STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676121	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver Tree Nursing and Rehabilitation Center	930 Roy Richard Dr Schertz, TX 78154

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 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44020 Based on interview and record review the facility failed to ensure the notice to residents was provided when changes in coverage were made to items and services covered by Medicare as soon as reasonable possible was provided to 2 of 2 residents (Resident #189, and Resident #190) reviewed for Medicare/Medicaid. The facility failed to give Resident #189 and Resident #190 a Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) CMS form 10055 when discharged from skilled services at the facility prior to covered days being exhausted. This failure could affect residents who use skilled services and could place them at risk of not being aware of changes to provided services. The findings were: Record review of Resident #189's face sheet, dated 04/18/2025, revealed the resident was admitted [DATE] and an initial admitted [DATE] with diagnoses that included: urinary tract infection, paroxysmal atrial fibrillation (a type of irregular heartbeat that comes and goes, lasting from a few hours to a few days, and then typically resolves on its own), hypokalemia(potassium level in your bloodstream is lower than is typical), and dementia (a general term for the progressive loss of cognitive function, including memory, thinking, and reasoning abilities, that interferes with daily life) in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Record review of the Notice of Medicare Non-Coverage (NOMNC) for Resident #189 revealed it had been completed with signature confirmation of understanding from Resident #189 on 10/08/2024 with services ending on 10/09/2024. However, the Skilled Nursing facility Advanced Beneficiary Notice (SNF ABN) CMS form 10055 was not completed which would have informed Resident #189 of the option to continue services at a private pay rate. (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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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Record review of Resident #190's face sheet, dated 04/18/2025, revealed the resident was admitted [DATE] and initial admitted [DATE] with diagnoses that included: chronic kidney disease stage 3 (moderate kidney damage, where the kidneys are not filtering as well as they should, leading to a buildup of waste and fluids in the body) unspecified, major depressive disorder, type 2 diabetes mellitus without complications, hyperlipidemia (a condition where there are elevated levels of lipids, including cholesterol and triglycerides, in the blood), unspecified, and cerebral infarction (a condition where brain tissue dies due to a lack of blood flow, causing a lack of oxygen and nutrients), unspecified, hemiplegia (a condition characterized by paralysis on one side of the body, either completely or partially affecting the face, arm, and leg) and hemiparesis (a condition characterized by weakness on one side of the body, affecting muscles in the arm, leg, hand, or face) following cerebral infarction affecting left non-dominant side. Record review of the Notice of Medicare Non-Coverage (NOMNC) for Resident #190 revealed it had been completed with signature confirmation of understanding from Resident #190 on 01/03/2025 with services ending on 01/07/2025. However, the Skilled Nursing facility Advanced Beneficiary Notice (SNF ABN) CMS form 10055 was not completed which would have informed Resident #190 of the option to continue services at a private pay rate. During an interview on 04/16/2025 at 4:17 p.m. MDS C stated she did not believe Resident #189 and Resident #190 had both the NOMNC and SNF ABN forms. MDS C further stated she was not aware the residents who remained in the facility after skilled services who had not exhausted days needed to be provided with a SNF ABN form. During an interview on 04/17/2025 at 11:26 a.m. MDS C stated she was unable to find the SNF ABN forms for Resident #189 and Resident #190 and provided the policy Advance Beneficiary Notice of Non-Coverage. MDS C further stated the SW would discuss the discharge from skilled care and residents were informed verbally regarding the daily rate and it was discussed. MDS C stated by not providing the SNF ABN for it could cause the lack of services and therapy due to not being provided the options. MDS C stated she did not know who would have been responsible but apparently it was her after she reviewed the policy. During an interview on 04/18/2025 at 3:37 p.m. the Administrator stated MDS was responsible for the completion of the SNF ABN forms and by not providing them residents or families would not be aware of the explanation of services or the what the cost would be to continue those services privately. Record review of facility's Advance Beneficiary Notice of Non-coverage policy, no date, read, The ABN is a notice given to beneficiaries in Original Medicare to convey that Medicare is not likely to provide coverage in a specific case .The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice . The ABN may also be used to provide notification of financial liability for items or services that Medicare never covers. ABN Notices are issued under the following circumstances: Part A only CMS 10055 #2. Part A stay will end because, SNF determines the beneficiary no longer requires daily skilled services. Resident has days remaining in benefit period. Resident will remain in the facility (custodial care).

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observations, interview, and record review, the facility failed to ensure the resident has a right to personal privacy and confidentiality of his or her personal and medical records for 1 (Resident #82) of 20 residents reviewed the privacy of medical records. RN-H left her computer open with Resident #82's personal and medical information on the nursing cart at the 400-hallway on 04/18/2025. This failure could place residents at risk of resident identifiable and medical information being accessed by unauthorized persons. The findings were: Record review of Resident #82's face sheet, dated 04/18/2025, revealed the resident was [AGE] years old female, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnoses of nonalcoholic steatohepatitis (the accumulation of liver fat), seizures (temporary abnormalities in muscle tome or movement), anemia (blood does not have enough healthy red blood cells and hemoglobin to carry oxygen all through the body), and type 2 diabetes mellitus (the body has trouble controlling blood sugar and using it for energy). Record review of Resident #82's Medicare 5days MDS assessment, dated 03/07/2025, revealed the resident's BIMS score was 14 out of 15, which indicated the resident's cognitive was intact, and the resident needed to have substantial/maximal assistances (helper does more than half the effort) to bed mobility, sit to stand, chair-to-bed, and toilet transfer. Observation on 04/18/2025 from 11:05 a.m. to 11:10 a.m. revealed the 400-hall nursing cart was parked at the 400-hallway without nurses for 5 minutes. The computer was open with Resident #82's personal and medical information on the cart, and the screen of the computer included Resident #82's picture, name, date of birth, room number, age, and medications to be provided. Observation and interview on 04/18/2025 at 11:10 a.m. revealed the DON was approaching the 400-hall nursing cart and saw the computer screen on the cart was opened with Resident #82's picture, name, date of birth, room number, age, and medications. The DON stated RN-H left her computer open with Resident #82's personal and medical information on the nursing cart at the 400-hallway, and it was Resident #82's privacy violation because anybody could see Resident #82's personal and medical information. Interview on 04/18/2025 at 12:07 p.m. with RN-H said she forgot to close her computer when she left her nursing cart at the 400-hallway. RN-H stated she should have locked her computer screen off on the cart when leaving her cart to protect Resident #82's personal and medical information, and it was her mistake. Record review of the facility policy, titled Resident Rights, revised 11/28/2016, revealed Privacy and confidentiality - The resident has a right to personal privacy and confidentiality of his or her personal and medical records.