

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675835	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/25/2024
NAME OF PROVIDER OR SUPPLIER  Cherokee Trails Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  330 E Bagley Rd Rusk, TX 75785	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339</b></p> <p>Based on observation, interview, and record review the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 2 residents reviewed for accident (Resident #1).</p> <p>The facility failed to put interventions in place to prevent Resident #1 from sliding out of the wheelchair during transport on 2/19/24 and ensure that she was secured by the shoulder and lap belt harness, resulting in Resident #1 sliding out of her wheelchair during transport.</p> <p>The facility failed to ensure the transport staff were aware of how to properly position the shoulder and lap belt harness to ensure Resident #1 did not have forward bodily movement in the event of the driver had to quickly stop the van.</p> <p>An Immediate Jeopardy (IJ) situation was identified on 9/24/24 at 4:00p.m. The IJ template was provided to the facility on [DATE] at 4:00 p.m. While the IJ was removed on 9/25/24 at 4:30 p.m., the facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to the facility's need to evaluate the effectiveness of the corrective systems.</p> <p>Failure to properly secure residents on the van placed all residents at risk of falls which could lead to injury or death.</p> <p>Findings included:</p> <p>Record review of Resident #1's face sheet dated 9/23/24 indicated she was a [AGE] year-old female admitted to the facility on [DATE]. Some of her diagnoses were cerebrovascular disease (conditions that affect blood flow to the brain), essential hypertension (high blood pressure), chronic kidney disease stage 4 (kidneys do not filter wastes from the blood).</p> <p>Record review of Resident #1's admission MDS assessment dated [DATE] indicated severe cognitive impairment with a BIMS score of 00. Review of Resident #1's functional abilities and goals indicated she was supervision or touching assistance for sit to stand and partial to moderate assistance for chair and bed transfers. The resident was partial to moderate assistance for walking.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's care plan dated 9/20/22 indicated a Resident #1 was a fall risk with an onset of 9/20/22. The intervention was to observe resident when ambulating for unsteady gait, dizziness, decreased balance, weakness and provide assistance as needed. Resident #1 had a diagnosis of chronic kidney disease. The intervention was to follow up with nephrologist (kidney doctor) as ordered and indicated. Resident #1 had end stage kidney disease and received dialysis. The intervention was to encourage resident to attend scheduled dialysis appointments. Resident #1 had an ADL self-care deficit. The interventions with transfers were supervision to limited assistance with transfers, encourage and remind to ask for assistance and provide assistance as needed.</p> <p>Record review of Resident #1's incident report dated 2/19/24 at 11:38 a.m. indicated the incident location: out of facility during transport. The description of the incident reflected: Received call from facility van driver that while enroute back to the facility another vehicle pulled out in front of the facility van causing the van driver to hit brakes hard which lead to resident sliding out of wheelchair. Van driver pulled into near by parking lot and called EMS to come and assist and assess the resident. Prior to EMS arriving the resident had gotten herself up and sat in the passenger seat of facility van when EMS arrived the resident denied hitting her head, denied EMS the ability to assess resident also refused vital signs and to go to the ER for further evaluation from EMS. The mental status of Resident #1 was oriented to person, place and time. She had impaired memory, gait balance and was confused. The incident report was electronically signed by LVN C on 2/19/24 at 11:38 a.m.</p> <p>Record review of Resident #1's nursing note dated 2/19/24 indicated it was electronically signed by LVN C on 2/19/24 at 11:38 a.m. The note indicated the nurse was informed by Van Driver D that while enroute back to the facility another vehicle pulled out in front of the facility van causing Van Driver D to hit the brakes hard which led to Resident #1 sliding out of her wheelchair. Van Driver D pulled into a nearby parking lot and called EMS to come assist and assess the resident. Prior to EMS arriving the resident had gotten herself up and sat in the passenger seat of facility van. When EMS arrived the resident denied hitting her head, denied EMS the ability to assess her, refused vital signs and refused to go to the ER for further evaluation from EMS, NP notified and called RP no answer left message to return call to facility.