STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676350	A. Building B. Wing	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights of Tomball	27840 Johnson Road Tomball, TX 77375

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26454 Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for 1 of 8 (Resident #1) residents reviewed for accidents and supervision. CNA A failed to provide safe transfers for Resident #1 via mechanical lift/ 2-person assist, as required on 11/20/2024. Resident #1 complained of leg pain and was diagnosed with an acute, mildly displaced (broken bone where the ends of the bones are no longer aligned) spiral fracture (a fracture occurring when torque is applied along with the axis of a bone. They often occur when the body is in motion while one extremity is planted) of the right mid/distal femoral shaft (the long, straight middle part of the femur, or thigh bone) and required surgical intervention. The noncompliance was identified as Past Non-Compliance. The IJ began on 11/20/2024 and ended on 11/21/2024. The facility corrected the noncompliance before the survey began. This failure placed dependent residents at risk of experiencing serious injury and pain. Findings include: Record review of Resident #1's face sheet dated 11/22/2024 revealed she was a [AGE] year-old female who was admitted to the facility on [DATE]. She was diagnosed with rhabdomyolysis (a breakdown of muscle tissue that releases a damaging protein into the blood), type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), acute kidney failure (when the kidneys suddenly cannot filter waste from the blood), dysphagia (difficulty swallowing), unspecified dementia (a diagnosis given when a person has dementia but it does not fit into a specific type), end stage renal disease (kidney failure), history of falls, pruritus (an uncomfortable, irritating sensation that creates an urge to scratch that can involve any part of the body), folate deficiency anemia (when the body does not have enough red blood cells due to a lack of folate), and adult failure to thrive (a syndrome that involves unexplained weight loss, malnutrition, disability, and other symptoms). (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed she had difficulty communicating some words or finishing thoughts but was able if prompted or given time; she missed some part/intent of the message but comprehended most conversation; she had a BIMS score of 0 (severe cognitive impairment); she did not exhibit any behavioral symptoms or rejection of care; she was dependent on staff (helper did all of the effort and resident did none of the effort to complete the activity or the assistance of 2 or more helpers was required) for toileting hygiene, showers, and personal hygiene; she required partial/moderate assistance from staff (helper did less than half of the effort. Helper lifted, held, or supported trunk or limbs, but provided less than half the effort) for chair/bed-to-chair transfers; and she was always incontinent of bowel and bladder. Record review of Resident #1's care plan revised 10/29/2024 revealed the following areas of concern: * Communication problem related to language barrier and resident's family translates for her. Goal included: Resident will be able to make basic needs known on a daily basis. Interventions included: Anticipate and meet needs. Monitor/document for physical/nonverbal indicators of discomfort or distress, and follow-up as needed. Provide translators as necessary to communicate with the resident. * Resident has a self-care deficit related to weakened condition secondary to failure to thrive. Goal included: Resident will maintain or improve ability to participate in her care with ADLs. Interventions included: Bathing/Shower Schedule: Resident prefers to be showered 2-3 times weekly. Mobility: resident uses a wheelchair. Total Lift x 2 team members. Total Lift Sling Size: small/red. Record review of Resident #1's physician progress note dated 10/24/2024 and signed by her PA revealed her past medical history included a diagnosis of osteoporosis (a condition in which bones become weak and brittle). Record review of Resident #1's nursing progress notes for November 2024 revealed: * On 11/20/2024, at 7:23 p.m. LVN B wrote, RP summoned writer to room voiced that resident complained of pain to her leg (resident speaks Laotian). Resident does not speak English. Upon assessment, writer noted that resident's right knee to her thigh was swollen, and tender to touch. Doctor notified, order given for stat x-ray of right knee, thigh, and hip . * On 11/20/2024, at 7:45 p.m. LVN C wrote, Tylenol 650 mg given for complaint of pain. Family member states that she would prefer resident go to hospital. Right leg noted with swelling from knee and up the right side of her thigh. Area is firm and cool to touch. No redness noted. Doctor notified and orders noted to send to local acute care hospital . Further review of Resident #1's progress notes for November 2024 revealed no note regarding Resident #1's unsafe transfers with CNA A on 11/20/2024. Record review of Resident #1's undated hospital records revealed she was admitted to a local acute care hospital on 11/20/2024 and was diagnosed with an acute, mildly displaced spiral fracture of the right mid/distal femoral shaft with approximately one shaft width lateral and posterior displacement of the distal fracture fragment and regional soft tissue swelling. The record read in part, . At this point, the best course of action is surgical intervention consisting of right femur retrograde nailing . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Observation and interview with Resident #1 at a local acute care hospital on 11/22/2024, at 4:45 p.m. revealed she was alert, but she did not respond directly to questions. There were multiple family members present but all except one left the room. The family member stated Resident #1 never really talked too much. The family member said Resident #1 understood English and could speak English but did not talk too much. The family member stated she previously asked Resident #1 where she got hurt, and she said the bathroom. The family member said Resident #1 said she did not fall when she got hurt. The family member stated Resident #1 was confused. An HHSC interpreter was contacted by phone to translate [NAME], but the interpreter could not understand Resident #1. The family member stated she understood the interpreter, but Resident #1 was confused. The family member asked Resident #1 questions (in [NAME]) about the incident, but Resident #1 stated she could not remember. The family member said Resident #1 got upset with her because she said the family member was asking her the same questions. The family member said Resident #1 refused to answer anything else. Resident #1 appeared to be listening to the conversation with the family member. The family member said Resident #1 understood everything being said, but she would not speak English. In an interview with the Administrator on 11/22/2024 at 9:45 a.m., she stated Resident #1 was sent out to the hospital on 11/20/2024 but they received paperwork from the hospital case manager on 11/21/2024 which indicated Resident #1's family had some concerns. The Administrator said Resident #1 went to the hospital per her family's request based on swelling to her leg, from her knee to her thigh. She said the swelling started on 11/20/2024. She said Resident #1 understood English and could answer in English, but she spoke [NAME] fluently. She stated Resident #1's RP was present when the swelling was identified but Resident #1 never told the RP anything happened to her, just that she was in pain. She said Resident #1 could not walk, but she often tried to walk and had a history of falls and osteoporosis. She said when the swelling was noted, her doctor (and Medical Director) ordered a stat x-ray, but the RP requested Resident #1 be sent out. She said the facility received Resident #1's clinical records from the hospital on 11/21/2024 because she was due to return to the facility. She said the clinical records indicated Resident #1 was diagnosed with a fracture, so she submitted a self-reported incident to HHSC as soon as they were made aware. She said the hospital case manager's notes indicated there was concern because there was no documentation from the facility about a fall, or any other incident. She stated the facility also had concerns, so they initiated an investigation and interviewed staff on all shifts up to 72 hours before she complained of pain, and nobody said anything abnormal happened. She said Resident #1 complained of pain during the 2:00 p.m. - 10:00 p.m. shift, but she had a shower during the 6:00 a.m. - 2:00 p.m. shift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with LVN B on 11/22/2024 at 12:45 p.m., she stated she worked the 6:00 a.m. - 6:00 p.m. (some staff worked 8-hour shifts and some staff worked 12-hour shifts) shift. She stated Resident #1 spoke English when she wanted to, usually during yes and no questions. She said Resident #1 was cognitively impaired, but she may have been more cognitive with family because the family members sometimes translate things Resident #1 said. She said Resident #1 let the staff know if she wanted something and she usually liked to be in her wheelchair most of the time. She said she never saw Resident #1 walk and if she fell on the floor, she would not be able to get herself off the floor alone. She said there was a camera inside Resident #1's room. She said she worked with Resident #1 on 11/20/2024 and she did not seem unusual that day. She said they had Resident #1 in bed after providing incontinent care, and she wanted to get back into her wheelchair. She said Resident #1 never expressed or indicated pain to her. She said later when she looked at Resident #1's leg at her RP's request, it looked slightly swollen. She said she called the doctor, and he ordered an x-ray. She said the night shift nurse, LVN C was already at the facility at that time, so she went to get Resident #1 a pain pill because the RP kept saying she was in a lot of pain, and it was unbearable. She said when she gave Resident #1 the pain pill, and looked at her leg again, it started to look bigger, and the swelling grew. She said she and LVN C both went in to look at Resident #1's leg the first time at about 6:30 p.m. She said Resident #1 did not appear to be in pain because she was smiling and looked excited. She said Resident #1 did not exhibit any indication of pain. She said no falls were reported and the aides were usually very good about coming to get the nurses quickly with any incident. An unsuccessful attempt was made to contact Resident #1's physician on 11/22/2024 at 12:58 p.m. In a telephone interview with Resident #1's RP on 11/22/2024 at 1:00 p.m., she stated she arrived to the facility on Wednesday, 11/20/2024 after 5:00 p.m. and Resident #1 let her know her leg was hurting and she wanted to go to the hospital. She said Resident #1 was not very verbal until she was in pain. She said she asked a CNA (she could not recall the name of the CNA) to put Resident #1 in bed. She said Resident #1's right leg, especially the thigh