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observation, interview and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 1 of 20 residents (Resident #140) reviewed for assessments: Resident #140's admission MDS, dated [DATE], identified the resident had a urinary indwelling catheter. However, Resident #140's urinary continence was coded to Always incontinence, instead of Not rated, resident had a catcher) in Section H (Bladder and Bowel). This failure could place residents at risk for inadequate care due to inaccurate assessments. The findings included: Record review of Resident #140's face sheet, dated 04/18/2025, revealed the resident was [AGE] years old female and admitted to the facility on [DATE] with diagnoses of chronic kidney disease-stage 3 (kidneys are less able to filter water and fluid out of the body), type 2 diabetes mellitus (the body has trouble controlling blood sugar and using it for energy), fluid overload (liquid portion of the blood is too high), dementia (over time destroy nerve cells and damage the brain), and urinary tract infection (bladder infection). Record review of Resident #140's admission MDS, dated [DATE], revealed the resident's BIMS score was 13 out of 15, which indicated the resident's cognitive was intact, and in Section H (Bladder and Bowel), it was coded that Resident #140 had indwelling catheter. However, Always urinary incontinent was coded at H0300-Urinary continence. Further record review of the MDS revealed if resident had a urinary catheter (indwelling, condom), Not rated should be coded. Record review of Resident #140's comprehensive care plan, dated 04/03/2025, revealed The resident had urinary catheter - For intervention: position catheter bag and tubing below the level of the bladder and in a privacy bag and changed the catheter as ordered. Observation on 04/15/2025 at 3:52 p.m. revealed Resident #140 was on the bed and sleeping in her room. The urinary indwelling catheter was secured to the bed and covered in a privacy bag. Interview on 04/18/2025 at 10:21 a.m. with MDS-C stated because Resident #140 had a urinary indwelling catheter, Not rated should have been coded at H0300-Urinary continence in Section H (Bladder and Bowel) of the resident's admission MDS, dated [DATE], instead of Always urinary incontinent. MDS-C said it was mistake, coding accurately was a MDS nurse's responsibility, and inaccurate MDS assessment might affect improper care to Resident #140. Interview on 04/18/2025 at 5:40 p.m. the DON said Not rated should have been coded, instead of Always urinary incontinent because Resident #140 had a urinary indwelling catheter. Coding accurately was a MDS nurse's responsibility, and inaccurate MDS assessment might affect improper care. Record review of the facility policy, titled Resident Assessment, revised 2003, revealed . 4. Results must be recorded to assure continued accuracy of the assessment.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46677 Based on interviews and record review, the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality care within 48 hours of a resident's admission for 1 of 8 residents (Resident #244) reviewed for baseline care plans. The facility failed to ensure a baseline care plan was completed within 48 hours from admission for Resident #244. This failure could place residents at risk of not receiving care and services to meet their needs. The findings were: Record review of Resident #244's face sheet, dated 04/15/2025, revealed Resident #244 was admitted on [DATE], with diagnoses which included: acute kidney failure, type 2 diabetes mellitus without complications, hyperlipidemia unspecified, essential (primary) hypertension, peripheral vascular disease, gastro-esophageal reflux disease without esophagitis, and personal history of pulmonary embolism. Record review of Resident #244's Admission MDS assessment, dated 04/10/2025, revealed Resident #244's BIMS score was not identified. Record review of Resident #244's electronic medical record revealed Resident #244 did not have a completed baseline care plan. An interview with Resident #244's representative on 04/17/2025 at 9:51 AM revealed resident was admitted to the facility on [DATE]. Resident #244's representative stated she and Resident #244 were happy with the care he was receiving but they had not received a copy of a base line care plan. An interview with the DON on 04/18/2025 at 2:30 PM revealed Resident #244 was admitted on [DATE] which was a Thursday. The DON stated the admitting nurse/charge nurse were responsible to initiate the baseline care plan upon admission. The DON stated once the baseline care plan was initiated in PCC, she would have been notified to initiate the care plan. The DON stated the admitting/charge nurse on the day Resident #244 was admitted had since given her two week notice and had called in every day since giving her notice. The DON stated she has been unable to clarify why the baseline care plan was not initiated when Resident #244 was admitted . The DON stated resident was receiving care based off his referral. The DON stated by not completing the baseline care plan, Resident #244 was at risk for not receiving care that addressed his needs. Attempted interview with LVN I on 04/18/2025 at 2:42 PM but LVN I did not answer the phone call. LVN I did not return surveyors call. Record review of facility's policy titled Baseline Care Plan, not dated, revealed Be developed within 48 hours of a resident's admission.

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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** 44020 Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental needs that are identified in the comprehensive assessment, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 1 of 8 residents (Resident #78) reviewed for care plans. The facility failed to ensure Resident #78's care plan reflected the resident's code status. This failure places residents at risk for not receiving proper care and services due to inaccurate care plans. The findings were: Record review of Resident #78's face sheet, dated [DATE], revealed he was admitted on [DATE] with diagnoses which included: malignant neoplasm (also known as a cancerous tumor, is an abnormal growth of cells that can spread to other parts of the body) of unspecified part of unspecified bronchus (any of the major air passages of the lungs which diverge from the windpipe) or lung, shortness of breath, and pain. Record review of resident #78's Admission MDS assessment, dated [DATE], revealed the resident's BIMS was score 15 indicating intact/borderline cognition and was receiving hospice services while a resident. Record review of Resident #78's Texas OOHDNR (out of hospital do not resuscitate) dated [DATE], completed by Resident #78, read Declaration of the adult person: I am competent and at least [AGE] years of age. I direct that none of the following resuscitation measures be initiated or continued for me: cardiopulmonary resuscitation (CPR), transcutaneous cardiac pacing, defibrillation, advanced airway management, artificial ventilation. Record review of Resident #78's physician order summary report, dated, [DATE], revealed a physician order reading DNR with an order date of [DATE]. Record review of Resident #78's care plan, last care plan review completed date of [DATE], revealed there was not a care plan reflecting Resident #78's DNR code status. During an interview on [DATE] at 2:21 p.m. the SW stated she did the care plans, however she stated when a resident was admitted nursing did the baseline care plan. The SW further stated she would resolve the code status and update it when it had changed. The SW state if a resident went from a full code to a DNR she would resolve the full code care plan and the DNR care plan would be added. The SW reviewed Resident #78's care plan and stated she did not sign off on the section of the care plan with the completion date of [DATE]. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:46 p.m. MDS D stated he primarily does the long term care residents care plans. MDS D reviewed the care plan for Resident #78 and stated there was not a care plan regarding code status. MDS D further stated the code status should have been care planned. MDS D stated the purpose of the care plan regarding the code status if someone coded, he would hope the staff wouldn't read the care plan to know what to do. MDS D further stated basically the care plan was to describe all the care that was being provided to the resident. MDS D stated typically social services was responsible to complete the code status care plan, but anybody who looks in the care plan can make changes it's an interdisciplinary document. MDS D stated Resident #78's care plan probably was not reviewed by the whole team at that time. MDS D stated the comprehensive care plan would be due by the 14th day and then quarterly their after. During an interview on [DATE] at 3:14 p.m. the Administrator stated the social worker would be responsible for the code status care plan. The Administrator further stated the care plan was to be person centered to help the staff take better care of the resident. The administrator stated if the staff went to look at the care plan and it wasn't complete the staff may not have the information to care for the resident hindering proper care to be provided. Record review of facility's Comprehensive Care Planning policy, no date, read, The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following-The services that are to be furnished to attain and maintain the resident's highest practicable physical, mental and psychosocial well-being; and the right to refuse treatment .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible for 1 (Resident #65) of 20 residents reviewed for accidents and hazards. The facility failed to ensure Resident #65 did not have a disposable razor in his restroom. This failure could place residents at risk of harm or injury and contribute to avoidable accidents and a decline in health. The findings included: Record review of Resident #65's face sheet, dated 04/18/2025, revealed the resident was [AGE] years old male and admitted to the facility on [DATE] with diagnoses of unspecific protein-calorie malnutrition (reduced availability of nutrients leads to changes in body composition and function), obstructive sleep apnea (intermittent airflow blockage during sleep), chronic kidney disease-stage 3 (kidneys are less able to filter water and fluid out of the body), and obstructive and reflux uropathy (urine cannot drain through the urinary tract). Record review of Resident #65's quarterly MDS, dated [DATE], revealed the resident's BIMS score was 6 out of 15, which indicated the resident had severe cognitive impairment, and needed to have substantial/maximal assistance (Helper does more than half the effort) to shower/bathe self, personal hygiene, sit to stand, chair-to-bed, and toilet transfer. Record review of Resident #65's comprehensive care plan, dated 11/06/2024, revealed The resident had impaired cognitive function or impaired though processes and activities of daily living care performance deficit. For intervention - communicate with the resident/family regarding resident capabilities and needs, and assist with personal hygiene as required: hair, shaving, oral care as needed. Observation on 04/15/2025 at 10:05 a.m. revealed Resident #65 was in the wheelchair and watching television in his room. Inside the resident's restroom, there was one disposable razor on the sink unattended. Further observation revealed the disposable razor was dirty with old hairs. Interview on 04/15/2025 at 11:00 a.m. with LVN-L stated a disposal razor was found in the sink inside Resident #65's restroom, and the razor was dirty with old hairs. Further interview with LVN-L said Resident #65 needed to have assistance to shave, and the staff should make sure all razors should have been discarded in a sharp container to protect the resident from harm and infection. LVN-L said she did not know why the razor was on the sink, and all staff who used or found the razor had responsibility to discard it inside a sharp container. Interview on 04/17/2025 at 3:17 p.m. with Administrator said Resident #65's family member might have brought the razor, but staff should have discarded it in a sharp container to prevent potential injury. The Administrator said she would talk to the resident's family member for education, and it was staff's responsibility to remove razors for safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy, titled Nursing home list of items not allowed in resident room, revised 12/19/2024, revealed Safety hazards: razors and blades.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observations, interviews, and record review, the facility failed to ensure a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 (Resident #37) of 4 residents reviewed for incontinence care. When CNA-M was providing incontinent care to Resident #37 on 04/16/2025, CNA-M did not separate and clean the resident's labia area. This failure could place residents who required incontinence care at risk for cross contamination and the development of new or worsening urinary tract infections. The findings included: Record review of Resident #37's face sheet, dated 04/18/2025, revealed the resident was [AGE] years old female, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (a group of lung disease that block airflow and make it difficult to breathe), type 2 diabetes mellitus (the body has trouble controlling blood sugar and using it for energy), hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body), cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it), and hypertension (high blood pressures). Record review of Resident #37's quarterly MDS, dated [DATE], revealed the resident's BIMS score was 5 out of 15, which indicated the resident had severe cognitive impairment and had always urinary and bowel incontinence. Record review of Resident #37's comprehensive care plan, dated 04/05/2023, revealed the resident had bladder and bowel incontinence. For intervention - incontinent care at least every 2 hour and apply moisture barrier after each episode. Observation on 04/16/2025 at 3:18 p.m. revealed CNA-M removed Resident #37's old and dirty brief and cleaned her suprapubic area, left, right groin area, and middle area of the resident's genital area without separating and opening the resident's labia, then turned the resident to left side to clean the resident's buttock area and then put a new and clean brief on the resident. Interview on 04/16/2025 at 3:49 p.m. CNA-M stated she did not separate and open Resident #37's labia area when cleaning the middle area of the resident's genital area because she was nervous and forgot. CNA-M said she should have separated and opened Resident #37's labia area to clean. CNA-M said she had peri-care training in March 2025. Interview on 04/17/2025 at 3:23 p.m. the DON stated CNA-M should have separated and opened Resident #37's labia area to clean and prevent possible infection. The DON was responsible for providing training related to peri-care and monitoring skill checkoffs. CNA-M had a skill checkoff on 03/04/2025, and CNA-M passed perineal care for female. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy, titled Perineal care, revised 05/11/2022, revealed Female resident - working from front to back, wipe one side of the labia majora, the outside folds of perineal skin that protect the urinary meatus and the vaginal opening.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observation, interview, and record review, the facility failed to ensure residents who were fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 1 (Resident #37) of 2 residents reviewed for enteral nutrition. When RN-N flushed Resident #37's gastrostomy tube with 250 ml of water, RN-N pushed water inside barrel of syringe with plunger, instead of using gravity. This failure could place residents with gastrostomy tube at risk for complications, aspiration, and pneumonia. Findings included: Record review of Resident #37's face sheet, dated 04/18/2025, revealed the resident was [AGE] years old female, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (a group of lung disease that block airflow and make it difficult to breathe), type 2 diabetes mellitus (the body has trouble controlling blood sugar and using it for energy), hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body), cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it), and hypertension (high blood pressures). Record review of Resident #37's quarterly MDS, dated [DATE], revealed the resident's BIMS score was 5 out of 15, which indicated the resident had severe cognitive impairment and had a feeding tube. Record review of Resident #37's comprehensive care plan, dated 01/28/2025, revealed the resident has a tube feeding related to CVA (cerebrovascular accident - Stroke). Receives medications and water flushed via gastrostomy tube. For intervention - Monitor/document/report to doctor for aspiration - fever, tube dislodged, infection at tube site. Observation on 04/17/2025 at 11:19 a.m. RN-N checked the placement of Resident #37's gastrostomy tube and residual, then flushed the gastrostomy tube with 250 ml of water by pushing the water inside barrel of syringe with plunger, instead of using gravity. Interview on 04/17/2025 at 11:26 a.m. with RN-N stated she flushed Resident #37's gastrostomy tube with 250 ml of water by pushing the water inside barrel of syringe with plunger, instead of using gravity. RN-N said she though pushing the water for flush was fine because Resident #37 did not have residual, and RN-N used gravity only when giving medications via Resident #37's gastrostomy tube. However, RN-N stated she should have used gravity when flushing Resident #37's gastrostomy tube to prevent possible aspiration and the resident's abdominal discomfort. Interview on 04/17/2025 at 3:31 p.m. the DON said per the facility policy, RN-N should have used gravity when flushing Resident #37's gastrostomy tube, instead of pushing a plunger, to prevent possible aspiration and the resident's abdominal discomfort. The DON said if gravity could not be used due to blockage of tube, nurses could push a plunger gently. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility policy, titled Enteral Medication Administration, revised 01/25/2013, revealed . 10. Do not force any medication or fluid into the tube. Allow gravity to work. If necessary, gentle pressure many be applied after repositioning the resident.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observation, interview, and record review, the facility failed to ensure parenteral fluids were administered consistent with professional standards for 1 (Resident #80) of 2 resident reviewed for intravenous fluids. RN-O flushed only one lumen for medication port of Resident #80's PICC line (peripherally inserted central catheter: used to deliver medications and other treatments directly to the large central veins near the heart) with 10 cc normal saline when administering evening antibiotic dose. RN-O did not flush the other lumen for blood port of the PICC line, but the physician order said, Flush blood port with 10 cc normal saline every evening antibiotic dose. This failure could affect residents by placing them at risk for blockage of PICC line and blood clots. Findings included: Record review of Resident #80's face sheet, dated 04/18/2025, revealed the resident was an [AGE] year old male and admitted to the facility on [DATE] with diagnoses of pneumonia (infection that inflames air sacs in one or both lungs), hypertension (high blood pressure), lymphedema (selling most often in an arms or legs caused by lymphatic system blockage), respiratory failure (inadequate gas exchange by the respiratory system), and pulmonary embolism (sudden blockage in an lung artery). Record review of Resident #80's admission MDS revealed the MDS was still in progress on 04/18/2025 because the resident was admitted on [DATE]. Record review of Resident #80's care plan, dated 04/11/2025, revealed The resident has intravenous access. For interventions - Flush the ports/lines as ordered. Record review of Resident #80's physician order, dated 04/06/2025, revealed Cefepime HCL intravenous solution 2 gm/100 ml. Use 100 ml intravenously three times a day for pneumonia. Flush with 10 cc normal saline before and after. Flush blood port with 10 cc normal saline every evening antibiotic dose. Record review of Resident #80's medication administration record, from 04/01/2025 to 04/30/2025 revealed Cefepime HCL intravenous solution 2 gm/100 ml. Use 100 ml intravenously three times a day for pneumonia. Flush with 10 cc normal saline before and after. Flush blood port with 10 cc normal saline every evening antibiotic dose was scheduled 0000, 0800, and 1600. Observation on 04/16/2025 at 04:22 p.m. revealed Resident #80 had two lumens of PICC line (one was for medication port, and the other was for blood port) for intravenous therapy. RN-O hung Resident #80's Cefepime HCL intravenous solution 2 gm/100 ml from a pole and flushed only one lumen for medication port of the resident's PICC line with 10 cc normal saline, then connected the medication to the lumen for medication port. RN-O left the resident's room without flushing the lumen for blood port. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/17/2025 at 5:00 p.m. with RN-O stated she flushed only one lumen for medication port of Resident #80's PICC line with 10 cc normal saline when administering evening antibiotic dose. RN-O said she did not flush the other lumen for blood port of the PICC line, but the physician order said, Flush blood port with 10 cc normal saline every evening antibiotic dose. Further interview with RN-O said she should have flushed the lumen for blood port of Resident #80's PICC line as ordered. RN-O said she did not remember the order of Flush blood port with 10 cc normal saline every evening antibiotic dose, and it might cause blockage of PICC line and blood clots. Interview on 04/18/2025 at 3:00 p.m. the DON said RN-O should have flushed the lumen for blood port of Resident #80's PICC line when the nurse administered evening antibiotic dose because the physician order said, Flush blood port with 10 cc normal saline every evening antibiotic dose, flushing PICC line was nurse's responsibility, and it might cause blockage of PICC line and blood clots. Record review of the facility policy, titled Central Venous Catheters, dated 2003, revealed . 3. The volume and dose of flush solutions and the frequency of flushing are according to physician order. Flushing - frequency of flushing varies from once per week to twice per day. Use a different syringe for flushing each lumen.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observation, interviews, and record review, the facility failed to ensure that a resident who needs respiratory care, is provided such care, consistent with professional standards of practice for 2 (Residents #17 and #80) of 3 reviewed for respiratory care. 1. Resident #17's nebulizer mask was not covered in a plastic bag when it was not used on 04/15/2025. 2. Resident #80 was receiving oxygen 4 liter per minutes via nasal cannular without a physician order. These failures could affect residents with oxygen therapy and could lead them to lack of care including possible infection by not following infection control. The findings included: 1. Record review of Resident #17's face sheet, dated 04/18/2025, revealed the resident was a [AGE] year-old female and admitted to the facility on [DATE] with diagnoses of aphasia (a language disorder that affects a person's ability to communicate), hypertension (high blood pressure), atrial fibrillation (irregular, often rapid heart rate that commonly causes poor blood flow), and chronic obstructive pulmonary disease (a group of lung disease that block airflow and make it difficult to breathe). Record review of Resident #17's admission MDS assessment, dated 02/28/2025, revealed the resident's BIMS score was 0 out of 15 which indicated the resident had severe cognition impairment and required partial/moderate assistance (helper does less than half the effort) to sit to stand, chair-to-bed, and toilet transfer. Record review of Resident #17's physician order, dated 04/11/2025, revealed the resident had the order of Ipratropium-Albuterol inhalation solution 0.5-2.5 93) mg/3ml - 1 viral inhale orally four times a day for short of breath for 7 days. Record review of Resident #17's medication administration record, from 04/01/2025 to 04/30/2025, revealed the order of Ipratropium-Albuterol inhalation solution 0.5-2.5 93) mg/3ml - 1 viral inhale orally four times a day for short of breath for 7 days was scheduled 0800, 1200, 1600, and 2000. Observation on 04/15/2025 at 10:03 a.m. revealed Resident #17 was on the bed and sleeping in her room. Resident #17's nebulizer mask connected to a nebulizer was on the nightstand uncovered. Interview on 04/15/2025 at 10:59 a.m. with LVN-L stated Resident #17's nebulizer mask was on the nightstand without a plastic bag. Further interview with LVN-L said the resident's nebulizer mask should have been covered in a plastic bag when it was not used to prevent possible infection. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/17/2025 at 2:06 p.m. the DON stated Resident #17's nebulizer mask should have been covered in a plastic bag when it was not used to prevent possible infections. Further interview with DON said the facility did not have a policy related to specifically covering a nasal cannula and mask in a plastic bag when not used, and it was nurse's responsibility. Record review of professional guidelines, titled HomeCare (https://www.homecaremag.com/february-2020/dont-let-oxygen-concentrator-lead-infection), dated 04/18/2025, revealed Patients receiving supplemental oxygen via an oxygen concentrator in the home are common. Unfortunately, compliance issues related to infection prevention and control are also common. To prevent these compliance issues-and, more importantly, to prevent respiratory infections-provide education based on the manufacturer's instructions for use. When none are provided, follow these five infection prevention and control strategies for a patient on oxygen at a liter flow of up to 5 liters per minute (L/min) in the home except those with an artificial airway, with cystic fibrosis, or who are severely immunosuppressed. These patients and those on higher liter flows of oxygen may require a higher standard of respiratory equipment management and additional disinfection activities. 2. Record review of Resident #80's face sheet, dated 04/18/2025, revealed the resident was an [AGE] year old male and admitted to the facility on [DATE] with the diagnosis of pneumonia (infection that inflames air sacs in one or both lungs), hypertension (high blood pressure), lymphedema (selling most often in an arms or legs caused by lymphatic system blockage), respiratory failure (inadequate gas exchange by the respiratory system), and pulmonary embolism (sudden blockage in an lung artery). Record review of Resident #80's admission MDS revealed the MDS was still in progress on 04/18/2025 because the resident was admitted on [DATE]. Record review of Resident #80's care plan, dated 04/11/2025, revealed The resident has pneumonia. For interventions - oxygen therapy as ordered. Record review of Resident #80's physician orders, from 04/05/2025 to 04/18/2025, revealed there was no physician orders related to oxygen. Observation on 04/18/2025 at 9:00 a.m. revealed Resident #80 was receiving oxygen 4 liters per minutes via nasal cannular. Interview on 04/18/2025 at 9:32 a.m. with ADON-A stated Resident #80 was receiving oxygen 4 liters per minutes via nasal cannular, and the resident's primary care physician was aware of it, but facility nurses forgot about putting the oxygen order on the system. It was a mistake, and DON or ADON should have checked physician orders regularly. Administering oxygen without a physician order might cause improper care. Record review of the facility policy, titled Oxygen Administration, revised 2003, revealed Oxygen therapy is also prescribed to ensure oxygenation of all body, organ, and systems. The amount of oxygen by percent of concentration or liter per minutes and the method of administration is ordered by the physician.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39049 Based on observations, interviews, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments for 1 (the long-term care medication room) of 2 medication rooms and 1 (Resident #80) of 20 residents reviewed for storage and medication carts. 1. The long-term care medication room was opened without locking. 2. There was one 10 cc syringe of normal saline for flushing Resident #80's PICC line (peripherally inserted central catheter: used to deliver medications and other treatments directly to the large central veins near the heart) on the resident's nightstand unattended. This failure could place residents at risk of misappropriation of medications and using normal saline to different purpose, such as drinking it. The findings were: 1. Observation on 04/17/2025 at 11:53 a.m. revealed the long-term care medication room was unlocked and opened without staff supervision, and inside the medication rooms, there were many over-the-counters and prescribed medication stored. Interview on 04/17/2025 at 11:54 a.m. with DON revealed the long-term care medication room was unlocked and opened without staff, and the room was supposed to be locked at all times to prevent possible misappropriation of medications. DON said nurses might not fully close the door of the medication room, so the door was left unlocked and opened. DON said she would talk to maintenance to fix the door. Record review of the facility's policy, titled Storage of controlled substance, revised 2003, revealed . 6. All medication and other drugs, including treatment items, shall be stored in a locked cabinet or room, inaccessible to patients and visitors. 2. Record review of Resident #80's face sheet, dated 04/18/2025, revealed the resident was [AGE] years old male and admitted to the facility on [DATE] with diagnoses of pneumonia (infection that inflames air sacs in one or both lungs), hypertension (high blood pressure), lymphedema (selling most often in an arms or legs caused by lymphatic system blockage), respiratory failure (inadequate gas exchange by the respiratory system), and pulmonary embolism (sudden blockage in an lung artery). Record review of Resident #80's admission MDS assessment revealed the MDS was still in progress on 04/18/2025 because the resident was admitted on [DATE]. Record review of Resident #80's care plan, dated 04/11/2025, revealed The resident has intravenous access. For interventions - Flush the ports/lines as ordered. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #80's physician order, dated 04/06/2025, revealed Cefepime HCL intravenous solution 2 gm/100 ml. Use 100 ml intravenously three times a day for pneumonia. Flush with 10 cc normal saline before and after. Flush blood port with 10 cc normal saline every evening antibiotic dose. Record review of Resident #80's medication administration record, from 04/01/2025 to 04/30/2025 revealed Cefepime HCL intravenous solution 2 gm/100 ml. Use 100 ml intravenously three times a day for pneumonia. Flush with 10 cc normal saline before and after. Flush blood port with 10 cc normal saline every evening antibiotic dose was scheduled 0000, 0800, and 1600. Observation on 04/15/2025 at 9:47 a.m. revealed Resident #80 was sleeping in the bed in his room, and there was one 10 cc syringe of normal saline to flush the resident's PICC line on the nightstand unattended. Interview on 04/15/2025 at 10:55 a.m. with LVN-L revealed there was one 10 cc syringe of normal saline to flush Resident #80's PICC line on the resident's nightstand unattended, and it should have been stored in a nursing cart, instead of the resident's room to prevent possible improper use, such as drinking. Interview on 04/17/2025 at 2:06 p.m. with DON revealed nurses should have stored normal saline for flushing Resident #80's PICC line in a nursing cart, instead of resident room to prevent possible improper using. Record review of the facility's policy, titled Storage of controlled substance, revised 2003, revealed . 6. Drugs shall be stored in an orderly manner in cabinets, drawer, or carts of sufficient size to prevent crowding. All medication and other drugs, including treatment items, shall be stored in a locked cabinet or room, inaccessible to patients and visitors.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44020 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen. The facility failed to ensure dietary staff used facial hair restraints properly during meal preparation. The facility failed to ensure the dietary staff used proper hand placement and hand hygiene during plate preparation. These failures could place residents who received meals and/or snacks from the kitchen at risk for food borne illness. The findings included: Observation on 04/17/2025 at 11:38 a.m. revealed the Dietary Manager while taking food temperatures was wearing a facial hair restraint over the hair on his chin, but not over his mustache. The Dietary Manager continued to cook while not wearing the facial hair restraint properly and was observed stirring soup and onions that were cooking on the stove that would be added to the pork chops. During an observation and interview on 04/17/2025 at 11:45 a.m. the Dietary Manager left the cooking side of the kitchen and when he returned, he was observed lifting his facial hair restraint to cover his mustache. The Dietary Manager stated he did not realize it had slipped down. The Dietary Manager stated the facial hair restraint was to protect the food from physical hazards. He further stated someone could get sick if hair was to get in the food. He stated staff were to wear hair restraints as soon as they came in the kitchen. Observation on 04/17/2025 at 12:33 p.m. revealed [NAME] B was placing plates on the plate warmer by grabbing plates with her thumb and finger placed down on the inner part of the plate while wearing gloves then patting the plates with her gloved hand. [NAME] B was then observed moving tray racks from one side of the serving line to another and continued to pick up plates placing them on the warmer by holding the plates by her thumb and fingers touching the inner part of the plates without having washed her hands or changing her gloves. Observation on 04/17/2025 at 12:40 p.m. revealed [NAME] B was removing noodles from the kitchen's warmer by opening the doors with gloved hands, using a towel to open doors, and then spooning out noodles and placing them on a plate. [NAME] B then proceeded to continue to place the plates on the warmer by grabbing the plate with thumb or fingers down on the plate and served a bowl of soup with thumb down in the inside of the bowl. [NAME] B was observed to not have washed her hands or change her gloves after getting items from the food warmer and having handled the towel with her gloved hands. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 04/17/2025 at 12:43 p.m. [NAME] B demonstrated how she would place plates on the warmer and as she did, she noticed she left something on the plate as she had her thumb and fingers on the plate. [NAME] B stated she should have washed her hands and changed gloves after getting items from the warmer. [NAME] B further stated after having touched the tray racks between plates she should have also washed her hands and changed gloves. [NAME] B further stated by touching the inside of the bowl while serving soup and touching the plates when placing on the warmer she could cause cross contamination. [NAME] B stated this could cause residents to get sick. During an interview on 04/17/2025 at 12:47 p.m. the Dietary Manger stated the cook should not have used the disposable towel when getting items out of the warmer oven. The Dietary Manager further stated the cook should have taken off her gloves and washed her hands after touching the tray racks and after getting items from the warmer oven and handling the disposable towel that was used to open doors to the warmer. The Dietary Manager stated someone could get hurt due to staff not washing hands and stated that could cause someone to get sick. During an interview on 04/18/2025 at 3:09 p.m. the DON stated those issues in the kitchen were an infection control issue and they could contaminate the food causing food borne illness. During an interview on 04/18/2025 at 3:10 p.m. the Administrator stated they were not to wear gloves on the line. The Administrator further stated the staff were supposed wash their hands after touching things that would be considered not clean such as the tray rack and warmer door handles. The Administrator stated that was cross contamination. The Administrator stated residents could be affected with a food borne illness. The Administrator stated hair restraints were to be worn anytime in the staff were in the kitchen. She stated hair could get in the food and cause cross contamination. Review of facility's policy, Dietary Food Service Personnel Policy and Procedures, dated 2012, read Sanitation and Food Handling: 2. Hair nets or hats covering the hairline are worn at all times. [NAME] guards are required for facial hair. 4. Handle all utensils and dishes so the food or customer contact surfaces are not touched . 5. Do not handle food with bare hands. Use proper utensil or wear disposable gloves. Remember to change gloves after touching anything that should not contact food, including clothing, hair, doorknobs, etc. Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 2-402 Hair Restraints, 2-402.11, Effectiveness., (A) Except as provided in paragraph (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. Review of the Food Code, U.S. Public Health Service, U.S. FDA, 2022, U.S. Department of H&HS, revealed, 2-301.14, When to Wash, FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTNESILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks;.

