STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555220	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vineyard Hills Health Center	290 Heather Court Templeton, CA 93465

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 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. Based on inspection of the facility's Medication Storage Rooms, the facility's storage carts, and interviews with the facility's nursing staff, the facility failed to: 1. Follow the facility's policy when the Medication Storage Refrigerator was out of temperature range. 2. Follow the facility's policy when The Medication Storage Rooms and the Medication Storage Refrigerators were missing temperature checks for May and June. 3. Write the open date/expiration date on the pharmacy sticker for Resident 32's Insulin Pen located in the medication cart. 4. Indicate an open date on a blood glucose test strip container of when the container was first opened and placed in the medication cart. This failure resulted in medications not safely stored to ensure their integrity and has the potential for medication administration not to be effective. Findings: Inspection of the facility's Medication Storage Areas on 6/24/25 beginning at 11:30 a.m. and interviews with the facility's Nursing Staff revealed: (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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. During a concurrent observation and interview on 6/24/25 at 11:30 a.m. with Assistant Director of Nursing (ADON) 1, of the Medication Storage Room in Station 2, the Medication Storage Refrigerator Temperature Log for June 2025 was reviewed with ADON1. On June 20, 2025, under Shift 2 a handwritten number 35 within a circle into the log outside of the printed temperatures. The Medication Storage Refrigerator Temperature Log printed temperature range is 36-46 degrees Fahrenheit. ADON1 agreed that the temperature documented of 35 was out of the acceptable range. ADON1 states that when the refrigerator temperature goes out of acceptable range, maintenance is to be notified, and the notification is to be documented in the maintenance logbook located at the nurse's station. ADON1 states that the temperature is to be adjusted and rechecked 1 hour later. Upon review of the maintenance logbook with ADON1 for June 20, 2025, there was no documentation regarding the temperature of the medication refrigerator being out of range nor is there documentation of the temperature adjustment. ADON1 states there is no documentation of the temperature being rechecked within 1 hour. ADON1 states there is no area on the log that the temperature was rechecked within the hour. During a concurrent interview and record review on 6/24/25 at 3:20 p.m. with Director of Maintenance (DOM), a review of the Maintenance logbook was reviewed. DOM verified there was no documentation that maintenance was informed of the medication refrigerator in Station 2 being out of acceptable temperature range or temperature adjustments made for June 20. During a review of the facility's policy and procedure titled, Label/Store Drugs & Biologicals, (undated), indicated in part, The proper range is 36-46 degrees Fahrenheit. If the temperature is found to be out of range, readjust the thermostat inside the refrigerator and recheck in 1 hour. If still out of range remove all medication into another secure medication storage refrigerator and notify maintenance. 2. During a review of Medication Room Temperature Log-Station 1, dated May 2025, the Medication Room Temperature Log-Station 1 indicated four days of missing temperature checks. During a review of Medication Storage Refrigerator Temperature Log-Station 1, dated May 2025, the Medication Storage Refrigerator Temperature Log-Station 1 indicated 12 days of missing temperature checks for Shift 1 and 31 days of missing temperature checks for Shift 2. During a review of Medication Room Temperature Log -Station 1, dated June 2025, the Medication Room Temperature Log -Station 1 indicated one day of missing temperature checks. During a review of Medication Storage Refrigerator Temperature Log -Station 1, dated June 2025, the Medication Storage Refrigerator Temperature Log -Station 1 indicated one day of missing temperature checks for Shift 1 and six days missing temperature checks for Shift 2. On June 17, both 37 and 42 are circled. ADON1 states there is no way to determine the correct temperature for that day with both numbers being circled. During a review of Medication Room Temperature Log -Station 2, dated May 2025, the Medication Room Temperature Log -Station 2 indicated 11 days of missing temperature checks. During a review of Medication Storage Refrigerator Temperature Log -Station 2, dated May 2025, the Medication Storage Refrigerator Temperature Log -Station 2 indicated missing temperature checks for 16 days for Shift 1 and missing temperature checks for 19 days for Shift 2. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Medication Storage Refrigerator Temperature Log -Station 2, dated June 2025, the Medication Storage Refrigerator Temperature Log -Station 2 indicated missing temperature checks for one day for Shift 1. On June 20, temperature for Shift 2 is documented at 35 degrees which is out of the range of 36-46 degrees Fahrenheit. During an interview on 6/24/25 at 12:11 p.m. with ADON1, ADON1 stated that the temperature of the medication storage room is to be checked daily, and the medication refrigerators should be checked twice a day. ADON1 states that the May and June medication storage room and refrigerator temperatures logs for Station 1 and Station 2 were both missing information. During a review of the facility's policy and procedure titled, Label/Store Drugs & Biologicals, undated, indicated in part, Temperatures will be taken daily inside the medication storage area and are to remain between 59-and 86 degrees Fahrenheit. Medications will be stored in a separate refrigerator. The temperatures will be taken twice daily. The proper range is 36-46 degrees Fahrenheit. 3. During a concurrent observation and interview on 6/26/25 at 11:25 a.m. with Director of Staff Development (DSD) while reviewing Hall C Medication Cart, a Lantus Insulin Pen (medication used to regulate blood sugar in diabetic patients) in Resident 32's medication drawer was observed without a written opening date or expiration date on the sticker placed by pharmacy to indicate when the medication has been used and should no longer be used. DSD states she is unable to verify if the medication had been used or not used. DSD states that the date the prescription was filled by the pharmacy was 5/15/25. DSD states that Per policy it is required to write an open date on everything. DSD states that the Insulin Pen (device that administers the medication Insulin to regulate blood sugar levels) should remain refrigerated until it is used for the first time. DSD states there is no way to verify how long the medication has been out of the refrigerator or when it will expire. DSD states that the Insulin Pen expires 28 days after it has been out of the refrigerator. During a review of the facility's policy and procedure titled Storage of Medications dated March 2024, indicates in part, Insulin bottles/Pens are to be dated when opened and discarded as per manufacturer recommendations. Insulin Pens can be stored at room temperature once opened for use. During a review of the facility's policy and procedure titled Insulin Pen Administration dated March 2024, indicates in part, Store unopened and opened insulin pen in labeled bag in refrigerator (36-46 degrees Fahrenheit). Indicate open date on appropriate sticker. 4. During a concurrent observation and interview on 6/26/25 at 11:35 a.m. with DSD while reviewing Hall C Medication Cart, a first opened date was not written on a blood glucose test strip container (devices used to test residents blood sugar) of when the container was first opened and placed in the medication cart. DSD states there is no way to verify if the container of blood glucose test strips has been opened and is being used. DSD states that the container should have an open date written on the outside of the container where the manufacture label indicates to write it. DSD states that the test strips are only good for 6 months after the bottle is opened. DSD stated They don't last that long around here. DSD states that an unopened container of blood glucose test strips would still be in the box so she would assume this container of test strips is opened and in use. During a review of the manufacture insert titled Medline EvenCare G3 Blood Glucose Test Strips with DSD the manufacture instructions states, DO NOT use test strips after their expiration date. Use within 6 months of first opening or the expiration date on the label, whichever comes first.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the staff had appropriate competencies and skill sets to carry out the functions of the food and nutrition services when one kitchen staff (Dietary Aide - DA) did not use portion sizes when making sandwiches that were made to be given to residents as an alternate. This failure had the potential to result in residents receiving food items that did not have appropriate amounts of macro and micronutrients which could result in a decrease in nutritional status and weight loss. Findings: During a concurrent observation and interview, on 6/24/25, at 3:34 p.m., with Dietary Aide (DA) was observed making peanut butter and jelly sandwiches and tuna sandwiches. DA was spreading peanut butter with a spatula and the tuna with a spatula. The peanut butter was thinly spread on one slice of bread. No measurements for peanut butter or jelly or tuna were used. DA stated, she has worked at the facility for three months and that she is making sandwiches for the following day. During an interview with the Kitchen Supervisor (KS) on 6/24/25 at 3:56 p.m., KS stated the sandwiches are for tomorrow for meals when a resident orders an alternate meal item. During a review of the facility document titled Sandwich Peanut Butter and Jelly, undated, specified that ¼ cup of peanut butter should be spread on half of the bread slices for each sandwich. Portion size states sandwich. One half sandwich served. During a review of the facility document titled VHHV Tuna, undated, indicated, to place a #16 scoop of tuna salad between two slices of bread, spread out smoothly. Portion size states sandwich [2]. One half sandwich served. During a review of DA personnel file, there was a Performance Enhancement Worksheet ([NAME]) dated 