STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675311	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Healthcare Residence	601 E Reunion St Fairfield, TX 75840

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41654 Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for 1 (Resident #1) of 5 residents reviewed for abuse. The facility failed prevent CNA A, on 01/20/25, from physically abusing Resident #1 when she approached Resident #1 in an aggressive manner and pushed into residents abdominal and chest area with her stomach. CNA A shoved Resident #1 in the right arm and in the back into the hallway 01/20/25. On 04/08/25 at 6:00 PM, an Immediate Jeopardy (IJ) was identified. The IJ template was provided to the facility on [DATE] at 6:13 PM. While the IJ was removed on 04/09/25, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. This failure could place residents at risk of emotional distress, fear, decreased quality of life, psychosocial harm, trauma, and abuse. Findings included: Record review of Resident #1's admission record dated 04/08/25 reflected Resident #1 was a [AGE] year-old female initially admitted to the facility on [DATE] with diagnoses including dementia (a general name for a decline in cognitive abilities that impacts a person's ability to perform everyday activities), schizoaffective disorder (a mental health condition including schizophrenia and mood disorder symptoms), diabetes (a group of diseases that result in too much sugar in the blood), anxiety (intense, excessive, and persistent worry and fear about everyday situations), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and anemia (a condition marked by a deficiency of red blood cells or of hemoglobin in the blood). Record review of Resident #1's Quarterly MDS dated [DATE] reflected a BIMS score of 10 indicating moderately impaired cognition. Quarterly MDS reflected Resident #1 was independent for eating, toileting, and personal hygiene and required set-up or clean up assistance for bathing. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of Resident #1's care plan initiated 01/20/25 reflected, Resident #1 has a behavior problem r/t psychotic and mood disturbances as well as anxiety. Verbal and physical. She thinks staff and other residents are taking her things and talking about her. Makes false allegations towards staff. She has exhibited verbal and physical aggression toward staff. Interventions initiated 01/21/25 and revised 01/23/25 included Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Care plan initiated 11/15/21 and revised 06/06/24 reflected Resident #1 has impaired cognitive function/impaired thought processes r/t Dementia. Interventions initiated 02/06/21 and revised 01/21/25 included If resident is agitated staff should leave resident in a safe environment and then reapproach resident after time to allow her to be redirected. Record review of the weekly skin assessment notes from 01/17/25 reflected Resident #1 had healing scattered faint bruising to BUE. Review of the weekly skin assessment notes from 01/24/25 reflected Resident #1 had healing scattered faint bruising to BUE, purple bruise noted to Lt. wrist 2.0 cm x 4.0 cm and left outer knee 4.0 cm x 2.0 cm bruise fading. Review of the weekly skin assessment notes from 01/31/25 reflected Resident #1 had fading scattered bruises to upper BUE and BLE. In an interview and observation on 04/07/25 at 4:15 PM, Resident #1 was in the common area of the secure unit sitting on a couch watching TV. Resident's appearance was good with no physical signs of abuse or neglect noted. Resident #1 exhibited no signs or distress or discomfort. Resident confirmed her identity when asked. Resident #1 stated that she felt safe and was not afraid of any resident or staff member at the facility. Resident stated that she was from the area and went to the local high school and could take care of herself. When asked if she had any recent incidents or altercations with staff the resident said she could not remember. In an observation and interview on 04/08/25 at 3:41 PM, Resident #1 stated she was doing fine. She stated she was [AGE] years old, and no one had hurt or bothered her, and she could take care of herself. Resident #1 appeared clean and groomed and showed no signs of pain or distress. During an interview on 04/07/25 at 11:14 AM with the ADM, he stated the employee involved in the incident was still employed with the facility. CNA A was reassigned from the secure unit. The ADM stated that the video was no longer available. During an interview on 04/07/25 at 2:27 PM, the DON stated she had reviewed the video because she was looking into another incident, and someone had already reported this incident. She stated she saw and heard CNA A asked about moving a chair and Resident #1 said no while getting loud. The DON said CNA A pushed the chair toward Resident #1 to put space in between them. The DON also said they went chest to chest. The DON was asked to see the video the DON reviewed, and she agreed . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 04/07/25 at 2:40 PM with the ADM and the DON returned in response to state surveyor's request for video. The ADM had the video on his cell phone and allowed surveyor to review it. The ADM and DON agreed to send surveyor a copy of the video. Asked what their policy was on disciplinary action and what was their reasoning for not terminating CNA A. They stated they felt CNA's move to the regular unit where she would be monitored by nurse and other staff would be sufficient. Asked them to continue to try reach CNA A and ask her to call me because I would like to interview her personally. The DON stated she would try to reach her. In an interview on 04/07/25 at 3:51 PM, CNA A stated she had worked in the facility for about five years, and she had been a CNA for [AGE] years. She stated she had never been reported for abuse. She stated she had not done anything bad and being burnt out is what caused this to occur. She stated it was not her fault. She stated she worked the night shift (6 pm to 6 am) together with a nurse often. She stated working nights was not easy and had been getting to her, especially with it being twelve hour shifts. She stated residents usually started with sundowners when she came in to work and it was chaotic. She stated residents became anxious and the nurse was usually getting medications to the residents, and she was in the nutrition room and cared for residents. She stated it was nothing unusual going on that day 01/20/25, and about 9 pm she had begun putting chairs out for the residents to sit at while the nurse gave out medications with snacks. She stated she went down the hall and came back and Resident #1 began doing her usual thing, which was moving things around. She stated she went back in the nutrition room and told the resident that she needed the chairs to be left in place and Resident #1 began arguing. She stated she told resident again about the chair and took the chair away from the resident. She stated the resident jumped up and began yelling and cursing and grabbed the chair. She stated she told the resident that the chair needed to be left where she had put it. She stated the resident slapped her with both hands. She stated she yelled for the nurse and started walking away and resident came at her and swung again. She stated she grabbed the resident behind her shoulders to stabilize the resident. CNA A stated she was hurting, and when she called for the nurse, she cussed when yelling that Resident #1 had slapped her across the fucking face. She stated she should have walked away. She stated she walked over to the rail on the wall with the resident and walked off at that point. She stated she told the nurse to call the DON and to tell her that resident had slapped her. She stated she was not cussing at Resident #1, and she would have usually walked off in that situation. She stated she was bruised on her left cheek for 3 days. She stated she should have walked away. She stated it was frustrating when she did not have a lot of help. She stated she told the DON a couple of months before that she was burnt out and it was becoming too much for her to work back in the secure unit. She stated there was an incident before where she was talking loud over a resident, and someone said she had been rude, and it was looked into. She stated she disclosed she had felt burnout. She stated she was in-serviced on abuse and neglect, and interventions in these types of situations would be to walk away. In an interview on 04/07/25 at 5:09 PM, CNA B said she had been employed at the facility for five years. She said she had been trained and in-serviced on abuse and neglect. CNA B said if she was to observe abuse or neglect she would report this to the nurse or administrator. She said the administrator is their abuse coordinator. CNA B denied ever observing abuse or neglect while working at the facility. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an observation on 04/08/2025 at 10:00 AM of video footage which included sound from incident regarding alleged abuse, video revealed Resident #1 was moving a chair from the side of the wall when CNA A walked over to resident while pointing at the table and telling resident to put it back at the table. CNA A pulled the chair out of residents hand and Resident #1 attempted to hit CNA A in stomach area. CNA then walked toward and into Resident #1's body, pushing resident back some. Resident #1 slapped CNA A on the left side of her face. CNA A turned around with her hand on the left side of her face and called for the charge nurse, yelling resident had just slapped her in the face. CNA A then turned back around. Resident #1 was walking past CNA A and CNA A grabbed resident by her right arm and shoved Resident #1 toward the hallway. CNA A walked into hallway behind Resident #1 and continued shoving Resident #1 toward wall and side handles on the wall. Once CNA A got Resident #1 to side handles she walked away from resident and continued yelling for the charge nurse. When charge nurse approached CNA, the CNA told the charge nurse that Resident #1 had slapped her in the fucking face. In an interview on 04/08/2025 at 12:51 PM with the CRN, he stated anytime a situation like this arose he would start by putting himself in the employees' place and then in the resident's place. He stated he observed the video of the incident, and the resident was standing by the table. He stated the CNA rushed over concerned the resident was going to fall and the resident did not like the interaction. He stated the resident started making punching motions toward CNA's stomach area and then slapped the CNA. He stated resident may have episode of being violent and was care planned for that and the CNA tried to remove the resident from the situation. He stated he felt like the CNA's approach could have been better. He stated the cursing was not directed toward the resident. He stated after interviewing the CNA, the DON and Administrator felt like the CNA was remorseful and needed a break and could learn from the