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 03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cherokee Trails Nursing Home	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)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46436 Based on observation, interview, and record review, the facility failed to provide a safe, clean, and sanitary environment 3 of 12 residents (Residents #6, #9, and #19) reviewed for resident rights. The facility failed to provide Resident #6 a safe, clean, and sanitary environment on 3/17/2025 when the mattress on his bed was torn and his toilet seat was broken. The facility failed to provide Resident #9 a safe, clean, and sanitary environment on 3/17/25 when a foul sour odor was observed in her room. The facility failed to provide Resident #19 a safe, clean, and sanitary environment on 3/17/25 when his toilet had no toilet seat. These failures could place residents and visitors at risk for exposure to an unclean, unsanitary environment, risk of falls and other injuries due to an unsafe environment. Findings include: 1. Record review of a facility face sheet dated 3/19/25 revealed Resident #6 was a [AGE] year-old male that admitted to the facility in 9/10/2012 with a diagnosis of atherosclerotic heart disease (blockage of arteries in the heart). Record review of a facility annual MDS assessment dated [DATE] revealed Resident #6 had a BIMS score of 5 indicating severe cognitive impairment and was independent with activities of daily living. Record review of a comprehensive care plan dated 7/18/2024 revealed Resident #6 had the potential for falls related to cognitive impairment, antihypertensive drug use, incontinence, unaware of safety needs, vision and hearing problems with goal to not sustain a fall related injury by utilizing fall precautions and was at risk for infections with goal to not experience signs and symptoms of infection. During an observation and interview on 3/17/25 at 9:13 AM Resident # 6 had a broken toilet seat and the mattress was ripped at the head exposing the foam. He said he had not noticed his seat being broken and bed torn. He said he had not had any complications from the broken items. (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

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 03/19/2025
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/17/25 at 10:15 am CNA D said that when things were broken in the past, she would notify the maintenance director and put it in the maintenance logbook, but things would not get fixed. She said that maintenance director was no longer at the facility, and they had a new one and she would let him know about the things that needed to be fixed. She said that a broken toilet seat could cause injury and a torn mattress could not be properly cleaned and could cause injury or infections. 2. Record review of a facility face sheet dated 3/18/25 for Resident #9 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnoses including emphysema (lung disease causing trouble breathing) and type 2 diabetes. Record review of a Quarterly MDS assessment dated [DATE] for Resident #9 indicated that she had a BIMS score of 14 which indicated she was cognitively intact. Assessment indicated no behaviors or rejection of care. During an observation and interview on 3/17/25 at 9:24 am Resident #9 was observed sitting in a wheelchair in her room. There was a very foul sour smell observed in her room. Resident did not speak much and only said everything was OK and she had no complaints. During an observation and interview on 3/17/25 at 2:45 pm Resident #9's room was still observed to have a sour smell. HR was in the hallway, and she was asked to come smell the room. She smelled the linens and the resident's shoes but could not find the smell. She found an avocado in a plastic produce bag inside of a plastic grocery store bag hidden under some other personal items that was covered in a green powdery substance that appeared to be mold. During an interview on 3/18/25 at 9:05 am CNA E said Resident #9 would not really let staff clean the room like it needed to be done and there was no telling what was in there. During an interview on 3/18/25 at 9:50 am Housekeeping Supervisor said housekeeping staff were responsible for cleaning resident rooms daily and said if there was a lingering odor observed that staff would try to find the cause, but some residents would hide things. He said if a resident gave the staff problems related to cleaning the rooms, then staff were to go to nursing staff to help intervene. He said Resident #9 liked to hide things. He said there was some old food found in her room yesterday (3/17/25) and if she had eaten it, she could have gotten sick. He said the foul odor could cause residents, staff, and visitors to feel uncomfortable. 3. Record review of a facility face sheet dated 3/19/25 for Resident #19 indicated that he was a [AGE] year-old man admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnosis including vascular dementia. Record review of a Quarterly MDS dated [DATE] for Resident #19 indicated he had a BIMS score of 6, which indicated severely impaired cognition. He was always incontinent of bowel and bladder and required partial to moderate assistance with toilet transfers. Record review of a comprehensive care plan dated 6/30/21 for Resident #19 indicated that he had an ADL self-care performance deficit and required extensive assist of one to two persons with toilet use. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 3/17/25 at 9:40 am Resident #19's toilet was observed with no toilet seat. During an interview on 3/17/25 at 1:56 pm the Maintenance Director said he had only been at the facility a few days and had not had a chance to review the logs and would be getting with the staff to discuss restarting the logbook. He said he could not speak on what occurred before him but would fix the broken toilet seat and exchange the mattress right away. During an interview on 3/18/25 at 3:00 pm the Administrator said that in the past the maintenance director was not completing task and he was no longer employed as of last week. She said they hired a new maintenance director and will make environmental rounds and retrain staff on using the logbook so things can be fixed. She said she would oversee the ambassadors for each hall to ensure all areas are clean and functional. She said when areas and items were broken or in disrepair it could cause injuries or infections. Record review of maintenance logbook revealed no request in the book for 2024 or 2025. Record review of a facility policy titled Resident Room Cleaning, undated, read: .Daily cleaning of resident rooms helps to provide a sanitary environment, prevent odors, and prolong the useful life of furniture, equipment, paint, and floor finish . Record review of a facility Resident Rights document dated 2/23/2016 indicated, .8. Safe environment. The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40124 Based on observations, interviews, and record review, the facility failed to ensure the residents' environment remained as free of accident hazards as possible for 3 of 12 residents (Residents #18, #28, and #45) reviewed for accidents/hazards. The facility failed to remove worn and damaged mechanical lift slings from service from 03/17/2025 through 03/19/2025. This failure could place residents at risk of a loss of quality of life due to injuries. Findings included: 1. Record review of a facility face sheet dated 3/18/25 for Resident #18 indicated that she was a [AGE] year-old female admitted to the facility 8/7/23 with diagnoses including essential hypertension (uncontrolled blood pressure) and chronic peripheral venous insufficiency (poor circulation to the extremities). Record review of a Quarterly MDS assessment dated [DATE] for Resident #18 indicated that she had a BIMS score of 13, which indicated she was cognitively intact. She was dependent for all transfers and most ADLs. Record review of a comprehensive care plan dated 8/18/23 for Resident #18 indicated she had ad ADL Self-Care Performance Deficit and required a Hoyer lift for all transfers.2. 2.Record review of a face sheet for Resident #28 dated 03/18/2025 indicated he admitted to the facility 03/24/2019 and was [AGE] years old with diagnoses of Alzheimer's disease, cerebral infarction (stroke), and blindness. Record review of a Quarterly MDS Assessment for Resident #28 dated 01/10/2025 indicated he had severe impairment in thinking with a BIMS score of 3. He was dependent on 2 staff from chair/bed to chair transfers. Record review of a care plan for Resident #28 revised on 01/21/2025 indicated he had an ADL self-care performance deficit related to impaired balance that included interventions for transfers and he required 2 staff for transfers. During an observation on 03/18/2025 at 12:00 pm Resident #28 was sitting in his wheelchair with mechanical lift sling underneath him, the straps were faded light in color. 3. Record review of a facility face sheet dated 3/19/25 for Resident #45 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] and was subsequently readmitted on [DATE] with diagnoses of hepatic encephalopathy and morbid obesity. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a Quarterly MDS assessment dated [DATE] for Resident #45 indicated that she had a BIMS score of 14 which indicated she was cognitively intact. She was dependent for all transfers. Record review of a comprehensive care plan dated 9/5/23 for Resident #45 indicated she had an ADL self-care performance deficit and required a Hoyer lift for transfers. During an observation and interview on 3/18/25 at 8:54 am Resident #18 was observed in her room sitting up in a motorized wheelchair with a mechanical lift sling underneath her. The strap colors were faded, and all were almost white in color. CNA B was in room with the resident and said they had just gotten her up with the lift to get her ready to leave for an appointment. She said she would check the slings to make sure they were not too thin before using them to transfer a resident. She said the CNAs do not really use the strap colors, they just call them strap 1, strap 2, etc. CNA B said she had been employed here about [AGE] years. When asked what the risks to residents could be if a worn sling was used, she replied I think it could be dangerous, they might snap and break. During an observation and interview on 3/18/2025 at 10:30 am, three mechanical lift lift slings were hanging to air dry in the clean area of the laundry room. All three Hoyer slings were faded and light in color. One sling, the straps were unraveling and had threads pulling away. The Laundry Aide said she had been employed at the facility off and on, for over [AGE] years and she bleaches the Hoyer slings if they have been soiled. She said she received training to air dry the lift slings; she hung them to dry. She said she was not aware that the bleach could fade and damage the slings making them unsafe for use. She said she inspected the slings for loose strings, rips, and tears before hanging them for drying. She said she took the damaged slings