STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676471	A. Building B. Wing	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Valley Inn Health Center	17751 Park Valley Drive Round Rock, TX 78681

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials for 1 (R#1) of 7 residents reviewed for incidents. The facility failed to report R#1's hematoma to left eyebrow area on 6/11/26 to the SSA. This failure could place residents at risk of their injuries worsening without proper medical intervention or remain vulnerable to further harm, abuse or neglect. Findings include: Review of R#1's admission Record, dated 6/26/26, reflected she was admitted to the facility on [DATE]. She had medical diagnoses of traumatic subarachnoid hemorrhage (bleeding in the fluid-filled space between the brain and the skull), difficulty walking, lack of coordination, muscle weakness, and Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory and thinking skills). Review of R#1's Quarterly MDS Assessment, dated 5/29/26, reflected she had a BIMS of 3, which indicated she had severe cognitive impairment. Review of R#1's Care Plan, revised 6/26/26, reflected there were no notes related injuries of unknown origin. Review of R#1's Progress Notes reflected: LVN A created a note on 6/11/26 at 11:48 a.m., While returning from morning meeting. This nurse was made aware from CNA that resident has a hematoma (a collection of pooled, clotted blood that forms outside of a blood vessel) to eyebrow area. Complete assessment done. No other injuries noted. NP at facility at assessed resident. Received new order for facial x-ray stat, and Tylenol 650mg po tid. Resident RP notified and voiced understanding. Neuros initiated per protocol. Resident keep in common area for close observation. care ongoing. LVN A created a note on 6/11/26 at 4:00 p.m., Complete assessment done. Hematoma noted to Right side of forehead/eyebrow area. No other new injuries noted at this time. vss. Afebrile (normal body temperature). no s/s of distress or discomfort noted. [RP] notified. NP notified. Xray here to do Xray on face. neuros initiated per protocol. care ongoing.Review of R#1's Physician Progress Notes reflected: Visit note, dated 6/11/26, reflected, Patient is seen today for hematoma to the right forehead. Nurse reports hematoma was noted today. No reports of recent trauma. Patient is a poor historian due to dementia. Neurochecks unremarkable. Will obtain facial x-ray. Multimodal pain management. Discussed with nursing to closely monitor and notify for worsening. DON has been notified.Review of R#1's Change in Condition Evaluation, created by LVN A on 6/11/26 at 10:00 a.m., reflected R#1 was observed with a skin issue on the left eyebrow area. Review of R#1's Injury of Unknown Origin Investigation, created by the ADON on 6/11/26, reflected the injury was discovered on 6/11/26 at 9:30 a.m. The investigation initiated on 6/11/26 and the ADM was conducting it. CNA H last observed R#1 in the memory care unit activity room on 6/11/26 at 9:15 a.m. before the injury was discovered. CNA N observed the injury. The source of the injury was not observed by anyone and the source of the injury could not be explained by R#1. Review of R#1's Facial X-Ray, created by LVN A on 6/11/26 at 9:15 (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a.m., reflected R#1 was examined on 6/11/26 at 4:33 p.m. The results were reported on 6/11/26 at 6:10 p.m. The NP reviewed the X-ray results on 6/18/26 at 11:38 a.m. The results reflected, Findings: Evaluated limited due to motion. The osseous structures demonstrate no acute fracture or destructive bone lesion.Conclusion: .Consider CT scan to best evaluate. Review of the facility's Incident Log, from 5/1/26 through 6/26/26, reflected R#1 had a skin bruise incident on 6/11/26 at 10:00 a.m. LVN A prepared the report, which reflected, While returning to morning meeting. This nurse was made aware from CNA that resident has a hematoma to left eyebrow area. The hematoma occurred due to resident ambulating without assistance and bumping into activity area furniture. Resident unable to give description. Incident was not witnessed. During a telephone interview with R#1's RP on 6/26/26 at 10:09 a.m., RP said R#1 was admitted to the facility's memory care unit due to her severe dementia, severe cognitive impairment, and diminished capacity to make informed decisions. They said DON called and notified them on 6/11/26 that R#1 was walking fast without standby assistance, fell, hit her face and head on the floor, and sustained injuries to her head and face on 6/11/26 between 8:00 a.m. and 12:00 p.m. They did not know whether R#1's first fall was witnessed or not. They also said the DON also told them that a nurse assessed R#1, had an x-ray done, and the x-ray showed she did not sustain any