</p> <p>Record review of Resident #1's nursing note dated 2/21/24 at 4:10 p.m. indicated Resident #1 had delayed bruising to her forehead.</p> <p>Record review of Resident #1's medication administration record dated February 2024 indicated Resident #1 had a pain level of 6 (which indicated moderately strong pain) on 2/19/24 and received Tramadol 50mg at 10:54 p.m.</p> <p>Record review of Van Driver D's employee file indicated a hire date of 2/24/23. The file reflected a a competency check-off Orientation Checklist Community Driver-Van-Bus for driving the van, dated 12/4/23 and 2/19/24, and signed by the Administrator and Maintenance Director F as the trainer. The [State name] Depart of Public Safety driver eligibility check revealed Van Driver A was eligible.</p> <p>Record review of Van Driver A's employee file indicated a hire date of 4/29/19. The [State name] Depart of Public Safety driver eligibility check revealed Van Driver A was eligible. The Orientation Checklist Community Driver-Van-Bus dated 8/23/24 indicated a check mark under the trainer's initials with no date listed and signed by the Administrator and Van Driver A. The personnel file did not indicate a job description.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of Van Driver B's employee file indicated a hire date of 12/29/21. The [State name] Department of Public Safety driver eligibility check revealed Van Driver A was eligible. The Orientation Checklist Community Driver-Van-Bus dated 8/23/24 indicated Van Driver A's initials under trainer's initials with no date listed and signed by the Administrator and Van Driver B. The personnel file did not indicate a job description.</p> <p>During an interview on 9/23/24 at 10:56 a.m. Resident #1 said she was facing forward in the van and Van Driver D forgot to strap down her chair in the van and had to break hard causing her to fall out of her chair. She said Van Driver D did put her seat belt on but just didn't strap down her chair so when she hit the brakes her chair moved forward causing her to fall out of the wheelchair. She said she was not hurt, got up and sat on the seat. She said Van Driver D pulled over and was scared she was going to get in trouble and wanted to take her to the hospital, but she was not hurt and didn't want to go. She said she didn't think Van Driver D worked at the facility any longer and said she had not been on any other transports with her .</p> <p>During an attempted a phone interview with Van Driver D on 9/23/24 at 2:49 p.m. a voicemail was left with no return call by the time of surveyor exit.</p> <p>During an observation and interview on 9/24/24 at 10:08 a.m. Van Driver A said he had been the primary van driver for 4 months but had worked at the facility for 6 years. He said he had been trained by the previous van driver before Van Driver D. He said he had not been trained by a maintenance director or anyone from corporate. He said he had only taken papers to the rental van company to be signed and was not trained on the van. Observed a demonstration of loading a resident wheelchair into the van and securing the wheelchair with four straps, one at each corner of the wheelchair. Van Driver A did strap the four corners of the wheelchair appropriately, so the wheelchair was secure and did not move. Van Driver A then latched a seatbelt over the wheelchair and it did not appear to have been done correctly. Surveyor asked Van Driver D to sit down in the wheelchair that was facing forward towards the windshield and attach the seatbelt as if he was a resident. Van Driver A placed the shoulder strap across the chest area and latched it to the lap belt that was attached to the front track of the van. The surveyor was able to reach over and slide the belt off the driver's lap and the driver was not secured in the wheelchair. Van Driver D said he had always strapped the seatbelt that way and did see how it would not hold a resident in the wheelchair if an incident were to occur.</p> <p>During an observation and interview on 9/24/24 at 11:25 a.m. Maintenance Director G said he had worked at the facility for about 1 and 1/2 months. He said since he had worked at the facility he had not been trained on the van and therefore did not drive the van or do any training with the van drivers. He said he knew there was a vehicle check system in their computer program, but he had not been put in the computer system therefore the vehicle checks had not been done. He said he had a notebook that he kept notes on of anything that he did with the van but did not have any notes of any problems regarding the resident securement system. He said he had worked for the company in the past at a different facility and had knowledge of how a resident should have been properly secured in the van. Observation of a demonstration of how he would secure a resident in the van revealed he moved the lap belt from the front floor track to the back floor track. He said by having the lap belt attached to the front floor track it would not stop a resident's front forward motion.