STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675976	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winfield Rehab & Nursing	1108 E Loop 304 Crockett, TX 75835

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 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** 43994 Based on observations, interviews, and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury for 1 of 8 residents (Resident #20) reviewed for neglect. The facility did not report to the state agency within 2 hours when an allegation of neglect occurred on 8/30/2024 that involved Resident #20 who had a fall from a mechanical lift and sustained a right subdural hematoma (brain bleed) and a left shoulder joint separation. This failure could place vulnerable residents at risk of harm due to delays in reporting an allegation of neglect. Findings included: Record review of an Admission Record dated 9/9/2024 for Resident #20 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of ID (limitation in metal abilities that affect thinking, learning and everyday life skills), DD (a group of conditions due to an impairment in physical, learning, language, or behavior areas), hypertension, and unspecified convulsions (involuntary contraction of the muscles that result in uncontrollable shaking). Record review of a Quarterly MDS assessment dated [DATE] for Resident #20 indicated she had severe impairment in thinking with a BIMS score of 3. She was totally dependent on staff for transfers. Record review of a care plan for Resident #20 revised on 9/1/2024 indicated she had an ADL self-care performance deficit and was at risk for not having their needs met in a timely manner. Interventions included: left arm splint/sling to immobilize the left shoulder. She was non-complaint, refused to wear it at times. Transfers: dependent: Hoyer lift x 2 CNA. Record review of a care plan for Resident #20 revised on 10/5/2023 indicated she had the potential for falls related to cognitive impairment secondary to intellectual disabilities. Interventions included: Hoyer lift x2 CNA for transfers from bed to chair/gurney or chair/gurney to bed, dated 8/24/2024. Staff training on Hoyer lift transfers, dated 8/31/2024. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of an incident report for Resident #20 dated 8/30/2024 at 8:25 PM by LVN W indicated a witnessed fall occurred in the resident's room during a transfer with a mechanical lift. Statements by witnessed staff NA A and CNA B indicated, .they were getting the resident ready to put her back in bed after her shower. As they were in the door frame putting the straps on the mechanical lift, they started pushing the lift into the room and one of the straps came off and her head and shoulder hit the door . The Administrator, the DON, and the responsible party were notified. Record review of an X-ray report dated 8/20/2024 for Resident #20 indicated she had a widening of the AC joint seen measuring approximately 6 mm suggesting AC joint separation (collarbone separated from the shoulder blade) of unknown acuity. Record review of a CT scan of head dated 8/30/2024 for Resident #20 indicated she had a small subdural hematoma and a soft tissue trauma. Record review of TULIP for the facility did not indicate a self-report was submitted to report the serious bodily injury of Resident #20. During an observation and interview on 9/9/2024 at 9:22 AM, Resident #20 was in her bed awake, alert to person and coloring on a piece of paper. Her Friend was present and said she had been with the resident since February 2024 and worked Monday-Friday with her from 8 am-11 am. She said Resident #20 had a fall about a week ago when she fell from the lift and had a left shoulder bruise and pain in her head. Resident #20 was very hard to understand when she spoke and pointed to her left shoulder and said it hurt. During a phone interview on 9/9/2024 at 6:33 PM, CNA B said she had been employed at the facility since July 2024 and worked 6 pm-6 am on hall 200. She said the incident involving Resident #20 on 8/30/2024, she was helping NA A. She said the resident had a shower and they were taking her back to her room. She said Resident #20 was on a shower bed and they placed the lift sling underneath her in the shower room. She said the mechanical lift had 6 rings (3 on each side) and the straps were placed on all 6 rings. She said NA A was operating the lift and she was helping to guide the resident. She said the resident was in the hallway in front of her room door, they were in the process of lifting Resident #20 with the lift, and one of the straps by her left leg came off and was not sure how. She said the resident began to lean to the left side and NA A started trying to lower the resident down and she could not catch her. She said Resident #20 fell on her left side in the doorway hitting her head and left shoulder on the door. She said the resident fell to the floor. She said they immediately called the nurse, who was across the hall in another resident's room. She said the nurse came in and assessed the resident, taking vital signs and called 911. Record review of an Associate Disciplinary Memorandum dated 8/30/2024 for CNA B indicated she was suspended for transferring a resident using the mechanical lift and a strap slipped off causing the resident to fall and hit her head and shoulder. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on 9/9/2024 at 6:52 PM, NA A said she was not certified as a nurse aide and would be testing on tomorrow 9/10/2024. She said she had been employed at the facility for almost a year and worked 6 pm-6 am and assigned to work hall 300 where Resident #20 resided. She said on 8/30/2024 she needed help with Resident #20 since she was a 2-person transfer and had CNA B to help with her shower and transfer. She said they put the straps on the lift and got her ready to take her in the room. She said the resident was on a shower bed. She said one of the lift straps came off and the resident was dangling and hit her head and left shoulder on the middle of the door. She said she tried to lower the lift and the resident fell to the floor. She said prior to the incident, she had skills check off that included lift transfers. She said the nurse came in and checked on the resident and she stayed with her until she was transferred out to the hospital. She said she was suspended for a 1 1/2 days and she did what she had been taught to do and was not sure how the strap came off. Record review of an associate disciplinary memorandum dated 8/30/2024 for NA A indicated she was suspended for transferring a resident using the mechanical lift and a strap slipped off causing the resident to fall and hit her head and shoulder. During a phone interview on 9/9/2024 at 7:02 PM, LVN W said she had been employed at the facility for [AGE] years and worked 6 pm-6 am as a charge nurse. She said the day of the incident on 8/30/2024 with Resident #20, she was down hall 300 where Resident #20 resided. She said she was aware the staff had taken her to the shower room. She said at the time of the incident, she was across the hall checking a resident's blood sugar. She said she heard a noise like something hit the wall or something. She said she looked across the hall and saw Resident #20 on the floor between the legs of the lift. She said the resident was assessed by her, they moved the lift out of the way, checked her vital signs, and talked to her. She said shortly after, her arm and legs started jerking for a few seconds and they placed her on her side. She said it happened again and after that she was ok, was comfortable. She said the resident left and went to the hospital. During an interview on 9/11/2024 at 11:42 AM, the Administrator said she was notified by staff on 8/30/2024 about Resident #20 falling out of the mechanical lift. She said she went to the facility and started an investigation with by talking to the nurse aides involved, had them perform a demonstration on how they connected the lift sling, and what they did. She said after the investigation, it was determined the incident was an accident as the staff were not aware of how the strap came off. She said she sent all the information to her regional support team who then informed her that it was an accident that was witnessed by staff and that it did not need to be reported to the state agency. She said they informed her that it did not meet the guidelines for reporting as there were not any problems with the sling or lift. During an interview on 9/11/2024 at 3:00 PM, the Regional Nurse and Regional Director both said after the incident on 8/30/2024 they were notified by the facility staff of the incident. They said a discussion was made about the findings of the incident after the facility had investigated and based on the reporting guidelines by the state agency, the incident did not involve any abuse or neglect and it was not reported to the state agency. Both said they used PL 19-17 for guidance to see if the incident needed to be reported and it did not meet the guidelines. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy titled Abuse, Neglect, and Exploitation revised on 9/6/2024 indicated, .It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse. VII. Reporting/Response: A. Reporting all alleged violations to the Administrator, state agency, withing specified time frames: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involves abuse (with or without bodily injury) b. An incident that results in serious bodily injury and involves any of the following: Neglect .

