STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676176	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crowley Nursing and Rehabilitation	920 E Fm 1187 Crowley, TX 76036

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 1 of 20 residents (Resident #59) reviewed for care plans. The facility failed to develop a care plan with measurable objectives and timeframes to address Resident #59' non-compliance with keeping a device in her hand for contractures. This failure could place residents at risk of receiving inadequate interventions not individualized to their care needs. Findings included: Review of Resident #59's MDS dated [DATE] revealed the resident was a [AGE] year-old female admitted to the facility on [DATE]. Her diagnoses included CVA (stroke), hemiplegia (paralysis to one side), paraplegia, and seizure disorder. The resident had a BIMS score of 9 indicating she had moderately impaired cognition, was understood and able to understand others. The MDS further reflected Resident #59 had impaired range of motion on both sides to upper and lower extremities. Resident #59 was dependent for all ADLs. Review of Resident #59's care plan revised on 05/15/24 revealed the resident had arthritis and contractures and at risk for pain, decline in ADLs, and mobility. Interventions included observe/document/report to MD signs or symptoms or complications related to arthritis: joint pain, joint stiffness, usually worse on wakening, swelling, decline in mobility, decline in self-care ability and contracture formation. Observation and interview on 05/14/24 at 12:26 PM with Resident #59 revealed she was in bed with her legs drawn up to her body and contractures were noted to both hands and there was no contracture management device in place. Resident #59 stated she usually had a carrot in her hand, but it would fall out of her hands. There was not carrot noted in the room at the time. (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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 05/16/24 at 8:27 AM revealed Resident #59 was in bed being fed by CNA B. After the resident was done eating CNA B slowly tried to open Resident #59' right hand and her palm appeared to be clean and free of odors. The resident's nails on her middle, ring, and pinkie finger were long, about half an inch, and the pointer finger and thumb were cut down. CNA B said they usually tried to keep a carrot or wash rag in the resident's hand contractures, but the resident would usually pull them out and throw them on the bed or floor, stating they were hurting her hands. Interview on 05/16/24 at 11:53 AM with LVN C revealed Resident #59 usually had carrots or wash rags in her hands for her contractures but the resident would complain her hands were in pain and take them out. LVN C further stated the Hospice Doctor had sent a letter stating Resident #59's hand could not be rehabbed, and the resident was to be kept comfortable. Review of a hospice note dated 05/15/24 signed by the hospice doctor reflected Resident #59 was on hospice services and the resident had too much pain when her hands were opened, and they were just trying to keep the resident comfortable. Interview on 05/16/24 at 12:21 PM with the Director of Rehab revealed Resident #59 had been on occupational therapy services for contracture management to her hands and she just been discharged from therapy services the week prior. During therapy services they got some carrots to put in the resident's hands for her contracture, but the resident would pull them out saying it hurt her. Once the carrots were put in her hands by therapy staff, they would go back about 5 minutes later, and the resident had already taken them out. Resident #59 was also non-compliant with having her palms cleaned and fingernails cut. The Director of Rehab further stated they had tried to use wash rags in the resident's hands, but she would begin to yell at them to take them out. Interview on 05/16/24 at 1:32 PM with the DON revealed adding resident care plans were a shared responsibility between nursing and the MDS nurse. The DON said the refusal care plan for Resident #59 should have been in place to let staff know how to care for the resident. Interview on 05/16/24 with the MDS Nurse revealed she w.as not aware of Resident #59's refusal to keep the carrots in her hand. The MDS nurse further stated the refusal should have been part of the resident's care plan and it was important to make sure all staff were aware of her choices and behaviors. Review of the facility's policy titled Care Plans, Comprehensive Person-Centered revised December 2016 reflected the following: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. .c. Describe services that would otherwise be provided for the above but are not provided due to the resident exercising his or her rights, including the right to refuse treatment

