STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675666	A. Building B. Wing	04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarcliff Health Center of Greenville	4400 Walnut St Greenville, TX 75401

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement written policies and procedures that prohibited and prevented abuse, neglect, and exploitation of residents and misappropriation of resident property for 2 of 3 residents (Resident #1 and Resident #2) reviewed for abuse. The facility failed to implement their abuse policy when CNA B and the ADON failed to report an allegation of abuse reported to them by Resident #2 regarding CNA A mistreating her and Resident #1 on 04/01/2026. This failure could place residents at risk of unreported abuse, neglect, exploitation, and a decreased quality of life.Findings include: Record review of the facility's Abuse Investigation and Reporting policy, revised 10/15/2022, indicated, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Role of the Administrator: 1. If an incident or suspected incident of resident abuse, mistreatment, exploitation, neglect or injury of unknown source is reported, under the direct supervision of the Administrator will assign the investigation to an appropriate individual. 3. The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than:a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury. 1. Record review of a face sheet dated 04/06/2026 indicated Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included closed fracture of the right patella (broken kneecap) and type 2 diabetes mellitus with hyperglycemia (insulin resistance leading to high blood sugars which result in nerve damage cause by prolonged high blood sugar levels). Record review of Resident #2's Comprehensive MDS assessment dated [DATE] indicated she was understood by others and understood others. The MDS assessment indicated Resident #2 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #2 required partial/moderate assistance with toileting, showering/bathing, and personal hygiene and supervision or touching assistance with eating. Record review of Resident #2's care plan revised 03/05/2026 indicated she had an ADL self-care performance deficit related to a right patella fracture, falls, lack or coordination, and weakness. Resident #2's care plan indicated she was independent with eating and required assistance with bathing, dressing, transferring, and toilet use. During an interview on 04/06/2026 at 10:38 AM, Resident #2 said there was a nurse who was very rude to her, and she had reported it to the head people. Resident #2 was unable to provide names of whom she reported it to. Resident #2 said she believed it was last Thursday (04/02/2026) or Friday (04/03/2026). Resident #2 said she asked CNA A for her breakfast tray, and she refused to give it to her. Resident #2 said CNA A told her she was her roommate's CNA, but not hers. Resident #2 said later a different nurse brought her tray. Resident #2 said later the same day CNA A asked her roommate if she wanted a shower and her roommate refused, and Resident #2 asked CNA A to change the sheets to her bed and CNA A refused. Resident #2 said she asked a different CNA who was her CNA because she needed her (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sheets changed, and they told her it was CNA A. Resident #2 said she returned to her room and was in her wheelchair when CNA A entered her room, and she could tell she was mad at her. CNA A did not speak to her and started changing the sheets on her bed and did not change the pillowcases or big blanket. Resident #2 said at that point she wanted to cry because she was asking herself what did I do to her for her to treat me this way. Resident #2 said then her roommate, Resident #1, asked CNA A to put her in bed, CNA A sighed loudly, did not speak to her, picked her roommate up by her brief, and almost dropped her when she picked her up to put her in the bed. Resident #2 said she could tell Resident #1 was scared. Resident #2 said she was frantic because she was afraid her roommate was going to be dropped on the floor, and she was unable to help her roommate. Resident #2 said CNA A adjusted her roommate in the bed and left the room without saying anything to either of them. Resident #2 said she told her roommate she needed to report CNA A for the way she had treated her, but her roommate did not want to report CNA A. Resident #2 said she told her roommate she was going to report CNA A for the way she had treated the both of them because she did not want her back in her room and she was not going to put up with abuse. Resident #2 said she reported what happened to the nurse, and she had not seen CNA A since the day of the incident. 