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 9/24/24 at 11:40 a.m. Maintenance Director H said if a new maintenance director was hired at one of the facility's, then a maintenance director from another facility would come to the facility and train the new maintenance director; then going forward that maintenance director would be responsible for training the van drivers. He said to his knowledge no one had trained Maintenance Director G and he would make sure that Maintenance Director G got trained on the weekly maintenance logs, passenger securement and the transportation policy.</p> <p>During a telephone interview on 9/24/24 at 12:05 p.m. the Rental Van Owner said that he received a call from the facility sometime in February of 2024 asking for him to train the van drivers at the facility. He said the 1st time he scheduled the training no one ever showed up for the training and the 2nd time he walked around the van with an unknown female driver and oriented her to the van. He said to properly secure a resident in the van that was facing forward toward the windshield the lap belt should be secured to the back floor track of the van. He said if the lap belt was secured in the front floor track of the van it would not secure the resident in the chair and the resident would slide out of the chair.</p> <p>During an interview on 9/24/24 at 2:10 p.m. Van Driver B said she had worked as the facility's human resources manager for about 4 months. She said she only transported residents in the van when Van Driver D was not available. She said in the last year she had maybe done 12 transports of an average of about 1 per month. She said she had been trained on the van by Maintenance Director F. She said when she had transported residents in the van the lap belt had usually been attached to the front floor track. She said she did not usually move the lap belt when she transported residents. She said she had not had any incidents while on transport with any residents. Van Driver B said on her Orientation Checklist Community Driver-Van-Bus dated 8/23/24 it was Van Driver A's initials that completed her checklist.</p> <p>During an interview on 9/25/24 at 2:27 p.m. the Administrator said she was not aware that staff were not securing residents in the van properly. She said Van Driver A had been trained by Maintenance Director F . She said if residents were not secured properly in the van and an incident occurred the resident could be significantly injured.</p> <p>Record review of Q'Straint QRT-1 Series user instructions undated indicated: .B. Secure Passenger: 1. A. On the aisle side, attach belt with female buckle to rear tie-down pin connector; ensuring buckle rests on passenger's hip. B. on the window-side, attach belt with male tongue to rear tie-down pin connector and insert into female buckle . 3. Ensure belts are adjusted as firmly as possible, but consistent with user comfort. Warning: 1. Lap and shoulder belt should not be held away from passenger's body by wheelchair components or parts such as the wheelchair's wheels, armrests, panels or frame . 3. Occupant belts should always bear upon the bony structure of passenger's body and be worn low across the front of the pelvis, with the junction between lap and shoulder belts located near passenger's hip .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review of the facility' policy titled Transportation Policy and Procedure for Center-Based Vehicle dated 11/16/23 with a revision date of 6/27/24 indicated: For our Residents to maintain the highest practical physical, mental, and psychological wellbeing it is the policy of ___(nursing center) to utilize the Facility vehicle for Residents who, because of medical or special needs, require transportation. Maintain a current log notebook to include: Vehicle Maintenance Log, which will include but is not limited to, all recommended routine maintenance as per the vehicle's operating manual, weekly full interior and exterior cleaning and any required non-routine maintenance. Driver Orientation: The authorized driver of the Center's vehicle must be completely oriented as to the transportation policy and procedure as well as successful completion of competency training on all facets of van usage before being permitted by the Center's executive director to drive the Center's vehicle and before being provided with keys to the vehicle. Standard orientation will also need to occur with appropriate verification in personal record.