incident. He stated they re-educated the CNA and assigned the CNA to another location after her suspension . He stated he had not interpreted abuse in the incident, but he had believed the CNA needed to be re-educated and given a break and moved to another location to continue working. He stated they check with the residents where CNA was working and have not had any complaints or allegations made about her. He stated they have terminated others for abuse, and they did take all allegations seriously. He stated the CNA was suspended and the local police were notified, and he felt like the situation could have been handled differently and the CNA could have learned from the incident. He stated they wanted to do right by all their residents and would not have ever put them in any way of harm. In an interview on 04/08/2025 at 1:22 PM, the DON and the ADON stated as a group, which included the DON, ADON, Social Worker, and Administrator, they checked with all residents frequently, which included the residents on the hall where CNA A had been moved to work. They stated they have not had any negative responses from any of these resident regarding CNA. They stated these interviews were not documented but they had recently done safe surveys, which were documented, in accordance with another incident and there were no concerns. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an interview on 04/08/2025 at 2:42 PM, CNA B, stated she had worked in the facility for about five years. She stated she had been in-serviced many times and the last one was about a month ago she believed. She stated did not have any concern for any of her fell ow staff members being abusive towards any residents. She stated she had not had any specific concern concerns with CNA A being abusive or aggressive towards any residents and she had not ever witnessed anything like that from CNA A before herself. She stated she had not had any residents report any abusive or aggressive behavior to her regarding CNA A. She stated an example of abuse was screaming at a resident and she had witnessed abuse in this facility about four years ago. She stated she reported that abuse right after she had stopped it, and the facility took care of that immediately. She stated suspected abuse should be immediately reported to the ADM, which was the Abuse Coordinator. In an interview on 04/08/25 at 5:41 PM, the ADM and the DON stated prior to them reviewing the video footage, it was reported to them that a resident had defecated in a trashcan in the secure unit, and they were trying to identify who it was and that was why they reviewed the video footage. They stated they saw the incident that occurred with CNA A and Resident #1 on the video when they reviewed it and immediately began the investigation and reported it to state. They stated inconclusive meant that they were not able to identify abuse but that it was an inappropriate response from staff. They stated they trained CNA A on abuse and neglect so that CNA A would have a clear understanding of what abuse and neglect was because CNA A felt like she had defended and protected herself and the other residents. They stated the accusatory tone CNA A had used when she questioned Resident #1 as to why resident had moved the chair made Resident #1 become defensive and this was why they felt CNA A needed to be educated on abuse and neglect. Record review on progress notes completed by LVN C on 01/20/25 at 9:38 PM reflected I was in medication room and heard CNA A hollering my name, I went back to the dining room where she was, and CNA A stated that resident just slapped her in the face while I was moving a chair that she had moved. I asked resident what happened, and resident stated that she was telling me not to move stuff around, this is my house and I slapped her, and I'll do it again. I asked resident if we could go to her room to talk and she said no, I asked CNA to go tend to other resident's separating them. I asked resident if she was ok or hurt, I assessed her, but she said no but I am tired of people telling me what to do. I educated resident that she cannot slap or hit people when she get's upset or angry, that she can talk to me or go to her room until she gets her feelings calmed, that hitting is not the answer. Resident then went to sit in a chair at the back of dining room. No other resident's seen incident or was affected by resident's agitation. Resident is calm, sitting in back alone. I tried calling MD, no response, sent message, pending call back. I notified family notified DON. Record review of personnel file for suspension information/training reflected CNA A had been suspended for three days immediately on 01/21/25 with no pay. Record review of in-servicing for the past 3 months which included staff signatures and covered customer service (01/21/25), attitude (01/21/25), resident rights (01/21/25), abuse and neglect (01/21/25), name badges, beds made, resident clothing and belongings, phone use, answering call lights, attitudes (01/29/25), snacks, resident rights (02/09/25), abuse and neglect (02/09/25), abuse and neglect (03/13/25), resident rights (03/13/25), customer service (03/13/25), and attitudes (03/13/25) reflected CNA A was present for all and had been in-serviced covering all areas regarding attitudes, abuse and neglect, and resident rights except for the in-services held on 02/29/25. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility policy Abuse, Neglect, Exploitation and Misappropriation Prevention Program dated 2001 and revised September 2022 reflected in part, Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. Policy Interpretation and Implementation - The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 1. Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: a. facility staff; 2. Develop and implement policies and protocols to prevent and identify: a. abuse or mistreatment of residents; b. neglect of residents; and/or c. theft, exploitation or misappropriation of resident property. 5. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive, or emotional problems. 8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. 9. Investigate and report any allegations within timeframes required by federal requirements . Review of the facility policy Abuse, Neglect, Exploitation and Misappropriation Reporting and Investigating dated 2001 and revised September 2022 reflected in part, Policy Statement - All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. Policy Interpretation and Implementation. Reporting Allegations to the Administrator and Authorities - 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Investigating Allegations - 1. All allegations are thoroughly investigated. The administrator initiates investigations. 2. Investigations may be assigned to an individual trained in reviewing, investigating, and reporting such allegations. 3. The administrator provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation. a. Any evidence that may be needed for a criminal investigation is sealed, labeled, and protected from tampering or destruction. 4. The administrator is responsible for keeping the resident and his/her representative (sponsor) informed of the progress of the investigation. 5. The administrator ensures that the resident and the person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator, or by anyone associated with the facility. 6. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete. Corrective Actions - 2. If the investigation reveals that the allegation(s) of abuse are founded, the employee(s) is terminated . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility policy Disciplinary Procedures dated 2010 reflected in part, It is the policy of this facility to employ a disciplinary system which is positive, equitable and directed toward the correction of conduct which does not conform to the policies and standards of the Company. Procedure: 1. General Provisions. a. Purpose. The purpose of discipline is to correct a deficiency in performance or conduct which does not conform to the policies and standards of the company. Discipline is to be administered in an objective, equitable and consistent manner. Discipline is to be invoked only after a thorough examination of the facts, which will include providing the employee an opportunity to explain his or her conduct. b. Documentation. All disciplinary action and the facts upon which such action is based will be maintained in an accurate written record. A copy of all records of disciplinary action will be maintained in the employee ' s personnel file. Written statements, using the Witness Statement Form or a blank sheet of paper may be obtained from all witnesses to conduct an investigation which may result in disciplinary action. c. Management Responsibilities. The management personnel in each office and facility are responsible for communicating to employees the policies, rules and expectations with which employees are to comply. Management personnel are also charged with ensuring that all policies and rules are fairly administered. All disciplinary action is to be conducted in a professional manner. The use of loud, abusive, or obscene language is not acceptable. Immediate Discharge. a. An employee may be immediately discharged without prior informal, verbal, or written counseling if the employee commits a serious offense such as are listed in b below. b. The following offenses are those for which immediate discharge may result. This list is not all-inclusive, and the Company reserves the right to discharge employees for other conduct which it deems to be serious in nature. l. Resident/patient abuse or neglect of resident/patient is duties directly related to the safety, health and/or physical or mental well-being of the resident/patient. 2. Violation of Resident's Rights. This was determined to be an IJ on 04/08/25 at 6:00 PM. The ADM and the DON were notified. The ADM was provided with the IJ template on 04/08/25 at 6:13 PM and a Plan of Removal was requested. The following Plan of Removal was submitted by the facility and was accepted on 04/09/25 at 10:40 AM and reflected the following: On 04/08/2025 an abbreviated survey was initiated. On 04/08/2025 the surveyor provided an Immediate Jeopardy (IJ) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety. The notification of Immediate Jeopardy states as follows: F600, the center failed to prevent CNA A from physically abusing Resident #1 when she shoved resident #1 in the right arm and in the back. F600-The center failed to prevent CNA A from physically abusing Resident #1 when she shoved resident #1 in the right arm and in the back. CNA A was placed on suspension pending termination on 4/8/2025 by the Administrator. Director of Operations conducted re-education on Abuse and Neglect including recognizing, responding, and reporting abuse and neglect with the Administrator and Director of Nursing on 4/8/2025. Administrator and Director of Nursing voiced understanding of the re-education to the Director of Operations and signed the re-education. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #1 was assessed for signs and symptoms of physical abuse by the Director of Nursing on 4/8/2025 with no negative findings. A progress note was charted on 4/8/2025. All residents that are able to be interviewed for any abuse and/or neglect event (no cognitive impairment) were interviewed by the Director of Nursing/Designee on 4/8/2025 with no negative findings identified. A progress note was charted for each resident on 4/8/2025. All residents with cognitive impairment/not inter-viewable were assessed by the Director of Nursing/Designee on 4/8/2025 for signs/symptoms of physical abuse with no negative findings. A progress note was charted for each resident on 4/8/2025. All staff were re-educated on abuse and neglect including recognizing, responding, and reporting abuse and neglect by the Administrator/Designee on 4/8/2025. Staff not present will be re-educated prior to the start of their next shift and this will be completed by 4/9/2025 (end of business day). Staff voiced understanding of the re-education to the Administrator/Designee and signed the re-education. The Medical Director of the center was notified of the immediate jeopardy event on 4/8/2025. The Medical Director had no recommendations. The findings of this event will be presented to the center Quality Assurance Committee. An ad hoc Quality Assurance Committee meeting will be conducted on 4/9/2025. The Administrator/Designee will monitor/review incident reports and do random resident interviews during the work week (Monday through Friday) to validate no resident abuse and/or neglect events have occurred. These audits will continue weekly for four weeks. Negative findings will be addressed at the time of discovery and presented to the center Quality Assurance Committee. Monitoring of the facility's Plan of Removal included the following: Record review of Resident #1's clinical records revealed the resident had been assessed by nursing after the incident on 01/21/25 and did not have any injuries. Record review of QAPI meeting conducted by facility in regard to immediate jeopardy event held on 04/09/25 at 11:45 AM and consisted of ADM, DON, CRN, and RDO, MD participated via telephone. Record review of in-servicing dated 04/08/25 conducted by RDO reflected ADM and DON were in-serviced on abuse and neglect and abuse, neglect, exploitation, or misappropriation - reporting and investigating policy. Record review on in-servicing dated 04/08/25 conducted by ADON reflected staff were in-serviced on attitude and attitude policy. Record review on in-servicing dated 04/08/25 conducted by ADON reflected staff were in-serviced on conduct and behavior and conduct and behavior policy. Record review on in-servicing dated 04/08/25 conducted by ADON reflected staff were in-serviced on reporting work burnout. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review on in-servicing dated 04/08/25 conducted by ADON reflected staff were in-serviced on courtesy and courtesy policy. Record review on in-servicing dated 04/08/25 conducted by ADON reflected staff were in-serviced on resident rights and resident rights policy. Record review of staff interviews dated 04/08/25 reflected 3 resident interviews were conducted regarding abuse and neglect with no negative outcomes and residents all felt safe and comfortable with reporting harm if it had occurred. Record review of employee interviews dated 04/09/25 reflected employee interviews were conducted regarding abuse and neglect with no negative outcomes and staff all knew that they were required to report abuse immediately to the abuse coordinator. Record review of comparison of schedules worked and staff which were in-serviced signatures reflected all staff that have worked in the facility since immediate jeopardy was identified have been in-serviced appropriately according to facility plan of removal. Interviews were conducted on 04/09/25 from 1:20 PM to 1:25 PM and 1:45 PM to 2:29 PM with staff from various shifts. The staff included LVN A, CNA F, HSK, CNA C, LVN B, CNA D, and CK. All staff were able to identify: What abuse was and the different types of abuse. The staff understood how to recognize, respond, and report abuse. Observations and interviews with Resident's #2, #3, and #4 on 04/09/25 from 1:28 PM to 1:39 PM revealed they felt safe and had no concerns for abuse or neglect. In an interview on 04/09/25 at 4:38 PM, the ADM, DON, and ADON stated they had in-serviced all staff that have worked since the immediate jeopardy was called and staff would continue to be in-serviced and would be in-serviced prior to their shifts if they had not already been, on attitude, conduct and behavior, burnout, courtesy, resident rights, and abuse and neglect, which included recognizing, responding, and report abuse. They stated they were in-serviced over these things as well. They stated CNA A has been suspended and will be terminated as soon as she returned their call or tried to show up at work. They stated they had been trying to call CNA A and had not been able to get ahold of her. In an interview on 04/09/25 at 4:45 PM, the DON stated CNA A had returned her call and would be coming to the facility the next day to be terminated. The Administrator and DON were informed the Immediate Jeopardy was removed on 04/09/25 at 4:54 PM. On 04/08/25 at 6:00 PM, an IJ was identified. While the IJ was removed on 04/09/25, the facility remained out of compliance at a scope of isolated and a severity level of potential for more than minimal harm due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal.