STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265164	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Vue Nursing and Rehabilitation Center	210 Davis Drive West Plains, MO 65775

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 - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify a resident's family in a timely manner after a transfer where the resident fell from a mechanical ceiling lift resulting in pain and subsequent injury for one resident (Resident #1) out of one sampled resident. The facility census was 115.The facility did not provide a policy regarding notification of a resident's change in condition to the resident's family/representative. Review of the facility's policy titled Falls – Clinical Protocol, dated 01/14/15, showed: - Families are to be notified of all falls; - The policy did not address the timeframe for notification of a fall to the family/representative; - The policy did not address post-fall assessments, monitoring or documentation. 1. Review of Resident #1's medical record showed: - An admission date of 11/16/22; - Diagnoses of arthritis, non-Alzheimer's dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), anxiety disorder (persistent worry and fear about everyday situations), muscle weakness, and history of falling; - No documentation of a post fall assessment dated [DATE]; - No documentation of a post fall skin assessment dated [DATE]; - No documentation of a post fall communication to Resident #1's physician or representative until 4:43 P.M. on 01/05/26. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff), dated 11/25/25, showed: - Severely impaired cognition; - No impairment to upper or lower extremities; (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
	265164	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Vue Nursing and Rehabilitation Center	210 Davis Drive West Plains, MO 65775

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 - Few	- Dependent on staff for oral hygiene, toileting hygiene, shower/bathe self, lower body dressing, putting on or taking off footwear, personal hygiene, sit to lying, lying to sitting, chair/bed-to-chair transfer, toilet transfer, tub/shower transfer. Review of the resident's Care Plan, revision date 01/08/26, showed: - Self-care deficit related to advancing dementia, weakness, history left ankle fracture (a broken bone), recent right tibia (the inner and usually larger of the two bones of the lower limb between the knee and ankle) fracture, and unable to ambulate; - At risk for falls, has history of falls, weakness, impaired vision, dementia, medication, unable to stand, periods of agitation and restlessness, and poor safety awareness. Interventions of anticipate and meet all needs, fall risk assessment, and resident is a Hoyer lift for transferring; family requested two staff members assist with all transfers using Hoyer lift after the incident. Review of the resident's progress notes showed: - On 01/05/26 at 8:58 A.M., Registered Nurse (RN) C swabbed the resident for streptococcus (a bacterial infection); - On 01/05/26 at 3:41 P.M., a portable x-ray was ordered, and the facility was notified the x-ray would be able to be completed until 01/06/26; - On 01/05/26 at 4:43 P.M., RN C documented he/she was alerted the resident was lowered to the floor per staff with help due to a mechanical ceiling lift transfer. The resident was assisted to the bed safely. RN C did a head-to-toe assessment with no injuries noted. Around lunch time, staff said the resident's right lower extremity (RLE) appeared bruised. Upon assessment, there was slight bruising noted to the RLE. The nurse contacted the physician for a STAT (immediate) x-ray to the RLE. The resident's family was aware. - On 01/05/26 at 4:56 P.M., the physician said may send the resident to the hospital per the family's request; - On 01/08/26 at 8:09 A.M., the Administrator documented a summary of the incident findings. On 01/05/26, the resident was lowered to the floor during a transfer with Certified Nursing Assistant (CNA) A while using a portable ceiling lift (a fixed battery-operated ceiling track hoist that is mounted in tracks that are installed into the ceiling). The CNA said he/she transferred the resident from the bed to a Geri chair after showering him/her. The CNA said during the transfer, he/she realized the resident was coming down, so he/she grabbed the resident and slid the resident against his/her body to a seated position and rested on the CNA's feet. The CNA called for assistance from another CNA. When CNA B entered the room, he/she said the resident was seated on the floor in front of CNA A. No distress was noted by either CNA A and CNA B. CNA A and CNA B assisted the resident to the Geri chair with a gait belt (an assistive device which is used to help safely transfer a person from one surface to another) and a fireman lift (a way to carry someone over a shoulder). Staff notified RN C regarding the incident. RN C assessed the resident while doing a throat swab in the resident's room and no injuries or immediate distress from the incident was noted. Mid-morning, staff reported the resident was developing a bruise to his/her RLE and the resident had some discomfort. The physician was notified, and an order was received for bedside x-rays; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265164	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Vue Nursing and Rehabilitation Center	210 Davis Drive West Plains, MO 65775

