by S1ADM. On 08/25/2025 at 3:20 p.m., video footage of the incident was reviewed with S1ADM. S1ADM confirmed the following:08/01/2025 at 7:56 p.m., Resident #2 wheeled himself beside Resident #1, who was sitting directly in front of the nurse's station in her

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, and record reviews, the facility failed to protect the residents' right to be free from sexual abuse, psychosocial abuse, and neglect for 1 (#1) of 6 (#1, #2, #3, #R4, #R5, and #R6) sampled residents reviewed for abuse. The facility failed to protect Resident #1 from being sexually and psychosocially abused by Resident #2. This deficient practice resulted in an Immediate Jeopardy (IJ) situation on 08/01/2025 at 7:59 p.m., when Resident #2, a cognitively intact resident with a history of sexually inappropriate behaviors and a convicted sex offender, put his hand between Resident #1's upper thighs and touched her vaginal area. Resident #1 had a BIMS of 2, which indicated she was severely cognitively impaired. From 7:59 p.m. to 8:43 p.m. At 8:13 p.m., S9CNA witnessed the sexual abuse and failed to separate the residents. Resident #2 was observed in video footage to sexually abuse Resident #1 intermittently while Resident #1 attempted to stop the abuse. At 8:43 p.m., S7LPN and S11CNA witnessed the touching and intervened. After the incident, Resident #1 stated she told Resident #2 no. Interviews revealed the facility failed to monitor any of the remaining 28 female residents who could have been affected by the deficient practice after the sexual abuse occurred. As a result of the investigation, despite there not being a significant decline in mental or physical functioning for Resident #1, it could be determined a reasonable person would be likely to experience severe psychosocial harm as a result of the sexual abuse since a reasonable person would not expect to be treated in this manner in their own home or a health care facility. S1ADM was notified of the Immediate Jeopardy situation on 08/27/2025 at 4:15 p.m. This deficient practice continued at a potential for more than minimal harm for any of the 28 female residents residing in the facility who were not assessed after the incident. Review of the facility's policy dated 01/14/1999 and titled, Adult, Disabled Person, or Elderly Abuse-Recognition and Reporting revealed the following, in part:Sexual abuse: Includes any non-consensual sexual contact of any type with a resident including:Unwanted intimate touching of any kind especially of breast or perineal area.Procedure: To protect the resident from real or suspected.sexual abuse, staff shall safeguard the resident from the offending individual. Resident #1Review of Resident #1's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Alzheimer's Disease, Mood (Affective) Disorder, and Major Depressive Disorder. Review of Resident #1's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/12/2025 revealed a Brief Interview for Mental Status (BIMS) of 2, which indicated Resident #1 was severely cognitively impaired. Review of the facility's Incident Log revealed, Resident #1 was involved in a Physical Aggression Received incident. Resident #1's Incident Report revealed the following, in part:Date: 08/01/2025 at 8:43 p.m. Person Preparing Report: S7LPNNursing Description: When S7LPN was walking up with S11CNA, S11CNA got her attention and pointed toward two residents in the front lobby in front of the nurse's station. S7LPN noticed Resident #2 had his hand between Resident #1's legs. S7LPN removed Resident #2's hand and separated the two residents. When S7LPN was speaking with Resident #1, she informed her Resident #2 said, Don't let no one see this. When Resident #1 was asked if she told Resident #2 no, she said, yes. S7LPN talked further with Resident #1, she asked if she could check her out and make sure that everything was ok. Resident #1 refused and put her right fist in the air saying she can handle anything that needs to be handled. At 10:12 p.m., local police arrived at the facility and spoke to Resident #1 and #2 regarding the incident. Information regarding both residents, as well as a typed statement, was given to the officers by S7LPN. Resident #1 remained at the nurse's station until she was ready to go to bed and at that time, she was assisted to the room and assisted to bed. S1ADM was notified. S2DON was made aware by S1ADM. Further review of Resident #1's Clinical Record revealed no new interventions or services to address the sexual abuse after the incident occurred. Resident #2Review of Resident #2's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Bipolar Disorder and Depression. Further review revealed Resident #2 had documentation showing he was a convicted sex offender. Review of Resident #2's admission Paperwork from a local hospital dated 11/24/2023 revealed the following, in part: Resident #2 was recently released from jail for not registering as a sex offender. Review of Resident #2's Quarterly MDS with an ARD of 07/23/2025 revealed a BIMS of 14, which indicated Resident #2 was cognitively intact. Review of Resident #2's current Care Plan revealed the following, in part:Created 02/26/2025Problem: The resident has a behavior problem: excessive masturbating and staying completely naked at all times when in room/makes sexual comments towards staff at times