fractures. During an observation and interview of R#1 on 6/26/26 at 11:25 a.m., R#1 was sitting in her wheelchair at the memory care unit nurse's station. She had a dark red laceration on the left side of her forehead that had stiches. The surveyor attempted to interview R#1, but she was unable to answer any questions.During an interview with the ADM on 6/26/26 at 12:31 p.m., he said there were no facility reported incidents he submitted to the SSA related to injuries of unknown origin within this and last week. During an interview with the ADM on 6/26/26 at 2:53 p.m., he said R#1's first incident on 6/11/26 was an unwitnessed fall. He said he initiated an investigation on 6/11/26 because R#1 had a hematoma observed on 6/11/26 around 9:45 a.m. During an interview with the NP on 6/26/26 at 3:20 p.m., he said he saw R#1 on 6/11/26, was not notified she fell at the time he observed her, he observed the hematoma to her forehead, asked the staff about the hematoma and they did not know what caused the hematoma on 6/11/26. He said staff did not tell him if R#1 had a fall prior to him seeing her on 6/11/26. He said he would have expected staff to notify him and said, So we can decide if additional treatment need to be ordered for the resident and if the resident needed to be sent out to the hospital.During an interview with the DON on 6/26/26 at 3:51 p.m., she said staff did not know if R#1's first incident on 6/11/26 was as a result of a fall. She explained staff observed a bruise on R#1, notified the NP, NP ordered a STAT x-ray, and they initiated neurological monitoring. She said the ADM was responsible for submitting injury of unknown origin reports to the SSA within 2 hours. She said she did not believe the ADM self-reported the first incident. She explained the ADM performed a soft investigation and found during staff interviews that staff suspected R#1 sustained the bruise as a result of hitting her head on furniture. She said she told the Unit Manager initiate in-services on abuse and neglect, resident rights, and accidents/incidents on 6/11/26 after R#1's first incident. During an interview with the ADM on 6/27/26 at 11:22 a.m., he said LVN A notified him on 6/11/26 around 9:30am-9:45am that R#1 had a bruise on her forehead. He said after the notification, he had the Unit Manager initiate in-services and he conducted a soft file investigation of the suspected injury of unknown origin. He said he was able to determine that R#1 hit her head on a piece of furniture and said, If there was an injury of unknown origin or if it was suspicion of abuse or neglect, I would have reported it. He said would report injury of unknown origin to the SSA within 2 hours. He said he did an internal report and he did not believe it warranted a report to the SSA.During an interview with the ADM on 6/26/26 at 3:10 p.m., he said the facility followed the Long-Term Care Regulation Provider Letter when determining Suspicious injuries of unknown source. During an interview with LVN I on 6/29/26 11:17 a.m., she said the ADM reported injuries of unknown origin to the SSA within 24 hours. During an interview with the ADON on 6/29/26 at 11:43 a.m., she said the ADM reported injuries of unknown origin to the SSA. She said the DON was the designee. She also said the report must be made within 2 hours of notification. She said she knew (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it was important to report injuries of unknown origin to the SSA and said, It's important because to inspect and determine if the incident occurred. Residents could be at risk of worsening change in condition. During a telephone interview with LVN A on 6/29/26 at 12:58 p.m., she said the ADM reported injuries of unknown origin to the SSA within an hour or 2 hours. Review of the facility's in-services from 6/1/26 through 6/26/26 reflected the Unit Manager trained staff on Abuse, Neglect and Exploitation. The Abuse, Neglect and Exploitation policy was attached. RN E, LVN F and LVN G were not listed on the roster. Review of the facility's Long Term Care Regulation Provider letter, issued 8/29/24, reflected, A nursing facility must report the following types of incidents, in accordance with applicable state and federal requirements: .Suspicious injuries of unknown source.Do report injuries of unknown source immediately, but not later than two hours after the incident occurs or is suspected.Injuries of unknown source:Note: an injury should be classified as an injury of unknown source whenALL of the following conditions are met:ˆ The source of the injury was not observed by any person; andˆ The source of the injury could not be explained by the resident; andˆ The injury is suspicious because of: the extent of the injury; or the location of the injury (e.g., the injury is located in an areanot generally vulnerable to trauma); or the number of injuries observed at one point in time; or the incidence of injuries over time.Review of the facility's Abuse, Neglect and Exploitation policy, revised 12/1/25, reflected, I. Reporting/ResponseA. The facility will have written procedures that include:1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes:a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. 