to the ADON and DON if they needed to be removed from service when she had concerns about holes or [NAME]. She said if a sling that was unsafe was used for residents, it could tear causing the resident to fall and get hurt. During an observation and interview on 3/18/25 at 1:45 pm CNAs D and E were observed to transfer Resident #45 using a mechanical lift sling that was faded in color and had no label. CNA D said she checks for any rips or tears on slings before using them to ensure safety. She said she did not think there was anything wrong with the colors of the loops on this sling. CNA E said she agreed with CNA D. During an interview on 3/18/2025 at 10:45 AM, the Laundry/Housekeeping Supervisor said the ADON was responsible for reordering new lift slings to replace them as needed. He said if staff found a lift sling that was ripped or torn, they would take to her and then she would give them a new one. He said the slings were washed by themselves and if a sling that was unsafe was used for residents, it could tear causing the resident to fall and get hurt. During an interview on 3/18/2025 at 1:31 PM, the ADON said the lift slings should be checked about every 6 months and checked every time they were washed. She said she was not aware of the manufacturer's guidelines for the lift slings that the slings should not in be use if they had been bleached and were faded. She said they planned to conduct an audit and the facility had ordered new slings for the facility. She said there could be risk for injury if the faded and [NAME] slings were being used. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/18/2025 at 3:10 PM, the Administrator said staff knew to report any torn or ripped mechanical lift slings and to throw them away. She said it was the responsibility of the DON or ADON to make sure they were not using worn or damaged lift slings. She said she was not aware that the laundry aide was bleaching the slings. She said the faded slings could not be in use and there would be a potential risk for falls or injuries. Record review of a facility policy titled Resident Rights, revised 02/20/2021 indicated: .8. Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely . Record review of the manufacturer instruction for Medline full body slings undated indicated, .Full body slings are made of durable materials and are ideal for patient transferring and toileting activities. Always inspect slings prior to each use. Signs of color fading, bleached areas, indicate improper laundering which is unsafe and could result in injury. Any slings with signs of wear or improper laundering should be immediately removed from use . Record review of the manufacturer instructions for Proactive full body slings accessed https://proactivemedical.com/products/lifts-slings/patient-slings/full-body-sling/ accessed 03/18/2025 indicated, .Proactive medical products . Guideline for Identifying Deteriorated Slings Accelerated Deterioration from Bleach, High Temperature Wash or Drying Slings, especially loop straps that have been damaged from being laundered in unsuitable conditions (bleach, high heat wash or dry) may appear to be in good condition but the actual tensile strength of the material may be compromised and pose a safety risk and should not be used for lifting a patient or resident. This Guide is intended to help staff and caregivers better identify slings that have been exposed to above laundry conditions and subsequent loss of tensile strength. We encourage any sling identified with the following characteristics to be removed from service immediately as a preventive measure. Proactive Medical slings have been designed and tested for laundry wash conditions of 170F degrees and air dry or dry at low temperature. The slings should never be bleached. Commercial washer and dryers are not recommended. Care instructions on the sling label should always be followed. Laundry equipment should be properly maintained and repaired when necessary. Completely Faded / Missing / Illegible Tag while the main body of the sling fabric is still intact and in relatively good condition. Colors are not faded or show very little fading . 46273

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 43994 Based on observation and interview, the facility failed to ensure nurse staffing data was posted daily and readily accessible to residents and visitors with all required information for 2 of 2 days reviewed (3/17/2025 and 3/18/2025) for nurse staffing posting. The facility failed to post the daily staffing information in a prominent place on 3/17/2025 and 3/18/2025. This failure could place residents, families, and visitors at risk of not being informed of the census and number of staff working each day to provide care on all shifts. Findings included: During an observation on 3/17/2025 at 10:58 AM, the daily staff posting was not in or around the front entrance. The daily staff posting was dated 3/17/2025 and on a wall by the SW office that was not clearly visible to see. During an observation 3/18/25 at 2:35 PM, the daily staff posting was dated 3/18/2025 and on a wall by the SW office that was clearly visible to see. During an interview on 3/19/2025 at 10:33 AM, HR said she was responsible for putting up the daily staff posting. She said the staff posting was put up so people would know about the current staff in the facility. She said she had always put the posting on the wall and if someone entered the facility, they would not be able to see it. She said she did not know the posting had to be visible for all to see when they entered the facility. She said she would move it. During an interview on 3/19/2025 at 10:45 AM, the interim Administrator said she had been at the facility for a couple of months. She said HR was responsible for putting up the daily staff posting. She said it was placed on the wall. She said she was not aware the staff posting had to be in a place that was visible for all to see who entered the facility including residents. She said the facility did not have a policy for the daily staff posting.