STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676079	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Nursing Care Center	1100 W Ave J Muleshoe, TX 79347

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 - Some	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** 47854 48491 Based on observation, interview and record review, the facility failed to ensure that all allegations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, and misappropriation of resident property are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury to the administrator of the facility and to other officials (including the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 2 of 16 residents (Residents #5 and #27) reviewed for abuse and neglect. The facility failed to report to the Administrator and State Survey Agency an allegation of abuse involving Residents #5 and #27 within 2 hours of the allegation. This failure could place residents at risk of not having incidents of abuse, neglect, exploitation, and misappropriation of resident property being reviewed and investigated in a timely manner by the facility and state survey agency. Findings included: 1. Record review of Resident # 5's face sheet dated 10/23/2024, revealed that the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses, included but not limited to, Neurocognitive Disorder with Lewy Bodies (cognitive decline in thinking abilities, visual perception, and visual hallucinations), Dementia (cognitive loss) with anxiety and agitation, Parkinsonism (slowness of movement, tremor, difficulty walking, or rigidity). Record review of Resident # 5's significant change of status MDS, dated [DATE], revealed a BIMS score of 2 out of 15 which indicated his cognition was severely impaired and he required substantial/maximal physical assistance from 1 staff member in most ADLs including moving between surface to and from bed, chair, and wheelchair. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Some	Record review of Resident #5's Care Plan dated 09/09/2024 revealed that resident was care planned for falls with an intervention that stated to keep resident in line of sight, because he will try to try to constantly stand. Record review of Resident #5's progress notes dated 10/16/2024 revealed that at approximately 7:00 PM on 10/15/2024 agency staff reported to nursing staff that Resident #5 was noted on the floor in the dining room on his belly with left side of face on the floor and w/c beside him. Upon assessment resident noted with small skin tear to bridge of nose and superficial abrasion to left side of forehead. Minimal bleeding noted to skin tear on bridge of nose. Resident assisted back to w/c with assistance x 2 and was not able to move all extremities without complaint of pain or discomfort. Unable to provide description of fall due to cognitive status. POA, physician, RN, and ADM notified of resident's fall. 2. Record review of Resident #27's face sheet dated 10/24/2024 revealed that the resident was an [AGE] year-old female admitted to the facility on [DATE] with an original admitted [DATE] with diagnoses, included but not limited to, Alzheimer's disease (memory loss). Record review of Resident #27's quarterly MDS, dated [DATE], revealed a BIMS score of 99 which revealed that the resident was unable to complete the interview and she required complete dependence on 2 or more helpers in most ADLs including toileting and personal hygiene. Record review of Resident #27's progress notes dated 9/1/2024 at 7:45 AM fell while eating breakfast in dining room and was found lying on her left side with blood coming out of her head. EMS was called and resident transported to ER, POA, physician, and ADM notified of fall. During an observation on 10/23/2024 at 9:21 AM, Resident #27 had stiches to the head and leg. Resident was non interview able. Interview with Resident's family member on 10/23/2024 at 9:22 AM, stated that she had an unwitnessed fall on 09/01/2024 which resulted in a laceration to the head and required a hospital visit. During an observation on 10/23/2024 at 11:08 AM, Resident #5 was sitting in w/c in common area with 2 wounds on his arms, both had bandages on arms with dates of 10/21/2024 on them. Resident was observed to have wounds on cheeks and nose, neither were bandaged. Resident was non interview able. During a phone interview on 10/23/2024 at 6:40 PM, Resident #5's family member stated that the resident fell on [DATE] because he was left alone and was always supposed to have someone with him or be in their line of sight. Resident's family member did not think this incident was investigated or reported to the state. During an interview on 10/24/2024 at 9:14 AM, the ADON revealed to surveyor that falls were not investigated and/or reported to the state for investigation. During an observation on 10/24/2024 at 11:45 AM, CE showed surveyor video footage of a fall for Resident #27 on 09/01/2024 around 8:11 AM. No witnesses were observed in footage. (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 - Some	During an observation on 10/24/2024 at 12:18 PM, CE showed surveyor video footage of Resident #5 without staff present. Video footage revealed at 7:06 PM on 10/15/2024 that Resident #5 fell from chair to his left side. Further footage of the video revealed at 7:08 PM on 10/15/2024, 2 unidentified staff walked away from Resident #5. During an interview on 10/24/2024 at 2:10 PM, the ADM stated that a negative outcome for not