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 43994 Based on observations, interviews, and record review, the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for 1 of 24 residents reviewed for accidents. (Resident #20) The facility failed to properly secure Resident #20 during a mechanical lift transfer on 8/30/2024 when she fell out of the mechanical lift and hit her head and left shoulder on the door in her room resulting in a subdural hematoma and a left shoulder separation. On 9/10/2024 at 10:00 AM an Immediate Jeopardy (IJ) situation was identified. While the IJ was removed on 9/10/2024 at 3:53 PM, the facility remained out of compliance at a potential for harm with a scope identified as isolated due to the facility continuing to monitor the implementation and effectiveness of their Plan of Removal. These failures could place residents at risk for serious injury and accidents. Findings included: 1.Record review of an Admission Record dated 9/9/2024 for Resident #20 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of ID (limitation in metal abilities that affect thinking, learning and everyday life skills), DD (a group of conditions due to an impairment in physical, learning, language, or behavior areas), hypertension and unspecified convulsions (involuntary contraction of the muscles that result in uncontrollable shaking). Record review of a Quarterly MDS assessment dated [DATE] for Resident #20 indicated she had severe impairment in thinking with a BIMS score of 3. She was totally dependent on staff for transfers. Record review of a care plan for Resident #20 revised on 9/1/2024 indicated she had an ADL self-care performance deficit and is at risk for not having their needs met in a timely manner. Interventions included: left arm splint/sling to immobilize left shoulder. She is non-complaint refusing to wear it at times. Transfers: dependent: hoyer lift x 2 CNA. Record review of a care plan for Resident #20 revised on 10/5/2023 indicated she had the potential for falls related to cognitive impairment secondary to intellectual disabilities. Interventions included: hoyer lift x2 CNA for transfers from bed to chair/gurney or chair/gurney to bed dated 8/24/2024. Staff training on hoyer lift transfers dated 8/31/2024. Record review of an incident report for Resident #20 dated 8/30/2024 at 8:25 PM by LVN W indicated a witnessed fall occurred in the resident's room during a transfer with a mechanical lift. Statements by witnessed staff NA A and CNA B indicated, .they were getting the resident ready to put her back in bed after her shower. As they were in the door frame putting the straps on the mechanical lift, they started pushing the lift into the room and one of the straps came off and her head and shoulder hit the door . The Administrator, DON, and responsible party were notified. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of an X-ray report dated 8/20/2024 for Resident #20 indicated she had a widening of the AC joint seen measuring approximately 6 mm suggesting AC joint separation (collarbone separated from the shoulder blade) of unknown acuity. Record review of a CT scan of head dated 8/30/2024 for Resident #20 indicated she had a small subdural hematoma and a soft tissue trauma. Record review of TULIP for the facility did not indicate a self-report was submitted to report the serious bodily injury of Resident #20. During an observation and interview on 9/9/2024 at 9:22 AM, Resident #20 was in her bed awake, alert to person and coloring on a piece of paper. Her Best Friend was present and said she had been with the resident since February 2024 and worked Monday-Friday with her from 8 am-11 am. She said Resident #20 had a fall about a week ago when she fell from the lift and had a left shoulder bruise and pain in her head. Resident #20 was very hard to understand when she spoke and pointed to her left shoulder and said it hurt. During an observation and interview on 9/9/2024 at 1:10 PM, CNA C and CNA D were in the room of Resident #20 to provide care. Resident #20 was transferred from her wheelchair to her bed using a mechanical lift. CNA D was operating the lift, the legs were widened, and the lift was positioned over the wheelchair. The lift sling straps were placed on the lift using the last strap which was a faded purple in color, and they connected the sling to all 3 hooks on both sides of the lift for a total of 6 straps. The wheelchair was checked and locked, the resident was lifted and positioned over the bed, and the staff did not lock the legs on the lift. The mechanical lift was taken back into the hallway and locked. Observation of the lift sling for the resident was faded in color and no manufacturer's tag was present. Both staff said the sling looked like one of the old ones. During an interview on 9/9/2024 at 1:35 PM, CNA D said she had been employed at the facility for 2 1/2 years and worked all over the facility and was not specifically assigned to a hall. She said she was supposed to be off that day on 9/9/2024 but came in to help. She said on the day Resident #20 had a fall from the mechanical lift, she was not working, and the incident occurred on the night shift. She said following the incident, they were taught how to properly use a mechanical lift, how to lift properly, and how to secure the lift pad along with safe transfers. She said when operating the mechanical lift, they should widen the base, apply the brakes so it does not move, apply straps, and make sure they do not move, make sure straps were intact, proceed with lifting with another person helped to guide and double checked that everything was good. She said they would then proceed to unlock the brakes and continue with the transfer. She said during the transfer with Resident #20, she did not apply the brakes when she moved her to the bed. She said the other CNA (CNA C) that helped her made her nervous and it was too late to apply the brake. She said she was watching the resident's legs and wanted to make sure they were on the bed. She said it was never too late to apply the brakes, but she did not. She said residents could be at risk for falls, breaking something, or a head injury if they were not transferred properly using the mechanical lift. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 9/9/2024 at 6:33 PM, CNA B said she had been employed at the facility since July 2024 and worked 6 pm-6 am on hall 200. She said the incident involving Resident #20 on 8/30/2024, she was helping NA A. She said the resident had a shower and they were taking her back to her room. She said Resident #20 was on a shower bed and they placed the lift sling underneath her in the shower room. She said the mechanical lift had 6 rings (3 on each side) and the straps were placed on all 6 rings. She said NA A was operating the lift and she was helping to guide the resident. She said the resident was in the hallway in front of her room door and they were in the process of lifting Resident #20 with the lift and one of the straps by her left leg came off and was not sure why. She said the resident began to lean to the left side and NA A started trying to lower the resident down and she could not catch her. She said Resident #20 fell on her left side in the doorway hitting her head and left shoulder on the door. She said the resident fell to the floor. She said they immediately called the nurse, who was across the hall in another resident's room. She said the nurse came in and assessed the resident taking vital signs and called 911. She said following the incident that same night, they had an Inservice provided by a therapist who showed them the proper way to use the lift with a return demonstration. She said she was suspended pending investigation for 2 days and came back to work on 9/1/2024. She said prior to the incident, she had a check off at a previous facility but not since returning to work in the facility. She said since being employed at the facility this time, she only had skills check off that included mechanical lift transfers on the night of the incident. Record review of a Nursing Assistant Skills Review Checklist dated 7/10/2024 for CNA B indicated she was successful with mechanical lift transfers. Record review of a skills validation checklist for transfers dated 8/30/2024 indicated CNA B was in attendance by her signature and was observed by the PTA on mechanical and gait belt transfer. Record review of an Associate Disciplinary Memorandum dated 8/30/2024 for CNA B indicated she was suspended for transferring a resident using the mechanical lift and a strap slipped off causing the resident to fall and hit her head and shoulder. During a phone interview on 9/9/2024 at 6:52 PM, NA A said she was not certified as a nurse aide and would be testing on tomorrow 9/10/2024. She said she had been employed at the facility for almost a year and worked 6 pm-6 am and assigned to work hall 300 where Resident #20 resided. She said on 8/30/2024 she needed help with Resident #20 since she was a 2-person transfer and had CNA B to help with her shower and transfer. She said they put the straps on the lift and got her ready to take her in the room. She said the resident was on a shower bed. She said one of the lift straps came off and the resident was dangling and hit her head and left shoulder on the middle of the door. She said she tried to lower the lift and the resident fell to the floor. She said prior to the incident, she had a skills check off that included lift transfers. She said the nurse came in and checked on the resident and she stayed with her until she was transferred out to the hospital. She said she was suspended for a 1 1/2 days and she did what she had been taught to do and was not sure how the strap came off. Record review of a Nursing Assistant Skills Review Checklist dated 7/2/2024 for NA A indicated she was successful with mechanical lift transfers. Record review of a skills validation checklist for transfers dated 8/30/2024 indicated NA A was in attendance by her signature and was observed by the PTA on mechanical and gait belt transfer. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of an associate disciplinary memorandum dated 8/30/2024 for NA A indicated she was suspended for transferring a resident using the mechanical lift and a strap slipped off causing the resident to fall and hit her head and shoulder. During a phone interview on 9/9/2024 at 7:02 PM, LVN U said she had been employed at the facility for [AGE] years and worked 6 pm-6 am as a charge nurse. She said the day of the incident on 8/30/2024 with Resident #20, she was down hall 300 where Resident #20 resided. She said she was aware the staff had taken her to the shower room. She said at the time of the incident, she was in across the hall checking a resident's blood sugar. She said she heard a noise like something hit the wall or something. She said she looked across the hall and saw Resident #20 on the floor between the legs of the lift. She said the resident was assessed by her, they moved the lift out of the way, checked her vital signs, and talked to her. She said shortly after, her arm and legs started jerking for a few seconds and they placed her on her side. She said it happened again and after that she was ok, was comfortable. She said the resident left and went to the hospital. She said she had never seen the resident had any seizure activity before and did not recall if the resident was taking any medications for seizures either. She said the staff were in-serviced on how to use a mechanical lift and someone from therapy demonstrated the proper way to use it with return demonstration that same night. Record review of a skills validation checklist for transfers dated 8/30/2024 indicated LVN U was in attendance by her signature and was observed by the PTA on mechanical and gait belt transfer. During an observation and interview on 09/10/24 8:36 AM, the Maintenance Supervisor was in the hallway of hall 300. Shown a picture of the Hoyer lift sling that was on Resident yesterday and he said they had checked all the slings on 8/31/2024 after the incident when she fell from the sling. He said they inspected all the slings in the facility after the incident with Resident #20 and they were in working order. Resident #20 was propelling herself down the hall in a wheelchair and he observed the sling that was in use for her on 9/9/2024 and said he did not see anything wrong with the sling the resident was using. He checked the straps and said they were good, but the color was the only thing that was faded. He said the binding was intact. During an interview on 9/10/2024 at 8:45 AM, the Administrator was shown a picture of the sling that was in use for Resident #20 and said the sling looked ok, stitching was ok on the straps, and the color was faded. She said following the fall with Resident #20, they checked all the slings in the facility but was unsure about that particular sling. She said the sling should not be in use for the resident. She said new slings had been ordered but had not arrived at the facility yet and they ordered the full body ones. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an observation and interview on 9/10/2024 at 11:05 AM, the Laundry staff said she had been employed at the facility for [AGE] years. She said she washed the lift slings with personal clothes and hung them to air dry. She said she checked the slings first to make sure they were not damaged and completed a checklist for the slings. She said on the checklist they would sign their name and date it when a sling came into the laundry room. She said once the slings were dry, they were taken back to the supply room on hall 400. The lift slings were observed in the supply room and the manufacturer label warning that indicated: do not wash with bleach. Slings can suffer damage during washing and drying. Check sling before each use. Bleached, torn, cut, frayed or broken slings are unsafe, and could result in serious injury or death to patient. Destroy and discard worn slings. She said they started completing a checklist back in May 2024 for the slings and prior to that they did not have one. She said the nurse aides were responsible for checking the lift slings prior to use. She said if a worn or damaged lift sling was in use, residents could be at risk for slipping or falling along with injuring any body part. Record review of a sling inventory check list undated indicated laundry staff started the checklist on 5/6/2024. The checklist had a box for staff to complete for the resident's name or number and date. The checklist did not have any resident's name listed on the checklist and only had staff signatures with dates and a check mark by the in column. During an interview with the interim DON on 9/11/24 at 8:10AM she said she had been employed at the facility since July 20, 2024. She said she was not at the facility on the evening when Resident had a fall from the mechanical lift. She said the Administrator called to notify that they had started in-servicing staff along with the ADON and began an investigation and determined that it was an accident. She said she was not directly involved in the investigation of the incident with Resident . She said yesterday 9/10/2024, CNA C had been informed by the Administrator that she would be suspended and would be able to return to work today after completing a skills check off on the proper use of a mechanical lift and a return demonstration. During an interview on 9/11/2024 at 9:20 AM, CNA C said she had been employed for [AGE] years and worked 6 am-6 pm shift. She said she had a mechanical lift transfer check off in the past. She said she was suspended yesterday (9/10/2024) following the incident and before she could return to work today, she had to complete a competency check off on proper use of a mechanical lift. She said residents could hurt themselves with the lift moving if they were left unattended. During an interview on 9/11/2024 at 11:42 AM, the Administrator said she was notified by staff on 8/30/2024 about Resident #20 falling out of the mechanical lift. She said she went to the facility and started an investigation with talking to the nurse aides involved, had them perform a demonstration on how they connected the lift sling, and what they did. She said after the investigation, it was determined the incident was an accident as the staff were not aware of how the strap came off. She said she sent all the information to her regional support team who then informed her that it was an accident and was witnessed by staff that it did not need to be reported to the state agency. She said they informed her that it did not meet the guidelines for reporting as there were not any problems with the sling or lift. Requested a mechanical lift policy/transfer and the Administrator said the facility did not have a policy and used a mechanical lift checklist as a policy for staff. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a Validation Checklist Mechanical List undated indicated, .Purpose: To determine if the staff is performing mechanical lift procedure in accordance with the facility's standard of practice. 1. Employee understands the maximum weight for each lift. 2. Employee understands to inspect sling for tears or loose stitching and report any findings to DON or designee. 3. Employee understands to not use any plastic back incontinence pad or seat cushion between resident and sling that could cause sliding. 4. Lifting the Resident: must have two staff members when using a lift. 5. Explain procedure to resident. 6. The adjustable legs must be in the maximum opened position and always locked while resident is in the lift. 7. Make sure the arms of the sling (leg sections) are crossed under the resident's legs and attach on the opposite side hook. 8. Match the corresponding colors on each side of the sling for an even lift of the resident. 9. When the sling is elevated a few inches, check to make sure that all hooks are connected to lift. 10. Do not lock the rear casters of the lift, this could cause tipping of the lift. 12. Use the steering handle when moving the lift. 13. When moving the resident lift away from the bed or chair, turn the resident so that he/she faces the employee transferring from or to a wheelchair, shower or bed is locked. 14. Employee understands how to activate the emergency release. 15. Employee understands to inspect lift for wear, tear, and broken parts: reporting any findings to DON or designee . Record review of a facility policy titled Incident/Accident Policy revised on 11/17 indicated, .It is the policy of this facility to report and investigate all incident and accidents that occur in the facility or on facility property in a timely manner. 