</p> <p>This was determined to be an Immediate Jeopardy (IJ) on 9/24/24 at 4:00 p.m. The facility Administrator, and DON were notified. The Administrator was provided with the IJ template on 9/25/24 at 4:00 p.m. and a plan of removal was requested.</p> <p>The facility's plan of removal was accepted on 9/25/24/24 at 2:32 p.m. and included:</p> <p>1. Immediate Action Taken</p> <p>A. Resident #1 remains in the facility on 9/24/24.</p> <p>B. The facility's van immediately stopped all van transport on 9/24/2024 at 4:00 pm.</p> <p>C. The Administrator or designee completed the following with the two facilities designated van drivers:</p> <p>In-service education on the Transportation Policy which provides direction on duties of driver, driving of the van, how to operate the wheelchair lift and the wheelchair securement system, use of seat and shoulder harness, and how to transport more than 1 wheelchair. This was completed on 9/24/2024 at 7:00 pm.</p> <p>In-service education on Q'Straint QRT-1 Series User Instructions which provides direction on wheelchair securement, passenger securement and passenger release. This was completed on 9/25/24 at 12:00 pm.</p> <p>In-service education provided to van driver by administrator/designee on weekly maintenance log which includes checking operable seatbelt straps, W/C/ tie down, shoulder strap, floor W/C tie down straps that van driver will complete and provide to administrator/designee weekly. This was completed on 9/24/2024 at 7:00 pm.</p> <p>Sister facility maintenance director completed a skills validation check list on van driver to acknowledge skills competence on how to operate the wheelchair lift and the wheelchair securement system, seatbelts including shoulder harness. The van driver completed a return demonstration. This will be completed on 9/25/2024 at 2:00 pm.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Maintenance Director completed training with sister facility maintenance director on wheelchair securement, passenger securement and passenger release. A skills validation check list was completed on maintenance director to acknowledge skills competence on how to operate the wheelchair lift and the wheelchair securement system, seatbelts including shoulder harness. This will be completed on 9/25/2024 at 2:00 pm.</p> <p>The Maintenance Director completed In-service education on Q'Straint QRT-1 Series User Instructions which provides direction on wheelchair securement, passenger securement and passenger release. This was completed on 9/25/24 at 12:00 pm.</p> <p>The Administrator and/or designee reviewed with van driver, a new signed job description. This was completed on 9/24/2024 at 7:00 pm.</p> <p>2. Identification of Residents Affected or Likely to be Affected:</p> <p>A. No other residents identified, all scheduled van transports for the remainder of the week will be transported by an outside vendor. This will allow the facility time for training all van drivers, complete skills competencies and return demonstration, with all van drivers.</p> <p>3.Actions to Prevent Occurrence/Recurrence:</p> <p>A. As of 9/24/2024, any staff member hired for van transports will be provided the following by the facility maintenance supervisor.</p> <p>In-service education on the Transportation Policy which provides direction on duties of driver, driving of the van, how to operate the wheelchair lift and the wheelchair securement system, use of seat and shoulder harness, and how to transport more than 1 wheelchair prior to driving the van.</p> <p>In-service education on Q'Straint QRT-1 Series User Instructions which provides direction on wheelchair securement, passenger securement and passenger release.</p> <p>In-service education on weekly maintenance log which includes checking Operable seatbelt straps, W/C/ tie down, shoulder strap, floor W/C tie down straps that van driver will complete and provides to administrator/designee weekly.</p> <p>Completed a skills validation check list on van driver to acknowledge skills competence on how to operate the wheelchair lift and the wheelchair securement system, seatbelts including shoulder harness, and will complete a return demonstration.</p> <p>Have van driver sign job description duties.</p> <p>B. The weekly maintenance log will be reviewed in the morning meeting by the Administrator or designee.