area, looked really swollen. She said Resident #1 was diagnosed with a fractured femur at the hospital and had surgery on 11/21/2024. She said another family member told her they asked Resident #1 where she got hurt, and Resident #1 said the restroom. She said a CNA took Resident #1 to the shower on 11/20/2024. She said from watching the camera footage, she heard Resident #1 call out for help when the CNA tried to put her in the wheelchair after her shower (before she went out and sat near the nurse's station). She said the CNA brought Resident #1 back to her room from the hall for incontinent care around 12:47 p.m. She said when the CNA opened the privacy curtain, she heard Resident #1 yelling out for help and saying she was in pain while she was in the bed. She said the same CNA who gave Resident #1 a shower was the same one who gave her incontinent care. She said Resident #1 never provided any other information about the incident. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In a telephone interview with CNA D on 11/22/2024 at 1:11 p.m., she stated she worked the 2:00 p.m. - 10:00 p.m. shift and she worked with Resident #1 on 11/20/2024. She stated she observed Resident #1 on 11/20/2024 at 2:00 p.m. when she was sitting in the hallway trying to take her clothes off. She said she tried to help put Resident #1's clothes back on, but she refused to let her touch her. She said some other co-workers (she did not identify these co-workers) tried to help but Resident #1 refused to let them touch her. She said Resident #1 had a blanket around her. She said they pulled the blanket over her, so she was not naked in the hallway. She said Resident #1 did not grimace or give any other indication of pain. She said they thought Resident #1 was hot, but she did not respond when they asked her if she was hot. She said Resident #1 pushed her away, so she did not try to take her to the room until her RP arrived and said another family member noticed on the camera that Resident #1 had not been inside the room for incontinent care for a while. She said the RP asked them to take her to the room and provide incontinent care. She said Resident #1's RP assisted them with getting her into bed and that was when they noticed the leg swelling. She said she touched Resident #1's leg and it was hot. She said the RP asked her to tell a nurse. She said when she touched Resident #1's leg, the resident told her RP it was painful. She said she did not know if Resident #1 told the RP if anything happened. She said they initially took Resident #1 to her room for incontinent care before dinner, but she could not recall the exact time. She said she arrived for her shift at 2:00 p.m. but she never provided Resident #1 incontinent care because her roommate said she thought Resident #1 had been changed (given incontinent care) and Resident #1 pushed her away. She said she thought Resident #1 was not in the mood for her to change her. She said if Resident #1 fell , she would not be able to get up alone. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with CNA A on 11/22/2024 at 1:30 p.m., she stated she worked for the facility one month on the 6:00 a.m. - 2:00 p.m. shift. She said she never heard Resident #1 talk other than in her native language. She said Resident #1 liked to watch people and smiled a lot. She said she and Resident #1 had a routine. She said she usually got Resident #1 up out of bed in the morning and if it was her shower days (Mondays, Wednesdays, and Fridays), she gave her a shower. She said 11/20/2024 was a Wednesday, so she got a shower chair and took Resident #1 to the shower (the shower was inside the bathroom in the resident's room), then got her dressed in the room. She said she gave Resident #1 two showers (she could not recall the date of the first shower she gave Resident #1). She said on 11/20/2024, nothing unusual happened. She said she put Resident #1 in the shower chair around 9:00 a.m., washed her with a sponge, put her in the bed to get her dressed, and then brought her back out on the hallway in her wheelchair. She said she never had to lift Resident #1's legs at all because she bent over to wash her legs. She said to transfer Resident #1 from the shower chair to the bed, she picked her up like a bear hug and turned her body towards the bed and got her on there. CNA A demonstrated how she transferred Resident #1 from the bed to the chair and chair to bed. CNA A demonstrated that she placed her arms underneath the resident's arms (like a hug while standing face-to-face) and picked her up then pivoted her top half to a seated position on the bed. CNA A said Resident #1 never grimaced or acted like she was in pain. She said she covered Resident #1 up before she was about to leave the room. She said she knew Resident #1 wanted something because she was talking to her. She said she called for the nurse, and they decided to get Resident #1 back up because they thought she wanted to get back up. She said they got Resident #1 back up and she was fine after that. She said she finished her rounds around 1:40 p.m., before the end of her shift and Resident #1 was still sitting in the hall close to the nurse's station. She said Resident #1 appeared to be fine at that time. She said the only difference on 11/20/2024 was that she usually left Resident #1 in the bed in the morning, but on that day, they got her back up because they thought she wanted to get up. She said after they got Resident #1 back up, she did not talk anymore, so they thought that was what she wanted (to get up). She said she saw some normal redness on Resident #1's legs where she scratched a lot. She said that was not unusual because Resident #1 had dry skin and she typically scratched there. She said she put lotion on Resident #1's legs after her shower, but she never indicated she was in pain and there was no swelling. She said Resident #1 would not be able to get up off the floor if she fell alone. In a follow-up telephone interview with CNA A on 12/03/2024 at 12:46 p.m., she stated she did not know Resident #1 required a mechanical lift transfer until after 11/20/2024. She said when she was initially hired, other staff trained her to transfer Resident #1 unassisted, the same way she transferred her on 11/20/2024. She said after 11/20/2024, she was trained by management to look at the residents' Kardex (a file system that gives a brief overview of each patient) to see their transfer status/method. She said she never would have known Resident #1 was a 2-person/mechanical lift transfer if she did not check the Kardex. She said she always knew how to check the Kardex, and what information was in it (including resident transfer method), but she just did not. She said she did not have a gait belt on Resident #1 that day either. She said Resident #1 could not bear any weight (assist in transfers by standing), so the staff lifted her whole weight alone when they transferred her. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with Resident #1's roommate on 11/22/2024 at 2:05 p.m., she stated at first, she and Resident #1 had a hard time communicating, but now they use fingers, like, thumbs up and thumbs down and she nods her head that she is ok. She said Resident #1 could speak a little English, but she just did not. She said on 11/20/2024, Resident #1 came back to the room all upset before 2:00 p.m. She said Resident #1 was just talking in her language. She said she knew Resident #1 she was upset, but she could not figure out what was wrong. She said Resident #1 was trying to take her pants off. She said when Resident #1's RP arrived, she took her covers off and saw the swelling from her thigh to past the knee. She said she could not recall if Resident #1's leg was discolored, but it was swollen. She said when Resident #1's RP arrived, Resident #1 was still talking a lot. She said the RP said Resident #1 was in a lot of pain and wanted to go to the hospital. She said the shower was inside the bathroom, but she could not hear anything, and the privacy curtain was closed. She said after Resident #1's shower, they took her straight out to the hall and sat her against the wall near the nurse's station. She said Resident #1 was the facility's greeter because she loved to say hello to people. She said they call Resident #1 the people watcher. She said she could not recall how long it was before they brought Resident #1 back to the room to provide incontinent care. She said that was when Resident #1 was talking a lot and tried to take her pants off. She said they changed her (provided incontinent care), and they should have seen the swelling then (it is unknown if Resident #1's roommate gave an accurate timeline of events). She said Resident #1 watched television and went to sleep after that until her RP arrived and noticed the swelling. She said they called the nurse and the nurse wanted to do an x-ray, but Resident #1 wanted to go to the hospital. She said LVN C called the ambulance. She said Resident #1 was straight faced (no indication of pain) but was talking a lot. She said Resident #1 did not indicate she was in pain, but the RP said Resident #1 said she was in pain. In an interview with the DON on 12/03/2024 at 8:30 a.m., she said Resident #1 returned to the facility on [DATE]. She stated she had already in-served CNA A and all other nursing staff on 11/21/2024 regarding safe transfers and checking the residents' Kardex to ensure their transfer methods. She said Resident #1's RP stated Resident #1 did not say anything happened or how she was hurt. She stated she spoke to staff and none of them noticed anything unusual. She said Resident #1 did not stand or walk at all and on 11/20/2024, she was a two-person transfer, but her RP allowed certain staff to transfer her unassisted. She stated staff were currently required to transfer Resident #1 via mechanical lift (2-person). She stated it was inappropriate for CNA A to transfer Resident #1 unassisted on 11/20/2024 and after she (CNA A) told her she picked Resident #1 up and transferred her to the chair unassisted, she was in-serviced. In a telephone interview with Resident #1's PA on 12/03/2024 at 9:20 a.m., she stated she cared for Resident #1 since she was admitted to the facility. She stated Resident #1 was diagnosed with osteoporosis, which possibly contributed to the fracture since no fall or other incident was reported by staff. She stated an improper transfer by staff could have caused Resident #1's fracture, but it was hard to say if that is what happened. In an interview with CNA E on 12/03/2024, at 10:30 a.m., she stated she regularly worked with Resident #1, but she was not present on 11/20/2024. She stated she gave Resident #1 a shower on Monday, 11/18/2024 and when she returned to work on Thursday, 11/21/2024, she was in the hospital. She stated Resident #1 was total care (she required staff assistance for all activities of daily living) and she always transferred her from the bed to chair and chair to bed unassisted. She stated before 11/20/2024, Resident #1 was a one-person assist for transfers, but since then, she was changed to a two-person assist. She said the DON made it clear that Resident #1 required mechanical lift transfers. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	In an interview with the DON on 12/03/2024 at 11:39 a.m., she said prior to 11/20/2024, Resident #1's care plan was not labeled transfer method, but Total Lift x 2 team members meant she required mechanical lift transfers. She said Resident #1 required mechanical lift transfers at her family's request, but it depended on which staff was with her. She said some of the staff used a mechanical lift, but she was made aware that some staff thought she was a one-person transfer. She said they in-serviced all staff and educated to go by what was on the care plan. She said she showed staff where the transfer information was on the Kardex. Record review of the facility's policy entitled, Safe Resident Handling/Transfers revised January 2023 revealed, Policy: It is the policy of this community to ensure that patients/residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure, and comfortable experience for the patient/resident while keeping the team members safe in accordance with current standards and guidelines . Compliance Guidelines: 1. The interdisciplinary team or designee will evaluate and assess individual mobility needs, considering other factors as well, such as weight and cognitive status. 2. The mobility needs will be addressed on admission and reviewed quarterly, after a significant change in condition or based on direct care staff observation or recommendations. 3. Mechanical lifting or other approved transferring aids will be used based on individualized needs and per the care plan to prevent manual lifting except in medical or other emergencies . 12. Team members are expected to maintain compliance with safe handling/transfer practices. Failure to maintain compliance may lead to disciplinary action up to and including termination of employment. 13. Lifting and transferring will be performed according to the individualized plan of care . Record review of the facility's document titled, 4 Step Response Plan: Care plan/Kardex/Safe Transfers Immediate Action Taken: All Team Members providing care to residents were provided re-education/re-training by the DON/Designee regarding: 100% Direct care education on review of the Kardex before providing care to all residents assigned to them to ensure proper assistance and interventions are utilized according to the resident's need and adherence to the resident's plan of care. Reporting any concerns or inaccuracies to the charge nurse/licensed nurse . 100% Education provided to all Nursing Department Preventing Accidents/Fall Prevention/Promoting Safety . 100% Skills validation on accessing the Kardex. 100% Education provided to all nursing staff: Reporting any changes noted in resident's condition,,, Out of an abundance of caution, DON/Designee provided re-education on: Prevention of Abuse and Neglect . Date of Completion: 11/21/2024. Community will ensure all staff on leave/agency/PRN staff are in-serviced and skill validated for Kardex use with compliance, prior to working their shift . Monitoring Response: DON/Designee will conduct random skills validations regarding Kardex use 3-7 days per week for two months to ensure direct staff is complaint with use of the Kardex and transfer needs of all residents assigned .Ad hoc QAPI Date: 11/21/2024 . Record review of In-Service Acknowledgement dated 11/21/2024 revealed CNA A (CNA A received 1:1 education) and all other nursing staff were educated by the DON regarding demonstrating accessing and utilizing the Kardex on PCC (the facility's computer system). Record review of In-Service Acknowledgement dated 11/21/2024 revealed all nursing staff were educated by the DON on utilizing the Kardex, demonstration and proper transfer, reporting any changes, and falls/incidents. Record review of in-Service Acknowledgement dated 11/21/2024 revealed all staff were educated by the DON regarding Abuse and Neglect. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Heights of Tomball	27840 Johnson Road Tomball, TX 77375

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Record review of the facility's document titled, Monitoring Tool: Kardex Audits dated 11/2024 revealed, DON/Designee will conduct random skills validations regarding Kardex use 3-7 days per week for two months to ensure direct staff are compliant with the use of the Kardex and transfer needs of all residents assigned . Frequency of Monitoring: 3-7 days/week for two months . Interviews were conducted with staff on 12/03/2024 8:45 a.m. until 4:30 p.m. including the Administrator, DON, CNA A, CNA E, LVN F, CNA G, CNA H, CNA I, CNA J, CNA K, and CNA L to verify the in-services were conducted and to validate the staff understanding of the information presented to them. No concerns were found regarding understanding of requirements, training material, and expectations. The Administrator, DON, CNA A, CNA E, LVN F, CNA G, CNA H, CNA I, CNA J, CNA K, and CNA L were able to explain the importance of reviewing each residents' Kardex prior to providing care to ensure proper transfer methods are used, providing safe and appropriate transfers using the method specified in each resident's care plan, and reporting any changes of condition. The noncompliance was identified as Past Non-Compliance. The IJ began on 11/20/2024 and ended on 11/21/2024. The facility corrected the noncompliance before the survey began. On 12/03/2024 at 3:48 p.m., the facility's Administrator, DON, and Regional Nurse were notified of the past noncompliance IJ. A plan of removal was not requested. An IJ template was provided to the Administrator on 12/03/2024 at 3:48 p.m.