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to coordinate assessments with the resident's Pre-admission Screening and Resident Review (PASRR) Level II by failing to incorporate PASRR Level II determinations and recommendations into a resident's transitions of care for 1 (#2) of 3 (#2, #3, and #R6) residents reviewed for sexual behaviors.Review of Resident #2's clinical record revealed he was admitted to the facility on [DATE] with diagnoses including, Bipolar Disorder and Depression. Review of Resident #2's Form 142 revealed he was approved for admission by Level II authority for a temporary period of 03/04/2025 - 03/03/2026. Review of Resident #2's PASRR Level II Evaluation Summary and Determination Notice dated 03/11/2025 revealed the Level II authority had approved 365 days for nursing facility placement and the following to occur: 1. Psychiatric Evaluation for assessment and medication management. 2. Referral for Dementia Testing/Evaluation by a Neurologist or Neuropsychologist. 3. Community Based Service via Mental Health Rehab Services to be rendered at NF Community Psychiatric Supportive Services and Psychosocial Rehab Individual counseling to occur by a licensed mental health professional. Review of Resident #2's clinical record revealed the last time he received a psychiatric evaluation was on 01/16/2025. Further review revealed none of the PASRR Level II recommendations listed above had been completed since 03/11/2025. An interview was conducted with S2DON on 08/27/2025 at 12:14 p.m. S2DON reviewed Resident #2's Level II Determination Notice dated 03/11/2025 and confirmed the PASRR level II recommendations mentioned above were not implemented, and should have been.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the provider failed to develop and implement a comprehensive person centered care plan for each resident as evidenced by failing to:1. Develop a comprehensive person centered care plan for 2 of 2 (#2 and #3) residents who were registered sex offenders; and 2. Implement a care plan intervention for 1 (#2) of 3 (#2, #3, and #R6) residents reviewed for sexual behaviors. Review of the facility's policy dated 12/27/2019 and titled, Plan of Care revealed the following, in part:Policy StatementIt is the policy of the facility to promote seamless interdisciplinary care for our residents by utilizing the interdisciplinary plan of care based on assessment, planning, treatment, service and intervention. It is utilized to plan for and manage resident care as evidenced by documentation from admission through discharge for each resident. Procedure:Developing the Comprehensive Care Plan: 3. Each discipline will check and/or add interventions/approaches to include but not limited to:b. Interventional entries reflect activities that incorporate observations, assessments, management and teaching components that will restore, maintain and/or promote the resident's well-being. 1.Resident #2Review of Resident #2's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Bipolar Disorder and Depression. Further review revealed Resident #2 was a registered sex offender. Review of Resident #2's admission Paperwork from a local hospital dated 11/24/2023 revealed the following, in part: Resident #2 was recently released from jail for not registering as a sex offender. Review the facility's Incident Log revealed, Resident #2 was involved in a Physical Aggression Initiated incident. Resident #2's Incident Report revealed the following, in part: Date: 08/01/2025 at 8:43 p.m.Person Preparing Report: S2DONNursing Description: S7LPN informed me of the incident between Resident #2 and Resident #1. S11CNA and S7LPN noticed Resident #2 had his hand between Resident #1's legs. S7LPN removed Resident #2's hand and separated the two residents. S2DON informed Resident #2 he was not allowed to touch the other residents. Resident #2 verbalized understanding. S7LPN notified S1ADM and doctor. Review of Resident #2's current Care Plan revealed the following, in part: Created 08/06/2025Problem: Documented safety concerns: Resident is a registered sex offender Interventions: Not permitted to participate in activities when children are