</p> <p>On 9/24/2024 the facility's Administrator notified the Medical Director regarding the Immediate Jeopardy the facility received related to Accidents/Hazards/Supervision and reviewed plan to sustain compliance</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Date Facility Asserts Likelihood for Serious Harm No Longer Exists: September 25, 2024</p> <p>On 9/25/24 the Surveyor confirmed the facility implemented their plan of removal sufficiently to remove the IJ by:</p> <p>Record review of in-service attendance record with topics Transportation Policy and Weekly Maintenance Vehicle Log dated 9/24/24 indicated Van Driver A, Van Driver B and Maintenance Director G had been educated on duties of driver, driving of the van, how to operate the wheelchair lift and the wheelchair securement system, use of seat and shoulder harness, and how to transport more than 1 wheelchair.</p> <p>Record review of in-service attendance record with topics Orientation securing wheelchair for transport Q'Straint QRT-1 Series dated 9/25/24 at 1:30 p.m. indicated Van Driver A, Van Driver B and Maintenance Director G had been educated on wheelchair securement, passenger securement and passenger release.</p> <p>Record review of in-service attendance record with topics Transportation Policy and Weekly Maintenance Vehicle Log dated 9/24/24 indicated Van Driver A, Van Driver B and Maintenance Director G had been educated on weekly maintenance log which included checking operable seatbelt straps, W/C/ tie down, shoulder strap, floor W/C tie down straps that van driver would complete and provide to administrator/designee weekly.</p> <p>Record review of the Orientation Checklist Community Driver-Van-Bus skills validation check list for Van Driver A and Van Driver B to acknowledge skills competence on how to operate the wheelchair lift and the wheelchair securement system, seatbelts including shoulder harness. Van Driver A and Van Driver B completed a return demonstration. The education was provided to Van Driver A and Van Driver B on 9/25/2024 at 2:00 pm by Maintenance Director H.</p> <p>Record review of in-service attendance record with topics Transportation Policy and Weekly Maintenance Vehicle Log dated 9/24/24 indicated Maintenance Director G had been educated on wheelchair securement, passenger securement and passenger release. A skills validation check list was completed with Maintenance Director G to acknowledge skills competence on how to operate the wheelchair lift and the wheelchair securement system, seatbelts including the shoulder harness. The skills validation was completed on 9/25/2024 at 2:00 pm by Maintenance Director H.</p> <p>Record review of in-service attendance record with topics Orientation securing wheelchair for transport Q'Straint QRT-1 Series dated 9/25/24 indicated Maintenance Director G had been educated on Q'Straint QRT-1 Series User Instructions which provided direction on wheelchair securement, passenger securement and passenger release.</p> <p>Record review of a job description titled: Van Driver dated 9/24/24 signed by Van Driver A, Van Driver B, and Maintenance Director G. Revealed Van Driver A, Van Driver B, and Maintenance Director G were educated on the expectations of transportation.</p> <p>Record review of an Ad Hoc QAPI meeting that was held on 9/24/24 at 5:30 p.m. with the facility's Medical Director, Administrator, DON, and ADON revealed discussion the facility's failed system for adequate training of the facility van drivers and reviewed a plan to sustain compliance.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/25/24 at 3:16 p.m. Maintenance Director G said he was educated on how to properly secure a resident on the van. He said he had received education on the Q'Straint QRT-1 series securement system. He said he had received education on the weekly maintenance log which included checking operable seatbelt straps, wheelchair tie down, shoulder straps, and floor wheelchair tie down straps. He said he had received a job description and was able to verbalize knew what the expectations were for van driving.</p> <p>During an interview on 9/25/24 at 3:36 p.m. Van Driver A said he was educated on how to properly secure a resident on the van. He said he had received education on the Q'Straint QRT-1 series securement system. He said he had received education on the weekly maintenance log which included checking operable seatbelt straps, wheelchair tie down, shoulder straps, and floor wheelchair tie down straps. He said he had received a job description and was able to verbalize knew what the expectations were for van driving.</p> <p>During an interview on 9/25/24 at 3:36 p.m. Van Driver B said she was educated on how to properly secure a resident on the van. He said she had received education on the Q'Straint QRT-1 series securement system. She said she had received education on the weekly maintenance log which included checking operable seatbelt straps, wheelchair tie down, shoulder straps, and floor wheelchair tie down straps. She said she had received a job description and was able to verbalize knew what the expectations were for van driving.</p> <p>During an observation on 9/25/24 at 3:48 p.m. Van Driver A, Van Driver B, and Maintenance Director G were able to demonstrate properly how to secure a resident on the facility van for transport.</p> <p>The Administrator was informed the Immediate Jeopardy was removed on 9/25/24 at 4:30 p.m. The facility remained out of compliance at a scope of isolated and a severity level of no actual harm with potential for more than minimal harm due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.</p>		