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on observations, interviews, and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 4 residents (Resident #153) and 1 of 5 staff (MDS Coordinator) reviewed for infection control. The MDS Coordinator failed to wear appropriate PPE for enhanced barrier precautions when providing care to Resident #153 on 3/18/2025. This failure could place residents at risk of exposure to infectious diseases due to improper infection control practices. Findings included: Record review of an Admission Record dated 3/18/2025 for Resident #153 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of osteomyelitis of left ankle and foot (bone infection), dementia, hypertension, acquired absence of left foot and right leg below knee (surgical removal). Record review of active physician orders for Resident #153 dated 3/18/2025 did not indicate an order for enhanced barrier precautions. Record review of an Admission/5 Day MDS for Resident #153 dated 3/17/2025 indicated it was not complete and in progress. Record review of a care plan for Resident #153 dated 3/12/2025 indicated he had a pressure ulcer and was at risk for infection. Interventions included to provide wound care per physician's order. Monitor and document for signs and symptoms of infection. Record review of a list of residents on enhanced barrier precautions undated indicated Resident #153 was listed with the reason for a wound. During an observation on 3/18/2025 at 09:34 AM in the room of Resident #153, RN C was present to perform wound care. There was a sign on his door for EBP. RN C sanitized her hands and donned (put on) a gown and gloves. The MDS Coordinator was present to assist, and she sanitized her hands and put on gloves, but not a gown and sat on the floor in the resident's room. Resident #153 was sitting up in a wheelchair and the MDS Coordinator lifted Resident #153's left leg and RN C performed wound care following physician orders and infection control with proper glove changes and sanitized her hands. After wound care was completed, RN C removed her gloves and placed them in the trash and sanitized her hands. The MDS Coordinator removed her gloves and placed them in the trash and sanitized her hands. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/18/2025 at 2:50 PM, the MDS Coordinator said residents who were on EBP, staff should wear a gown and gloves when care was provided and that included residents who had wounds. She said during the care provided to Resident #153, she should have worn a gown and only had on gloves. She said she did not think about him being on EBP and did not notice the sign on his door or the container of ppe that was outside of his door. She said she should not have been sitting on the floor while assisting him. She said there could be a risk of passing germs to other residents if staff did not wear gown and gloves when care was provided. During a joint interview on 3/19/2025 at 10:37 AM, the ADON and DON said they were both responsible for training staff on infection control. The ADON said she trained staff monthly on infection control and about every 2-3 months on EBP that included all staff. She said a resident who had wounds would be on EBP and Resident #153 was. She said when staff provided care to him, they should wear a gown and gloves at minimum. She said she was not aware the MDS Coordinator did not wear proper ppe when assisting with wound care on yesterday 3/18/2025 and she should have worn a gown and not have been sitting on the floor. She said residents could be at risk for infections and planned to inservice the MDS Coordinator and provide training with her. She said she had a training a few months ago on EBP with all staff. Record review of a facility inservice training on EBP dated 3/18/2025 indicated the MDS Coordinator received the training as indicated by her signature. Record review of a facility inservice training on EBP dated 1/31/2025 indicated the MDS Coordinator received the training as indicated by her signature. During an interview on 3/19/2025 at 10:45 AM, the interim Administrator said she had been at the facility for a couple of months. She said the ADON and DON were responsible for training staff on infection control in the facility. She said when care was provided to residents who were on EBP, staff should wear a gown and gloves. She said residents on EBP included residents with wounds. She said there could be a risk of cross contamination and infections if staff did not wear the proper ppe when care was provided. Record review of a facility policy titled Infection Prevention and Control Program revised 11/6/2024 indicated, .This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection as per accepted national standards and guidelines. 6. Enhanced Barrier Precautions: EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP are indicated for residents with any of the following: b. Wounds; During high-contact resident care activities: wound care: any skin opening requiring a dressing. Gloves and gowns prior to the high-contact care activity .

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on interview and record review, the facility failed to develop, implement, and maintain an effective training program for 3 of 14 employees (AD, DOR, and CNA B) reviewed for training. The facility failed to ensure the AD, DOR, and CNA B were trained on HIV annually. This failure could place residents at risk of not receiving care to attain or maintain their highest practicable physical, mental, and psychosocial well-being due to lack of staff training. Findings include: Record review of the personnel file for the AD indicated she was hired at the facility on 9/29/2023 and did not have annual training on HIV. Training was last completed on 2/19/2024. Record review of the personnel file for the DOR indicated she was hired at the facility on 6/1/2023 and did not have annual training on HIV. Training was last completed on 2/19/2024. Record review of the personnel file for CNA B indicated she was hired at the facility on 5/23/2023 and did not have annual training on HIV. Training was last completed on 5/23/2023. During an interview on 3/19/2025 at 9:22 AM, HR said she had been employed at the facility for a year. She said she was responsible for ensuring staff received the required trainings on hire. She said she was not sure who was responsible for ensuring staff received annual trainings. She said she used a guide that staff were given during orientation that included all the required trainings. During a follow up interview on 3/19/2025 at 10:33 AM, HR said if staff did not receive the required trainings on hire and annually thereafter, residents could be at risk of getting hurt and staff not receiving proper communication. During an interview on 3/19/2025 at 10:45 AM, the interim Administrator said the required trainings were the responsibility of HR. She said she was not aware that some of the employees did not have their annual trainings. She said the facility recently changed to a different online training program and they did not recognize that all the trainings were not being done. She said they updated the training profiles of all staff to include the missing trainings. She said there could be a risk of staff not receiving the proper training and residents not receiving proper care. Record review of a facility assessment dated [DATE] indicated, .Our facility's training program includes an orientation process and ongoing training for all new and existing staff including managers, nursing and other direct care staff, individuals providing services under contractual arrangement, and volunteers consistent with their expected roles. The content at a minimum includes infection control and dementia management . (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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy titled Training Requirements dated 11/29/2023 indicated, .It is the policy of this facility to develop, implement, and maintain an effective training program for all new hire and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. 5. Training requirements should be met prior to staff and volunteers independently providing services to residents, annually and as necessary based on the facility assessment. 6. Training content includes, at a minimum: h. HIV; i. Dementia management and care of the cognitively impaired .