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48236 Based on observations, interviews, and record reviews the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene for 3 (Residents #82, #37, and #26) of 5 residents reviewed for ADL care. The facility failed to ensure Residents #82, #37, and #26 were shaved regularly, and failed to keep their fingernails trimmed, according to their wishes. This failure placed residents at the facility at risk of diminished quality of life. Findings included: Review of Resident #82's undated Admission Record revealed he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy (blood disorder cause by illnesses), major infection, communication deficit, and diabetes. Review of Resident #82's admission MDS, dated [DATE], revealed a BIMS score of 15 indicating he was cognitively intact. His Functional Status indicated he required some help with his self-care, particularly personal hygiene. Review of Resident #82's care plan, dated 5/05/24, revealed he had a self-care deficit related to weakness. The Goal was the resident would be clean, well-groomed, and appropriately dressed. Interventions were to be carried out by the CNAs. Observation/Interview on 5/14/24 at 11:51 AM of Resident #82 revealed he had several days of facial hair growth. Resident appeared to be clean; he could not recall his last shower. Resident #82's fingernails were overgrown. Resident stated he liked to be clean shaven, and his nails kept trimmed. Review of Resident #82's May 2024 shower log revealed his last shower was on 5/13/24. Review of Resident #82's May 2024 Personal Hygiene log revealed personal hygiene was performed daily. Personal hygiene consisted of combing hair, brushing teeth, shaving, and washing face and hands. Observation on 5/16/24 at 12:00 PM revealed Resident #82 had not been shaved, he was scratching at his facial hair and dry flaky skin was falling onto his shirt. Resident #82 stated he had not been showered since his first interview. Interview on 5/16/24 at 12:45 PM with CNA L stated Resident # 82's shower days were Monday, Wednesday, and Friday on the 2p-10p shift. She stated she did not know when his last shower was since it was scheduled on the evening shift. CNA A stated as far as she knew Resident #82 was not one to refuse care. Review of Resident #37's undated Admission Record revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included fracture of left upper leg, left upper arm, and multiple fractures of left ribs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #37'S admission MDS revealed a BIMS score of 14, indicating he was cognitively intact. Review of his Functional Status revealed he required assistance with his hygiene. Review of Resident #37's care plan, dated 5/05/24, revealed he had an ADL self-care deficit, with goals of being cleaned, well groomed, and appropriately dressed and the interventions are to be performed by the CNAs. Observation and interview on 5/16/24 at 12:05 PM of Resident #37 revealed he had several days of facial hair growth and his fingernails needed to be trimmed. Resident #37 stated he used to be a limo driver and his appearance was very important. Resident #37 stated the CNAs did not trim their nails unless they asked for it. Review of Resident #37's hygiene log for May 2024 revealed hygiene was performed daily for the resident. Review of Resident #26's undated Admission Record revealed he was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included dementia, stroke, and muscle wasting. Review of Resident #26's quarterly MDS, dated [DATE], revealed a BIMS score of 8, indicating he was moderately cognitively impaired. His Functional Status indicated he required assistance with his personal hygiene. Review of Resident #26's care plan, dated 5/08/24, revealed he had a self-care deficit with a goal of having his ADL needs met by staff. Observation/Interview on 5/16/14 at 12:18 PM revealed Resident #26 had several days growth of facial hair. Resident was unable to answer questions about his preferences. Review of Resident #26's hygiene log for May 2024 revealed hygiene had been performed daily . Interview on 5/16/24 at 2:20 PM the DON stated her expectation was for all residents to have basic hygiene performed daily, including trimming fingernails and shaving the male residents according to their preferences. The CNAs could trim fingernails, or if they were uncomfortable with doing so, they should notify the nurse so the nurse could trim them. The DON did not know why the CNAs would document hygiene being performed if they had not done all the steps. The DON stated not performing daily hygiene could lead to infections. Review of the facility's policy Care of Fingernails/Toenails dated April 2007, reflected: The purposes of this procedure are to clean the nail bed, to keep the nails trimmed, and to prevent infections.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32227 Based on observation, interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 5 residents (Resident #1) reviewed for medication administration. The ADON failed to administer medications for Resident #1, leaving the cup with two pills on the resident's shelf in the room. This failure placed residents at risk of not receiving medications as prescribed, decreased therapeutic effects of the medications, risk for drug diversion, delay in medication administration and worsening of their medical conditions. Findings included: Review of Resident #1's MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included hypertension, diabetes, cerebral palsy, seizure disorder, gastric ulcer, and hypothyroidism. Resident #1 had a BIMS score of 12 which indicated moderate cognition and was usually understood when she would express ideas. Review of Resident #1's care plan initiated on 06/12/23 reflected the resident had the potential for discomfort, complications or signs or symptoms related to diagnosis of GERD. Interventions included to give medications as ordered. The care plan further reflected Resident #1 had hypothyroidism. Interventions included to administer thyroid replacement medication to help restore the level of thyroid hormone. Review of Resident #1's physician orders for May 2024 revealed she was taking the following medications: Levothyroxine Sodium Oral Tablet 75 MCG; Give 1 tablet by mouth in the morning for Hypothyroidism. Omeprazole 20 MG Capsule delayed release; Give 1 tablet by mouth in the morning related to Gastro-esophageal reflux disease without esophagitis. Review of Resident #1's Medication Administration Record revealed both the Omeprazole and Levothyroxine were to be given daily at 5:30AM. Observation and interview on 05/16/24 at 8:41 AM with Resident #1 revealed she was in her motorized wheelchair going down the hall towards the nurse's station holding a medicine cup with two pills inside. The resident was asked why she was holding the pills and she stated she had found them on top of her drawer. Resident #1 said she did not know who left them there and did not know if they were her medications. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/16/24 at 8:50 AM with MA A revealed Resident #1 had taken all her medication she had given her that morning and the two pills in the medication cup were Omeprazole and her thyroid medication which would have been given by the night shift nurse. Interview on 05/16/24 at 12:37 PM with the ADON revealed she had worked the night shift and she was giving Resident #1 her omeprazole and Levothyroxine, but the aides were in the process of transferring the resident into her wheelchair, so she set the medication cup with the two pills on the drawer. The ADON said she meant to go back after the aides had gotten Resident #1 up to give her the medication, but she forgot and took full responsibility. The ADON further stated it was important to ensure all residents received their medication because they were treating specific health conditions. Interview on 05/16/24 at 1:26 with the DON revealed the pills in the medication cup Resident #1 were omeprazole and levothyroxine. The DON said the ADON told her she had forgotten to give the resident the pills because the aides were getting the resident up for the day so she set them down and would return after the resident had gotten up. The DON said it was important for Resident #1 to receive her medications to maintain her health status especially her levothyroxine because that was being used to maintain the resident's TSH level. Review of the facility's policy titled Administering Medications revised December 2012 reflected the following: Medications shall be administered in a safe and timely manner, and as prescribed. .3. Medications must be administered in accordance with the orders, including any required time frame

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 32227 Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored securely for 1 of 5 residents (Resident #1) on one hall reviewed for storage of medications. The ADON failed to administer medications for Resident #1, leaving the cup with two pills on the resident's shelf in the room. This failure could place residents at risk of consuming unsafe medications. Findings included: Review of Resident #1's MDS dated [DATE] reflected the resident was a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included hypertension, diabetes, cerebral palsy, seizure disorder, gastric ulcer, and hypothyroidism. Resident #1 had a BIMS of 12, moderate cognition, and was usually understood when she would express ideas. Review of Resident #1's care plan initiated on 06/12/23 reflected the resident had the potential for discomfort, complications or signs or symptoms related to diagnosis of GERD. Interventions included to give medications as ordered. The care plan further reflected Resident #1 had hypothyroidism. Interventions included to administer thyroid replacement medication to help restore the level of thyroid hormone. Review of Resident #1's physician orders for May 2024 revealed she was taking the following medications: Levothyroxine Sodium Oral Tablet 75 MCG; Give 1 tablet by mouth in the morning for Hypothyroidism Omeprazole 20 MG Capsule delayed release; Give 1 tablet by mouth in the morning related to Gastro-esophageal reflux disease without esophagitis. Review of Resident #1's Medication Administration Record revealed both the Omeprazole and Levothyroxine were to be given daily at 5:30AM. Observation and interview on 05/16/24 at 8:41 AM with Resident #1 revealed she was in her motorized wheelchair going down the hall towards the nurse's station holding a medicine cup with two pills inside. The resident was asked why she was holding the pills and she stated she had found them on top of her drawer. Resident #1 said she did not know who left them there and did not know if they were her medications. Interview on 05/16/24 at 8:50 AM with MA A revealed Resident #1 had taken all her medication she had given her that morning and the two pills in the medication cup were Omeprazole and her thyroid medication which would have been given by the night shift nurse. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 05/16/24 at 12:37 PM with the ADON revealed she had worked the night shift and she was giving Resident #1 her omeprazole and Levothyroxine but the aides were in the process of transferring the resident into her wheelchair, so she set the medication cup with the two pills on the drawer. The ADON said she meant to go back after the aides had gotten Resident #1 up to give her the medication, but she forgot and took full responsibility. The ADON further stated it was important to make sure medications were not left unattended because another resident could walk in and take them. Interview on 05/16/24 at 1:26 PM with the DON revealed the pills in the medication cup Resident #1 had were omeprazole and levothyroxine. The DON said the ADON told her she had forgotten to give the resident the pills because the aides were getting the resident up for the day so she set them down and would return after the resident had gotten up. The DON said it was important that medications are not left out due to the danger to other residents if they accidentally took them. Review of the facility's policy titled Storage of Medications revised April 2007 reflected the following: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on interview and record review, the facility failed to ensure medical records were accurately documented in accordance with accepted professional standards for 1 of 5 residents (Resident #41) reviewed for medical records. The facility failed to ensure nursing documentation was accurate for Resident #41. This failure could lead to errors in treatment based on incorrect information. Findings included: Review of Resident #41's undated Admission Record revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included stroke, liver disease, and cystic fibrosis. Review of Resident #41's admission MDS, dated [DATE], revealed a BIMS score of 5, indicating severe cognitive impairment. Her Functional Status indicated she required assistance with her ADLs. Review of Resident #41's care plan, dated 04/03/24, she was at risk for bowel and bladder incontinence and had an ADL self-care deficit. Review of Resident #41's EHR revealed she had developed a UTI and was placed on antibiotics for three days, 05/06/24-05/09/24. Review of Resident #41's physician orders revealed an order for Sulfamethoxazole-Trimethoprim Tablet 800-160 mg. Give 1 tablet by mouth two times a day for bacterial infection for 3 Days Start Date-05/07/2024 0600 [6:00 AM] Review of Resident #41's MAR for May 2024 reflected her last dose of antibiotics was on 05/09/24. Review of Resident #41's nursing documentation reflected nurses continued to document the resident was on antibiotic therapy for a UTI from 05/10/24 until 05/14/24. Interview on 05/15/24 at 1:40 PM with RN M revealed her documentation of Resident #41 still being on antibiotic therapy after it had been completed was just a mistake. RN B stated incorrect documentation could provide false information to providers. Interview on 05/15/24 at 1:45 PM the DON stated there was no explanation or excuse for nurses to document incorrectly. Accurate documentation was a basic expectation for professional nurses, and other providers and disciplines relied on accurate documentation. Review of the facility's policy Charting and Documentation, dated July 2017, reflected: .All services provided to the resident .shall be documented in the resident's medical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.3. Documentation in the medical record will be objective, complete, and accurate.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43791 Based on observation, interview, and record review, the facility failed to ensure staff followed an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 4 residents (Residents #41 and #42) reviewed for infection control. MA A failed to sanitize a reusable blood pressure cuff between Resident #41 and #42. This failure could place residents at risk of transmitting disease from one resident to another resident. Findings included: Review of Resident #42's undated Admission Record revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included brain disorder causing dying brain tissue, senile degeneration of the brain, and diabetes. Review of Resident #41's undated Admission Record revealed the resident was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included stroke, liver disease, and cystic fibrosis. Observation on 05/15/24 at 8:22 AM revealed MA N checking Resident #42's blood pressure with a re-usable blood pressure cuff. MA A did not disinfect the cuff after use, and placed it back in her cart. Observation on 05/15/24 at 8:47 AM revealed MA A checking Resident #41's blood pressure with the same re-usable blood pressure cuff used on Resident #42 without disinfecting it before or after using it and placing it back in her cart. Interview on 05/15/24 at 10:10 AM with MA A revealed she knew to disinfect the blood pressure cuff, but she was nervous. She stated failing to disinfect it could cause a disease to spread from one resident to another. Interview on 05/16/24 at 2:20 PM with the DON revealed all staff had been in-serviced on infection control multiple times, including disinfecting re-usable medical equipment. The DON stated there should be no reason staff should forget to wipe down equipment between resident uses. Review of the facility's policy Cleaning and Disinfection of Resident-Care Equipment, dated August 2009, reflected: .4. Reusable resident care equipment will be decontaminated and/or sterilized between residents .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 48236 Based on interview and record review, the facility failed to develop, implement, and maintain an effective training program for 8 of 12 staff (CNA D, CNA E, CNA F, MA G, CNA H, RN I, LVN C, LVN J,) reviewed for training, in that: The facility failed to ensure Trainings-Resident Rights, Dementia, HIV, Falls, Restraints, and ANE (Abuse, Neglect, and Exploitation) were completed during orientation and prior to start date. These failures could place residents at-risk for abuse and neglect due to lack of training. The findings were: 1. Record review of the Staff Roster, undated, revealed the CNA D was hired on 3/18/20. Record review of CNA D's training history revealed CNA D's training transcript did not indicate when last previous restraint training had been completed. 2. Record review of the Staff Roster, undated, revealed CNA E was hired on 11/8/23. Record review of CNA E's training history revealed CNA E's training transcript did not indicate when last previous restraint training had been completed. 3. Record review of the Staff Roster, undated, revealed CNA F was hired on 11/1/23. Record review of CNA F's training history revealed CNA F's training transcript did not indicate when last previous restraint training, falls, dementia, HIV, and ANE (abuse, neglect, and exploitation) had been completed. 4. Record review of the Staff Roster, undated, revealed MA G was hired on 5/21/21. Record review of MA G's new hire history revealed MA G's training transcript did not indicate when last previous restraint training had been completed. 5. Record review of the Staff Roster, undated, revealed CNA H was hired on 3/13/08. Record review of CNA H's new hire history revealed CNA H's training transcript did not indicate when last previous restraint training had been completed. 6. Record review of the Staff Roster, undated, revealed RN I was hired on 7/11/2019. Record review of RN I's required annual training history revealed RN I's training transcript did not indicate when last previous restraint training had been completed. 7. Record review of the Staff Roster, undated, revealed LVN C was hired on 10/1/2021. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676176	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crowley Nursing and Rehabilitation	920 E Fm 1187 Crowley, TX 76036

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of LVN C's required annual training history revealed LVN C's training transcript did not indicate when last previous restraint training had been completed. 8. Record review of the Staff Roster, undated, revealed LVN J was hired on 7/13/18. Record review of LVN J's required annual training history revealed LVN J's training transcript did not indicate when last previous restraint training, falls, dementia, HIV, and ANE (abuse, neglect, and exploitation) had been completed. Interview with ADON A on 5/16/2024 at 4:31 PM revealed that the responsibility to train staff was the DON's responsibility. ADON A stated, for example, if staff were not trained properly on restraints, it can result in physical or psychosocial harm to the patient. In addition, ADON A said that nurses and MA's need to know what can be considered a chemical restraint to also prevent harm to a restraint. Interview with the DON on 5/16/2024 at 4:35 PM revealed that the DON was aware that the facility had not completed their required annual restraint training with their staff. The DON stated that when staff members do not complete their annual trainings which are falls, HIV, restraints, ANE (abuse, neglect, and exploitation), and dementia there was a risk that the staff member does not know how to carry out all appropriate aspects of their job which can result in harm to a resident. The DON went on to say that this can especially be seen when nurses or MAs over medicate a resident because the facility was restraint free, and a resident should not experience a chemical restraint. The DON stated that LVN J and CNA F work the night shift and therefore frequently miss the required in-services. The DON also stated that it is the ADON's responsibility to monitor the in-service trainings. Record review of facility policy titled Staff Development Program, origination revised 8/2010 revealed, .The following in-service training classes are mandatory: a. Hepatitis B b. HIV c. Tuberculosis d. Infection Control e. Resident Rights f. Resident Abuse g. Fire Safety and Disaster Preparedness h. Hazard Communication Plan (i.e., exposure to chemicals) i. Exposure Control (i.e., exposure to blood or body fluids).