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<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Employ staff that are licensed, certified, or registered in accordance with state laws.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47339</b></p> <p>Based on interviews and record review the facility failed to ensure professional staff were licensed, certified, or registered in accordance with applicable State laws for 2 of 5 staff (CNA I and CNA J) reviewed for staff qualifications.</p> <p>The facility failed to ensure CNA I was appropriately certified to practice and provide CNA care in the State of Texas.</p> <p>The facility failed to ensure CNA J was appropriately certified to practice and provide CNA care in the State of Texas.</p> <p>This failure could place residents at risk of not receiving care and services from staff who were properly trained.</p> <p>The findings included:</p> <p>Record review of the computer program CNA certification verification portal TULIP (Texas unified licensure information portal) revealed CNA I's certification was initially issued on [DATE] and expired on [DATE].</p> <p>Record review of the computer program CNA certification verification portal TULIP revealed CNA J's certification in initially issued on [DATE] and expired on [DATE].</p> <p>During an interview on [DATE] at 12:39 PM with CNA I, he said he had last worked at the facility on [DATE]. CNA I said he worked at the facility full time for about the last 6 years. CNA I said he believed he had until [DATE] to get his certification renewed. CNA I said he had his girlfriend try to log in to the credentialing system to get his certification renewed but there was a problem with his name being wrong in the system. CNA I said he learned the license was expired when the facility staff informed him a few months ago. CNA I said he had not received any information from the state that his certification was current. CNA I said he was instructed by the facility to check the state's website to renew his certification but was not able to get logged into the system. CNA I was informed by the Administrator that per the state's certification verification website, his certification had been expired since [DATE]. CNA I said the Administrator was trying to help him get his certification renewed. He said if he could not get his certification renewed, he was planning on asking the Housekeeping Supervisor if he could go to work in housekeeping.</p> <p>During an attempted phone interview on [DATE] at 1:22 p.m. CNA J did not answer the phone and did not return call by the time of surveyor exit on [DATE] at 5:15 p.m.</p> <p>During an interview on [DATE] at 2:27 p.m. the Administrator said based on the language of the state's CNA license extension, CNA I's certification would not have been valid. The Administrator said she had tried to help CNA I get logged into the computer system but there was something wrong with the way he initially signed up for the portal and she could not get him signed in.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  675835	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/25/2024
NAME OF PROVIDER OR SUPPLIER  Cherokee Trails Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  330 E Bagley Rd Rusk, TX 75785	

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)
<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of staffing schedules dated [DATE]-[DATE] indicated CNA I worked 8 shifts as a CNA during that time period.</p> <p>Record review of staffing schedules dated [DATE]-[DATE] indicated CNA J worked 13 shifts as a CNA during that time period.</p> <p>Record Review of the facility's undated Certified Nurse Aide (C.N.A.) job description for CNA's revealed the facility's CNA's essential job duties and responsibilities: Assists residents with activities of daily living including bathing, dressing, grooming, toileting, changing of bed linens, and positioning in and out of bed, chair, etc. Assists with resident recreation programs. Prepares residents for meals and snacks, assists residents in eating where needed and records food intake . Qualifications: Must be a Certified Nursing Aide in good standing with the State or must within four (4) months of employment have completed state required training and a competency evaluation program .</p>