6/2/25. The [NAME] indicated there were blanks in multiple logs and milk left out overnight. Educational information was provided. The job description for each position provides everything that needs to be done. There was a new employee orientation check list with initials by DA and KS on 03/19/2025. The record included but is not limited to: Diet Roster and provides residents with an appropriate diet; Recipes and Spreadsheets: .KS wrote imperative that they are used accurately and that proper serving size is given to residents. Snack Lists all snacks must follow the diet ordered. There were no other job specific competencies in the job description. During an interview with KS and the Registered Dietitian on 6/16/25 at 10:05 a.m., KS stated that new employees complete an orientation, and use a checklist to go over department specific items. KS explained that competency is determined by preceptor training in all areas of the kitchen. KS stated DA has had limited training due to illness. KS stated DA has been educated on scoop sizes. No written competency check list. KS stated she does not complete 90-day evaluations on staff. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility Policy and Procedure (P&P) titled Training Orientation, dated 2022, the P&P indicated Food and nutrition services staff will be adequately trained to preform assigned duties. During a review of the facility policy and procedure titled Evaluating Food and Nutritional Services Personnel, dated 2022, the P&P indicated The director of food and nutrition services will complete periodic written evaluations for department staff. Clinical staff should be evaluated using a competency-based assessment . The employee competency check list may be completed at the end of the probationary period or 90 days and periodically as needed . Competency based evaluations will be used. All evaluations should include a list of suggestions for improvement, educational resources for action and recommended completion date.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, staff interviews and facility document review, the facility failed to follow the menu when: 1. Five residents (Residents 8, 13, 36, 38, 63) received mashed potatoes instead of whipped sweet potatoes when the facility ran out of whipped sweet potatoes for the lunch meal on June 24, 2025. 2. Four residents (Residents 4, 18, 57, 76) received roasted turkey that was greater than 3 ounces for the lunch meal on June 24, 2025. 3. A #6 scoop (5.33 ounces) instead of a #8 scoop (4 ounces) of the mashed potatoes and meatloaf were given to 16 residents (Residents 2, 3,11, 20, 21,29, 31,39, 41,47,62, 73, 80, 85, 341, 640) on the soft and bite diet (a texture-modified diet where foods are bite sized, soft, tender and moist with no thin liquid dripping from food) and five residents (Residents 5, 16, 22, 71, 81) on a minced and moist diet (a texture-modified diet that is soft and moist with no liquid dripping from the food and minimal chewing required) for the lunch meal on June 25, 2025. 4. Five residents (Residents 8,13,36,63) on a puree diet, (a textured-modified diet where foods are blended into a smooth, pudding-like consistency, and then enriched with extra nutrients like calories and protein to meet specific dietary needs) received a # 8 scoop instead of a #6 scoop of the puree meatloaf and a # 6 scoop for the mashed potatoes instead of a #8 scoop for the lunch meal on June 25, 2025. 5. Two of two residents (Resident #34 and #46) on finger foods diet received cut up red potatoes instead of tater tots and a whole meatloaf patty instead of meatloaf bites for the lunch meal on June 25, 2025. This failure had the potential to result in residents not receiving the facility's Registered Dietitian's approved menu that can lead to over or under nutrition which can compromise the residents' nutritional status and overall clinical condition. Findings: 1. During a review of the facility document titled, Diet Spread Sheet dated 6/24/25, for the lunch meal, indicated the following diets would receive ½ cup of whipped sweet potatoes: Regular, small portion, soft and bite, minced and moist, and Puree diets. Resident 8 was on a Puree, Nectar Thick diet. Resident 13 was on a Puree, Nectar Thick diet. Resident 38 was on a Puree diet. Resident 36 was on a Puree, Nectar Thick diet. Resident 63 was on a Puree, Nectar Thick. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/24/25 at 12:48 p.m., at the end of the lunch meal service with the Day [NAME] (DC), DC stated he was preparing food for 90 residents at the facility, and he used four cans of sweet potatoes when he prepared the recipe. DC stated that was usually enough for all the residents. DC stated that they only had four cans of sweet potatoes so that is all he could use and could not make more. 2. During a review of the facility document titled Diet Spread Sheet, dated 6/24/25 for the lunch meal, indicated, the regular diet would provide three ounces of roast turkey. During an observation of the lunch meal service on 6/24/25 starting at 11:39 a.m., the steam table had whipped sweet potatoes, roast turkey that was sliced, and a vegetable blend. DC was placing the sliced roast turkey on the plates for the residents during the meal service. The sliced turkey was various