2. Record review of a face sheet dated 04/06/2026 indicated Resident #1 was an [AGE] year-old female originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included chronic systolic congestive heart failure (heart is unable to pump enough force to push enough blood into circulation) and adult failure to thrive (a condition characterized by significant decline in physical and emotional well-being, often leading to weight loss, decreased appetite, and reduced functional abilities). Record review of Resident #1's Comprehensive MDS assessment dated [DATE] indicated she was understood by others and understood others. The MDS assessment indicated Resident #1 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #1 was dependent on staff for transfers. Record review of Resident #1's care plan revised 04/01/2026 indicated she had an ADL self-care performance deficit related to muscle wasting and lack of coordination and required assistance with transferring. During an interview on 04/06/2026 at 2:31 PM, CNA B said last Wednesday (04/01/2026), when she checked on Resident #2 around 2 PM, she told her she was so glad to see her because CNA A had been very rude and mistreated them (Resident #2 and Resident #1). CNA B said Resident #2 told her CNA A did not want to give her her tray, change her sheets, give her a shower, and almost dropped Resident #1 when she transferred her to the bed. CNA B said she told Resident #2 she was going to get the ADON to report it to her. CNA B said she told the ADON, and the ADON went to talk to Resident #2. CNA B said she was not going to put up with any of the staff being abusive to the residents. CNA B said abuse should be reported to the nurse or the DON. During an interview on 04/06/2026 at 3:16 PM, the ADON said CNA B told her to talk to Resident #2 because Resident #2 told her the aide was rough with her roommate. Resident #2 reported to her that CNA A had been rough with her roommate, Resident #1, and felt like she threw her in the bed. The ADON said Resident #2 did not report CNA A mistreating her or anything about herself. The ADON said it was only about her roommate, Resident #1. The ADON said she asked Resident #1 if CNA A had hurt her, and Resident #1 did not say anything, just shook her head no. The ADON said allegations of abuse should be reported immediately to the Administrator. The ADON said she did not report the allegation made to the Administrator because she thought she had addressed the situation, and she was not going to schedule CNA A on Resident #1's and Resident #2's hall. The ADON said not reporting allegations of abuse placed the residents at risk for further abuse. During an interview on 04/06/2026 at 3:41 PM, the Administrator said she was just notified by the ADON of a statement Resident #2 made last week. The Administrator said the ADON told her Resident #2 reported to her CNA A was not polite, had an attitude, and sounded like Resident #1 was thrown into the bed by CNA A. The Administrator said the ADON asked Resident #1 what happened, and Resident #1told the ADON nothing happened. The Administrator said today (04/06/2026), she went to talk to Resident #2 and Resident #1. Resident #2 told her she saw CNA A pick up Resident #1 by the brief and throw her in the (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed, and she asked CNA A for her breakfast tray and she did not give it to her. Resident #1 told her when CNA A went into the room, she had an attitude and did not speak to her. Resident #1 said CNA A picked her up to put her in the bed and almost dropped her. The Administrator said Resident #1 did not remember all the incident and told her whatever Resident #2 said happened was what happened. The Administrator said CNA A would be terminated because she had already been suspended a couple of weeks ago related to the way she talked to the residents and was educated on customer service. The Administrator said when Resident #2 made the allegations they should have been reported to her immediately. She said she expected all her staff to report allegations of abuse immediately so she could investigate the allegations made. The Administrator said she expected the staff to follow the facility's policy and any allegation of abuse be reported to her, the abuse coordinator. The Administrator said it was important for them to notify her so she could investigate and ensure the proper procedures were followed pending the investigation to protect the residents. The Administrator said not reporting abuse and neglect immediately could result in future issues with the residents and that employee. During an interview on 04/06/2026 at 4:52 PM, CNA A said she did not refuse to give Resident #2 her tray or give her a shower (on 04/01/2026). CNA A said she had not taken care of Resident #1 or Resident #2 in the past, and she did not know when Resident #2's shower days were. CNA A said when Resident #2 requested a shower she told her she did not know if it was her shower day that she would go check and give her one later, but she did not go back to give her a shower. CNA A said a different CNA gave her the shower later that day. CNA A said she did not remember if she had given Resident #2 her tray or if it was someone else. CNA A said she changed Resident #2's linens when she was asked to change them. CNA A said when she provided care to Resident #1 and Resident #2, she explained to both of them what she was doing. CNA A said other residents complained about her not talking enough to them. She said she was more closed off when she did not know the residents, but she tried to tell them what she was doing. CNA A said some of the residents reported her because she was not happy enough for them. CNA A said she was not rude or rough with Resident #1 or Resident #2. CNA A said when she transferred Resident #1 from her wheelchair to her bed, she did not use a gait belt. CNA A said she grabbed her from the back of her pants to transfer her into her bed. CNA A