investigating a fall would be that they would not be able to find the root cause of the incident and to prevent future incidents of the same nature from happening and a negative outcome for failing to report a fall would be that it is required and expected . Record review of facility provided policy titled Abuse and Neglect - Clinical Protocol, dated 2001 and revised November 2018 , revealed the following in part: Assessment and Recognition, #4. Significant injuries in physically dependent individuals. Cause Identification, #1. The staff, with the physician's input as needed, will investigate alleged abuse and neglect to clarify what happened and identify possible causes. Record review of facility provided policy title Accidents and Incidents - Investigating and Reporting, dated 2001 and revised July 2017, revealed the following in part: Policy Statement. All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. Record review of facility employee in service training records revealed Falls-Prevention of Falls and Interventions training was conducted 08/09/2024 and 10/21/2024. Record Review of Tulip for intakes for this facility, revealed no incidents reported on either fall for Resident #5 or Resident #27.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47854 Based on observation, interview, and record review, the facility failed to have evidence that all alleged violations were thoroughly investigated for 2 of 16 (Residents #5 & #27) residents reviewed for abuse and neglect. The facility failed to conduct a thorough investigation when Resident #5 fell from his wheelchair unobserved and obtained a skin tear to the bridge of nose and abrasion to left side of forehead. The facility failed to conduct a thorough investigation when Resident #27 fall leading to a head wound on her left side. This failure could place residents at risk of abuse and neglect. Findings included: Record review of Resident # 5's face sheet dated 10/23/2024, revealed that the resident was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses, included but not limited to, Neurocognitive Disorder with Lewy Bodies (cognitive decline in thinking abilities, visual perception, and visual hallucinations), Dementia (cognitive loss) with anxiety and agitation, Parkinsonism (slowness of movement, tremor, difficulty walking, or rigidity). Record review of Resident # 5's significant change of status MDS, dated [DATE], revealed a BIMS score of 2 out of 15 which indicated his cognition was severely impaired and he required substantial/maximal physical assistance from 1 staff member in most ADLs including moving between surface to and from bed, chair, and wheelchair. Record review of Resident #5's Care Plan dated 09/09/2024 revealed that resident was care planned for falls with an intervention that stated to keep resident in line of sight, because he will try to try to constantly stand. Record review of Resident #5's progress notes dated 10/16/2024 revealed that at approximately 7:00 PM on 10/15/2024 agency staff reported to nursing staff that Resident #5 was noted on the floor in the dining room on his belly with left side of face on the floor and w/c beside him. Upon assessment resident noted with small skin tear to bridge of nose and superficial abrasion to left side of forehead. Minimal bleeding noted to skin tear on bridge of nose. Resident assisted back to w/c with assistance x 2 and was not able to move all extremities without complaint of pain or discomfort. Unable to provide description of fall due to cognitive status. POA, physician, RN, and ADM notified of resident's fall. Record review of Resident #27's face sheet dated 10/24/2024 revealed that the resident was an [AGE] year-old female admitted to the facility on [DATE] with an original admitted [DATE] with diagnoses, included but not limited to, Alzheimer's disease (memory loss). (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #27's quarterly MDS, dated [DATE], revealed a BIMS score of 99 which revealed that the resident was unable to complete the interview and she required complete dependence on 2 or more helpers in most ADLs including toileting and personal hygiene. Record review of Resident #27's progress notes dated 9/1/2024 at 7:45 AM, fell while eating breakfast in dining room and was found lying on her left side with blood coming out of her head. EMS was called and resident transported to ER, POA, physician, and ADM notified of fall. During an observation on 10/23/2024 at 9:21 AM, Resident #27 had stiches to the head and leg. Resident was non interview able. Interview with Resident's family member on 10/23/2024 at 9:22 AM stated that she had an unwitnessed fall on 09/01/2024 which resulted in a laceration to the head and required a hospital visit. During an observation on 10/23/2024 at 11:08 AM, Resident #5 was sitting in w/c in common area with 2 wounds on his arms, both had bandages on arms with dates of 10/21/2024 on them. Resident was observed to have wounds on cheeks and nose, neither were bandaged. Resident was non interview able. During a phone interview on 10/23/2024 at 6:40 PM, Resident #5's family member stated that the resident fell on [DATE] because he was left alone and was always supposed to have someone with him or be in their line of sight. Resident's family member did not think this incident was investigated or reported to the state. During an interview on 10/24/2024 at 9:14 AM, the ADON revealed to surveyor that falls were not investigated and/or