9. The Administrator and Director of Nursing will review the incident/accident to determine if investigation is required . This was determined to be an Immediate Jeopardy (IJ) on 9/10/2024 at 10:00 AM. The facility's Administrator and Interim DON were notified. The Administrator was provided the IJ template on 9/10/2024 at 10:29 AM. The following Plan of Removal (POR) submitted by the facility was accepted on 9/10/2024 at 4:02 PM. Tag Cited: F-689 Issue Cited: Free of Accidents/Hazards/Supervision Failure to ensure a safe transfer of resident using a Mechanical Lift. 1. Immediate Action Taken A. Resident # 20 was sent to the ER for evaluation/treatment on 8/30/2024 B. Resident #20 returned to facility on 9/1/2024; head to toe physical assessment was completed upon return to the facility and documented; new diagnosis Acute Right Subdural Hematoma, no midline shift; Left Shoulder Separation Grade 1 C. On 9/10/2024 The DON and/or designee trained all facility nurses and nurse aides on the use of mechanical lift. All facility nurses and nurse aides were trained prior to their next shift. D. On 9/10/24 The DON and/or designee completed a skills validation with return demonstration on all facility nurses and nurse aides on the use of Hoyer lifts to ensure knowledge and understanding of training. All facility nurses and nurse aides were trained prior to their next shift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	E. The MDS Coordinator and/or designee reviewed the care plans for each resident who requires the use of a mechanical lift to ensure resident specific interventions were present. F. On 9/10/2024, the facility discarded the mechanical lift sling that was faded in color without a manufacturer's tag. G. On 9/10/24, CNA A was suspended pending retraining and will not be reinstated until CNA A is able to demonstrate competency with Hoyer lift skills validation. H. On 9/10/24, CNA B was suspended pending retraining and will not be reinstated until CNA B is able to demonstrate competency with Hoyer lift skills validation. This was completed on 9/10/2024 by 10:00 pm. 2. Identification of Residents Affected or Likely to be Affected: A. No other residents identified, on 9/10/24 the DON/Designee completed an audit on all facility resident's requiring Hoyer lift transfers to ensure interventions currently in place are appropriate for resident's receiving required care and transfer interventions. This will be completed on 9/10/24 by 10:00 pm. 3.Actions to Prevent Occurrence/Recurrence: A. As of 9/10/2024, any staff member hired for facility nurse and/or nurse aide positions will be provided the following by the facility DON and/or designee: o In-service education on the Mechanical Lift will be completed by the facility DON and/or designee during orientation. o Skills Validation with Return Demonstration will be completed by facility DON and/or designee during orientation. B. The DON/Designee will conduct weekly random observations two (2) times a week for eight (8) weeks to ensure staff are transferring residents who require Hoyer lift properly. C. Results of weekly observations will be reviewed in the morning meeting by the Administrator or designee On 9/10/2024 the facility's Administrator notified the Medical Director to conduct an Ad Hoc QAPI meeting regarding the Immediate Jeopardy the facility received related to Accidents/Hazards/Supervision and reviewed plan to sustain compliance. Date Facility Asserts Likelihood for Serious Harm No Longer Exists: _____9/10/2024_____ Surveyors monitored the Plan of Removal as follows: Record review of hospital record for Resident #20 dated 8/30/2024 at 11:27 PM indicated she was admitted to the facility following a fall from a mechanical lift at the nursing home. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Record review of a late entry admit/readmit progress note dated 9/1/2024 at 5:00 PM for Resident #20 indicated she arrived at the facility from a hospital with an admitting diagnosis of subdural hematoma. Record review of an in-service program attendance record dated 9/10/2024 indicated training was provided to RN N, LVN U, ADON L, CNA Q, CNA X, and CNA Y on mechanical lift transfers. Record review of a Transfer Skills Validation dated 9/10/2024 indicated ADON L, MDS Coordinator, DON, LVN U, CNA B, RNA, RN N, CNA X, CNA F, and CNA Y were observed performing a transfer with a mechanical lift. Record review of the care plans for residents who require a mechanical lift for transfers indicated 12 out of 66 residents were care planned appropriately with interventions for mechanical lift transfers. Record review of an attestation dated 9/10/2024 by the Administrator indicated she discarded in the dumpster at the back of the facility, the mechanical sling that was faded in color without a manufacturer's tag. Record review of an Associate Disciplinary Memorandum for CNA D dated 9/10/2024 was suspended for improper use of a mechanical lift. Record review of an Associate Disciplinary Memorandum for CNA C dated 9/10/2024 was suspended for improper use of a mechanical lift. Record review of an Ad Hoc QAPI meeting dated 9/10/2024 indicated at approximately 3:30 PM the facility discussed with the medical director the mechanical lift incident with Resident #20 and the facility's follow-up plan to sustain compliance. The Administrator, the Interim DON, the MDS Coordinator, and the Regional Nurse were in attendance. Observations and interviews on 9/11/2024 from 2:00 PM to 3:19 PM included: During an observation on 9/11/2024 at 2:00 PM, RNA and CNA C were in the room of Resident #61 to transfer him from his wheelchair to his bed using a mechanical lift. Resident #61 was transferred properly and safely without any issues or concerns noted by RNA and CNA C. During an interview on 9/11/2024 at 2:21 PM, RNA said he had been employed at the facility for 3 years. He received training on the proper of use of a mechanical lift and the MDS Coordinator and the DON showed them how to use the lift with a return demonstration. He said he was taught all steps on how to properly attach the straps for residents' safety. During an interview on 9/11/2024 at 2:24 PM, CNA C said she had been employed at the facility for [AGE] years. She said she had training on proper use of use of the mechanical lift, was instructed to make sure the wheels were locked, and positioned correctly. She said she did a check off with a return demonstration. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/11/2024 at 2:29 PM, CNA T said she had been employed at the facility for 3 years. She said she had a training on how to use the mechanical lift and the ADON conducted a demonstration on the use of the mechanical lift. She said the DON had another demonstration this morning and she had to complete a return demonstration. During an interview on 9/11/2024 at 2:45 PM, CNA D said she had been employed at the facility for 2 1/2 years. She said she was suspended after the incident on 9/10/2024 and came back to work today after lunch. She said she had to complete an in-service on proper use of a mechanical lift before she was allowed to return. She said she was taught the correct operation of the lift by the DON with a return demonstration. During an interview on 9/11/2024 at 2:49 PM, CNA S said she had been employed at the facility for 6 months. She said she had an in-service training on the mechanical lift and the DON showed them how to properly use it and had to complete a return demonstration. During an interview on 9/11/2024 at 2:52 PM, CNA V said she had been employed at the facility since 2019. She said she had an in-service training on the mechanical lift and was shown how to properly use it and had to complete a return demonstration. During an interview on 9/11/2023 at 3:01 PM, CNA F said she had been employed at the facility for 2 years. She said she received training on the use of the mechanical lift with the MDS Coordinator. She said they discussed the different sling sizes and demonstrated how to use it. She said they must make sure the wheels were locked and did a return demonstration. She said they were also shown a video on how to properly use the lift. During an observation on 9/11/2024 at 3:07 PM, CNA S and CNA T both transferred Resident #20 from her wheelchair to her bed using a mechanical lift properly and safely. During an interview on 9/11/2024 at 3:09 PM, CNA R said she worked and had been employed at the facility for 1 1/2 years. She said she received training on the use of the mechanical lift with a return demonstration. She said you must make sure it was locked. During an interview on 9/11/2024 at 3:15 PM, ADON L said she received training on the mechanical lift and provided training to the staff in the facility. She said she had a return demonstration on proper use and safety of the mechanical lift. During an interview on 9/11/2024 at 2:17 PM, LVN P said she received training on the mechanical lift with proper use, which required 2 people to operate, how to use the slings, and which colors on the sling straps to use on the lift. She said she completed a return demonstration. During an interview on 9/11/2024 at 2:19 PM, MA O said she received training on the mechanical lift with proper use, weight limits, and make sure it was locked. She said she completed a return demonstration with the DON. All above staff were able to appropriately answer questions regarding the proper use of the mechanical lift and had return demonstrations to show knowledge of training. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Administrator was informed the Immediate Jeopardy was removed on 9/11/2024 at 3:53 PM. The facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy with a scope of isolated due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40124 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 4 of 10 staff (CNA F, Medication Aide H, Medication Aide M, and ADON L) observed for compliance to infection control standards during meal and medication pass. 1. The facility failed to ensure CNA F washed or sanitized her hands before and after resident contact when passing out meal trays to residents on Hall 100. 2. The facility failed to ensure Medication Aide H washed or sanitized before and after resident contact during medication pass. 3. The facility failed to ensure Medication Aide M washed or sanitized before and after resident contact during medication pass. 4. The facility failed to ensure reusable equipment was sanitized. These failures could place residents at risk of exposure to communicable diseases and infections. Findings included: 1.During observation of meal service on 09/09/2024 at 12:30 PM to 12:48 PM, CNA F did not wash or sanitize hands prior to exiting rooms or handling meal trays for the next room for the following rooms: room [ROOM NUMBER] took meal tray into room, repositioned resident linens, adjusted bed using bed controller and moved bedside table in position with tray on top of table; room [ROOM NUMBER] opened milk, used bed controller to adjust bed, repositioned bedside table; room [ROOM NUMBER] opened health shake and soda can then pushed residents wheelchair up to table; room [ROOM NUMBER] turned on light switch, pushed bedside table to resident; room [ROOM NUMBER] opened door and placed meal tray on table; room [ROOM NUMBER] placed meal tray on table; room [ROOM NUMBER] placed meal tray on table; room [ROOM NUMBER] placed meal tray on table; room [ROOM NUMBER] placed meal tray on table and pushed bedside table to resident; room [ROOM NUMBER] opened door and placed tray on table; room [ROOM NUMBER] opened door and placed tray on table; room [ROOM NUMBER] moved remote from bedside table, moved wallet from table, set up meal tray, turned on room light; room [ROOM NUMBER] removed personal items from bedside table, removed drink from personal refrigerator, opened drinks, applied residents personal spices to soup. During an interview on 09/09/2024 at 1:32 PM CNA F said that she was the transportation aide but would work on the floor as a CNA when needed. She said that she did not have an assigned hall but worked where she was needed. She said that when she was passing trays on hall 100, she did not sanitize her hands after exiting rooms when passing out the trays. She said that not sanitizing or washing hands could spread germs to the residents. She said that she has had hand hygiene training and that skills check off included hand hygiene. She said that the facility provided hand sanitizer and that sanitizer stations were located down each hall. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Record review of a face sheet dated 9/10/2024 for Resident #66 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of cancer of the liver, blindness of the right eye, and weakness. Record review of an Admission MDS assessment dated [DATE] for Resident #66 indicated she had no impairment in thinking with a BIMS score of 15. During an observation and interview on 09/10/2024 at 7:30 AM Medication Aide H sprayed her hands with an aerosol disinfectant spray and rubbed them together then administered medications to Resident #66. Medication Aide H said that she did not like the way the alcohol hand rubbed felt on her hands and she chose to use the spray. After administration of medications to Resident #66, Medication Aide H went in the bathroom and washed her hands then returned to her medication cart. Medication Aide H said that she would use the spray before and then she only washed her hands afterward between residents, but she did not use alcohol hand gel when prepping medications, taking blood pressures, or entering her cart. Medication Aide H said that she was aware the facility policy for hand hygiene specified the use of alcohol hand gel for sanitizing her hands, but she chose to use the spray and thought that the spray would kill any germs she potentially came into contact with. 3.Record review of a face sheet dated 9/10/2024 for Resident #20 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of cerebrovascular disease (disease of the brain circulatory system), knee pain, and weakness. Record review of a Quarterly MDS assessment dated [DATE] for Resident #20 indicated he had moderate impairment in thinking with a BIMS score of 11. During an observation on 09/11/24 at 07:45 AM Medication Aide M did not sanitize with alcohol-based sanitizer or wash her hands before or after taking Resident # 8's blood pressure with a wrist cuff that was wrapped with tape to keep the battery cover plate in place. Medication Aide M then entered medication cart for hall 100 and prepared medications for Resident #8. Medication Aide M did not sanitize her hands before or after medication administration to Resident # 8. Medication Aide M said that she should have sanitized before and after each resident contact and not doing so, could spread infections. Medication Aide M said that the tape would not allow proper sanitizing of her wrist cuff and that using it could spread infection resident to resident. 4. During an observation and interview on 09/10/24 at 11:25 AM of the 200/300 Nurse medication cart an electronic thermometer sticky paper tape with brown edges with debris attached in the top medication drawer. The thermometer was sitting beside gauze pads and alcohol pads. ADON L said that the broken thermometer should not be in use due to it not being cleaned properly due to the tape. ADON L said the broken cuff with the dirty tape wrapped around it could transmit infection resident to resident. During an interview with the Interim DON on 9/11/2024 at 9:00 AM she stated that the facility policy was that staff was to use hand sanitizer each time they exit a resident room regardless of the reason why they were in the room. She said that she expected the staff to use hand sanitizer and wash hands according to the facility policy. She stated that the residents and staff were at risk when hand hygiene was not performed. She said that germs can be spread to other rooms if staff do not sanitize their hands when exiting a resident room. She said that she would be reviewing the hand hygiene policy with all staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/11/24 at 1:00 PM with ADON L she said that all staff had been in-serviced on hand hygiene and the requirement to use alcohol-based sanitizer. ADON L said that not using correct hand hygiene could result in the spread of infections. During an interview on 09/11/24 at 2:13 PM with the Interim DON, she said that all staff had been in-serviced on hand hygiene and the requirements to use alcohol-based sanitizer if not using soap and water. The Interim DON said that using reusable equipment with tape on it would impede the sanitization of the medical device between residents. The DON said the staff should be removing any broken items from use and not applying tape to keep it together. The DON said that not sanitizing the equipment could spread infections. During an interview on 09/11/24 at 02:30 PM with the Administrator, she said that all staff had been in-serviced on hand hygiene and the requirements to use alcohol-based sanitizer of not using soap and water between resident interventions. She said that not using correct hand hygiene could result in the spread of infections. The Administrator said that the staff could not clean and sanitize equipment that had tape applied and by doing so they could spread infections. Record Review of nurse aide skills review checklist indicated that handwashing procedural guideline demonstration was completed correctly for CNA F on 7/15/2024. Record Review of a staff in-service dated 8/12/2024 titled Infection Control Quarterly Training Guidelines that included review of the hand hygiene policy was signed by CNA F. Record Review of a staff in-service dated 8/13/2024 titled Infection Control Quarterly Training Guidelines that included review of the hand hygiene policy was signed by ADON L. Record Review of a staff in-service dated 8/14/2024 titled Infection Control that was signed by Medication Aide H. Record review of a facility policy titled Hand Hygiene with a revised date of 2/11/2022 indicated .All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub. A condition listed on the hand hygiene table included between resident contacts. Record Review of a Facility Policy: Infection Prevention and Control Program dated 10/24/2022- revised 3/26/2024 Indicated . This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines . 10. Equipment Protocol: a. all reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be sanitized. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49017

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on observations, interviews, and record review, the facility failed to be equipped to allow residents to call for staff through a communication system which relayed the call directly to a centralized staff work area for 3 of 24 residents (Resident #7, Resident #65, and Resident #38) reviewed for call lights. The facility failed to ensure Resident #7, #65, and #38's emergency call light string in the bathroom were not tied in knots or wrapped around the grab bar on 9/9/2024-9/11/2024. These failures could place residents at risk of injury, pain, hospitalization , and a diminished quality of life. Findings included: 1. Record review of an Admission Record dated 9/10/2024 for Resident #7 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of ID (limitation in metal abilities that affect thinking, learning and everyday life skills), down syndrome (a genetic disorder caused by an extra chromosome), end stage renal disease (kidneys do not function normally), and type 2 diabetes. Record review of a Quarterly MDS assessment dated [DATE] for Resident #7 indicated she did not have any impairment in thinking with a BIMS score of 14. She was independent with ADLs except for showering/bathing. She was always continent of bladder and bowel. Record review of Resident #7's care plan dated 4/20/2023 and revised on 9/10/2023 indicated he was at risk for falls related to gait/balance problems. Interventions included to place her call light within reach and encourage her to use it for assistance as needed. During an observation and interview on 9/9/2024 at 9:45 AM, Resident #17 was in her room and said she had been at the facility for a long time. She said she was able to use her bathroom. Her call light string in the bathroom was not long enough to reach the floor. During an observation on 9/10/2024 at 1:52 PM, Resident #17 was not in her room and the bathroom call light string was not long enough to reach the floor. 2. Record review of an Admission Record dated 9/10/2024 for Resident #65 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of fracture of upper and lower end of left fibula (the leg bone that forms the calf and ankle), anxiety disorder, and depression disorder. Record review of a Quarterly MDS assessment dated [DATE] for Resident #65 indicated she did not have any impairment in thinking with a BIMS score of 15. She was independent with toileting hygiene and always continent of bladder and bowel. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a care plan for Resident #65 revised on 5/28/2024 indicated she had the potential for falls related to gait/balance problems. Interventions included to place the resident's call light in reach and encourage the resident to use it for assistance as needed. During an observation and interview on 9/9/2024 at 11:35 AM, Resident #65 said she had been at the facility for 4 months. She said she was able to go to the bathroom on her own and did not realize the call light string in the bathroom was not long enough. The call light string in the bathroom was not long enough to reach the floor. During an observation and interview on 9/10/2024 at 1:49 PM, Resident #65 was in her room. She said she has never seen anyone check the call lights in the bathroom. She observed the call light in the bathroom and said if she fell , she would not be able to reach the call light in the bathroom because it was too short. 3. Record review of an Admission Record dated 9/10/2024 for Resident #38 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of type 2 diabetes, ID (limitation in metal abilities that affect thinking, learning and everyday life skills), and hypertension. Record review of an Annual MDS assessment dated [DATE] for Resident #38 indicated she had severe impairment in thinking with a BIMS score of 6. She was independent with toileting hygiene and was always continent of bladder and bowel. During an observation and interview on 9/9/2024 at 11:45 AM, Resident #38 was in her room sitting up in a wheelchair and said she had been at the facility for [AGE] years. Her call light string in the bathroom was wrapped around the grab bar and she said she did not wrap the string around the grab bar, and it had always been that way. During an observation and interview on 9/10/2024 at 1:47 PM, Resident #38 was in her room sitting in a wheelchair. Her call light string was at an appropriate length close to the floor. She said the call light string in the bathroom unwrapped on its own fell . She said there had not been anyone in the room to check the call light string in the bathroom. During an observation and interview on 9/10/2024 at 1:53 PM, CNA F said she was assigned to hall 300 today 9/10/2024 where Resident #65, #38, and #7 resided. She said she had been employed at the facility for 2 years. She said the nurse aides were responsible for checking the call light strings in the bathrooms and if there was a problem, then they would let the Maintenance Supervisor know. She observed the call lights in the bathrooms of Resident #7 and #65 and said the strings were tied in a double knot and the residents would not be able to reach them if they fell . She said residents could not reach them and could be lying on the floor for a long period of time. (continued on next page)

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Winfield Rehab & Nursing	1108 E Loop 304 Crockett, TX 75835

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 9/11/2024 from 9:57 AM-10:05 AM, the Maintenance Supervisor said he was responsible for checking the call light strings in the resident bathrooms. He said he had a checklist that he went by and checked the facility weekly for call light strings. He said normally staff would let him know if there was a problem with the call light strings. He said the facility had problems with them being wrapped around the grab bars in the bathrooms at times. He observed the call light string in the bathroom of Resident #65 and said her string had knots in it and needed to be longer. He untied the string, and the call light string was the appropriate length and not touching the floor. He went into the room of Resident #7 and said her call light string in the bathroom was too short, was tied in knots, and untied it. He said residents might not be able to reach the strings if they fell and could be there for a long time. Record review of a Tasks in Use dated 8/19/2024 indicated there were not any tasks assigned for maintenance to check the call lights. During an interview on 9/11/2024 at 11:42 AM, the Administrator said no one was responsible for checking the call lights in the resident bathrooms and was not aware that the Maintenance Supervisor was checking them. She was aware that the call lights in the bathroom needed to be close to the floor. She said going forward she would add them to the quality-of-life rounds checks where the department heads had assigned rooms they checked daily. She said residents could be at risk for lying in the floor for a while until someone came in. Record review of a facility policy titled Call Light Response dated 2/10/2021 indicated, .The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. 1. All staff shall be educated on the proper use of the resident call system, including how the system works, and ensuring resident access to the call light. 5. With each interaction in the resident's room or bathroom, staff will ensure the call light is within reach of resident and secured, as needed.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on observations, interviews, and record review, the facility failed to follow their own established smoking policy for 1 of 8 resident (Resident #15) reviewed for smoking. The facility failed to follow their policy on smoking when Resident #15 had smoking materials that included a lighter in his possession from 9/9/2024-9/11/2024. These failures could place residents at risk of injury, burns, and an unsafe smoking environment. The findings included: Record review of an Admission Record for Resident #15 dated 9/10/2024 indicated he admitted to the facility on [DATE] and was [AGE] years old with diagnoses of atherosclerotic heart disease (arteries become narrowed and hardened due to a buildup of plaque), heart failure, type 2 diabetes, and COPD (a group of lung disease that affect breathing). Record review of an Admission MDS assessment dated [DATE] for Resident #15 indicated he did not have any impairment in thinking with a BIMS score of 15. He required supervision with personal hygiene. Record review of a care plan dated 6/18/2024 for Resident #15 indicated he was a smoker and at risk for injury. Interventions included to remind resident and family that all cigarettes, lighters, matches, and smoking paraphernalia must be kept at the nurse's station. The resident was a dependent smoker and required staff supervision to reduce the risk for smoking related injuries. During an observation and interview on 9/9/2024 at 9:30 AM, Resident #15 was in the room in a power chair and said she had been at the facility for 3-4 months. He said he was a smoker, and the facility kept his cigarettes locked up, but he kept a lighter with him. A blue lighter was observed in his room in a cup on the overbed table. During an observation and interview on 9/11/2024 at 9:06 AM, Resident #15 was in his room watching television and said his lighter was on his bed covered up with a napkin. He said the director (Administrator) was aware that he kept it on him. He said he was not able to go smoke by himself and he tried to follow by the rules. He said he had problems in the past with the staff not having lighters during smoke times and he wanted to be sure he had one. He said he was not supposed to keep it with him according to the rules. During an interview on 9/11/2024 at 11:42 AM, the Administrator said smoking materials that included cigarettes and lighters were kept at the nurse station behind the desk and the extra cigarettes were locked in the medication room. She said she removed the lighter from Resident #15 earlier today and he told her that he was tired of not having one available at smoke times. She said she had taken lighters from him before. She said going forward she would interview the smokers to make sure they were not keeping lighters on them. She said if residents kept lighters there could be a risk of them deciding to smoke in their rooms. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy titled Smoking Policy revised on 7/14/2023 indicated, .It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees as related to smoking. 6. Retention, storage and distribution of smoking accessories are to be kept under the control of center staff when not in use. This included cigarettes, electronic cigarettes, pipes, lighters, matches, lighter fluid, etc .