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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** 39049 Based on observations, interviews, and record review, the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections for 2 residents (Residents #37 and #20) of 20 residents reviewed for infection control practices. 1. CNA-M put a new and clean brief under Resident #37 without changing gloves after removing an old and dirty brief. 2. LVN-P changed her gloves without sanitizing or washing her hands after cleaning Resident #20's stoma (small opening in the abdomen that is used to remove body waste) with feces. 3. The facility failed to ensure CNA E and NA F wore the proper PPE when entering Resident #20's room who was isolated due to COVID-19 exposure. These deficient practice could place residents at risk for cross contamination and infections. The findings included: 1. Record review of Resident #37's face sheet, dated 04/18/2025, revealed the resident was a [AGE] year-old female, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (a group of lung disease that block airflow and make it difficult to breathe), type 2 diabetes mellitus (the body has trouble controlling blood sugar and using it for energy), hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body), cerebral infarction (disrupted blood flow to the brain due to problems with the blood vessels that supply it), and hypertension (high blood pressures). Record review of Resident #37's quarterly MDS assessment, dated 01/31/2025, revealed the resident's BIMS score was 5 out of 15, which indicated the resident had severe cognitive impairment. She always had urinary and bowel incontinence. Record review of Resident #37's comprehensive care plan, dated 04/05/2023, revealed the resident had bladder and bowel incontinence. For intervention - incontinent care at least every 2 hour and apply moisture barrier after each episode. Observation on 04/16/2025 at 3:18 p.m. revealed CNA-M removed Resident #37's old and dirty brief and cleaned her suprapubic area, left, right groin area, and middle area of the resident's genital area. CNA-M turned the resident to left side to cleaned the resident's buttock area and then put a new and clean brief under the resident using CNA-M's old and dirty gloves. After completing perineal care, CNA-M took off the old and dirty gloves and washed her hands before leaving the resident's room. Interview on 04/16/2025 at 3:49 p.m., CNA-M stated she did not change her gloves after cleaning Resident #37's buttock area. CNA-M said she should have changed her gloves after sanitizing or washing hands before putting a new and clean brief under the resident to prevent possible infection. (continued on next page)

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Silver Tree Nursing and Rehabilitation Center	930 Roy Richard Dr Schertz, TX 78154

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 04/17/2025 at 3:23 p.m. DON stated CNA-M should have changed her gloves after sanitizing or washing hands before putting a new and clean brief under the resident to prevent possible infection. 2. Record review of Resident #20's face sheet, dated 04/18/2025, revealed the resident was a [AGE] year-old female, originally admitted on [DATE], and readmitted to the facility on [DATE] with diagnoses of dementia (over time destroy nerve cells and damage the brain), and urinary tract infection (bladder infection), covid-19, intestinal obstruction (digested material is prevented from passing normally through the bowel), colostomy status (opening in the large intestine), and hypertension (high blood pressure). Record review of Resident #20's quarterly MDS, dated [DATE], revealed the resident's BIMS score was 7 out of 15 which indicated the resident had severe cognitive impairment. She had ostomy (including urostomy, ileostomy, and colostomy - small opening in the abdomen that is used to remove body waste). Record review of Resident #20's comprehensive care plan, revised 10/15/2020, revealed The resident has an ostomy. For intervention - perform ostomy care as ordered. Observation on 04/17/2025 at 9:10 a.m. revealed LVN-P removed Resident #20's old colostomy bag and cleaned the stoma because the stoma was dirty with feces. After cleaning the stoma, LVN-P changed only her gloves without sanitizing or washing her hands, then put the new colostomy bag to the resident. Interview on 04/17/2025 at 9:23 a.m. with LVN-P revealed she should have sanitized or washed her hands first and put on new gloves after cleaning Resident #20's stoma because she cleaned feces from the stoma to prevent possible infection. LVN-P said she was nervous and forgot. Interview on 04/17/2025 at 2:06 p.m. with the DON stated LVN-P should have sanitized or washed her hands first and put on new gloves after cleaning Resident #20's stoma because LVN-P cleaned feces from the stoma to prevent possible infection. 3. Record review of Resident #20's face sheet, dated 04/15/2025, revealed he was admitted on [DATE] and original admitted d 01/11/2013 with diagnoses which included: dementia (a general term for the progressive loss of cognitive function, including memory, thinking, and reasoning abilities, that interferes with daily life) in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, covid-19, intestinal obstruction (digested material is prevented from passing normally through the bowel), colostomy status (opening in the large intestine), and hypertension (high blood pressure). Record review of Resident #20's Quarterly MDS assessment, dated 02/28/2025, revealed the resident's BIMS score was a 07 indicating moderate cognitive impairment. Record review of Resident #20's physician order summary report, dated, 04/15/2025, revealed a physician order reading, Aerosol isolation precautions r/t COVID exposure with a start date of 04/15/2025. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #20's care plan, initiated date of 04/15/2025, revealed Resident #20 had a Focus of I have been exposed to COVID-19. and interventions/tasks revealed, Encourage to use clean hygiene techniques to avoid cross-contamination. Record review of Resident #20's physician order summary report, dated, 04/15/2025, revealed a physician order reading, Aerosol isolation precautions r/t COVID exposure with a start date of 04/15/2025. Observation on 04/15/2025 at 11:47 a.m. revealed Aerosol Contact Precautions signage on Resident #20's room door with PPE supplies outside and CNA E and NA F donning gown, gloves, and regular face mask before going. CNA E and NA F were then observed exiting the room with CNA E carrying a clear trash bag with both of their gowns and gloves in it. During an interview on 04/15/2025 at 11:48 a.m. CNA E stated when entering Resident #20's room staff should wear a mask and a gown. CNA E further stated he believed he was able to go in the room with a regular mask. CNA E stated he believed Resident #20 was isolated due having been exposed to COVID. CNA E stated trash was taken to that room (pointing to soiled room) as long as it was in a bag. NA F stated it was her second day and she was training. During an interview on 04/15/2025 at 12:22 p.m. CNA E stated staff were to wear a N95 mask when they were in Resident #20's room. He stated those masks were on the cart outside of the resident's room. During an interview on 04/18/2025 at 1:38 p.m. CNA E stated staff were aware of precautions due to the set up outside of the room before they went in the room, and they were given a picture that alerted them to the type of isolation on the door. CNA E further stated the sign on the door instructions them on what they needed when they went in the room. CNA E stated that after staff finished and took everything off the staff would want to be sure they were placing items in a double plastic bag that should be in the room for them. CNA E stated he felt on that day he did not fully understand that even if it was just exposure of the resident he still needed to gown up, mask up, wear eye protection and that the trash should have been double bagged and left in the room. CNA E stated he did not have to remove the trash from the contact rooms, and he assumed it was the nurse that removed it. CNA E further stated by not following the aerosol contact isolation precaution it could cause the spread of infection. CNA E stated when he first started, he was trained on infection control and he had been trained on droplet, air, and contact precautions but couldn't remember all of them. During an interview on 04/18/2025 at 1:49 p.m. NA F stated it had been her 2nd day of training. NA F further stated she did receive orientation prior to being placed on the floor and during the orientation they did discuss isolation. NA F stated the training had discussed what to wear in the different situations by following the signage on the doors, to use the items provided in the bins before entering the rooms and to sanitize hands. NA F stated when her and CNA E left the room they should have removed the items, placed in the trash inside the room, and sanitize hands. NA F stated by using the precautions it would keep her and CNA E from getting infected and from spreading the virus to others. NA F stated this was for the patient's safety and her safety. (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 04/18/2025 at 3:21 p.m. the Administrator stated staff should have been wearing a N95 mask and a face shield when entering Resident #20's room due to the Aerosol Contact Precautions. The Administrator further stated the trash should have been taken to the barrel in double bags. The Administrator stated by following these precautions the staff would have protected themselves and kept from spreading the virus to other residents. During an interview on 04/18/2025 at 3:32 p.m. the DON stated the staff should have been wearing N95 mask and face shields when entering Resident #20's room and by not doing so could cause cross contamination or spread of the virus. During an interview on 04/18/2025 at 4:06 p.m. LVN Q stated Resident #20 was on air isolation and had been on the isolation for a couple of days. LVN Q stated Resident #20's former roommate had tested positive. LVN Q stated when staff entered Resident #20's room they should wear a gown, gloves, face mask and face shield. LVN Q further stated she believed it was safe to wear a regular mask with a face shield. LVN Q stated by not wearing PPE it could expose staff to the virus and they could carry it to others. Record review of facility's Aerosol Contact Precautions sign from door, no date, read, Stop Aerosol Contact Precautions in addition to Standard Precautions .Everyone Must: including visitors, doctors & staff. Clean hands when entering and leaving room. Respirator Use a NIOSH-approved N95 or equivalent or higher-level respirator .Wear eye protection (face shield or goggles). Gown and glove at door. Record review of facility's Infection Control Plan: Overview policy, updated 03/2024, read, Infection Control: The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection . Preventing Spread of Infection: When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility will isolate the resident .The facility will require the staff to Donn and Doff PPE before and after contact with resident who needs isolation to prevent the spread of infection to others in the facility. 44020