reported to the state for investigation. Footage of the falls were reviewed but that is the extent of the investigation. During an observation on 10/24/2024 at 11:45 AM, CE showed surveyor video footage of a fall for Resident #27 that happened on 09/01/2024 around 8:11 AM. No witnesses were observed in footage . During an observation on 10/24/2024 at 12:18 PM, CE showed surveyor video footage of Resident #5 without staff present. Video footage revealed at 7:06 PM on 10/15/2024 that Resident #5 fell from chair to his left side. Further footage of the video revealed at 7:08 PM on 10/15/2024, 2 unidentified staff walked away from Resident #5. During an interview on 10/24/2024 at 2:10 PM, ADM stated that a negative outcome for not investigating a fall would be that they would not be able to find the root cause of the incident and to prevent future incidents of the same nature from happening and a negative outcome for failing to report a fall would be that it is required and expected . Record review of facility provided policy titled Abuse and Neglect - Clinical Protocol, dated 2001 and revised November 2018, revealed the following in part: Assessment and Recognition, #4. Significant injuries in physically dependent individuals. Cause Identification, #1. The staff, with the physician's input as needed, will investigate alleged abuse and neglect to clarify what happened and identify possible causes. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility provided policy title Accidents and Incidents - Investigating and Reporting, dated 2001 and revised July 2017, revealed the following in part: Policy Statement. All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. Record review of facility employee in service training records revealed Falls-Prevention of Falls and Interventions training was conducted 08/09/2024 and 10/21/2024. Record review of Tulip for intakes for this facility, revealed no incidents reported on either fall for Resident #5 or Resident #27.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47854 Based on observation, interview, and record review the facility failed to develop and implement a comprehensive care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs as identified in the comprehensive assessment for 1 of 16 (Resident #5) reviewed for care plans. This facility failed to implement the comprehensive care plan for Resident #5, resulting in a fall with injury. This failure could place residents at risk of not receiving the care needed to live at their highest practicable level of health and mental well-being. Findings included: A review of Resident #5's clinical face sheet revealed a [AGE] year-old male who was admitted to the facility on [DATE] with a BIMS of 02 indicating severe cognitive impairment with a diagnosis of, but not limited to, Neurocognitive Disorder with Lewy Bodies (clumps of abnormal protein that, for reasons unknown, accumulate in the brain), Dementia in Other Diseases Classified Elsewhere (loss of cognitive function), Unspecified Severity with Other Behavioral Disturbance, Agitation and Anxiety, Parkinsonism (a clinical syndrome which manifests with motor symptoms such as rigidity, tremors, slow movements, unstable posture and gait impairment), Unspecified, Muscle Weakness, (Generalized), Cognitive Communication Deficit, Other Lack of Coordination, Delirium (a mental state in which you are confused, disoriented, and not able to think clearly) Due to Known Physiological Condition and History of Falling. A review of Resident #5's MDS dated [DATE] revealed bilateral Functional Limitation in Range of Motion in both the upper and lower extremities. Resident #5 used a wheelchair for ambulation and needed Substantial (helper does more than half) to Dependent help (2 or more helpers) with ADLs. Review of Resident #5's Care Plan dated 09/09/2024 revealed Resident #5 had an actual fall with injury prior to admission and continued to be a fall risk since admission. The goal for Resident #5 was to be free of injury related to falls, and a decrease the number of falls. The interventions for Resident #5 were bed in lowest position with fall mat on floor, shoes, or non-skid socks at all times, especially during transfers and keep resident within line of sight at all times, as he would constantly try to stand alone. Record review of facility incidents revealed on 10/15/2024, Resident #5 sustained an unwitnessed fall. An observation of Resident #5 on 10/22/2024 revealed a large bruise in various stages of healing to the right side of Resident #5's face, and a skin tear to the bridge of the nose. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress notes for Resident #5 from 10/15/2024 revealed he was assessed by facility staff, and it was determined Resident #5 did not need to seek medical attention. Neuro checks were performed by licensed staff every 2 hours for the first 24 hours after the fall, and Resident #5 continued to perform within normal limits. An interview with Resident #5's family member on 10/22/24 at 6:37PM revealed the facility called him immediately after Resident #5 fell . The facility surveillance tape from 10/15/2024 was reviewed by the family member and it was determined Resident #5 fell at or around 7pm. The family member stated Resident #5 sustained injuries which in his opinion might have required x-rays, but Resident #5 was not sent out for x-ray, nor was the mobile x-ray unit called. The family member stated Resident #5 is never to be out of