5.Taking all necessary actions as a result if the investigation, which may include, but are not limited to, the following:a.Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences;b.Defining how care provision will be changed and/or improved to protect residents receiving services;c.Training of staff on changes made and demonstration of staff competency after training is implemented;d.Identification of staff responsible for implementation of corrective actions;e.The expected date for implementation; andf.Identification of staff responsible for monitoring the implementation of the plan.B.The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to review and revise residents' comprehensive care plans for 1 (R#1) of 7 residents reviewed for care plans. The facility failed to timely review and revise R#1's care plan after her two incidents on 6/11/26 and one incident on 6/23/26.This failure could place residents at risk of not receiving treatment and care to meet residents' needs. Findings include:Review of R#1's admission Record, dated 6/26/26, reflected she was admitted to the facility on [DATE]. She had medical diagnoses of traumatic subarachnoid hemorrhage (bleeding in the fluid-filled space between the brain and the skull), difficulty walking, lack of coordination, muscle weakness, and Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory and thinking skills). Review of R#1's Quarterly MDS Assessment, dated 5/29/26, reflected she had a BIMS of 3, which indicated she had severe cognitive impairment.Review of R#1's Care Plan, revised 6/26/26, reflected she was at risk for falls related to her unsteady gait and history of falling and getting herself back up. She had a witnessed fall on 6/11/26 and 6/23/26. Interventions initiated on 6/15/26 included ensure she wore non-skid, well-fitting shoes. Interventions initiated on 6/19/26 included move her closer to the nurse's station. Interventions initiated on 6/26/26 included conduct purposeful staff rounding. Review of R#1's Progress Notes reflected: LVN A created a note on 6/11/26 at 11:48 a.m., While returning from morning meeting. This nurse was made aware from CNA that resident has a hematoma to eyebrow area. Complete assessment done. No other injuries noted. NP at facility at assessed resident. Received new order for facial x-ray stat, and Tylenol 650mg po tid. Resident RP notified and voiced understanding. Neuros initiated per protocol. Resident keep in common area for close observation. care ongoing. LVN A created a note on 6/11/26 at 4:00 p.m., Complete assessment done. Hematoma (a collection of pooled, clotted blood that forms outside of a blood vessel) noted to Right side of forehead/eyebrow area. No other new injuries noted at this time. vss. Afebrile (normal body temperature). no s/s of distress or discomfort noted. [RP] notified. NP notified. Xray here to do Xray on face. neuros initiated per protocol. care ongoing. LVN B created a note on 6/12/26 at 5:09 a.m., Resident on a witnessed fall follow-up with neuro check & head injury. Large hematomas approximately golf ball-sized to bilateral forehead/eyebrow areas. Swelling and bruising noted around affected sites. No active bleeding observed. X-ray completed with negative results for fracture. Neurological status remains at baseline. Resident alert and responsive. Vital signs stable. No s/s of pain, headache, dizziness, nausea, vomiting, visual changes, or changes in mental status noted. Remains in bed this shift, bed at lowest position, call light within easy reach. Care ongoing. LVN B created a note on 6/13/26 at 4:45 a.m., F/u witnessed fall Day 3/3 with neuro check & head injury. Large hematomas approximately golf ball-sized to bilateral forehead/eyebrow areas healing well. Continues with swelling and bruising around affected sites. Neurological status remains at baseline. Resident alert and responsive. Vital signs stable. No s/s of pain, headache, dizziness, nausea, vomiting, visual changes, or changes in mental status noted. Remains in bed this shift, bed at lowest position, call light within easy reach. Care on going. LVN A created a note on 6/14/26 at 1:04 p.m., Aaox1- pleasantly confused. Wanders. Poor safety awareness. No s/s of distress or discomfort noted. Fall precautions in place. Kept at nurses station for close observation. VSS afebrile. Care ongoing. Cont. neuros WNL. F/u fall. Bruising noted to both sides of face with facial swelling noted to ous. Care ongoing. LVN C created a note on 6/14/26 at 5:45 a.m., Resident has increased orbital edema to right eye. Ice pack administered for comfort and to reduce edema (the abnormal accumulation of excess fluid within the interstitial spaces (the spaces between cells and tissues), which leads to swelling). LVN A created a note on 6/14/26 at 1:08 p.m., Aaox1- pleasantly confused. Wanders. Poor safety awareness. No s/s of distress or discomfort noted. Fall precautions in place. Kept at nurses station for close observation. VSS afebrile. Care ongoing. Cont. neuros WNL. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	F/u fall. Bruising noted to both sides of face with facial swelling noted to ous. Care ongoing. RN D created a note on 6/15/26 at 10:09 a.m., Resident arrived back to facility from appt. with orders. This writer notified NP of orders and received new orders to transfer to medical center for increased (R) eye orbital edema. RP aware. RN D created a note on 6/15/26 at 10:36 a.m., EMS just left facility to transport resident to medical center. RN D created a note on 6/18/26 at 11:28 a.m., Resident arrived at facility via medical transport on a gurney accompanied by two EMS personnel. Transferred from gurney to bed by two-person slide. She is alert and oriented x 1. She denies pain or discomfort. Hospital wrist bands removed. Resident has discoloration around both eyes as expected from previous bruising. No new skin issues observed. Vital signs. 122/66 P 77 R 18 T 97.8 O2 Sat. 97% room air FSBS 121mg/dl. No acute distress observed. Bed placed in lowest position, call light within reach. Care ongoing. RN E created a note on 6/20/26 at 5:15 p.m., Skilled for Traumatic subarachnoid hemorrhage. Noted bruises on both sides of the eyelids. Took all meds and tolerated well. Denies pain or discomfort. Even and unlabored breathing. Res stays on wheelchair. The DON created a note on 6/23/26 at 6:10 p.m., Resident was observed sitting on the couch in the common area watching television. Resident attempted to transfer from the couch to her wheelchair. While attempting to sit, resident realized the wheelchair was not properly positioned, with the seat not facing her. Resident attempted to correct her position and stand upright but lost her balance, stumbled several steps forward, and fell into the lower portion of an electric piano. During the fall, resident sustained a skin tear/abrasion to the left temple after making contact with the lower edge of the piano. RN D and Unit Manager, immediately responded to the scene and found resident on the floor. Pressure was applied to the left temple wound with gauze and an ABD pad to control bleeding. Resident remained awake, verbal, and responsive throughout the event. No loss of consciousness noted. PERRLA 2+ bilaterally. Vital signs obtained and within normal limits. Resident alert and oriented x1, consistent with baseline cognitive status. DON notified and responded to the scene. Resident's (RP), notified by DON. EMS activated for evaluation and transport. EMS arrived at 1625. Resident remained responsive and exhibited no signs of acute distress while awaiting EMS arrival. LVN F created a note on 6/23/26 at 9:00 p.m., Resident returned back to the facility transported by ambulance via stretcher post ER visit SPF with laceration to the LF side of the forehead, noted dry dressing to area of laceration, stable and situated in room, neuro checks cont., NP notified, RP notified, notified DON/Administrator.Review of R#1's Physician Progress Notes reflected: Visit note, dated 6/11/26, reflected, Patient is seen today for hematoma to the right forehead. Nurse reports hematoma was noted today. No reports of recent trauma. Patient is a poor historian due to dementia. Neurochecks unremarkable. Will obtain facial x-ray. Multimodal pain management. Discussed with nursing to closely monitor and notify for worsening. DON has been notified. Visit note, dated 6/23/26, reflected, R#1 was sent to ED on 6/15/26 due to worsening hematoma to the forehead. Hematoma to the forehead was initially detected on 6/11/26. I saw R#1 at that time and facial X-ray was ordered which resulted negative for fracture. Nurse called to report that patient had increased hematoma to the forehead and therefore patient was sent to ED for further evaluation on 6/15/26. ED workup included CT of the head which was remarkable for minimal SAH in the left sided high cerebral region. NSGY was consulted and no acute intervention was recommended. Brilinta was discontinued and patient discharged back to facility on 6/18/26 in stable condition. On exam, patient is seen in the memory care unit up in wheelchair watching TV. She is awake and alert. No acute distress or discomfort. She has bruising and hematoma to bilateral forehead right slight larger than left side. She is a poor historian due to dementia. Neuro exam are unremarkable. Fall precautions per facility protocol. PT/OT to eval and treat. Chart reviewed including nurses notes, recent labs and medications.During a telephone interview with R#1's RP on 6/26/26 at 10:09 a.m., RP said R#1 often fell at home before she was admitted to the facility's memory care unit due to her severe dementia, severe cognitive impairment, and diminished capacity to make informed decisions. They said DON called and notified them on 6/11/26 that R#1 was walking fast without standby assistance, fell, hit her face and head on the (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	floor, and sustained injuries to her head and face on 6/11/26 between 8:00 a.m. and 12:00 p.m. They did not know whether R#1's first fall was witnessed or not. They also said the DON also told them that a nurse assessed R#1, had an x-ray done, and the x-ray showed she did not sustain any fractures. They said the DON also called and notified them on 6/11/26 that she witnessed R#1 walking fast without standby assistance, fell and hit her face again on 6/11/26 between 1:00 p.m. and 6:00 p.m. They said R#1 was not sent to the hospital after the first and second fall on 6/11/26. They said they did not know why R#1 was not sent to the hospital. They also said they observed R#1 sitting at the nurse's station with a swollen eye and blood noticeable in her eyes on 6/13/26. They said R#1 was sent to the hospital on 6/15/26, was x-rayed again, CT scanned, the CT scan reflected she sustained internal bleeding to her eyes and brain and was sent to the ICU. They said R#1 was discharged from the hospital and returned to the facility with discharge paperwork and instructions from the hospital doctor to make sure she rest and not fall again on 6/18/26. They said the ADM and DON told them on 6/19/26 that the staff could not monitor her at all times. They said the ADM and DON did not mention anything to them about what interventions they were going to put in place to prevent and intervene when she fell. They said the DON called and notified them on 6/23/26 that R#1 wandered away during an activity, fell, hit her face and head on the floor, sustained a head laceration, bled, staff could not control her bleeding, and sent her to the hospital on 6/23/26. They said R#1 received stiches at the hospital and returned to the facility on 6/23/26. During an observation and interview of R#1 on 6/26/26 at 11:25 a.m., R#1 was sitting in her wheelchair at the memory care unit nurse's station. She had a dark red laceration on the left side of her forehead that had stiches. The surveyor attempted to interview R#1, but she was unable to answer any questions.During an interview with the ADM on 6/27/26 at 11:22 a.m., he said he expected the IDT (MDS, ADONs, DON, ADM, Wound Care and Social Worker) to meet every morning within the first 72 hours of admission, during initial baseline care plan, after care plan review, after each incident, and quarterly to review incidents, discuss interventions, and implement interventions for staff to follow. He said he believed the MDS nurse updated the care plan for R#1. He also said he expected care plans to be revised as soon as possible.During an interview with LVN A on 6/29/26 at 12:58 p.m., she said the nurse manager reviewed and revised residents' care plans. She said the nurses on the floor had access to residents' care plans. She knew the importance of reviewing and revising residents' care plans in a timely manner and said, For any changes the physician made or wanted to do, to ensure continuity of care, and to ensure physician's orders were followed.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (R#1) of 7 residents reviewed for falls. The facility failed to notify the NP from 6/12/26 through 6/14/26 when R#1's head injury worsened after her two incidents [PH1.1][SB1.2]on 6/11/26. R#1 was sent to the hospital on 6/15/26, diagnosed with traumatic subarachnoid hemorrhage and required care in the ICU. The facility failed to follow R#1's hospital discharge orders of discontinuing her Ticagrelor [PH2.1][SB2.2]when she returned to the facility on 6/18/26. R#1 was sent to the hospital and received stiches to her forehead because staff could not stop the bleeding from her laceration after sustaining a fall on 6/23/26. An IJ was identified on 6/27/26. The IJ template was provided to the facility on 6/27/26 at 2:47 p.m. While the IJ was removed on 6/29/26, the facility remained out of compliance at a scope of pattern and a severity level of no actual harm with the potential for more than minimal harm that is not immediate jeopardy because of the facility's need to evaluate the effectiveness of their corrective systems.These failures could place residents at risk of delayed medical