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on interview and record review, the facility failed to provide effective communications mandatory training for 4 of 14 employees (ADON, AD, CNA A and CNA F) reviewed for training, in that: The facility failed to ensure effective communication training was provided to the ADON, AD, CNA A and CNA F annually. This failure could place residents at risk of miscommunication and social isolation due to lack of staff training. Findings include: Record review of the personnel file for the ADON indicated she was hired at the facility on 4/16/2020 and did not have annual training on effective communication. Training was last completed on 2/19/2024. Record review of the personnel file for the AD indicated she was hired at the facility on 9/29/2023 and did not have annual training on effective communication. Training was last completed on 2/19/2024. Record review of the personnel file for CNA A indicated she was hired at the facility on 9/3/2020 and did not have annual training on effective communication. Training was last completed on 2/23/2024. Record review of the personnel file for CNA F indicated she was hired at the facility on 2/8/2024 and did not have annual training on effective communication. Training was last completed on 2/9/2024. During an interview on 3/19/2025 at 9:22 AM, HR said she had been employed at the facility for a year. She said she was responsible for ensuring staff received the required trainings on hire. She said she was not sure who was responsible for ensuring staff received annual trainings. She said she used a guide that staff were given during orientation that included all the required trainings. During a follow up interview on 3/19/2025 at 10:33 AM, HR said if staff did not receive the required trainings on hire and annually thereafter, residents could be at risk of getting hurt and staff not receiving proper communication. During an interview on 3/19/2025 at 10:45 AM, the interim Administrator said the required trainings were the responsibility of HR. She said she was not aware that some of the employees did not have their annual trainings. She said the facility recently changed to a different online training program and they did not recognize that all the trainings were not being done. She said they updated the training profiles of all staff to include the missing trainings. She said there could be a risk of staff not receiving the proper training and residents not receiving proper care. (continued on next page)

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a facility assessment dated [DATE] indicated, .Our facility's training program includes an orientation process and ongoing training for all new and existing staff including managers, nursing and other direct care staff, individuals providing services under contractual arrangement, and volunteers consistent with their expected roles. The content at a minimum includes Effective communication . Record review of a facility policy titled Training Requirements dated 11/29/2023 indicated, .It is the policy of this facility to develop, implement, and maintain an effective training program for all new hire and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. 5. Training requirements should be met prior to staff and volunteers independently providing services to residents, annually and as necessary based on the facility assessment. 6. Training content includes, at a minimum: a. Effective communication for direct care staff .

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on interview and record review, the facility failed to develop, implement, and maintain an effective training program for 1 of 14 employees (DM) reviewed for training. The facility failed to ensure the DM was trained on dementia training annually. This failure could place residents at risk of not receiving care to attain or maintain their highest practicable physical, mental, and psychosocial well-being due to lack of staff training. Findings include: Record review of the personnel file for the DM indicated she was hired at the facility on 2/15/2024 and did not have annual training on dementia. Training was last completed on 2/16/2024. During an interview on 3/19/2025 at 9:22 AM, HR said she had been employed at the facility for a year. She said she was responsible for ensuring staff received the required trainings on hire. She said she was not sure who was responsible for ensuring staff received annual trainings. She said she used a guide that staff were given during orientation that included all the required trainings. During a follow up interview on 3/19/2025 at 10:33 AM, HR said if staff did not receive the required trainings on hire and annually thereafter, residents could be at risk of getting hurt and staff not receiving proper communication. During an interview on 3/19/2025 at 10:45 AM, the interim Administrator said the required trainings were the responsibility of HR. She said she was not aware that some of the employees did not have their annual trainings. She said the facility recently changed to a different online training program and they did not recognize that all the trainings were not being done. She said they updated the training profiles of all staff to include the missing trainings. She said there could be a risk of staff not receiving the proper training and residents not receiving proper care. Record review of a facility assessment dated [DATE] indicated, .Our facility's training program includes an orientation process and ongoing training for all new and existing staff including managers, nursing and other direct care staff, individuals providing services under contractual arrangement, and volunteers consistent with their expected roles. The content at a minimum includes infection control and dementia management . Record review of a facility policy titled Training Requirements dated 11/29/2023 indicated, .It is the policy of this facility to develop, implement, and maintain an effective training program for all new hire and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. 5. Training requirements should be met prior to staff and volunteers independently providing services to residents, annually and as necessary based on the facility assessment. 6. Training content includes, at a minimum: h. HIV; i. Dementia management and care of the cognitively impaired .