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 - Few	- There were no progress notes addressing a head-to-toe assessment, family contact or description of the incident on 01/05/26. Review of the facility's Incident report dated 01/05/26, showed: - A family member was notified on 01/05/26 at 4:42 P.M., of the resident's fall; - The cameras that service the hall ways and common area showed times staff entering, exiting Resident #1's room. At 8:46 A.M., RN C entered the room and stayed for 7 minutes and 11 seconds within an hour following the incident. RN C reported no visible signs of injury at that time. However, RN C's nurse's notes do not indicate this visit with the resident; - In an interview CNA B said the nurse was not immediately notified because they (CNAs A and B) didn't feel that Resident #1 was injured and the nurse was busy at that time; - In an interview CNA A said the lift broke and Resident #1 was going to drop to the ground, so he/she (CAN A) grabbed and pulled the resident towards his/her chest and slid the resident on to the floor. CNA A also said the nurse was not notified immediately and that he/she knew that wasn't what he/she should have done. During an interview on 01/14/26 at 4:45 P.M. the Director of Nursing (DON) said she would expect the nurse to contact a resident's physician and the family immediately following an assessment of the resident after an incident such as a fall. During an interview on 01/14/26 at 4:50 P.M., Licensed Practical Nurse (LPN) F said he/she came on shift on 01/05/26 at 2:00 P.M., and received report from RN C and the CNAs, which included the resident's fall from the mechanical ceiling lift. Following report, LPN F completed an assessment of the resident because he/she did not see one in the chart. LPN F also contacted the resident's family member to let them know the resident was being sent to the hospital for further assessment due to the resident's RLE started hurting, and then sent the resident to the hospital by ambulance. During an interview on 01/14/26 at 5:00 P.M., the resident's responsible party (RP) said he/she was not contacted until 2:15 P.M., on 01/05/26, and made aware of the resident's fall and what had happened. The RP's spouse was in the facility around 9:30 A.M., on 01/05/26, and no one said anything to him/her at that time about the resident's fall. RP came to the facility at 4:30 P.M., on 01/05/26, and resident's leg was black and blue and swelling. LPN F looked at the resident's right leg and called the physician since the mobile x-ray could not come until the next day. The resident was sent to the hospital. During an interview on 01/14/26 at 6:00 P.M., a Nursing Manager and the Administrator said it was the expectation of the facility that nurses should immediately assess the resident and contact the physician and the family after a fall. During an interview on 01/14/26 at 6:15 P.M., CNA B said on 01/05/26 at approximately 8:00 A.M., he/she heard someone yelling and went to see what was going on and found Resident #1 on the floor in front of CNA A. CNA B notified RN C of the resident's incident when RN C entered the building later that morning. RN C went to Resident #1's room to complete a swab for strep and assessed the resident at that time. CNA B did not know if RN C completed any forms or contacted the doctor of family. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265164	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Vue Nursing and Rehabilitation Center	210 Davis Drive West Plains, MO 65775

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 - Few	The administrator was notified on 01/16/26 of the Past Non-Compliance which occurred on 01/05/26. On 01/05/26, facility staff started an investigation, completed disciplinary action and began in-servicing all staff on policies and procedures related to contacting family/resident representatives in a timely manner following an event. The noncompliance was corrected 01/06/26.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265164	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Vue Nursing and Rehabilitation Center	210 Davis Drive West Plains, MO 65775

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure staff followed professional standards of practice when staff did not immediately assess one resident (Resident #1) out of two sampled residents after a witnessed fall. The facility census was 115.The facility did not provide a policy regarding assessments of a resident after a change in condition. Review of the facility's policy titled, Falls – Clinical Protocol, dated 01/14/15, showed: - According to the Centers for Medicare and Medicaid Services (CMS), Minimum Data Set (MDS – a federally mandated assessment to be completed by the facility) 3.0 Guidelines, a fall is defined as the unintentional change in position coming to rest on the ground, floor, or onto the next lower surface (e.g., onto a bed, chair or bedside mat). An intercepted fall occurs when the resident would have fallen if he/she had not caught him/herself or had not been intercepted by another person – this is still considered a fall; - The nurse shall assess and document/report the following: vital signs, recent injury, especially fracture or head injury, musculoskeletal function, observing for change in normal range of motion, weight bearing, etc., change in cognition or level of consciousness, neurological status, pain, precipitation factors, details on how the fall occurred, all current medications, especially those associated with dizziness or lethargy; - The staff will evaluate and document the falls that occur while the individual is in the facility; - Residents who fall will be assessed for injury at the time of the fall. They will be assessed and charted on for that shift and for 72 hours total. Families are to be notified of all falls; - The staff, with the physician's guidance, will follow up with associated injury until the resident is stable and delayed complications such as late fracture or subdural hematoma (a life-threatening medical emergency characterized by a buildup of blood on the surface of the brain) have been ruled out or resolved; - Delayed complications such as late fractures and major bruising may occur hours or several days after a fall, while signs of subdural hematomas or other intracranial (bleeding inside the skull) bleeding could occur up to several weeks after a fall; - The staff will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. Review of Resident #1's medical record showed: - An admission date of 11/16/22; - Diagnoses of arthritis, non-Alzheimer's dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), anxiety disorder (persistent worry and fear about everyday situations), muscle weakness, and history of falling; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265164	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Vue Nursing and Rehabilitation Center	210 Davis Drive West Plains, MO 65775