sizes. During concurrent observation and interview, of the lunch meal service on 6/24/25 at 12:32 p.m., DC was asked to weigh the turkey slices, DC placed four different slices of turkey on the scale. The slices were 3.5 ounces, 4 ounces, 4 ounces and 5 ounces. DC confirmed the amounts on the scale. DC stated that some slices are bigger than three ounces, but they are close to three ounces. DC then placed those slices on the resident's plates for the following residents: Residents 4, 18, 57 and 76. During a review of the tray ticket for Resident 4, 18, 57, 76 indicated, they were on a Regular Diet. 3. During a review of the lunch menu titled Diet Spread Sheet dated 6/25/25, indicated ½ cup (#8 scoop) of mashed potatoes for the soft and bite diet and minced and moist diet. During an observation of the lunch meal service on 6/25/25 starting at 11:45 a.m., there was a #6 scoop (5. 33 ounces) in the mashed potatoes. DC was using the #6 scoop during the lunch meal service for the residents on the soft and bite (Resident 2, 3,11 20, 21,29,31,39, 41,47,62, 73, 80, 85, 341, 640,) minced and moist diet (Residents 5, 16, 22, 71, 81). During a review of the meal tickets indicated the following: Resident (5,16, 22, 71,81) were on a minced and moist diet Residents (2, 3,11 20, 21,29,31,39, 41,47,62, 73, 80, 85, 341, 640) were on a soft and bite diet. During an interview with DC on 6/25/25 at 12:41 p.m. at the end of the lunch meal service, DC confirmed he was using the #6 scoop for the mashed potatoes and that was not correct. During an interview with the Kitchen Supervisor (KS) on 6/24/25 at 12:43 p.m, KS stated it should have been a #8 scoop for the mashed potatoes. 4. During a review of the lunch menu titled Diet Spread Sheet dated 6/25/25, indicated # 6 scoop for the puree meatloaf and #8 scoop for the mashed potatoes for the residents on a puree diet. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of the lunch meal service on 6/25/25 starting at 11:34 a.m., there was a #8 scoop in the puree meatloaf and a #6 scoop in the mashed potatoes. DC would portion for the residents (Residents 8, 13, 36, 38, 63) on the puree diet using a #8 scoop for the meatloaf and #6 for the mashed potatoes. During an interview with DC on 6/25/25 at 12:41 p.m. at the end of the lunch meal service, DC confirmed he was using the #6 scoop for the mashed potatoes and that was not correct. During a review of the meal tickets for Residents 8, 13, 36, 38, 63, indicated puree diet. 5. During a review of the lunch menu titled Diet Spread Sheet dated 6/25/25, indicated for the finger food diet they would receive three ounces of meatloaf bites, ½ cup tater tots, ½ cup carrot coins. During an observation of the lunch meal service on 6/25/25 starting at 11:45 AM, there were meatloaf patties, red potatoes, and carrot coins on the steam table. During the 2nd meal cart there were two residents (Resident 34 and 46) on a finger food diet. DC placed red potatoes, carrot coins and one whole meatloaf patty with gravy on top on the plates. At 12:02 p.m., the cart was leaving the kitchen and the surveyor asked KS about the residents with finger food diets. KS looked at the trays and the foods on the plates while reviewing the meal tickets and stated they should have tater tots instead of the potatoes. KS asked DC about the Tater Tots and DC stated he forgot to make them. KS pulled the trays from the cart then put tater tots in the oven. During a review of the tray ticket for Resident 34 and 46 indicated, it was noted that both residents were on Fingers Foods diet (small, bite-sized pieces of food). During a review of the facility document for Dining Assistance/ Special Needs, Finger Food Diet, dated 2016, indicated, Finger Food Diet is small, bite-sized pieces of food that can be easily picked up and eaten with the fingers, without the need for utensils for individuals with certain dietary needs for individuals who need to eat with their fingers to improve hand movements, maintain utilization of utensils, cannot sit still to eat, or medical conditions prohibiting the use of utensils. It indicated foods are in a form that reduces the amount of spilling. A person served finger foods should be in complete control over what they eat .decreases frustration, enhance dignity and self-esteem . improvement in appetite may also occur. During an interview with the Registered Dietitian (RD) and KS on 6/26/25 at 10:05 a.m., RD stated when they re-sent the trays after they were brought to their attention, the plates had the meatloaf cut and with Tater Tots. RD and KS stated the expectation is that the meatloaf is to be cut or in bite size pieces and the gravies and sauces should be served in a cup. RD stated the expectation is to follow menus and the portion sizes. KS stated she does audit or observation of tray line portions, monthly audits done for textures and quarterly audits done. KS stated they do monthly in-services with staff. During a review of the facility document titled In Services Training Report Dietary Staff titled portion sizes/spread sheets' dated 05/20/2025, indicated, Portion sizes are not being served properly .These are state and federal regulations not and just a preference for the company. Included in the education is a copy of scoop sizes and spread sheet examples.