said she did not almost drop Resident #1. CNA A said Resident #1 did not get hurt and she was not rushing when she helped her. During an interview on 04/06/2026 at 5:28 PM, Resident #1 said she did not remember any CNAs transferring her inappropriately or mistreating her. During an interview on 04/06/2026 at 5:41 PM, the DON said she received complaints about CNA A's attitude from the residents, but it was more of customer service issues not any abuse allegations. The DON said verbal education was provided to CNA A on customer service. The DON said any allegation of abuse should be reported to the abuse coordinator, the Administrator, immediately. The DON said not reporting allegations of abuse immediately placed the residents at risk for further issues and for the same thing to happen to them. The DON said not following the facility's abuse policy placed the residents at risk for abuse.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source were reported immediately, but no later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse, for 2 of 3 residents (Resident #1 and Resident #2) reviewed for abuse and neglect reporting. The facility failed to ensure CNA B and the ADON reported an allegation of abuse to the Administrator immediately when Resident #2 reported to them CNA A mistreated her and Resident #1 on 04/01/2026. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress.Findings included: 1. Record review of a face sheet dated 04/06/2026 indicated Resident #2 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included closed fracture of the right patella (broken kneecap) and type 2 diabetes mellitus with hyperglycemia (insulin resistance leading to high blood sugars which result in nerve damage cause by prolonged high blood sugar levels). Record review of Resident #2's Comprehensive MDS assessment dated [DATE] indicated she was understood by others and understood others. The MDS assessment indicated Resident #2 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #2 required partial/moderate assistance with toileting, showering/bathing, and personal hygiene and supervision or touching assistance with eating. Record review of Resident #2's care plan revised 03/05/2026 indicated she had an ADL self-care performance deficit related to a right patella fracture, falls, lack or coordination, and weakness. Resident #2's care plan indicated she was independent with eating and required assistance with bathing, dressing, transferring, and toilet use. During an interview on 04/06/2026 at 10:38 AM, Resident #2 said there was a nurse who was very rude to her, and she had reported it to the head people. Resident #2 was unable to provide names of whom she reported it to. Resident #2 said she believed it was last Thursday (04/02/2026) or Friday (04/03/2026). Resident #2 said she asked CNA A for her breakfast tray, and she refused to give it to her. Resident #2 said CNA A told her she was her roommate's CNA, but not hers. Resident #2 said later a different nurse brought her tray. Resident #2 said later the same day CNA A asked her roommate if she wanted a shower and her roommate refused, and Resident #2 asked CNA A to change the sheets to her bed and CNA A refused. Resident #2 said she asked a different CNA who was her CNA because she needed her sheets changed, and they told her it was CNA A. Resident #2 said she returned to her room and was in her wheelchair when CNA A entered her room, and she could tell she was mad at her. CNA A did not speak to her and started changing the sheets on her bed and did not change the pillowcases or big blanket. Resident #2 said at that point she wanted to cry because she was asking herself what did I do to her for her to treat me this way. Resident #2 said then her roommate, Resident #1, asked CNA A to put her in bed, CNA A sighed loudly, did not speak to her, picked her roommate up by her brief, and almost dropped her when she picked her up to put her in the bed. Resident #2 said she could tell Resident #1 was scared. Resident #2 said she was frantic because she was afraid her roommate was going to be dropped on the floor, and she was unable to help her roommate. Resident #2 said CNA A adjusted her roommate in the bed and left the room without saying anything to either of them. Resident #2 said she told her roommate she needed to report CNA A for the way she had treated her, but her roommate did not want to report CNA A. Resident #2 said she told her roommate she was going to report CNA A for the way she had treated the both of them because she did not want her back in her room and she was not going to put up with abuse. Resident #2 said she reported what happened to the nurse, and she had not seen CNA A since the day of the incident. 2. Record review of a face sheet dated 04/06/2026 indicated Resident #1 was an [AGE] year-old female originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included chronic systolic congestive heart failure (heart (continued on next page)

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	675666	A. Building B. Wing	04/06/2026

