STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675032	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Healthcare Center	230 S Clark Rd Cedar Hill, TX 75104

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 34399 Based on observations, interview, and record review, the facility failed to provide a safe, clean, comfortable and homelike environment for two (End of Hall 100 shower room and Hall 200 shower room) of three shower rooms reviewed for physical environment. The facility failed to ensure shower rooms were clean for the end of hall 100 shower room and Hall 200 shower room. These failures could place residents at risk for a diminished quality of life and an unsanitary environment. Findings included: Interview on 06/24/24 at 12:24 PM with Resident #78's family member revealed she would often do Resident #78's shower because she would not let the staff shower her. She stated the shower room was filthy on hall 200. She stated she had seen feces on the floor and diapers in the shower room. Observation on 06/25/24 at 10:49 AM revealed unoccupied shower room for end of hall 100 revealed several blackish marks on shower tile in one of two shower room areas along with black debris in shower room area. Interview on 06/25/24 at 10:51 AM with LVN S revealed end of hall 100 shower room was unoccupied and it needed to be cleaned including the resident shower room area. She stated she would notify housekeeping to clean the shower room. Observation on 06/25/24 at 12:26 PM of shower room for Hall 200 with Housekeeper R revealed seven dark brown spots and particles on the floor tile near wall to the left of the toilet and sink. Interview on 06/25/24 at 12:27 PM with Housekeeper R revealed he had not cleaned the shower room yet for hall 200. He stated he cleaned it after lunch when it was not in use. He had not cleaned it yet on his shift. Interview on 06/26/24 at 10:02 AM with CNA Q revealed the resident shower rooms were cleaned twice daily by housekeeping and as needed. She stated CNAs were responsible to clean between resident showers. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 06/26/24 at 10:09 AM revealed the dark brown particles and spots were still on the floor tile near the left of the toilet in unoccupied shower room for Hall 200. Observation on 06/26/24 at 10:10 AM of shower room for Hall 200 revealed a thick dark brown substances on floor tile about 3 inches by 3 inches in the corner behind shower door with a plastic cup and debris. Interview on 06/26/24 at 10:18 AM with Maintenance/Housekeeping Supervisor revealed the resident shower rooms should be checked 2 times daily and cleaned at least daily or more often as needed. He stated housekeeping should be cleaning the shower rooms. He stated the resident shower rooms should be cleaned including the floor and shower areas. He stated the dark brown spots on the floor tiles in the 200 hall shower should have been cleaned since yesterday when it was brought to attention of the Housekeeper. He stated the brown spots on the 200 hall shower room were able to be scrubbed. He stated the housekeepers should be checking the shower rooms in the morning and cleaning them if need to be. He stated they should be moving items and cleaning the showers. He stated right behind shower door on 200 hall did not look like it had been cleaned daily due to the buildup and debris. He stated he would in-service housekeeping staff on the shower rooms to be cleaned properly to ensure resident rooms were clean and sanitary. He stated not cleaning the shower rooms placed residents at risk of an unsanitary environment. Interview on 06/26/24 at 01:18 PM with the Administrator revealed she had received a complaint from a resident's family member on the lack of cleanliness of the shower room earlier this week. She stated they had a manager doing spot checks in shower room so resident shower rooms should have been cleaned. She stated she went to hall 200 shower room and moved the items. She stated the resident shower rooms should be cleaned by housekeeping. Review of the facility's policy Bathrooms last revised April 2006 reflected Bathrooms shall be maintained in a clean and sanitary manner and shall be cleaned on a daily basis .1. Bathrooms, include showers will be cleaned daily in accordance with our established procedures. 2. Daily bathroom cleaning includes i. Sweeping, mopping and scrubbing floors.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42971 48560 Based on observation, interview, and record review, the facility failed to provide the necessary services for residents who are unable to carry out activities of daily living to maintain good grooming and personal hygiene for 3 (Resident #47, Resident #71, and resident #3) of 8 residents reviewed for quality of life. The facility failed to ensure: 1- Resident #47 had his fingernails cleaned and trimmed. 2- Resident #71 had her fingernails cleaned and trimmed. 3- Resident #3 had his fingernails cleaned. This failure could place residents who were dependent on staff for ADL care at risk for loss of dignity, risk for infections and a decreased quality of life. Findings include: 1. Record review of Resident #47's Quarterly MDS assessment dated [DATE] reflected Resident #47 was a [AGE] year-old male admitted to the facility on [DATE]. His diagnoses included cerebral infarction (occurs because of disrupted blood flow to the brain due to problems with the blood vessels that supply it), Hemiplegia (paralysis that affects only one side of the body) affecting left side, and cognitive communication deficit. Resident #47 had a BIMS score of 11 which indicated Resident #47's cognition was moderately impaired. Resident #47 required assistance with personal hygiene. Review of Resident #47's Comprehensive Care Plan, revised 11/15/23, reflected the following: Problem: [Resident #47] has an ADL self-care performance deficit related to limited mobility, weakness. Goal: [Resident #47] will remain free of complications related to immobility. An observation and interview on 06/24/24 at 2:38 PM revealed Resident #47 was sitting in the wheel chair in his room. The nails on both hands were approximately 0.3 centimeter in length extending from the tip of his fingers and the underside had dark brown colored residue. Resident #47 stated he did not like his long nails; he wanted them clean and short, but he did not tell the staff because he did not want to be in trouble. 2. A record review of Resident #71's Quarterly MDS assessment dated [DATE] reflected Resident #71 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses included dementia, lack of coordination, and cognitive communication deficit. Resident #71 had a BIMS score of 00 which indicated Resident #74 was unable to complete the interview. She required moderate assistance of one-person physical assistance with personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #71's Comprehensive Care Plan, revised 01/26/24, reflected the following: Focus: [Resident #71] has an ADL self-care performance deficit. Goal: [Resident #71] will maintain current level of function in through the review date. An observation and interview on 06/24/24 at 2:45 PM revealed Resident #71 was laying in her bed. The nails on both hands were approximately 0.3 centimeter in length extending from the tip of his fingers and the underside had dark brown colored residue. Resident #71 was unable to answer questions. In an interview with CNA G on 06/24/24 at 2:52 PM, she stated both CNAs and LVNs were responsible for nail care. She stated if a resident had diabetes, only nurses were allowed to provide nailcare. She stated the risk for not performing nailcare was increased risk of infection. She stated Resident #47 was not diabetic and she offered to clean and trim his fingernails after the interview. In an interview with LVN F on 06/24/24 at 2:58 PM, he stated in the secured unit, nurses were responsible for fingernails care because most of the resident had behaviors. He stated the risk for not performing nailcare was increased risk of infection and skin break down. He offered to clean and trim Resident #71's fingernails after the interview. 3. Review of Resident #3's Quarterly MDS assessment dated [DATE] reflected Resident #3 was a [AGE] year-old male with initial admitted to the facility on [DATE]. His diagnoses included coronary artery disease (chronic condition of plaque buildup in heart), hypertension (high blood pressure), Renal insufficiency (poor functioning of kidneys), Diabetes Mellitus (high blood glucose levels), hyperlipidemia (high blood lipid levels), Depression (serious mood disorder), and Schizophrenia (chronic brain disorder that affects a person's ability to think, feel, and behave clearly). Resident #3 had a BIMS score of 03 which indicated he had severe cognitive impairment. Resident #3 required supervision with personal hygiene. Review of Resident #3's Comprehensive Care Plan, revised 12/08/2023, reflected the following: Problem: [Resident #3] had ADL self-care deficit related to limited physical mobility. Problem: [Resident #3] has an ADL self-care performance deficit related to impaired balance. Goal: The resident will maintain current level of function in ADLs through the review date. Interventions: The resident requires supervision completing hygiene and oral care. An observation on 06/24/24 at 1:49 PM revealed Resident#3's nail on both hands had dirt under the nail bed. Resident #3 was unable to participate in an interview related to poor BIMS score. An Interview and Observation with RN K on 06/24/24 at 3:52 PM revealed Resident #3 had dirty nails and they needed to be cleaned. He stated that nail care should be provided on shower days and as needed, and Nurses were responsible for cleaning fingernails for residents who had diagnosis of diabetes. He stated the risk of not providing adequate nail care was increased infections. He offered to clean Resident #3's fingernail after the interview. In an interview on 6/26/24 at 9:37 AM with the ADON revealed her expectation was that nail care should be provided every shower day and as needed. She stated that both CNAs and Nurses were responsible for doing nail care on all residents; except Nurses were responsible for nailcare if resident had a diagnosis of diabetes. She also stated that as the ADON she conducted spot checks and daily rounds for monitoring. The ADON stated residents who had dirty fingernails could be an infection control issue. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of the facility policy titled Care of Fingernails/Toenails revised October 2010 reflected, The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections 1. Nail care includes daily cleaning and regular trimming

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on observation, interview, and record review, the facility failed to ensure residents who needed respiratory care were provided such care, consistent with professional standards of practice and the comprehensive person-centered care plan for one of two (Resident #84) reviewed for quality of care. The facility failed to ensure the supplemental O2 was provided at the physician ordered rate for Resident #84. This failure could place residents who received oxygen therapy at risk of oxygen toxicity. Findings Included: Record review of Resident #84's admission MDS assessment dated [DATE], reflected an [AGE] year-old male admitted to the facility on [DATE]. He had a BIMS score of 9 which indicated he was moderately cognitively impaired. Diagnoses included pulmonary hypertension (type of high blood pressure that affects the arteries in the lungs and heart), diabetes, heart failure and respiratory failure. He was dependent on ADL's and required maximum assistance with transfers. Resident #84 had received Oxygen therapy in the last 14 days. Record review of Resident #84's care plan initiated on 03/14/24 and revised on 04/09/24 reflected, [Resident 84] has altered respiratory status/difficulty breathing related respiratory failure .Interventions .Oxygen settings: O2 via n/c @2 liters continuous. Humidified . Record of Resident #84's Active Physician orders dated 06/26/24, reflected, oxygen at 2 Liters per minute via n/c (nasal cannula) every shift ., with a start date of 03/13/24. Record review of Resident #84's TAR dated June 2024 reflected, .O2 @ 2Liters per minute via N/C continuous every shift with a start date of 03/13/24 . The TAR was signed off by staff on the day shift, evening shift and night shift from 06/01/24 through the day shift on 06/25/24 which indicated O2 was administered at 2 liters per minute An observation on 06/24/24 at 12:45 p.m. revealed Resident #84 had a nasal cannula in place and the oxygen flow rate was set to deliver 4.5 liters per minute via an oxygen concentrator. In an interview with Resident #84 on 06/24/24 at 12:46 p.m. he stated he had been on O2 continuously. He stated he had not felt well the past few days and complained of his hands being swollen and stiff. An observation on 06/25/24 at 08:50 a.m. revealed CNA O and CNA P transferred Resident #84 from the bed to his wheelchair with a mechanical lift. Resident #84 had a nasal cannula in place and the oxygen flow rate was set to deliver 5.5 liters per minute. In an interview with Resident #84 on 06/25/24 at 08:55 a.m., he stated he had not adjusted to the Oxygen flow rate and stated he could not reach the oxygen concentrator from his bed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation made with the ADON on 06/25/24 at 09:10 a.m. revealed the O2 flow rate was set to deliver 5.5 liters per minute. The ADON stated Oh no, that is not right, and turned the flow rate to 2 liters. The ADON asked the resident who had adjusted the flow rate and he stated he did not know. An interview with the ADON on 06/25/4 at 09:15 a.m. revealed any resident with oxygen had to have an order with the number of liters per minute to be delivered. She stated providing inaccurate amounts of oxygen could make the resident's breathing worse and could result in increased carbon dioxide levels. She stated the nurses were supposed to check the oxygen levels each shift. In an interview with RN A on 06/25/24 at 10:00 a.m., she stated she had assessed Resident #84 when she came on duty and had checked his O2 saturation level but did not look to see what the O2 concentrator was set on. RN A stated she should had checked the levels instead of assuming it was set on the correct rate. She stated too much oxygen could result in oxygen toxicity. Record review of the facility's policy titled, Oxygen Administration, dated October 2010, reflected, The purpose of this procedure is to provide guidelines for safe oxygen administration .Verify that there is a physician's order for this procedure .Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following .signs or symptoms of oxygen toxicity .lung sounds .Unless otherwise orders, start the flow of oxygen at the rate of 2 to 3 liters per minutes .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on observation, interview, and record review, the facility failed to ensure that the medication error rate was not 5% or greater. The facility had a medication error rate of 9.38 %, based on 3 errors of 32 opportunities, which involved two of six residents (Residents #23 and #39) and one (MA D) of four staff reviewed for pharmacy services. 1. The facility failed to ensure MA D administered Resident #23's Flonase allergy relief nasal suspension 50 mcg on 06/25/24 as ordered by the physician. 2. The facility failed to ensure MA D administered Resident #39's Namenda 5 mg and Polyethylene Glycol powder 17 gm on 06/25/24 as ordered by the physician. This failure could place residents at risk for not receiving therapeutic effects of their medications and possible adverse reactions. The findings include: 1. A record review of Resident #23's Quarterly MDS assessment, dated 05/26/24, reflected a [AGE] year-old male with an admitted [DATE]. He had a BIMS score of 3, which indicated he was severely cognitively impaired. Diagnoses included coronary artery disease (damage or disease in the heart's major blood vessels), dementia, and chronic obstructive pulmonary diseases (lung disease that blocks air flow) A record review of Resident #23's Physician's order Summary report dated 06/25/24, reflected Resident #23 was to receive the following medications daily: Flonase Allergy Relief Nasal suspension 50 mcg/act 2 sprays in both nostrils one time a day for allergy. Record Review of Resident #23's medication administration record on 06/25/24 at 10:45 a.m. reflected Flonase Allergy Relief Nasal suspension 50 mcg/act 2 sprays in both nostrils one time daily at 0900 (09:00 a. m.). The medication was signed out as given by MA D on 06/25/24. A medication pass observation on 06/25/24 at 07:40 a.m. revealed MA D administered the following medications to Resident #23: Colace Capsule 100 mg (Stool softener) 1 capsule, Aspirin 81 mg 1 tablet, Ativan (anti-anxiety) 0.5 mg 1/2 tablet, Divalproex delayed release (mood stabilizer) 250 mg 1 tablet, Donepezil (cognition enhancing)10 mg 1 tablet, Gabapentin (anti-convulsant) 300 mg 1 capsule, Omeprazole (acid reducer) 20 mg 1 capsule, and Paroxetine (anti-depressant) 20 mg 1 tablet. 2. A record review of Resident #39's Annual MDS assessment, dated 04/14/24, reflected a [AGE] year-old male with an admitted [DATE]. He had a BIMS score of 2, which indicated he was severely cognitively impaired. Diagnoses included hypertension, Alzheimer's, and fecal impaction. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident #39's Physician's order Summary report dated 06/25/24, reflected Resident #39 was to receive the following medications: Namenda (cognition enhancement) Oral tablet 5 mg 1 tablet two times a day and Polyethylene glycol 1450 powder 17 grams by mouth one time a day. Record Review of Resident #39's medication administration record on 06/25/24 at 10:50 a.m. reflected: Namenda Oral tablet 5 mg 1 tablet by mouth two times a day at 0800 (8:00 a.m.) and 1700 (05:00 p.m.) and Polyethylene glycol 1450 powder 17 grams by mouth one time a day at 0900 (09:00 a.m.). Both medications were signed out as given by MA D on 06/25/24. During a medication pass observation on 06/25/24 at 07:50 a.m. revealed MA D administered the following medications to Resident #39: Lorazepam (antianxiety) 0.5 mg 1 tablet, Rivastigmine (used to treat dementia) Patch 24 Hour 4.6 MG/24 HR, Cetirizine (anti-histamine) 10 mg 1 tablet, Senna (laxative) 8.6 mg 1 tablet, Plavix (blood thinner) 75 mg 1 tablet, Gemtesa (overactive bladder)75 MG 1 tablet, Hydralazine (vasodilator) 25 mg 1 tablet, Nifedipine (anti-hypertensive) extended release 60 mg 1 tablet, Potassium (mineral) 20 meq 1 tablet and Sertraline (Antidepressant) 50 mg 1 tablet, Sertraline (Antidepressant) 25 mg 1 tablet. 3. In an interview with MA D on 06/25/24 11:55 a.m., he stated he had not administered any additional medication to Resident #23 or Resident #39 prior to or since the medication observation on 06/25/24 at 07:40 a.m. for Resident #23 and 07:50 a.m. for Resident #39. A record review on 06/25/24 at 11:56 a.m. of the medication administration record with MA D for Resident #23 which indicated the Flonase had been administered, MA D verified he had not given the Flonase even though he had signed it off as given. He stated he had overlooked it. A record review on 06/25/24 at 11:57 a.m. of the medication administration record with MA D for Resident #39, which indicated he had administered Namenda 5 mg and Polyethylene glycol 1450 powder 17 grams. MA D verified he had not given the Polyethylene glycol 1450 powder 17 grams, but stated he thought he had given the Namenda. He stated he was supposed to check the medication against the medication administration record and physician orders and only sign off on a medication once it had been administered. He stated failing to give prescribed medications could result in the resident not receiving the medication as ordered by the physician and could impact their health. In an Interview with the ADON on 06/25/24 at 01:00 p.m., she stated staff were required to verify the physician orders and match it to the medication administered. She stated they were supposed to sign off on the medication once it was administered. She stated not giving the prescribed medications could impact the resident depending on the medication that was overlooked. She stated this could cause a decline in cognition if it was something for behaviors, it could cause constipation if they were not giving the laxatives as ordered, and it could cause an increase in allergy symptoms if a resident is not administered there ordered nasal spray. She stated the medication aides were checked off annually for competency. Record Review of MA D Skill assessment dated [DATE] reflected he was proficient in administration of medications. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility policy titled Administrating Medications, dated December 2012, reflected, . Medications shall be administered in a safe and timely manner, and as prescribed .The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication . The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones .

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48560 Based on interview and record review, the facility to provide or obtain laboratory services to meet the needs of its residents for 1 (Resident #51) of 4 residents reviewed for labs. The facility failed to ensure labs for Depakote levels (used to monitor the level of Depakote) were not drawn monthly after December 2023 as ordered by the physician for Resident #51. This failure could place residents at risk for a delay in identifying or diagnosing a problem, adjusting medications, and ensuring treatment needs were identified and addressed. Findings include: Record review of Resident #51's quarterly MDS assessment dated [DATE] revealed Resident #51 was a [AGE] year-old Male with admitted [DATE]. Relevant diagnoses included Stroke (damage to the brain from interruption to blood supply), Hypertension (high blood pressure), Anxiety (feeling of fear and uneasiness), Psychotic disorder (mental disorder characterized by a disconnection from reality), Mood disturbances (mental health condition that affects emotional state). Resident #51 had BIMS score of 00 which indicated he had severe cognitive impairment. Record review of Resident #51's Physician order dated 5/21/2024 reflected, Depakote Tablet Delayed Release 250 MG (Divalproex Sodium) Give 1 tablet by mouth two times a day for Mood. Record review of Resident #51's Physician order dated 3/16/2023 reflected, Depakote Levels every 30 days one time a day every 30 day(s) related to unspecified Dementia, psychotic Disturbance, Mood Disturbance. Record review of Resident #51's Medication Administration Record from January 1, 2024, to June 26, 2024, reflected Resident #51 received Depakote tablets daily by mouth. Record Review of Resident #51 Lab results dated 12/22/2023 revealed Depakote levels were drawn for the month of December 2023 Record Review of Resident #51 lab results from January 2024 to June 25,2024 indicated there were no lab results for Depakote levels. An interview on 06/25/24 at 1:55 PM with RN A revealed that she had been working in the facility since December 2023. She stated Resident #51 had Depakote tablets ordered daily and had been receiving it as ordered. She stated that Resident #51 had Lab orders for Depakote to be drawn once every 30 days as noted on physician orders. She stated she searched EHR for Depakote levels and stated she could only see Depakote laboratory values drawn until December 2023 and did not observed lab values for Depakote levels from January 2024 until June 25, 2024. She stated that nurses and Nursing Management were responsible to ensure that Labs are drawn per physician orders. She stated she was not sure why Depakote levels were not drawn monthly despite having physician orders and will need to check with the facility ADON. She stated the risk to residents for not drawing physician ordered labs in a timely manner could lead to delays in receiving needed care. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 6/25/24 at 2:46 PM with the ADON revealed her expectation was Labs should be drawn on all residents per physician orders. She stated that they changed their pharmacy system in January 2024, which could have affected why Resident #51 did not have a Depakote level drawn since January. She stated that despite the change in the lab ordering system, Nurses and herself were responsible for checking that physician ordered lab values were ordered and drawn in a timely manner. She stated that it was a system failure since nurses and Nursing Management, including herself, did not check if Resident #51 received his monthly Depakote labs and will follow-up with the Physician about it. She stated the risk to the resident for not following physician ordered lab draws was a decrease in quality of care and possibly timely intervention, if needed, to adjust Depakote dose. In a phone interview on 6/25/24 at 3:15 PM with the Nurse Practitioner revealed that her expectation was that all physician orders including lab draws should be completed by the nursing facility. She stated Resident #51 had been stable, and she would recommend Depakote labs quarterly. She further added, she was not sure why Resident #51 had monthly lab draws for Depakote. However since the labs were ordered by the physician previously, the facility should have been drawing them. She stated that she looked at quarterly labs for all residents and noted that Depakote labs were not drawn for Quarter 1 in 2024. She stated Resident #51 was using Depakote for a mood disorder, which is an off-label use, and periodic lab draws were only necessary to determine toxicity. She stated the risk for Resident #51 not having lab draws for Depakote was very low since Resident #51 was stable. However, she added, in general the risk for not following physician ordered lab draws could lead to delay in needed interventions for the care of the resident. Record Review of Resident #51 lab drawn on 06/26/2024 reflected, Valproic Acid < 12.5 ug/mL , Normal Range: 50.0 - 100.0 ug/mL. (Lab values below normal range indicate resident is not at risk for depoakote toxicity.) Review of the facility policy titled Lab and Diagnostic Test Results - Clinical Protocol revised September 2012, reflected, Assessment and Recognition 1. The physician will identify, and order diagnostic and lab testing based on diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48560 Based on observations, interviews and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for the facility's only kitchen in that: 1. The facility failed to ensure food items in the facility freezer and preparation area had use-by date. 2. The facility failed to perform hand hygiene while preparing food for lunch service. 3. The facility failed to maintain sanitary conditions in the kitchen that was free of flies. These failures could affect residents who received their meals from the facility's only kitchen, by placing them at risk for food-borne illness, and food contamination. Findings included: Observation on 06/24/24 at 11:59 AM in facility's walk-in freezer revealed 2 packets of frozen broad beans did not had a use by date. Observation on 06/24/24 at 12:22 PM in facility's dining area revealed 6 house flies on resident's food plate and tables during the lunch service. Observation on 6/25/24 at 11:30 AM on facility's kitchen preparation and serving area revealed 2 houseflies sitting on a tray of cornbread that was left uncovered. Observation on 6/25/24 at 11:42 AM in facility's kitchen preparation and serving area revealed flies sitting on the serving scoop, and [NAME] I used the same scoop to serve food to the residents. Observation on 6/25/24 at 11:45 AM in facility's kitchen preparation and serving area revealed a quart size bag of cookies without a use by date. Observation on 6/25/24 at 11:54 AM in facility's kitchen preparation and serving area revealed the Dietary Manager was cooking a grilled cheese sandwich. The Dietary Manager donned gloves without washing hands, then proceeded to add bread to the skillet that was heating on the gas stove. He then went to the walk-in refrigerator, opened the door of the refrigerator with the same gloves, grabbed a packet of sliced cheese, came back to the gas stove, removed cheese slices from the packet and added cheese slices onto the bread without changing gloves or performing hand hygiene. The Dietary Manager then proceeded to move utensils to the dishwashing area, without changing gloves. He came back to the gas stove to remove the previous grilled cheese sandwich and added additional bread slices to the skillet, all by using the same set of gloves or without performing hand hygiene. Observation on 6/25/24 at 12:02 PM in facility's kitchen preparation and serving area revealed [NAME] I and Dietary Aide J were shooing away the flies while serving lunch. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 6/25/24 at 12:18 PM with the Dietary Manager, he stated he was not aware that he needed to wash hands between kitchen tasks and just changing gloves would be adequate. He stated that if he touched raw meats then he would have changed gloves and washed his hands. He stated he should have changed gloves and performed hand hygiene when he went from different tasks that included meal prep to refrigerator to dishwasher area. He stated the risk to resident for not performing adequate hand hygiene while cooking or serving food was infection control and possibility of residents getting food borne illness. He also stated he was aware that the facility had concerns with flies, but he had only seen flies in the resident dining area. He stated the flies came through the back door of the facility and he had ordered a blower that was to be delivered at a future date in July 2024 to the facility. He also added that the facility had conducted pest control in June 2023. However, that was not as effective to control flies. He stated that he had never seen flies in the kitchen area before, however later stated that since there was a door between the kitchen and dining room, the flies could easily come into the kitchen from the dining area. He stated that he threw away corn bread because he observed flies sitting on the corn bread. He stated that risk of having flies in the kitchen or dining room could possibly lead to food borne illness in residents. He stated that frozen broad beans should have a use-by date on them and the cook, dietary aide , and himself were responsible for dating the foods. He stated that frozen beans were out of their original box and mixed with other pre-cut vegetables such as spinach and hence labeling the box alone would not be sufficient. He stated that cookies were prepared on 6/24/24 as a PM snack and should had been dated with the use-by date and the dietary aide forgot to date it. His expectation was that all food items should have a use-by date. He stated the risk of not dating food items was infection control. In an interview on 6/25/24 at 12:47 PM with Dietary Aide J stated she had been working in the facility for 9 months. She stated that she had always seen house flies in the kitchen and had informed the Dietary Manager about it. She stated that having flies in the kitchen posed a risk to the resident and can cause food borne illness. She stated that the cookies were made on 6/24/24 as a night snack for the residents; however, she forgot to date the cookies with use-by date on them. She stated that cooks and herself were responsible for dating all food items and the risk for not dating food items correctly could cause residents being sick. An interview on 6/25/24 at 12:26 PM with [NAME] I revealed she had been working in the facility for 4 months. She stated they had seen flies in the kitchen since she started working at the facility. She stated that the scoop was left on the top of the tray line since they were going to use it for serving food and had not seen the flies on the scoop but was aware that they had flies in the kitchen. She stated if she was aware that the flies had sat on the scoop, she would not have used the scoop for serving food. She stated that risk to resident with having flies in the kitchen area was food borne illness. She stated that they received in-services for dating and labeling all food items. She stated cooks, dietary aides and the Dietary Manager were all responsible for labeling and putting use-by dates on all food items. She stated she did not work on 6/25/24 but stated the cookies should had a use-by date on them. She stated the risk for not dating food items was infection control lapses in the kitchen. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on 06/25/24 at 04:32 PM with the Administrator revealed the facility were aware of concerns with flies in the facility for about 9-12 months, however she was not aware that they had flies in the kitchen area. She stated that flies are nature and they are unable to control them. She stated they conducted a thorough pest control of the kitchen in June 2023 to mitigate the risk. She stated that the Dietary Manager was looking for a device that could prevent flies, however they did not have any device in place, at the time of interview, to prevent flies in the kitchen. She stated that the risk to residents with flies in kitchen was food contamination and food safety concerns. In an interview on 06/26/24 at 12:55 PM with the Consultant Dietitian revealed that it was her expectation that all kitchen staff should be changing gloves and performing hand hygiene in-between kitchen tasks to prevent any cross contamination and food borne illness. She stated that all kitchen staff were in-serviced about dating food items with the use-by date and her expectation was that all kitchen staff adhered to food storage facility policy. She stated that she was new to the facility and was not aware of flies in the kitchen or dining room; however, per facility policy the kitchen should be free of any pest infestation to prevent risk of any food borne illness for the residents. Record Review of the facility's policy titled Sanitation dated October 2008 reflected.All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects. Record Review of the facility's policy titled Handwashing dated October 2018 reflected, . Use of Gloves - a. Gloves are not a substitute for thorough and frequent hand washing. When using gloves, always wash hands before touching or putting on new glove . c. Use single use gloves for one task. d. Change gloves: i. Between each food preparation task. ii. After touching items, utensils or equipment not related to task. iii. After touching hair, face, or any other source of contamination iv. When leaving food preparation area for any reason. v. When damaged, soiled or when interrupted. vi. Every hour for all tasks taking longer than one hour. Record Review of facility's policy titled, Food Receiving and Storage revised July 2014, reflected Foods shall be received and stored in a manner that complies with safe food handling practices .7. All foods stored in the refrigerator or freezer will be covered, labeled, and dated (use-by-date). Review of the Food and Drug Administration Food Code, dated 2022, reflected, .3-302.12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food, or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food 3-305.11 Food Storage.(B) .refrigerated, ready-to eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34918 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for three (Resident #22, Resident #34, and Resident #39) of eight residents reviewed for infection control. 1. The facility failed to ensure LVN E prevented cross contamination of a bottle of test strips used to obtain glucose levels when she carried the bottle of test strips into Resident #22's room and returned it to the medication cart without sanitizing it. 2. The facility failed to ensure CNA B and CNA C performed hand hygiene during incontinence care for Resident #34. 3. The facility failed to ensure MA D sanitized the blood pressure cuff between uses on Resident #34 and Resident # 39. These failures could place residents at risk for infection and cross contamination. Findings include: 1. Record review of Resident #22's face sheet, dated 07/26/24, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #22 had a diagnosis which included type 2 diabetes mellitus. Observation during medication pass on 06/25/24 at 11:30 a.m. revealed LVN E preparing to obtain fingerstick blood sugar for Resident #22. LVN E pulled a glucometer, a bottle of test strips, 3 lancets and an alcohol wipe and gauze from the medication cart and entered the resident's room. LVN E placed the supplies on the prepared barrier on his bedside table. LVN E performed hand hygiene and put on gloves and proceeded to obtain the blood sugar reading. LVN E removed her gloves and gathered the glucometer, lancets and used alcohol wipe, and the bottle of test strips and returned to the medication cart where she disposed the lancet in the sharps container and laid the glucometer and bottle of test strips on the medication cart. LVN E performed hand hygiene and put on gloves and cleaned the glucometer with a germicidal wipe but did not clean the bottle of test strips. LVN E removed her gloves and performed hand hygiene and then opened the medication cart and retrieved the Resident's insulin pen and placed the un-sanitized bottle of test strips back into the medication cart. In Interview with LVN E on 06/25/24 at 11:40 a.m., she stated she should have only carried in the supplies she needed. She stated she just was not thinking. She stated anything carried in the room was considered contaminated and needed to be sanitized prior to placing it back in the cart. She stated the risk for not sanitizing the bottle of strips was cross contamination. In an interview with the ADON on 06/25/24 at 01:00 p.m., she stated nurses were only to carry in required supplies when doing a blood sugar test and should not carry in the entire bottle of test strips. She stated the nurse should not put anything back in the cart without first sanitizing it due to the risk of cross contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of Resident #34's quarterly MDS assessment, dated 05/11/24, reflected a [AGE] year-old female with an admitted [DATE]. Resident #34 had a BIMS score of 14, which indicated she was cognitively intact. She required extensive assistance of one-to-two-persons with toileting and was frequently incontinent of bowel and bladder. Her diagnoses included diabetes and hemiplegia (partial paralysis of one side). Record review of Resident #34's care plan, revised on 01/05/24, reflected . The resident has bladder incontinence related to activity intolerance .Interventions .Clean peri-area with each incontinence episode . An observation on 06/24/24 at 03:25 p.m. revealed CNA B and CNA C entered Resident #34's room preparing to provide incontinence care. Both staff performed hand hygiene and put on gowns and gloves. CNA C unfastened Resident #34's brief to reveal the resident had been incontinent of urine and bowel. CNA C pushed the soiled brief back toward the residents' buttocks and both staff assisted the resident to roll on her side. CNA B took a peri- wipe and cleaned the resident's perineal area, wiping from front to back, changed wipes and wiped each of the resident's buttocks and cleaned the anal area from front to back, removing the small bowel movement. CNA B removed the soiled brief and with the same gloves, placed a clean brief under the resident and rolled her back onto her back and fastened the brief. CNA B and CNA C covered the resident with a sheet, repositioned her in the bed, and placed her personnel belongings back in the bed with her and repositioned her bedside table, while still wearing the gloves used to perform incontinence care. Staff then removed their gloves and gowns and left the room without performing hand hygiene. In an interview with CNA B and CNA C on 06/24/24 at 3:40 p.m., both stated they were supposed to wash their hands before and after performing incontinence care. Both staff then stated they were supposed to change their gloves during incontinence care, once they had cleaned the resident, they were supposed to perform hand hygiene and change their gloves before they put the clean brief on her. They stated they were supposed to perform hand hygiene before they left the room and verified, they had failed to do that. Both staff members stated failure to perform hand hygiene placed the resident at risk of infections and stated they had been in-serviced on hand hygiene and infection control. In an interview with the ADON on 06/25/24 at 10:00 a.m., she stated staff were to change their gloves and perform hand hygiene after they performed incontinence care and before applying the clean brief and always before they left a resident's room. She stated by not following proper hand hygiene it placed residents at risk of urinary tract infections. She stated they had done extensive in-services with the staff on infection control, especially hand hygiene and the use of PPE. She stated in addition they made rounds and watched care to ensure the staff were following correct procedures. 3. Record review of Resident #34's quarterly MDS assessment, dated 05/11/24, reflected a [AGE] year-old female with an admitted [DATE]. Her diagnoses included diabetes and hemiplegia (partial paralysis of one side). Record review of Resident #39's Annual MDS assessment, dated 04/14/24, reflected a [AGE] year-old male with an admitted [DATE]. Diagnosis included hypertension, Alzheimer's, and fecal impaction. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation during medication pass on 06/25/24 at 7:30 a.m. revealed MA D entered Resident #34's room to obtain her blood pressure. After performing the blood pressure reading, MA D returned to the medication cart and placed the blood pressure cuff on top of the medication cart. MA D obtained the resident's morning medications and administered them. MA D proceeded to Resident # 39's room and with the un-sanitized blood cuff, entered his room and obtained his blood pressure without sanitizing the blood pressure cuff. MA D returned to the medication cart and obtained the resident's morning medications and administered them. MA D performed hand hygiene but did not sanitize the blood pressure cuff. In an interview with MA D on 06/25/24 at 9:20 a.m., he stated he was supposed to clean the blood pressure cuff with a germicidal wipe after each use. He stated he knew he was supposed to clean all the equipment between residents to prevent the spread of infection, he just forgot. In an interview with the ADON on 01/10/24 at 06/25/24 at 10:10 a.m., she stated the staff were required to clean the equipment used after each use before using it on another resident. She stated failure to do this could potentially spread germs. Record review of the facility's policy titled, Cleaning, Disinfection of Environmental Surfaces, dated June 2009, reflected The following categories are used to distinguish the level of sterilization/disinfection necessary for items used in resident care .non-critical items are those that come in contact with intact skin but not mucous membranes .Non-critical surface will be disinfected with an EPA-registered intermediate or low level hospital disinfectant according to the labels safety precautions and use directions Record review of the facility's policy titled, Hand Hygiene, dated June 2024, reflected, .All staff will perform proper hand hygiene procedure to prevent the spread of infection to other personnel, residents, and visitors . The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves .Hand Hygiene Table .Hands are visibly soiled . When, during resident care, moving from a contaminated body sit to a clean body site .

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34399 Based on observation, interview, and record review, the facility failed to ensure an effective pest control program was implemented so the facility was free of pests and rodents for the facility's only kitchen, dining room and one of three halls (Hall 200) reviewed for pest control. The facility failed to keep an effective pest control program to ensure the kitchen, dining room, and residents' rooms were free of flies. This failure could place residents at risk for reduced quality of life. Findings included: Observation on 06/24/24 at 12:22 PM in facility's dining area revealed 6 house flies on a resident's food plate and tables during the lunch service. Observation on 06/25/24 at 8:56 AM revealed two residents in room [ROOM NUMBER] eating breakfast. A fly landed on Resident #138's plate while she was eating her breakfast. Observation on 6/25/24 at 11:30 AM on facility's kitchen preparation and serving area revealed 2 houseflies sitting on a tray of cornbread that was left uncovered. Observation on 6/25/24 at 11:42 AM in facility's kitchen preparation and serving area revealed flies sitting on the serving scoop, and [NAME] I used the same scoop to serve food to the residents. Observation on 6/25/24 at 12:02 PM in facility's kitchen preparation and serving area revealed [NAME] I and Dietary Aide J were shooing away the flies while serving lunch. Interview on 6/25/24 at 12:18 PM with the Dietary Manager stated he was aware that the facility had concerns with flies, but he had only seen flies in the resident dining area. He stated the flies came through the back door of the facility and he had ordered a blower that was to be delivered at a future date in July 2024 to the facility. He also added that the facility had conducted a pest control in June 2023, however that was not as effective to control flies. He stated that he had never seen flies in the kitchen area before, however later stated that since there is a door between the kitchen and dining room, the flies could easily come into the kitchen from the dining area. He stated that he threw away corn bread because he observed flies sitting on the corn bread. He stated that risk of having flies in the kitchen or dining room could possibly lead to food borne illness in residents. Interview on 6/25/24 at 12:47 PM with Dietary Aide J stated she had been working in the facility for 9 months. She stated that she has always seen house flies in the kitchen and had informed the Dietary Manager about it. She stated that having flies in the kitchen posed a risk to the resident and can cause food borne illness. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 6/25/24 at 12:26 PM with [NAME] I revealed she had been working in the facility for 4 months. She stated they have seen flies in the kitchen since she started working at the facility. She stated that the scoop was left on the top of the tray line since they were going to use it for serving food and had not seen the flies on the scoop but was aware that they had flies in the kitchen. She stated she was aware that the flies had sat on the scoop, she would not have used the scoop for serving food. She stated that risk to resident with having flies in the kitchen area was food borne illness. Observation on 06/24/24 at 1:04 PM revealed, in resident room [ROOM NUMBER], 1 fly was observed in resident's room while Resident #65 was lying in bed. Interview on 06/25/24 at 04:32 PM with the Administrator revealed the facility were aware of concerns with flies in the facility for about 9-12 months, however she was not aware that they had flies in the kitchen area. She stated that flies are nature and they are unable to control them. She stated they conducted a thorough pest control of the kitchen in June 2023 to mitigate the risk. She stated that the dietary manager was looking for a device that could prevent flies, however they do not have any device in place at the time of interview to prevent flies in the kitchen at the time of this interview. She stated that the risk to residents with flies in kitchen was food contamination and food safety concerns. Interview on 06/26/24 at 9:25 AM with Maintenance /Housekeeping Supervisor stated the facility had ordered blower fans to be placed on hall 200 to keep the flies from entering the facility which would assist in keeping the flies off of the 200 hall and in the dining room which was located on hall 200. He stated the facility did not have anything ordered to deal with the flies in the kitchen. He stated he had noticed flies in the facility for the last 2 months. He stated pest control came out at least monthly. Interview on 06/26/24 at 10:02 AM with CNA Q revealed she noticed the flies in the last month or two at the facility. She stated when the resident meal trays were out on the hallways and in the dining room she would notice flies would come out. She stated the shower rooms were cleaned twice daily by housekeeping and as needed. She was not sure what pest control was doing to assist with the fly issues. Interview o n 06/26/24 at 10:06 AM with CNA G revealed she started noticing flies and gnats in the facility starting end of April 2024 and had seen flies in dining room. She stated when resident meal trays were sitting out and residents eating their resident meals in their rooms in hall 200 she would see flies attracted to the resident meal trays. CNA G did not know what pest control measures had been put in place by the facility. Interview on 06/26/24 12:55 PM with Consultant Dietitian revealed per facility policy, the kitchen should be free of any pest infestation to prevent risk of any food borne illness for the residents. Interview on 06/26/24 at 01:18 PM with the Administrator revealed pest control had been coming out at least monthly or more often to address the pests. She stated they had ordered some blower fans to keep the flies from coming in when staff open the door. She did not have anything ordered to address the pests in the kitchen. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675032	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Hill Healthcare Center	230 S Clark Rd Cedar Hill, TX 75104

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Contract Pest Control service visits documentation from April to June 2024 reflected the following about gnats and flies: -dated 04/04/24 pest control found active gnats at the dish pit area. An areosol fly bait was applied to this area to reducate gnats pressure. Pest control placed a granular fly bait scattered at the dumpter area. -dated 05/11/24 pest control observed gnat activity in the kitchen and applied a liquid residual product in the dish pit and kitchen areas. Review of facility's policy Pest Control revised May 2008 reflected Our facility shall maintain an effective pest control program. 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675032	A. Building B. Wing	06/26/2024

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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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 49427 Based on interviews, and record review, the facility failed to develop, implement, and maintain an effective training program for all existing staff, individuals providing services under a contractual arrangements and volunteers, consistent with their expected roles for 2 of 5 employees (CNA L and CNA M) reviewed for required trainings. The facility failed to ensure the new hire orientation training was completed for CNA L and CNA M. This failure could place residents at risk of being cared for by staff who have been insufficiently trained. Findings included: Record review of CNA L personnel file revealed a hire date of 05/09/2024 and there was no new hire orientation training. Record review of CNA M personnel file revealed a hire date of 04/11/2024 and there was no new hire orientation training. Interview on 06/25/2024 at 11:24 AM with CNA M revealed when she was hired in April 2024, she had a tour of facility and read a binder of information on each resident with their care plans and did not remember if she completed any other training by the facility other than monthly in-services. Interview on 06/25/2024 at 3:42 PM with CNA L revealed she had worked at the facility for 2 months, had monthly in-services on various topics, and did not recall if she completed any onboarding or orientation training. Interview on 06/26/2024 at 3:51 PM with CNA M revealed she was hired in April 2024 and did not complete the new hire orientation training until 06/26/2024 after being told by the Human Resources Supervisor (HRS) that it had to be completed. CNA M stated she was aware that she had not completed the trainings and was told by the HRS about 2 weeks ago by text and by email to complete the trainings. CNA M stated the orientation trainings were online and she was not proficient with using computers and believed the onboarding training to be redundant to her CNA licensure training and had not completed it until 06/26/2024. CNA M stated there was no risk to a resident by not having the onboarding training completed because she had her CNA license training. Interview on 06/26/2024 at 2:00 PM with the Administrator and the HRS revealed they were looking for CNA L and CNA M's orientation training and it should have been completed when the staff were first onboarded. They stated the ADON, DON, or Administrator provided in-services for staff, skills check offs, and one-on-one training as needed and the HRS was responsible for ensuring employees had their training requirements up to date. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 06/26/2024 at 3:00 PM with the HRS revealed when staff were hired, they were required to complete trainings through an online computer system before being trained in person at the facility for their respective role.The HRS stated that she had worked at facility for one month and was in the process of going through every employee's training record and some staff were missing required training including CNA L and CNA M. The HRS stated that she informed the Administrator and facility department heads which employees were past due in their training in a weekly morning meeting and did not remember if she had mentioned CNA L and CNA M in those meetings. The HRS stated she was responsible to follow up with staff and ensure the required trainings were completed. The HRS stated that staff who had not completed the initial online training should not work on the floor until it was completed. The HRS stated that staff not being appropriately trained before working with residents could put residents at risk of poor quality of care. Review of the facility's staff development policy titled Orientation Program for Newly Hired Employees, Transfers and Volunteers dated, 2001 and revised January 2008, reflected: An orientation program shall be conducted for all newly hired employees, transfers from other departments, and volunteers . 1. All newly hired personnel/volunteers/transfers must attend a 10-hour orientation program within their first five (5) days of employment. (Note: The orientation program is not included in the basic 75-hour Nurse Aide Training Program.) 2. Our orientation program includes, but is not limited to: a. A tour of the facility . b. Instructions in procedures to be followed in an emergency which includes, but is not limited to: (1) Unusual occurrences with residents (i.e., accidents, wandering, missing, ect.); (2) Fire safety; (3) Disaster Preparedness; and (4) Accident prevention and emergency first aid procedures .