present; two staff members shall be present at all times while providing care for resident; while interacting with others, staff will be with resident at all times; when appointments or things that cause resident to leave facility, resident will be under the supervision of staff; notification will be made to staff, residents, and family members that a sex offender is housed here, but name will not be mentioned. Resident #3Review of Resident #3' Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Major Depressive Disorder, Anxiety Disorder, and Hemiplegia and Hemiparesis Following Cerebral Infarction. Review of Resident #3's Care Plan created on 08/04/2025 revealed the following, in part: Problem: Documented safety concerns: Resident is a registered sex offender Interventions: Not permitted to participate in activities when children are present; two staff members shall be present at all times while providing care for resident; while interacting with others, staff will be with resident at all times; when appointments or things that cause resident to leave facility, resident will be under the supervision of staff; notification will be made to staff, residents, and family members that a sex offender is housed here, but name will not be mentioned; Resident counseled by administrative staff on guidelines to follow during his admission here. On 08/26/2025 at 1:10 p.m., an interview was conducted with S4CP. She stated she knew Resident #2 was a registered sex offender when he was admitted to the facility because it was in his admission paperwork. She stated she was also aware Resident #3 was a registered sex offender. She stated she was not initially trained to care plan residents for being sex offenders. She confirmed Residents #2 and #3's care plans were developed to reflect their sex offender status after the incident occurred between Residents #1 and #2. On 08/26/2025 at 2:25 p.m., an interview was conducted with S2DON. She stated she was unaware Resident #2 and Resident #3 were registered sex offenders until after the incident occurred between Resident #1 and #2 on 08/01/2025. S2DON stated if she would have known Resident #2 was a registered sex offender, she would have been more aggressive with initiating interventions for him, which could have made staff more aware of Resident #2's behaviors. She stated if S4CP was aware Residents #2 and #3 were registered sex offenders, they should have been care planned for being sex offenders prior to the incident between Residents #1 and #2 on 08/01/2025. 2. Review of Resident #2's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Bipolar Disorder and Depression

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, and interviews, the facility failed to ensure a resident's care plan was revised by failing to update problems, goals, and interventions after she was sexually and psychosocially abused for 1 (#1) of 4 (#1, #2, #3, and #R6) residents reviewed for care plans. Review of Resident #1's Clinical Record revealed she was admitted to the facility on [DATE] with diagnoses, which included Alzheimer's Disease, Mood (Affective) Disorder, and Major Depressive Disorder. Review of Resident #1's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 07/12/2025 revealed a Brief Interview for Mental Status (BIMS) of 2, which indicated Resident #1 was severely cognitively impaired. Review of the facility's Incident Log revealed, Resident #1 was involved in a Physical Aggression Received incident. Resident #1's Incident Report revealed the following, in part:Date: 08/01/2025 at 8:43 p.m. Person Preparing Report: S7LPNNursing Description: When S7LPN was walking up with S11CNA, S11CNA got her attention and pointed toward two residents in the front lobby in front of the nurse's station. S7LPN noticed Resident #2 had his hand between Resident #1's legs. S7LPN removed Resident #2's hand and separated the two residents. When S7LPN was speaking with Resident #1, she informed her Resident #2 said, Don't let no one see this. When Resident #1 was asked if she told Resident #2 no, she said, yes. S7LPN talked further with Resident #1, she asked if she could check her out and make sure that everything was ok. Resident #1 refused and put her right fist in the air saying she can handle anything that needs to be handled. At 10:12 p. m., local police arrived at the facility and spoke to Resident #1 and #2 regarding the incident. Information regarding both residents, as well as a typed statement, was given to the officers by S7LPN. Resident #1 remained at the nurse's station until she was ready to go to bed and at that time, she was assisted to the room and assisted to bed. S1ADM was notified. S2DON was made aware by S1ADM. On 08/25/2025 at 3:20 p.m., video footage of the incident was reviewed with S1ADM. S1ADM confirmed the following:08/01/2025 at 7:56 p.m., Resident #2 wheeled himself beside Resident #1, who was sitting directly in front of the nurse's station in her wheelchair. 