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is unable to pump enough force to push enough blood into circulation) and adult failure to thrive (a condition characterized by significant decline in physical and emotional well-being, often leading to weight loss, decreased appetite, and reduced functional abilities). Record review of Resident #1's Comprehensive MDS assessment dated [DATE] indicated she was understood by others and understood others. The MDS assessment indicated Resident #1 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #1 was dependent on staff for transfers. Record review of Resident #1's care plan revised 04/01/2026 indicated she had an ADL self-care performance deficit related to muscle wasting and lack of coordination and required assistance with transferring. During an interview on 04/06/2026 at 2:31 PM, CNA B said last Wednesday (04/01/2026), when she checked on Resident #2 around 2 PM, she told her she was so glad to see her because CNA A had been very rude and mistreated them (Resident #2 and Resident #1). CNA B said Resident #2 told her CNA A did not want to give her her tray, change her sheets, give her a shower, and almost dropped Resident #1 when she transferred her to the bed. CNA B said she told Resident #2 she was going to get the ADON to report it to her. CNA B said she told the ADON, and the ADON went to talk to Resident #2. CNA B said she was not going to put up with any of the staff being abusive to the residents. CNA B said abuse should be reported to the nurse or the DON. During an interview on 04/06/2026 at 3:16 PM, the ADON said CNA B told her to talk to Resident #2 because Resident #2 told her the aide was rough with her roommate. Resident #2 reported to her that CNA A had been rough with her roommate, Resident #1, and felt like she threw her in the bed. The ADON said Resident #2 did not report CNA A mistreating her or anything about herself. The ADON said it was only about her roommate, Resident #1. The ADON said she asked Resident #1 if CNA A had hurt her, and Resident #1 did not say anything, just shook her head no. The ADON said allegations of abuse should be reported immediately to the Administrator. The ADON said she did not report the allegation made to the Administrator because she thought she had addressed the situation, and she was not going to schedule CNA A on Resident #1's and Resident #2's hall. The ADON said not reporting allegations of abuse placed the residents at risk for further abuse. During an interview on 04/06/2026 at 3:41 PM, the Administrator said she was just notified by the ADON of a statement Resident #2 made last week. The Administrator said the ADON told her Resident #2 reported to her CNA A was not polite, had an attitude, and sounded like Resident #1 was thrown into the bed by CNA A. The Administrator said the ADON asked Resident #1 what happened, and Resident #1told the ADON nothing happened. The Administrator said today (04/06/2026), she went to talk to Resident #2 and Resident #1. Resident #2 told her she saw CNA A pick up Resident #1 by the brief and throw her in the bed, and she asked CNA A for her breakfast tray and she did not give it to her. Resident #1 told her when CNA A went into the room, she had an attitude and did not speak to her. Resident #1 said CNA A picked her up to put her in the bed and almost dropped her. The Administrator said Resident #1 did not remember all the incident and told her whatever Resident #2 said happened was what happened. The Administrator said CNA A would be terminated because she had already been suspended a couple of weeks ago related to the way she talked to the residents and was educated on customer service. The Administrator said when Resident #2 made the allegations they should have been reported to her immediately. She said she expected all her staff to report allegations of abuse immediately so she could investigate the allegations made. The Administrator said she expected the staff to follow the facility's policy and any allegation of abuse be reported to her, the abuse coordinator. The Administrator said it was important for them to notify her so she could investigate and ensure the proper procedures were followed pending the investigation to protect the residents. The Administrator said not reporting abuse and neglect immediately could result in future issues with the residents and that employee. During an interview on 04/06/2026 at 4:52 PM, CNA A said she did not refuse to give Resident #2 her tray or give her a shower (on 04/01/2026). CNA A said she had not taken care of Resident #1 or Resident #2 in the past, and she did not know when Resident #2's shower days were. CNA A said when Resident #2 requested a shower she told her she did not know if it was her shower day that she would go (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	check and give her one later, but she did not go back to give her a shower. CNA A said a different CNA gave her the shower later that day. CNA A said she did not remember if she had given Resident #2 her tray or if it was someone else. CNA A said she changed Resident #2's linens when she was asked to change them. CNA A said when she provided care to Resident #1 and Resident #2, she explained to both of them what she was doing. CNA A said other residents complained about her not talking enough to them. She said she was more closed off when she did not know the residents, but she tried to tell them what she was doing. CNA A said some of the residents reported her because she was not happy enough for them. CNA A said she was not rude or rough with Resident #1 or Resident #2. CNA A said when she transferred