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 40124 Based on interviews and record review, the facility failed to develop, implement, and maintain an effective training program for 3 of 17 employees (Interim DON, Dietary Manager, and CNA S) new and existing staff reviewed for training. The facility failed to ensure the Interim DON was trained on HIV, dementia, and restraint reduction on hire. The facility failed to ensure the Dietary Manager was trained on dementia annually. The facility failed to ensure CNA S was trained on HIV, dementia, and restraint reduction on hire. 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 included: Record review of the personnel file for the Interim DON indicated she was hired at the facility on 7/30/2024 by contract and did not have on hire training on HIV and restraint reduction until 8/14/24 and had no training for dementia. Record review of the personnel file for the Dietary Manager indicated she was originally hired at the facility on 06/26/2012 and now was an employee by contract. The personnel file indicated the Dietary Manager did not have annual training on dementia. Record review of the personnel file for CNA S indicated she was hired at the facility on 3/15/2024 and did not receive training on HIV and dementia until 4/17/24. CNA S did not receive restraint training until 8/28/24 after a reprimand for non-completion by the Administrator. During an interview on 9/11/2024 at 9:24 AM, HR said she was responsible for completing the orientation and other paperwork. She said she was not aware of the required trainings for employees on hire had to be completed before they started resident care until the State Surveyor requested the trainings for selected employees. HR said she usually gave the new employees two weeks to complete the new hire training before they were released to work on their own. HR said going forward she will make sure all training is completed before resident care is started. She said going forward she would complete a checklist for the required trainings. She said staff could be at risk of lack of information and residents could be at risk of harm for a multitude of things if staff did not receive the training they needed. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/11/2024 at 9:32 AM, the Administrator said the staff were watching videos on trainings by logging into a website and have continued to watch them that included abuse/neglect, blood borne pathogens, misuse of resident property, resident rights, dementia, and fall prevention. She said she was ultimately responsible for ensuring the staff received the required trainings during orientation prior to employment and annually. She said if staff were not receiving the training, they would not know how to care for residents, and it may have a negative impact on their care. She said there was a system in place and a check list for the trainings.

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 40124 Based on interviews and record review, the facility failed to ensure employees received the required training effective communications for 2 of 17 new employees (Interim DON and CNA S) reviewed for training. The facility did not ensure an effective communication training was completed by the Contract Interim DON and CNA S during orientation. This failure could place residents at risk of miscommunication and social isolation due to lack of staff training. Findings included: Record review of employee files indicated the following staff had not completed training during orientation on effective communication: * Interim DON, hire date 07/30/24; and * CNA S, hire date 03/15/24. During an interview on 9/11/2024 at 9:24 AM, HR said she was responsible for completing the orientation and other paperwork. She said she was not aware of the required trainings for employees on hire had to be completed before they started resident care until the Surveyor requested the trainings for selected employees. She said going forward she would complete a checklist for the required trainings. She said staff could be at risk of lack of information and residents could be at risk of harm for a multitude of things if staff did not receive the training they needed. HR said she usually gave the new employees two weeks to complete the new hire training before they were released to work on their own. HR said going forward she will make sure all training is completed before resident care is started. During an interview on 9/11/2024 at 9:32 AM, the Administrator said the staff were watching videos on trainings by logging into a website and have continued to watch them that included abuse/neglect, blood borne pathogens, misuse of resident property, resident rights, dementia, and fall prevention. She said she was ultimately responsible for ensuring the staff received the required trainings during orientation prior to employment and annually. She said if staff were not receiving the training, they would not know how to care for residents, and it may have a negative impact on their care. She said there was a system in place and a check list for the trainings. (continued on next page)

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy dated 11/29/2022 indicated, .It is the policy of this facility to develop, implement, and maintain an effective training program for all new 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 contents includes, at a minimum: a. Effective communication for direct care staff. b. Resident Rights and facility responsibilities for caring of residents. C. Elements and goals of the facility's QAPI program . g. Restraints, h. HIV, i. Dementia management and care of the cognitively impaired .

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 40124 Based on interviews and record review, the facility failed to ensure the rights of the resident and responsibilities of the facility were completed for 2 of 17 employees (Interim DON and CNA S) reviewed for training. The facility failed to ensure the rights of the resident and responsibilities of the facility training was completed by the Interim DON and CNA S during orientation. These failures could affect residents and place them at risk of being uninformed due to lack of staff training. Findings include: Record review of employee files indicated the following staff had not completed resident rights and responsibilities of the facility training during orientation: * Interim DON, hire date 07/30/24; and * CNA S, hire date 03/15/24. During an interview on 9/11/2024 at 9:24 AM, HR said she was responsible for completing the orientation and other paperwork. She said she was not aware of the required trainings for employees on hire had to be completed before they started resident care until the Surveyor requested the trainings for selected employees. She said going forward she would complete a checklist for the required trainings. She said staff could be at risk of lack of information and residents could be at risk of harm for a multitude of things if staff did not receive the training they needed. HR said she usually gave the new employees two weeks to complete the new hire training before they were released to work on their own. HR said going forward she will make sure all training is completed before resident care is started. During an interview on 9/11/2024 at 9:32 AM, the Administrator said the staff were watching videos on trainings by logging into a website and have continued to watch them that included abuse/neglect, blood borne pathogens, misuse of resident property, resident rights, dementia, and fall prevention. She said she was ultimately responsible for ensuring the staff received the required trainings during orientation prior to employment and annually. She said if staff were not receiving the training, they would not know how to care for residents, and it may have a negative impact on their care. She said there was a system in place and a check list for the trainings. (continued on next page)

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy dated 11/29/2022 indicated, .It is the policy of this facility to develop, implement, and maintain an effective training program for all new 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 contents includes, at a minimum: a. Effective communication for direct care staff. b. Resident Rights and facility responsibilities for caring of residents. C. Elements and goals of the facility's QAPI program . g. Restraints, h. HIV, i. Dementia management and care of the cognitively impaired .

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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. 40124 Based on interviews and record review, the facility failed to ensure employees received the required training on Abuse, Neglect, and Exploitation and dementia management training for 2 of 17 (Interim DON and CNA S) reviewed for training. The facility did not ensure Abuse, Neglect, and Exploitation and dementia management training was completed by the Interim DON and CNA S during orientation. This failure could place residents with dementia at risk of abuse, neglect, and exploitation and a poor quality of care by staff with inadequate training when caring for dementia residents. Findings included: Record review of employee files indicated the following staff had not completed Abuse, Neglect, and Exploitation and dementia management training was completed by the Interim DON and CNA S during orientation. * Interim DON, hire date 07/30/24; and * CNA S, hire date 03/15/24. During an interview on 9/11/2024 at 9:24 AM, HR said she was responsible for completing the orientation and other paperwork. She said she was not aware of the required trainings for employees on hire had to be completed before they started resident care until the Surveyor requested the trainings for selected employees. She said going forward she would complete a checklist for the required trainings. She said staff could be at risk of lack of information and residents could be at risk of harm for a multitude of things if staff did not receive the training they needed. HR said she usually gave the new employees two weeks to complete the new hire training before they were released to work on their own. HR said going forward she will make sure all training is completed before resident care is started. During an interview on 9/11/2024 at 9:32 AM, the Administrator said the staff were watching videos on trainings by logging into a website and have continued to watch them that included abuse/neglect, blood borne pathogens, misuse of resident property, resident rights, dementia, and fall prevention. She said she was ultimately responsible for ensuring the staff received the required trainings during orientation prior to employment and annually. She said if staff were not receiving the training, they would not know how to care for residents, and it may have a negative impact on their care. She said there was a system in place and a check list for the trainings. (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy dated 11/29/2022 indicated, .It is the policy of this facility to develop, implement, and maintain an effective training program for all new 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 contents includes, at a minimum: a. Effective communication for direct care staff. b. Resident Rights and facility responsibilities for caring of residents. C. Elements and goals of the facility's QAPI program . g. Restraints, h. HIV, i. Dementia management and care of the cognitively impaired. j. Abuse, Neglect, and Exploitation prevention .

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 40124 Based on interviews and record review, the facility failed to ensure Quality Assurance and Performance Improvement (QAPI) training that outlines and informs staff of the elements and goals of the facility's QAPI program was completed for 3 of 17 employees (Interim DON, Dietary Manager, and CNA S) reviewed for orientation and annual training. The facility did not ensure QAPI training was completed by the Interim DON, the Dietary Manager, and CNA S during their orientation. This failure could place staff and residents at risk for not being aware of facility programs, implementation, and monitoring. Findings included: Record review of employee files indicated the following staff had not completed QAPI training during orientation: Record review of the personnel file for the Interim DON indicated she was hired at the facility on 7/30/2024 by contract and did not have on hire training for Quality Assurance and Performance Improvement (QAPI) training. Record review of the personnel file for the Dietary Manager indicated she was originally hired at the facility on 06/26/2012 and now is an employee by contract. The personnel file indicated the Dietary Manager did not have annual training on Quality Assurance and Performance Improvement (QAPI) training. Record review of the personnel file for CNA S indicated she was hired at the facility on 3/15/2024 and did not receive training on Quality Assurance and Performance Improvement (QAPI) training until 4/17/24. During an interview on 9/11/2024 at 1:58 PM, HR said she was responsible for completing the orientation and other paperwork. She said she was not aware of the required trainings for employees on hire had to be completed before they started resident care until the Surveyor requested the trainings for selected employees. She said going forward she would complete a checklist for the required trainings. She said staff could be at risk of lack of information and residents could be at risk of harm for a multitude of things if staff did not receive the training they needed. HR said she usually gave the new employees two weeks to complete the new hire training before they were released to work on their own. HR said going forward she will make sure all training is completed before resident care is started. (continued on next page)

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/11/2024 at 2:05 PM, the Administrator said the staff were watching videos on trainings by logging into a website and have continued to watch them that included abuse/neglect, blood borne pathogens, misuse of resident property, resident rights, dementia, and fall prevention. She said she was ultimately responsible for ensuring the staff received the required trainings during orientation prior to employment and annually. She said if staff were not receiving the training, they would not know how to care for residents, and it may have a negative impact on their care. She said there was a system in place and a check list for the trainings. Record review of a facility policy dated 11/29/2022 indicated, .It is the policy of this facility to develop, implement, and maintain an effective training program for all new 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 contents includes, at a minimum: . c. Elements and goals of the facility QAPI program .g. Restraints, h. HIV, i. Dementia management and care of the cognitively impaired .