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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. During a concurrent observation and interview on 6/24/2025, at 4:10 p.m. with LN3. observed the oxygen tubing for Resident 643 was not labeled with a date. LN3 confirmed there was no dated label on the oxygen tubing. LN3 stated, No, it's not there. During a review of the facility's policy and procedure (P&P) titled. Oxygen Procedure, undated, the P&P indicated in part, Purpose: Patients that require oxygen as ordered by a physician . The equipment will be maintained in a manner to ensure the best possible outcome for the patient. . Protocol: . oxygen tubing and bag will be replaced weekly. Based on observation, interview and record review the facility failed to maintain infection control practices for three of 10 sampled residents when: 1. Oxygen tubing and nasal cannula (tubing device placed in a person's nose that delivers oxygen) was found on the floor of resident's room (Resident 55). 2. Oxygen tubing was not labeled for two residents (Resident 339 and Resident 643). These failures had the potential to transmit and spread infection to residents. Findings: 1. During an observation on 06/24/25, at 11:30 a.m. in Resident 55's room, oxygen tubing with nasal cannula attached was observed connected to the oxygen concentrator (a medical device that provides supplemental oxygen to individuals with low blood oxygen levels) and placed on the floor. During a concurrent observation and interview on 06/24/25, at 1:10 p.m. with Licensed Nurse (LN6), observation of Resident 55's tubing attached to nasal cannula was observed. LN 6 stated that oxygen tubing and nasal cannula are to be labeled with the date opened and changed every 7 days. LN6 stated that when tubing and cannula are not in use, they are to be stored in a plastic bag with date written on the bag. LN6 confirmed that Resident 55's oxygen tubing and nasal cannula were on the floor and acknowledged that they should have been placed in the bag provided. 2. During a concurrent observation and interview on 06/24/2,5 at 1:10 p.m. in Resident 339's room, with LN6, observation of Resident 339's oxygen tubing was found to not include a label with a date. LN 6 stated that all oxygen tubing be labeled with the date opened and changed every 7 days. LN6 confirmed that Resident 339's oxygen tubing should have been labeled when opened and acknowledged that it was not.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview and record review, the facility failed to maintain the walk-in freezer in safe operating condition when ice build up was present. This facility failure had the potential to affect the overall efficiency and temperature regulation within the freezer. Findings: During an observation on 06/24/2025 at 11:00 a.m., during the initial kitchen tour, of the walk-in freezer, condensation was present on the lower half of the outside of door. The baseboard, on the outside lower left, is lifted and bent. Tile flooring was cracked along baseboard. There was ice present on the floor on the left side when entering the freezer towards the back and on the lower back shelves. Ice was present on pipes near the condenser that was approximately six inches long and three inches wide at ceiling. During a review of the Registered Dietitian (RD) sanitation audits, dated January 2025 through June 2025 documented the following issues: January, February and March: torn freezer seal, ice buildup inside the freezer, and threshold in freezer loose. April: freezer gasket replaced, ice build up in freezer and door not closing tightly. May: freezer door not closing tight. June: freezer is snowing. During an interview with the Kitchen Supervisor (KS) on 06/25/2025 at 9:33 a.m., KS stated the tiles have been cracking, the ice in the freezer can be cleaned up, however two hours later it comes back. KS stated, she brings in up to maintenance to regularly check the pipe at the ceiling. During a concurrent observation and interview with the Maintenance Director (MD) on 06/25/2025 at 3:09 p. m., MD stated that the freezer is defrosted once per month, and the coils and condensers are wiped down. MD stated, he is aware of the gaps and cracked tiles. During a review of the Food and Drug Administration (FDA) Food Code 2022, Section 6-501.11 Repairing, indicating in part, Physical Facilities shall be maintained in good repair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555220	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vineyard Hills Health Center	290 Heather Court Templeton, CA 93465

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review the facility failed to ensure that one certified nursing assistant (CNA1) received 12 hours of annual in-service which included dementia management as well as abuse prevention training and reporting. This failure had the potential to affect the quality of care and services provided to the residents. Findings: During a concurrent interview and record review on 6/26/25 at 4:09 p.m. with the Director of Staff Development (DSD), CNA1's Individual In-service Attendance Record was reviewed. The record indicated that CNA1 worked at the facility in 2023, 2024, and 2025, and is still employed at the facility, CNA1 did not attend 12 hours of in-services training that included dementia management as well as abuse prevention and reporting for the year of 2024. The DSD acknowledged and confirmed that CNA1 did not receive 12 hours of in-service training for the year of 2024.