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide training in compliance and ethics. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on interview and record review, the facility failed to provide the required compliance and ethics training for 3 of 14 employees (CNA A, CNA B and CNA F) reviewed for training in that: The facility failed to ensure annual compliance and ethics training was provided to CNA A, CNA B, and CNA F. This failure could affect residents and place them at risk of poor care or victimization due to lack of staff training. Findings included: Record review of the personnel file for CNA A indicated she was hired on 9/3/2020 and had not completed annual training on compliance and ethics. Training was last completed on 2/23/2024. Record review of the personnel file for CNA B indicated she was hired on 5/23/2023 and had not completed annual training on compliance and ethics. Training was last completed on 5/23/2023. Record review of the personnel file for CNA F indicated she was hired on 2/8/2024 and had not completed annual training on compliance and ethics. Training was last completed on 2/9/2024. During an interview on 3/19/2025 at 9:22 AM, HR said she had been employed at the facility for a year. She said she was responsible for ensuring staff received the required trainings on hire. She said she was not sure who was responsible for ensuring staff received annual trainings. She said she used a guide that staff were given during orientation that included all the required trainings. During a follow up interview on 3/19/2025 at 10:33 AM, HR said if staff did not receive the required trainings on hire and annually thereafter, residents could be at risk of getting hurt and staff not receiving proper communication. During an interview on 3/19/2025 at 10:45 AM, the interim Administrator said the required trainings were the responsibility of HR. She said she was not aware that some of the employees did not have their annual trainings. She said the facility recently changed to a different online training program and they did not recognize that all the trainings were not being done. She said they updated the training profiles of all staff to include the missing trainings. She said there could be a risk of staff not receiving the proper training and residents not receiving proper care. Record review of a facility assessment dated [DATE] indicated, .Our facility's training program includes an orientation process and ongoing training for all new and existing staff including managers, nursing and other direct care staff, individuals providing services under contractual arrangement, and volunteers consistent with their expected roles. The content at a minimum includes compliance and ethics . (continued on next page)

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a facility policy titled Training Requirements dated 11/29/2023 indicated, .It is the policy of this facility to develop, implement, and maintain an effective training program for all new hire and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. 5. Training requirements should be met prior to staff and volunteers independently providing services to residents, annually and as necessary based on the facility assessment. 6. Training content includes, at a minimum: e. Written standards, policies, and procedures for the facility's compliance and ethics program .

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on interview and record review, the facility failed to provide mandatory effective behavioral health training for 3 of 14 employees (CNA A, CNA B and CNA F) reviewed for training, in that: The facility failed to ensure annual effective behavioral health training was provided to CNA A, CNA B and CNA F. This failure could place residents with behaviors at risk of not receiving care to attain or maintain their highest practicable physical, mental, and psychosocial well-being due to lack of staff training. Findings included: Record review of the personnel file for CNA A indicated she was hired on 9/3/2020 and had not completed annual training on behavioral health. Training was last completed on 2/23/2024. Record review of the personnel file for CNA B indicated she was hired on 5/23/2023 and had not completed annual training on behavioral health. Training was last completed on 5/23/2023. Record review of the personnel file for CNA F indicated she was hired on 2/8/2024 and had not completed annual training on behavioral health. Training was last completed on 2/9/2024. During an interview on 3/19/2025 at 9:22 AM, HR said she had been employed at the facility for a year. She said she was responsible for ensuring staff received the required trainings on hire. She said she was not sure who was responsible for ensuring staff received annual trainings. She said she used a guide that staff were given during orientation that included all the required trainings. During a follow up interview on 3/19/2025 at 10:33 AM, HR said if staff did not receive the required trainings on hire and annually thereafter, residents could be at risk of getting hurt and staff not receiving proper communication. During an interview on 3/19/2025 at 10:45 AM, the interim Administrator said the required trainings were the responsibility of HR. She said she was not aware that some of the employees did not have their annual trainings. She said the facility recently changed to a different online training program and they did not recognize that all the trainings were not being done. She said they updated the training profiles of all staff to include the missing trainings. She said there could be a risk of staff not receiving the proper training and residents not receiving proper care. Record review of a facility assessment dated [DATE] indicated, .Our facility's training program includes an orientation process and ongoing training for all new and existing staff including managers, nursing and other direct care staff, individuals providing services under contractual arrangement, and volunteers consistent with their expected roles. The content at a minimum includes caring for residents who are cognitively impaired . (continued on next page)

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a facility policy titled Training Requirements dated 11/29/2023 indicated, .It is the policy of this facility to develop, implement, and maintain an effective training program for all new hire and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. 5. Training requirements should be met prior to staff and volunteers independently providing services to residents, annually and as necessary based on the facility assessment. 6. Training content includes, at a minimum: f. Behavioral health including informed trauma care .