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- No documentation of a post fall assessment dated [DATE]; - No documentation of a post fall skin assessment dated [DATE]. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff), dated 11/25/25, showed: - Severely impaired cognition; - No impairment to upper or lower extremities; - Dependent on staff for oral hygiene, toileting hygiene, shower/bathe self, lower body dressing, putting on or taking off footwear, personal hygiene, sit to lying, lying to sitting, chair/bed-to-chair transfer, toilet transfer, tub/shower transfer. Review of the resident's Care Plan, revision date 01/08/26, showed: - Self-care deficit related to advancing dementia, weakness, history left ankle fracture (a broken bone), recent right tibia (the inner and usually larger of the two bones of the lower limb between the knee and ankle) fracture, and unable to ambulate; - At risk for falls, has history of falls, weakness, impaired vision, dementia, medication, unable to stand, periods of agitation and restlessness, and poor safety awareness. Interventions of anticipate and meet all needs, fall risk assessment, and resident is a Hoyer lift for transferring; family requested two staff members assist with all transfers using Hoyer lift after the incident. Review of the resident's progress notes showed: - On 01/05/26 at 8:58 A.M., Registered Nurse (RN) C swabbed the resident for streptococcus (a bacterial infection); - On 01/05/26 at 3:41 P.M., a portable x-ray was ordered, and the facility was notified the x-ray would be able to be completed until 01/06/26; - On 01/05/26 at 4:43 P.M., RN C documented he/she was alerted the resident was lowered to the floor per staff with help due to a mechanical ceiling lift transfer. The resident was assisted to the bed safely. RN C did a head-to-toe assessment with no injuries noted. Around lunch time, staff said the resident's right lower extremity (RLE) appeared bruised. Upon assessment, there was slight bruising noted to the RLE. The nurse contacted the physician for a STAT (immediate) x-ray to the RLE. The resident's family was aware; - On 01/05/26 at 4:56 P.M., the physician said may send the resident to the hospital per the family's request; - On 01/08/26 at 8:09 A.M., the Administrator documented a summary of the incident findings. On 01/05/26, the resident was lowered to the floor during a transfer with Certified Nursing Assistant (CNA) A while using a portable ceiling lift (a fixed battery-operated ceiling track hoist that is mounted in tracks that are installed into the ceiling). The CNA said he/she transferred the resident from the bed to a Geri chair after showering him/her. The CNA said during the transfer, he/she realized (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265164	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Vue Nursing and Rehabilitation Center	210 Davis Drive West Plains, MO 65775

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident was coming down, so he/she grabbed the resident and slid the resident against his/her body to a seated position and rested on the CNA's feet. The CNA called for assistance from another CNA. When CNA B entered the room, he/she said the resident was seated on the floor in front of CNA A. No distress was noted by either CNA A and CNA B. CNA A and CNA B assisted the resident to the Geri chair with a gait belt (an assistive device which is used to help safely transfer a person from one surface to another) and a fireman lift (a way to carry someone over a shoulder). Staff notified RN C regarding the incident. RN C assessed the resident while doing a throat swab in the resident's room and no injuries or immediate distress from the incident was noted. Mid-morning, staff reported the resident was developing a bruise to his/her RLE and the resident had some discomfort. The physician was notified, and an order was received for bedside x-rays; - There were no progress notes addressing a head-to-toe assessment or description of the incident on 01/05/26. Review of the facility's Incident report dated 01/05/26, showed: - The cameras that service the hallways and common area showed times staff entering and exiting Resident #1's room. At 8:46 A.M., RN C entered the room and stayed for 7 minutes and 11 seconds within an hour following the incident. RN C reported no visible signs of injury at that time. However, RN C's nurse's notes do not indicate this visit with the resident; - In an interview CNA B said the nurse was not immediately notified because they (CNAs A and B) didn't feel that Resident #1 was injured, and the nurse was busy at that time. - In an interview CNA A said the lift broke, and Resident #1 was going to drop to the ground, so he/she (CNA A) grabbed and pulled the resident towards his/her chest and slid the resident on to the floor. CNA A also said the nurse was not notified immediately and that he/she knew that wasn't what he/she should have done. During an interview on 01/14/26 at 4:40 P.M., CNA D said if a resident fell or was found on the floor, staff were to call the nurse immediately. Staff should grab the vital sign equipment, take the resident's vital signs, and help the nurse if needed. A nurse should be the only one to assess a resident after a fall, not a CNA, and the resident should not be moved until the nurse assessed the resident. Staff should follow the nurse's instructions if the resident was to be moved, or anything else needed to be done. The transfer method for a resident was on the resident's care plan. During an interview on 01/14/26 at 4:45 P.M., the Director of Nursing (DON) said she would expect a fall to be reported to the nurse immediately. The nurse should assess a resident as soon as he/she was told of a fall, skin tear, or anything. The nurse should always assess a resident first following a fall and before a resident was moved. The nurse then should call the physician and the family immediately. A CNA should not assess a resident but should get the nurse immediately. During an interview on 01/14/26 at 4:50 P.M., Licensed Practical Nurse (LPN) F said he/she came on shift on 01/05/26 at 2:00 P.M., and received report from RN C and the CNAs, which included the resident's fall from the mechanical ceiling lift. Following report, LPN F completed an assessment of the resident because he/she did not see one in the chart. LPN F also contacted the physician for further assessment due to the resident's RLE started hurting and then sent the resident to the hospital by ambulance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265164	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Vue Nursing and Rehabilitation Center	210 Davis Drive West Plains, MO 65775

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/14/26 at 5:30 P.M., CNA E said if a resident fell or was found on the floor, the staff should make sure the resident was safe, turn the call light on or yell out to get help. The nurse should come to the resident and don't move the resident. The nurse was the one to assess the resident. During an interview on 01/14/26 at 6:00 P.M., the Nursing Manager and the Administrator said the nurse should be contacted immediately if a resident had a fall. The nurse should assess the resident immediately and contact the physician and the family immediately. The resident should not be moved until he/she was assessed by the nurse. During an interview on 01/14/26 at 6:15 P.M., CNA B said the incident happened to the resident on 01/05/27 at approximately 8:00 A.M. He/She helped transfer the resident from the floor to the Geri chair with CNA A without notifying the nurse and having the resident assessed prior to moving him/her. During a phone interview on 01/15/26 at 11:22 A.M., CNA A said if a resident fell, you notify the nurse and have the nurse come in and see the resident. The nurse should immediately assess the resident following a fall and before the resident was moved off the floor. This didn't happen with the fall for Resident #1 on 01/05/26. The administrator was notified on 01/16/26 of the Past Non-Compliance which occurred on 01/05/26. On 01/05/26, facility staff started an investigation, completed disciplinary action and began in-servicing all staff on policies and procedures related to post-fall assessments. The noncompliance was corrected 01/06/26.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265164	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Vue Nursing and Rehabilitation Center	210 Davis Drive West Plains, MO 65775

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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on interview and record review of the facility policy, the facility failed to implement and maintain a training program for mechanical ceiling lift equipment training for one Certified Nursing Aide (CNA A). This failure to train CNA A had the potential to affect the care and services provided to any resident that might require lift transfers by CNA A. The facility census was 115.The facility did not provide a policy on employee training and competencies. Review of the facility policy titled, Orientation Program for Newly Hired Employees, Transfers, Volunteers, Revised May 2019, showed:- Did not address training on facility equipment. Review of CNA A's Training Record showed:- A hire date of 10/08/25;- No documentation of education and competencies provided on the safe use of mechanical lifts. During an interview on 01/14/26 at 10:27 A.M., the Administrator said she would expect CNAs to be trained and be competent to use mechanical lifts prior to transferring a resident. During an interview on 01/14/26 at 1:58 P.M., the Director of Staff Development said CNA A had not received training and a competency check for a mechanical lift. During an interview on 01/14/26 at 3:24 P.M., the Director of Nursing (DON) said she would expect CNAs to be trained on the mechanical ceiling lift if they cared for a resident that utilized them. CNA A did not have training on the mechanical ceiling lift. During an interview on 01/14/26 at 3:24 P.M., the Nursing Manager said no one trained CNA A on the mechanical ceiling lifts. She would expect staff to be trained on the mechanical ceiling lifts. During a phone interview on 01/15/26 at 11:22 A.M., CNA A said he/she had worked at the facility for three months and had not had any training or demonstrated competency on the mechanical ceiling lift used to transfer a resident.