Resident #1 from her wheelchair to her bed, she did not use a gait belt. CNA A said she grabbed her from the back of her pants to transfer her into her bed. CNA A said she did not almost drop Resident #1. CNA A said Resident #1 did not get hurt and she was not rushing when she helped her. During an interview on 04/06/2026 at 5:28 PM, Resident #1 said she did not remember any CNAs transferring her inappropriately or mistreating her. During an interview on 04/06/2026 at 5:41 PM, the DON said she received complaints about CNA A's attitude from the residents, but it was more of customer service issues not any abuse allegations. The DON said verbal education was provided to CNA A on customer service. The DON said any allegation of abuse should be reported to the abuse coordinator, the Administrator, immediately. The DON said not reporting allegations of abuse immediately placed the residents at risk for further issues and for the same thing to happen to them. The DON said not following the facility's abuse policy placed the residents at risk for abuse. Record review of the facility's Abuse Investigation and Reporting policy, revised 10/15/2022, indicated, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Role of the Administrator: 1. If an incident or suspected incident of resident abuse, mistreatment, exploitation, neglect or injury of unknown source is reported, under the direct supervision of the Administrator will assign the investigation to an appropriate individual. 3. The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. 2. An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than:a. Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (Resident #1) reviewed for accidents and hazards. The facility failed to ensure CNA A performed a proper transfer, when she grabbed Resident #1 from the pants to transfer her from her wheelchair to her bed and did not use a gait belt on 04/01/2026. This failure could place residents at risk for falls, injuries, and a decreased quality of life. Findings included: Record review of a face sheet dated 04/06/2026 indicated Resident #1 was an [AGE] year-old female originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses which included chronic systolic congestive heart failure (heart is unable to pump enough force to push enough blood into circulation) and adult failure to thrive (a condition characterized by significant decline in physical and emotional well-being, often leading to weight loss, decreased appetite, and reduced functional abilities). Record review of Resident #1's Comprehensive MDS assessment dated [DATE] indicated she was understood by others and understood others. The MDS assessment indicated Resident #1 had a BIMS score of 15, which indicated her cognition was intact. The MDS assessment indicated Resident #1 was dependent on staff for transfers. Record review of Resident #1's care plan revised 04/01/2026 indicated she had an ADL self-care performance deficit related to muscle wasting and lack of coordination and required assistance with transferring. The care plan did not address the type of equipment required to transfer Resident #1. During an interview on 04/06/2026 at 3:41 PM, the Administrator said Resident #1 told her CNA A picked her up to put her in the bed and almost dropped her. The Administrator said Resident #1 did not remember all the incident. During an interview on 04/06/2026 at 4:52 PM, CNA A said on 04/01/2026, when she transferred Resident #1 from her wheelchair to her bed, she did not use a gait belt. CNA A said she grabbed Resident #1 from the back of her pants to transfer her into her bed. CNA A said she did not almost drop Resident #1. CNA A said she should have used a gait belt when she transferred Resident #1 to her bed. CNA A said it was important to use a gait belt for transfers for the residents' safety. CNA A said not using a gait belt when transferring Resident #1 could have resulted in Resident # 1 getting hurt. CNA A said Resident #1 did not get hurt and she was not rushing when she helped her. During an interview on 04/06/2026 at 5:41 PM, the DON said Resident #1 required assistance of one person for transfers, and a gait belt should be used when transferring her. The DON said she was responsible for ensuring the CNAs were properly transferring the residents, and this was monitored by competencies she completed with the ADONs assistance. The DON said not using a gait belt during transfers placed the residents at risk for falls and injuries. During an interview on 04/06/2026 at 5:56 PM, the Administrator said she expected the staff to follow the policies and procedures and use a gait belt for one person transfers. The Administrator said nursing administration, the DON or designee, were responsible for ensuring the staff properly transferred the residents. The Administrator said if residents were not transferred properly it could result in an injury. Record review of the facility's policy titled, Safe Lifting and Movement of Residents, revised September 8, 2024, indicated, In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. 2. Manual lifting of residents shall be eliminated when feasible. You may need to utilize manual lifting in situations such as emergencies. 4. Staff responsible for direct resident care will be trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices as necessary.