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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. 46677 Based on interview and record review the facility failed to develop, implement, and maintain an effective training program for all new and existing staff for 5 of 27 (CNA G, Dietary Aide K, MA J, Dietary Manager, and ADON A) employees reviewed for training requirements. The facility failed to implement and maintain a training program that ensured CNA G, Dietary Aide K, MA J, Dietary Manager, and ADON A received required trainings annually. This failure could affect residents and place them at risk of being uninformed due to lack of staff training. Findings include: Record review of the personnel records for CNA G revealed a hire date of 09/13/2021. Review of a training in-services for CNA G from 04/15/2024 to 04/15/2025, provided by the HR Coordinator revealed no evidence of communication training being provided annually. Record review of the personnel records for Dietary Aide K revealed a hire date of 11/10/2022. Review of a training in-services for Dietary Aide K from 04/15/2024 to 04/15/2025, provided by the HR Coordinator revealed no evidence of ethics training being provided annually. Record review of the personnel records for MA J revealed a hire date of 01/18/2023. Review of a training in-services for MA J from 04/15/2024 to 04/15/2025, provided by the HR Coordinator revealed no evidence of communication training being provided annually. Record review of the personnel records for Dietary Manager revealed a hire date of 04/17/2023. Review of a training in-services for Dietary Manager from 04/15/2024 to 04/15/2025, provided by the HR Coordinator revealed no evidence of resident rights training, ethics training, and behavior health training being provided annually. Record review of the personnel records for ADON A revealed a hire date of 02/07/2022. Review of a training in-services for ADON A from 04/15/2024 to 04/15/2025, provided by the HR Coordinator revealed no evidence of ethics training being provided annually. Interview with the HR Coordinator on 04/17/2025 at 12:00 PM, revealed the facility used Relias (computer based training program) for employee's annual trainings. The HR Coordinator stated employees received emails informing them they had annual trainings due. The HR Coordinator stated that department heads also received emails when their employees had an annual training due. The HR Coordinator stated department heads were responsible to ensure staff completed their annual trainings timely. The HR Coordinator stated it was important that staff had their annual trainings because without the annual training's residents could be hurt. (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Administrator 04/18/2025 at 11:32 AM revealed the facility used Relias for employee's annual trainings. The Administrator stated corporate assigned employees their annual trainings in Relias. The Administrator stated nursing also completed in-services annually. The Administrator stated staff and their supervisor were notified via email that they had a new training assigned in Relias. The Administrator stated it was the responsibility of the employees and their supervisors to ensure their annual trainings were completed once assigned. The Administrator stated it was important to train staff annually to ensure residents were safe and free from abuse. Interview with the DON on 04/18/2025 at 2:30 PM, revealed she has only worked for the facility about a month. The DON stated staff were trained annually via Relias. The DON was not sure how the annual trainings were assigned. The DON stated it was the responsibility of the department heads to ensure their staff completed their annual trainings. The DON stated it was important to train staff annually to ensure resident receive care that meet their needs. Record review of the facility's employee handbook, section named HR-Personnel Handbook 2019, dated 09/20/2019, revealed EMPLOYEE EDUCATION PROGRAM All employees, regardless of status or classification, are required to complete mandatory training as defined by Federal, State and company policies. This facility provides multiple avenues of training that include an online learning management system, external CEU training, reimbursement for program or licensure training and more. For additional information about education opportunities, please contact the Benefits office. A policy addressing required annual training including communication training, resident rights training, ethics training, and behavior health training was requested from the HR Coordinator on 04/17/2025 at 12:00 PM but was not provided prior to exit. A policy addressing required annual training including communication training, resident rights training, ethics training, and behavior health training was requested from the Administrator on 04/18/2025 at 11:32 AM but was not provided prior to exit. A policy addressing required annual training including communication training, resident rights training, ethics training, and behavior health training was requested from the DON on 04/18/2025 at 02:30 PM but was not provided prior to exit.

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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 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. 46677 Based on interview and record review, the facility failed to provide communications training for 2 of 27 employees (CNA G and MA J) reviewed for training, in that: The facility failed to ensure effective communication training was provided to CNA G and MA J annually. This failure could affect residents and place them at risk of being uninformed due to lack of staff training. Findings include: Record review of the personnel records for CNA G revealed a hire date of 09/13/2021. Review of a training in-services for CNA G from 04/15/2024 to 04/15/2025, provided by the HR Coordinator revealed no evidence of communication training being provided annually. Record review of the personnel records for MA J revealed a hire date of 01/18/2023. Review of a training in-services for MA J from 04/15/2024 to 04/15/2025, provided by the HR Coordinator revealed no evidence of communication training being provided annually. Interview with the HR Coordinator on 04/17/2025 at 12:00 PM, revealed the facility used Relias (computer based training program) for employee's annual trainings. The HR Coordinator stated employees received emails informing them they had annual trainings due. The HR Coordinator stated that department heads also received emails when their employees had an annual training due. The HR Coordinator stated department heads were responsible to ensure staff completed their annual trainings timely. The HR Coordinator stated it was important that staff had their annual trainings because without the annual training's residents could be hurt. Interview with the Administrator 04/18/2025 at 11:32 AM revealed the facility used Relias for employee's annual trainings. The Administrator stated corporate assigned employees their annual trainings in Relias. The Administrator stated nursing also completed in-services annually. The Administrator stated staff and their supervisor were notified via email that they had a new training assigned in Relias. The Administrator stated it was the responsibility of the employees and their supervisors to ensure their annual trainings were completed once assigned. The Administrator stated it was important to train staff annually to ensure residents were safe and free from abuse. Interview with the DON on 04/18/2025 at 2:30 PM, revealed she has only worked for the facility about a month. The DON stated staff were trained annually via Relias. The DON was not sure how the annual trainings were assigned. The DON stated it was the responsibility of the department heads to ensure their staff completed their annual trainings. The DON stated it was important to train staff annually to ensure resident receive care that meet their needs. Record review of the facility's employee handbook, section named HR-Personnel Handbook 2019, dated 09/20/2019, revealed EMPLOYEE EDUCATION PROGRAM (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 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All employees, regardless of status or classification, are required to complete mandatory training as defined by Federal, State and company policies. This facility provides multiple avenues of training that include an online learning management system, external CEU training, reimbursement for program or licensure training and more. For additional information about education opportunities, please contact the Benefits office. A policy addressing required annual training including communication training was requested from the HR Coordinator on 04/17/2025 at 12:00 PM but was not provided prior to exit. A policy addressing required annual training including communication training was requested from the Administrator on 04/18/2025 at 11:32 AM but was not provided prior to exit. A policy addressing required annual training including communication training was requested from the DON on 04/18/2025 at 02:30 PM but was not provided prior to exit.

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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 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. 46677 Based on interview and record review, the facility failed to provide mandatory effective training on rights of the resident training for 1 of 27 employees (Dietary Manager) reviewed for training, in that: The facility failed to ensure effective rights of the resident training was provided to Dietary Manager annually. This failure could affect residents and place them at risk of being uninformed due to lack of staff training. The findings include: Record review of the personnel records for Dietary Manager revealed a hire date of 04/17/2023. Review of a training in-services for Dietary Manager from 04/15/2024 to 04/15/2025, provided by the HR Coordinator revealed no evidence of resident rights training being provided annually. Interview with the HR Coordinator on 04/17/2025 at 12:00 PM, revealed the facility used Relias (computer-based training program) for employee's annual trainings. The HR Coordinator stated employees received emails informing them they had annual trainings due. The HR Coordinator stated that department heads also received emails when their employees had an annual training due. The HR Coordinator stated department heads were responsible to ensure staff completed their annual trainings timely. The HR Coordinator stated it was important that staff had their annual trainings because without the annual training's residents could be hurt. Interview with the Administrator 04/18/2025 at 11:32 AM revealed the facility used Relias for employee's annual trainings. The Administrator stated corporate assigned employees their annual trainings in Relias. The Administrator stated nursing also completed in-services annually. The Administrator stated staff and their supervisor were notified via email that they had a new training assigned in Relias. The Administrator stated it was the responsibility of the employees and their supervisors to ensure their annual trainings were completed once assigned. The Administrator stated it was important to train staff annually to ensure residents were safe and free from abuse. Interview with the DON on 04/18/2025 at 2:30 PM, revealed she has only worked for the facility about a month. The DON stated staff were trained annually via Relias. The DON was not sure how the annual trainings were assigned. The DON stated it was the responsibility of the department heads to ensure their staff completed their annual trainings. The DON stated it was important to train staff annually to ensure resident receive care that meet their needs. Record review of the facility's employee handbook, section named HR-Personnel Handbook 2019, dated 09/20/2019, revealed EMPLOYEE EDUCATION PROGRAM (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 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All employees, regardless of status or classification, are required to complete mandatory training as defined by Federal, State and company policies. This facility provides multiple avenues of training that include an online learning management system, external CEU training, reimbursement for program or licensure training and more. For additional information about education opportunities, please contact the Benefits office. A policy addressing required annual training including resident rights training was requested from the HR Coordinator on 04/17/2025 at 12:00 PM but was not provided prior to exit. A policy addressing required annual training including resident rights training was requested from the Administrator on 04/18/2025 at 11:32 AM but was not provided prior to exit. A policy addressing required annual training including resident rights training was requested from the DON on 04/18/2025 at 02:30 PM but was not provided prior to exit.

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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. 46677 Based on interview and record review, the facility failed to provide mandatory ethics training for 3 of 27 employees (Dietary Aide K, Dietary Manager, and ADON A) employees reviewed for training, in that: The facility failed to ensure ethics training was provided to Dietary Aide K, Dietary Manager, and ADON A annually. This failure could affect residents and place them at risk of being uninformed due to lack of staff training. The findings include: Record review of the personnel records for Dietary Aide K revealed a hire date of 11/10/2022. Review of a training in-services for Dietary Aide K from 04/15/2024 to 04/15/2025, provided by the HR Coordinator revealed no evidence of Ethics training being provided annually. Record review of the personnel records for Dietary Manager revealed a hire date of 04/17/2023. Review of a training in-services for Dietary Manager from 04/15/2024 to 04/15/2025, provided by the HR Coordinator revealed no evidence of ethics training being provided annually. Record review of the personnel records for ADON A revealed a hire date of 02/07/2022. Review of a training in-services for ADON A from 04/15/2024 to 04/15/2025, provided by the HR Coordinator revealed no evidence of ethics training being provided annually. Interview with the HR Coordinator on 04/17/2025 at 12:00 PM, revealed the facility used Relias (computer-based training program) for employee's annual trainings. The HR Coordinator stated employees received emails informing them they had annual trainings due. The HR Coordinator stated that department heads also received emails when their employees had an annual training due. The HR Coordinator stated department heads were responsible to ensure staff completed their annual trainings timely. The HR Coordinator stated it was important that staff had their annual trainings because without the annual training's residents could be hurt. Interview with the Administrator 04/18/2025 at 11:32 AM revealed the facility used Relias for employee's annual trainings. The Administrator stated corporate assigned employees their annual trainings in Relias. The Administrator stated nursing also completed in-services annually. The Administrator stated staff and their supervisor were notified via email that they had a new training assigned in Relias. The Administrator stated it was the responsibility of the employees and their supervisors to ensure their annual trainings were completed once assigned. The Administrator stated it was important to train staff annually to ensure residents were safe and free from abuse. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the DON on 04/18/2025 at 2:30 PM, revealed she has only worked for the facility about a month. The DON stated staff were trained annually via Relias. The DON was not sure how the annual trainings were assigned. The DON stated it was the responsibility of the department heads to ensure their staff completed their annual trainings. The DON stated it was important to train staff annually to ensure resident receive care that meet their needs. Record review of the facility's employee handbook, section named HR-Personnel Handbook 2019, dated 09/20/2019, revealed EMPLOYEE EDUCATION PROGRAM All employees, regardless of status or classification, are required to complete mandatory training as defined by Federal, State and company policies. This facility provides multiple avenues of training that include an online learning management system, external CEU training, reimbursement for program or licensure training and more. For additional information about education opportunities, please contact the Benefits office.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676121	A. Building B. Wing	04/18/2025

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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. 46677 Based on interview and record review, the facility failed to ensure CNA received the required minimum 12 hours annual in-service for 1 of 4 CNAs (CNA G) reviewed for training. The facility failed to provide the required 12 hours of annual training to CNA G. This failure could affect residents and place them at risk of being uninformed due to lack of staff training. The findings include: Record review of the personnel records for CNA G revealed a hire date of 07/31/2023. Review of a training in-services for CNA G from the previous 12 months, provided by the HR Coordinator revealed no evidence that the facility provided the required 12 hours of in-service trainings including communication training being provided annually. Interview with the HR Coordinator on 04/17/2025 at 12:00 PM, revealed the facility used Relias(computer-based training program) for employee's annual trainings. The HR Coordinator stated employees received emails informing them they had annual trainings due. The HR Coordinator stated that department heads also received emails when their employees had an annual training due. The HR Coordinator stated department heads were responsible to ensure staff completed their annual trainings timely. The HR Coordinator stated it was important that staff had their annual trainings because without the annual training's residents could be hurt. Interview with the Administrator 04/18/2025 at 11:32 AM revealed the facility used Relias for employee's annual trainings. The Administrator stated corporate assigned employees their annual trainings in Relias. The Administrator stated nursing also completed in-services annually. The Administrator stated staff and their supervisor were notified via email that they had a new training assigned in Relias. The Administrator stated it was the responsibility of the employees and their supervisors to ensure their annual trainings were completed once assigned. The Administrator stated it was important to train staff annually to ensure residents were safe and free from abuse. Interview with the DON on 04/18/2025 at 2:30 PM, revealed she has only worked for the facility about a month. The DON stated staff were trained annually via Relias. The DON was not sure how the annual trainings were assigned. The DON stated it was the responsibility of the department heads to ensure their staff completed their annual trainings. The DON stated it was important to train staff annually to ensure resident receive care that meet their needs. Record review of the facility's employee handbook, section named HR-Personnel Handbook 2019, dated 09/20/2019, revealed EMPLOYEE EDUCATION PROGRAM (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All employees, regardless of status or classification, are required to complete mandatory training as defined by Federal, State and company policies. This facility provides multiple avenues of training that include an online learning management system, external CEU training, reimbursement for program or licensure training and more. For additional information about education opportunities, please contact the Benefits office. A policy addressing required minimum 12 hours annual in-service for CNA was requested from the HR Coordinator on 04/17/2025 at 12:00 PM but was not provided prior to exit. A policy addressing required minimum 12 hours annual in-service for CNA was requested from the Administrator on 04/18/2025 at 11:32 AM but was not provided prior to exit. A policy addressing required minimum 12 hours annual in-service for CNA was requested from the DON on 04/18/2025 at 2:30 PM but was not provided prior to exit.

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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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 46677 Based on interview and record review, the facility failed to provide behavioral health training consistent with the requirements at S483.40 and as determined by the facility assessment at S483.71 for 1 of 27 (Dietary Manager) employees reviewed for training, in that: The facility failed to ensure behavioral health training was provided to Dietary Manager annually. This failure could affect residents and place them at risk of being uninformed due to lack of staff training. The findings include: Record review of the personnel records for Dietary Manager revealed a hire date of 04/17/2023. Review of a training in-services for Dietary Manager from 04/15/2024 to 04/15/2025, provided by the HR Coordinator revealed no evidence of behavior health training being provided annually. Interview with the HR Coordinator on 04/17/2025 at 12:00 PM, revealed the facility used Relias (computer-based training program) for employee's annual trainings. The HR Coordinator stated employees received emails informing them they had annual trainings due. The HR Coordinator stated that department heads also received emails when their employees had an annual training due. The HR Coordinator stated department heads were responsible to ensure staff completed their annual trainings timely. The HR Coordinator stated it was important that staff had their annual trainings because without the annual training's residents could be hurt. Interview with the Administrator 04/18/2025 at 11:32 AM revealed the facility used Relias for employee's annual trainings. The Administrator stated corporate assigned employees their annual trainings in Relias. The Administrator stated nursing also completed in-services annually. The Administrator stated staff and their supervisor were notified via email that they had a new training assigned in Relias. The Administrator stated it was the responsibility of the employees and their supervisors to ensure their annual trainings were completed once assigned. The Administrator stated it was important to train staff annually to ensure residents were safe and free from abuse. Interview with the DON on 04/18/2025 at 2:30 PM, revealed she has only worked for the facility about a month. The DON stated staff were trained annually via Relias. The DON was not sure how the annual trainings were assigned. The DON stated it was the responsibility of the department heads to ensure their staff completed their annual trainings. The DON stated it was important to train staff annually to ensure resident receive care that meet their needs. Record review of the facilitiy's employee handbook, section named HR-Personnel Handbook 2019, dated 09/20/2019, revealed EMPLOYEE EDUCATION PROGRAM (continued on next page)

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