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	675976	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winfield Rehab & Nursing	1108 E Loop 304 Crockett, TX 75835

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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 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 40124 Based on interviews and record review, the facility failed to provide the mandatory training on standards, policies, and procedures for an infection prevention and control program for 3 of 17 employees (Interim DON, Dietary Manager, and CNA S) new and existing staff reviewed for training. The facility failed to ensure the Interim DON was trained on an infection prevention and control program on hire. The facility failed to ensure Dietary Manager was trained on an infection prevention and control program annually. The facility failed to ensure CNA S was trained on an infection prevention and control program on hire. This failure could place residents at risk of illness due to lack of staff training. Findings included: Record review of the personnel file for the Interim DON indicated she was hired at the facility on 7/30/2024 by contract and did not have on hire training for infection prevention and control program until 8/14/24. Record review of the personnel file for the Dietary Manager indicated she was originally hired at the facility on 06/26/2012 and now is an employee by contract. The personnel file indicated the Dietary Manager did not have annual training on an infection prevention and control program. Record review of the personnel file for CNA S indicated she was hired at the facility on 3/15/2024 and did not receive training on an infection prevention and control program until 4/17/24. During an interview on 9/11/2024 at 1:58 PM, HR said she was responsible for completing the orientation and other paperwork. She said she was not aware of the required trainings for employees on hire had to be completed before they started resident care until the Surveyor requested the trainings for selected employees. She said going forward she would complete a checklist for the required trainings. She said staff could be at risk of lack of information and residents could be at risk of harm for a multitude of things if staff did not receive the training they needed. HR said she usually gave the new employees two weeks to complete the new hire training before they were released to work on their own. HR said going forward she will make sure all training is completed before resident care is started. (continued on next page)

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/11/2024 at 2:05 PM, the Administrator said the staff were watching videos on trainings by logging into a website and have continued to watch them that included abuse/neglect, blood borne pathogens, misuse of resident property, resident rights, dementia, and fall prevention. She said she was ultimately responsible for ensuring the staff received the required trainings during orientation prior to employment and annually. She said if staff were not receiving the training, they would not know how to care for residents, and it may have a negative impact on their care. She said there was a system in place and a check list for the trainings. Record review of a facility policy dated 11/29/2022 indicated, .It is the policy of this facility to develop, implement, and maintain an effective training program for all new 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 contents includes, at a minimum .d. Written standards, policies, procedures for the facility's infection control program . g. Restraints, 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. 40124 Based on interview and record review, the facility failed to ensure training on Compliance and Ethics was completed for 3 of 17 employees (Interim DON, Dietary Manager, and CNA S) reviewed for training. The facility failed to ensure the Interim DON was trained on compliance and ethics on hire. The facility failed to ensure Dietary Manager was trained on compliance and ethics annually. The facility failed to ensure CNA S was trained on compliance and ethics on hire. 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 included: Record review of the personnel file for the Interim DON indicated she was hired at the facility on 7/30/2024 by contract and did not have on hire training on compliance and ethics. Record review of the personnel file for the Dietary Manager indicated she was originally hired at the facility on 06/26/2012 and now was an employee by contract. The personnel file indicated the Dietary Manager did not have annual training on compliance and ethics. Record review of the personnel file for CNA S indicated she was hired at the facility on 3/15/2024 and did not receive training on compliance and ethics. During an interview on 9/11/2024 at 9:24 AM, HR said she was responsible for completing the orientation and other paperwork. She said she was not aware of the required trainings for employees on hire had to be completed before they started resident care until the Surveyor requested the trainings for selected employees. She said going forward she would complete a checklist for the required trainings. She said staff could be at risk of lack of information and residents could be at risk of harm for a multitude of things if staff did not receive the training they needed. HR said she usually gave the new employees two weeks to complete the new hire training before they were released to work on their own. HR said going forward she will make sure all training is completed before resident care is started. During an interview on 9/11/2024 at 9:32 AM, the Administrator said the staff were watching videos on trainings by logging into a website and have continued to watch them that included abuse/neglect, blood borne pathogens, misuse of resident property, resident rights, dementia, and fall prevention. She said she was ultimately responsible for ensuring the staff received the required trainings during orientation prior to employment and annually. She said if staff were not receiving the training, they would not know how to care for residents, and it may have a negative impact on their care. She said there was a system in place and a check list for the trainings. (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 dated 11/29/2022 indicated, .It is the policy of this facility to develop, implement, and maintain an effective training program for all new 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 contents includes, at a minimum .e. Written standards, policies, and procedures for the facility's compliance and ethics program . g. Restraints, h. HIV, i. Dementia management and care of the cognitively impaired .

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 40124 Based on interviews and record review, the facility failed to ensure CNAs completed Abuse, Neglect, and Exploitation (ANE) and dementia management trainings for 1 of 5 CNAs (CNA S) reviewed for training. The facility did not ensure ANE, and dementia management trainings were completed by CNA S during orientation. This failure could place residents with dementia at risk of abuse, neglect, and exploitation and a poor quality of care by staff with inadequate training when caring for dementia residents. Findings included: Record review of employee files indicated CNA S, hire date 3/15/24, had not completed ANE and dementia management trainings during orientation. During an interview on 09/11/24 at 9:15 AM the Interim DON indicated she expected nursing staff to have all of the trainings during orientation and for them to have their annual trainings as required. She indicated all trainings were done in the computer except for the skills competencies she conducted on CNAs and LVNs upon hire. She indicated staff not having the trainings as required could cause residents not to receive the care needed. During an interview on 9/11/2024 at 9:24 AM, HR said she was responsible for completing the orientation and other paperwork. She said she was not aware of the required trainings for employees on hire had to be completed before they started resident care until the Surveyor requested the trainings for selected employees. She said going forward she would complete a checklist for the required trainings. She said staff could be at risk of lack of information and residents could be at risk of harm for a multitude of things if staff did not receive the training they needed. HR said she usually gave the new employees two weeks to complete the new hire training before they were released to work on their own. HR said going forward she will make sure all training is completed before resident care is started. During an interview on 9/11/2024 at 9:32 AM, the Administrator said the staff were watching videos on trainings by logging into a website and have continued to watch them that included abuse/neglect, blood borne pathogens, misuse of resident property, resident rights, dementia, and fall prevention. She said she was ultimately responsible for ensuring the staff received the required trainings during orientation prior to employment and annually. She said if staff were not receiving the training, they would not know how to care for residents, and it may have a negative impact on their care. She said there was a system in place and a check list for the trainings. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a facility policy dated 11/29/2022 indicated, .It is the policy of this facility to develop, implement, and maintain an effective training program for all new 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 contents includes, at a minimum: g. Restraints, h. HIV, i. Dementia management and care of the cognitively impaired. J. Abuse, Neglect, and exploitation .

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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. 40124 Based on interviews and record review, the facility failed to provide mandatory effective behavioral health training for 2 of 15 employees (Interim DON and CNA S) reviewed for training. The facility failed to ensure effective behavioral health training was provided to the Interim DON and CNA S on hire. 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 CNA S's personnel file revealed the CNA S was hired on 03/15/2024 and had not completed on hire behavioral health training as required by policy and regulation. Record review of the Interim DON's personnel file revealed the Interim DON was hired on 07/30/2024 and had not completed on hire behavioral health training as required by policy and regulation. During an interview on 9/11/2024 at 9:24 AM, HR said she was responsible for completing the orientation and other paperwork. She said she was not aware of the required trainings for employees on hire had to be completed before they started resident care until the Surveyor requested the trainings for selected employees. She said going forward she would complete a checklist for the required trainings. She said staff could be at risk of lack of information and residents could be at risk of harm for a multitude of things if staff did not receive the training they needed. HR said she usually gave the new employees two weeks to complete the new hire training before they were released to work on their own. HR said going forward she will make sure all training is completed before resident care is started. During an interview on 9/11/2024 at 9:32 AM, the Administrator said the staff were watching videos on trainings by logging into a website and have continued to watch them that included and behavioral health. She said she was ultimately responsible for ensuring the staff received the required trainings during orientation prior to employment and annually. She said if staff were not receiving the training, they would not know how to care for residents, and it may have a negative impact on their care. She said there was a system in place and a check list for the trainings. Record review of a facility policy dated 11/29/2022 indicated, .It is the policy of this facility to develop, implement, and maintain an effective training program for all new 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 contents includes, at a minimum: .f. Behavioral health including informed trauma care. g. Restraints, h. HIV, i. Dementia management and care of the cognitively impaired .