eyesight of staff, yet Resident #5 was on the floor for 6-7 minutes before staff found him, according to the surveillance tape. An interview with Resident #5's POA on 10/24/24 at 12:27PM revealed she was called immediately after the fall. The POA stated she was told by staff Resident #5 fell out of his wheelchair and onto the floor. The POA stated she was told by staff x-rays were not required and Resident #5 had been treated for any injury to his face. The POA stated she had spoken with the Rounding Provider and was told x-rays were not needed for Resident #5. The POA stated Resident #5 was to be in eyesight of staff at all times, but felt the facility was not at fault for the fall, as Resident #5 tried to stand alone regularly. Review of facility Policy and Procedure for Person-Centered Care Plans revealed the following: 4. Each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her care plan, including the right to: (g.) Receive the services and/or items included in the care plan. 8. The comprehensive, person-centered care plan will: (a.) Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; (g.) Incorporate identified problem areas; (h.) Incorporate risk factors associated with identified problems; (m.) Aid in preventing or reducing decline in the resident's functional status and/or functional levels; (n.) Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and (o) Reflect currently recognized standards of practice for problem areas and conditions. 11. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(a.) When possible, interventions address the underlying source(s) of the problem(s), not just addressing the only the symptoms and triggers.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 48491 Based on interviews, and record review, the facility failed to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week for 1 (10/12/2024) of the 90 days reviewed. The facility did not have an RN working in the facility on 10/12/2024. This failure has the potential to affect the residents in the facility and place them at risk of not having staff with advance care skills available to assist in their care needs. Findings included: Record review of the facility's last 90 days (07/22/2024-10/22/2024) of RN coverage provided by the BOM revealed the facility had no RN working in the facility for the following date: 10/12/2024. During an interview on 10/22/24 at 12:20 PM, the BOM verified that the facility did not have an RN working in the facility on 10/12/24. During an interview on 10/24/24 at 9:15 AM, the ADON stated that a possible negative outcome for not having an RN working for 8 hours/day would be that if something bad happened, the staff would not know what to do and would not have anyone to go to. During an interview on 10/24/24 at 10:20 AM, LVN A stated that a negative outcome for not having an RN on staff every day would be that if a major clinical issue came up in the facility, the correct treatment might not be given. During an interview on 10/24/24 at 10:24 AM, the DON stated that a negative outcome for not having an RN on staff each day would be that management or direction would not be there and there could be a lack of care due to that. Policy for RN coverage was requested on 7/24/24 at 8:14 AM but was not provided.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47159 Based on observation, interview and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety for 1 of 1 kitchen reviewed for food safety. The facility failed to ensure all food in the dry pantry and cold storage were properly sealed, labeled and dated. The facility failed to ensure all foods in the dry pantry were at least 18 inches off the floor as required by facility policy for dry pantry storage. These failures could place residents at risk of residents at risk of food-borne illness and a diminished quality of life. Findings included: On [DATE] at 10:04AM an initial observation of the kitchen was conducted, and the following was noted: Dry Pantry: (3) partial 5lb. bags corn tortillas with no received date and one bag open to air. (1) partial 10lb. bag elbow macaroni with no received date and open to air. (1) partial 50lb. bag white rice with no received date and open to air. (2) 3oz. boxes dry raspberry gelatin with no received date. (1) partial 2lb. 3oz. bag frosted flake cereal with no received date and open to air. (1) 1gal. zip top bag crisp rice cereal with no received date and open to air. (1) partial 16oz. bag mini marshmallows open to air. (1) 1lb. box corn starch with no received date. (17) 3.2oz. packages dry Ranch dressing with no received date. (44) 4oz. cans pineapple juice with no received date. (36) 4oz. cans vegetable juice with no received date. (19) 4oz. cans chicken noodle soup with no received date. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(4) 4oz. containers Thick-n-Easy Clear, Cranberry Flavored Drink with no received date. (10) 4oz containers Thick-n-Easy Clear, Orange flavored drink with no received date (12) 4oz. containers Thick-n-Easy Clear, Red Tea Flavored Drink with no received date. Dry pantry foods were not stored at least 18-inches above the floor as required by facility policy. Cold Storage Unit: ,d+[DATE] fresh tomato in a bowl with no label, no use by date and open to air. (3) 6oz. cups prepared thickened drink mix with no label, no use by date and open to air. 1qt. enchilada sauce with no received date. (4) 5lb. bags chicken breasts with no received date. 2 fresh cantaloupes with no received date. (1) 50lb. box fresh potatoes with no received date. (1) 1gal. container barbeque sauce with no received date. (1) 9lb 14oz box individual serving margarine cups with no received date. (4) 48-count fresh eggs in cardboard pallets with no received date. An interview with the Head [NAME] [DATE] at 11:12AM revealed there was no Dietary Manager working for the facility at that time. She stated the negative outcome of residents eating foods which were not labeled and dated was they could become sick if they ate foods which were expired. She stated there was no facility policy regarding Recommended Maximum Storage Periods for dry or cold storage foods. Review of facility policy for Food Receiving and Storage dated [DATE] revealed the following: (6.) Food stored in designated dry storage areas shall be kept off the floor (at least 18 inches) and clear of sprinkler heads, sewage/waste disposal pipes and vents. (8.) All foods stored in the refrigerator or freezer will be covered, labeled, and dated (use by date) (14.) d. Beverages must be dated when opened and discarded after twenty-four (24) hours. e. Other opened containers must be dated and sealed or covered during storage.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676079	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Nursing Care Center	1100 W Ave J Muleshoe, TX 79347

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 47159 Based on interview and record review the facility failed to develop, implement, and maintain an effective training program for all new and existing staff and individuals providing services under a contractual agreement, consistent with their expected roles for 4 of 11 (interim DON, LVN B, CNA C and CNA D) staff reviewed for nursing home training. The facility failed to ensure Interim DON, LVN B, CNA C and CNA D were trained in the prevention of Resident Abuse, Neglect and Exploitation, HIV Policy and Procedures, Fall Prevention, Use of Restraints, Emergency Procedures and Dementia. This failure could place residents at risk for a diminished quality of life and diminished psychosocial well-being, due to lack of training in essential resident care and facility practice. Findings included: Record review of employee files revealed the following staff did not have training in the prevention of Resident Abuse, Neglect and Exploitation, HIV Policy and Procedures, Fall Prevention, Use of Restraints, Emergency Procedures and Dementia prior to interacting with and caring for residents in the facility: Record review of the interim DON's employment file revealed a hire date of 10/14/2024, and no training in the prevention of Resident Abuse, Neglect and Exploitation, HIV Policy and Procedures, Fall Prevention, Use of Restraints, Emergency Procedures and Dementia prior to interacting with and caring for residents in the facility. Record review of the LVN B's employment file revealed a hire date of 10/20/2024, and no training in the prevention of Resident Abuse, Neglect and Exploitation, HIV Policy and Procedures, Fall Prevention, Use of Restraints, Emergency Procedures and Dementia prior to interacting with and caring for residents in the facility. Record review of the CNA C's employment file revealed a hire date of 10/11/2024, and no training in the prevention of Resident Abuse, Neglect and Exploitation, HIV Policy and Procedures, Fall Prevention, Use of Restraints, Emergency Procedures and Dementia prior to interacting with and caring for residents in the facility. Record review of the CNA D's employment file revealed hire date of 10/01/2024, and no training in the prevention of Resident Abuse, Neglect and Exploitation, HIV Policy and Procedures, Fall Prevention, Use of Restraints, Emergency Procedures and Dementia prior to interacting with and caring for residents in the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676079	A. Building B. Wing	10/24/2024

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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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Administrator on 10/24/2024 at 11:28 AM, revealed she was not aware there were 4 employees who had been caring for residents without any prior training. She was unaware it was the facility's responsibility to train contract employees prior to employment. She stated she assumed the agency providing the employees had trained them prior to their employment with the agency. She stated she had a notebook of PowerPoint slides which covered the training information regarding Abuse/Neglect/Exploitation, HIV, Fall Prevention, Use of Restraints, Emergency Procedures and Dementia that employees were welcome to read at any time. She stated she had not confirmed the competency of these 4 employees in Abuse/Neglect/Exploitation, HIV, Fall Prevention, Use of Restraints, Emergency Procedures and Dementia prior to their employment. An interview with the Administrator on 10/24/2024 at 2:36 PM, revealed she could not define a negative outcome of these 4 employees caring for residents with no training. An interview with the Administrator on 10/24/2024 at 2:51 PM, revealed the negative outcome of the Interim DON mentoring LVN B and LVN B mentoring CNA's C and D would be the potential hinderance of health and safety of residents. The Administrator could not provide the facility's policy and procedures regarding training and stated she followed the regulation guidance provided by the State Operations Manual (SOM).