7:58 p.m., Resident #2 was observed touching Resident #1's right shin.7:59 p.m., Resident #2's left hand moved from Resident #1's shin to between her upper thigh and vaginal area, outside of her pants. Resident #1 immediately put her hands on Resident #2's left arm.8:01 p.m., Resident #1 attempted to remove Resident #2's hand but was unsuccessful. Resident #2's hand remained between Resident #1's upper thighs until 8:12 p.m., when Resident #1 stood up. Resident #2's hand was observed going behind Resident #1's buttocks. 8:13 p.m., S9CNA was observed to walk within approximately 6 feet from where Residents #1 and #2 were and Resident #1 sat back down. S9CNA pointed at Resident #2, and was observed to say something, then S9CNA walked away. Resident #2's hand remained in between Resident #1's upper thighs when she sat down. 8:18 p.m., Resident #2 removed his hand from between Resident #1's thighs. 8:22 p.m., Resident #2 put his right hand between Resident #1's upper thighs and Resident #1 started tapping on the top Resident #2's hand. Resident #2 removed his hand at 8:23 p.m. when S8LPN and S17LPN was observed walking back to the nurse's station with their medication carts. 8:25 p.m., S8LPN was observed administering Resident #2 his medications and S17LPN was observed administering Resident #1 her medications, then both nurses walked away. 8:29 p.m., Resident #2 placed his left hand between Resident #1's upper thighs again and Resident #1 attempted to remove it. After attempting to remove it, it could not be determined where Resident #2's hand was until 8:42 p.m., when Resident #2's left hand was observed coming from behind the left wheel of his wheelchair. 8:43:37, Resident #2 was observed putting his left hand back between Resident #1's upper thighs and Resident #1 was observed slapping at his hand. 8:43:47, S11CNA was observed walking up the hall back to the nurse's station. S11CNA grabbed at S7LPN, who was walking beside her, and pointed towards Residents #1 and #2. S7LPN immediately removed Resident #2's hand from between Resident #1's thighs and separated the residents. S7LPN was observed talking to Resident #1 then she picked up the phone and called someone. 8:48 p.m., Resident #2 was brought to his room. Review of Resident #1's current Care Plan revealed it was not revised after 08/01/2025 to reflect problems, goals, and interventions related to her being a victim of sexual and psychosocial abuse. On 08/26/2025 at 1:10 p.m., an interview was conducted with S4CP. She confirmed Resident #1's care plan was not revised after 08/01/2025 to reflect she was a victim of sexual and psychosocial abuse. She stated Resident #1's care plan should have been revised for staff to observe Resident #1 for any psychosocial or behavioral changes. On 08/26/2025 at 2:25 p.m., an interview was

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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 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. Based on record reviews and interview, the facility failed to ensure staff was provided Quality Assurance and Performance Improvement (QAPI) training for 5 (S7LPN, S8LPN, S9CNA, S10CNA, and S11CNA) of 5 (S7LPN, S8LPN, S9CNA, S10CNA, and S11CNA) personnel files reviewed. Review of S7LPN's personnel file revealed a hire date of 07/26/2024. Further review of S7LPN's personnel file revealed no documented evidence, and the facility presented no documented evidence, S7LPN received QAPI training as required. Review of S8LPN's personnel file revealed a hire date of 12/01/2023. Further review of S8LPN's personnel file revealed no documented evidence, and the facility presented no documented evidence, S8LPN received QAPI training as required. Review of S9CNA's personnel file revealed a hire date of 04/16/2025. Further review of S9CNA's personnel file revealed no documented evidence, and the facility presented no documented evidence, S9CNA received QAPI training as required. Review of S10CNA's personnel file revealed a hire date of 03/29/2022. Further review of S10CNA's personnel file revealed no documented evidence, and the facility presented no documented evidence, S10CNA received QAPI training as required. Review of S11CNA's personnel file revealed a hire date of 12/11/2024. Further review of S11CNA's personnel file revealed no documented evidence, and the facility presented no documented evidence, S11CNA received QAPI training as required. On 08/28/2025 at 10:20 a.m., an interview was conducted with S1ADM. He stated there was no documentation any staff had completed QAPI training.