intervention, severe medical complications, or death. Review of R#1's admission Record, dated 6/26/26, reflected she was admitted to the facility on [DATE]. She had medical diagnoses of traumatic subarachnoid hemorrhage (bleeding in the fluid-filled space between the brain and the skull), difficulty walking, lack of coordination, muscle weakness, and Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory and thinking skills). Review of R#1's Quarterly MDS Assessment, dated 5/29/26, reflected she had a BIMS of 3, which indicated she had severe cognitive impairment. She had no falls since admission.Review of R#1's Discharge MDS, dated [DATE], reflected she had one fall with no injury since admission. She also required supervision or touching assistance when she walked. Review of R#1's Care Plan, revised 6/26/26, reflected she was at risk for falls related to her unsteady gait and history of falling and getting herself back up. She had a witnessed fall on 6/11/26 and 6/23/26. Interventions initiated on 6/15/26 included ensure she wore non-skid, well-fitting shoes. Interventions initiated on 6/19/26 included move her closer to the nurse's station. Interventions initiated on 6/26/26 included conduct purposeful staff rounding. Review of R#1's Progress Notes reflected: LVN A created a note on 6/11/26 at 11:48 a.m., While returning from morning meeting. This nurse was made aware from CNA that resident has a hematoma to eyebrow area. Complete assessment done. No other injuries noted. NP at facility at assessed resident. Received new order for facial x-ray stat, and Tylenol 650mg[PH3.1][SB3.2] po tid. Resident RP notified and voiced understanding. Neuros initiated per protocol. Resident keep in common area for close observation. care ongoing. LVN A created a note on 6/11/26 at 4:00 p.m., Complete assessment done. Hematoma (a collection of pooled, clotted blood that forms outside of a blood vessel) noted to Right side of forehead/eyebrow area. No other new injuries noted at this time. vss. Afebrile (normal body temperature). no s/s of distress or discomfort noted. [RP] notified. NP notified. Xray here to do Xray on face. neuros initiated per protocol. care ongoing. LVN B created a note on 6/12/26 at 5:09 a.m., Resident on a witnessed fall follow-up with neuro check & head injury. Large hematomas approximately golf ball-sized to bilateral forehead/eyebrow areas. Swelling and bruising noted around affected sites. No active bleeding observed. X-ray completed with negative results for fracture. Neurological status remains at baseline. Resident alert and responsive. Vital signs stable. No s/s of pain, headache, dizziness, nausea, vomiting, visual changes, or changes in mental status noted. Remains in bed this shift, bed at lowest position, call light within easy reach. Care ongoing. LVN B created a note on 6/13/26 at 4:45 a.m., F/u witnessed fall Day 3/3 with neuro check & head injury. Large hematomas approximately golf ball-sized to bilateral forehead/eyebrow areas healing well. Continues with swelling and bruising around affected sites. Neurological status remains at baseline. Resident alert and responsive. Vital (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	increased hematoma to the forehead and therefore patient was sent to ED for further evaluation on 6/15/26. ED workup included CT[PH11.1][SB11.2] of the head which was remarkable for minimal SAH[PH12.1][SB12.2] in the left sided high cerebral region. NSGY[PH13.1][SB13.2] was consulted and no acute intervention was recommended. Brilinta was discontinued and patient discharged back to facility on 6/18/26 in stable condition. On exam, patient is seen in the memory care unit up in wheelchair watching TV. She is awake and alert. No acute distress or discomfort. She has bruising and hematoma to bilateral forehead right slight larger than left side. She is a poor historian due to dementia. Neuro exam are unremarkable. Fall precautions per facility protocol. PT/OT to [PH14.1][SB14.2]eval and treat. Chart reviewed including nurses notes, recent labs and medications.Review of R#1's Facial X-Ray, created by LVN A on 6/11/26 at 9:15 a.m., reflected R#1 was examined on 6/11/26 at 4:33 p.m. The results were reported on 6/11/26 at 6:10 p.m. The NP reviewed the X-ray results on 6/18/26 at 11:38 a.m. The results reflected, Findings: Evaluated limited due to motion. The osseous structures demonstrate no acute fracture or destructive bone lesion.Conclusion: .Consider CT scan to best evaluate. Review of R#1's Hospital Records, dated 6/15/26, reflected, On presentation to the ER.CT head showing minimal SAH in L sided high cerebral region, no hematoma or mass effect, RT sided scalp trauma with hematoma and swelling.Review of R#1's Hospital Discharge summary, dated [DATE], reflected, Stop taking the following medications: Ticagrelor (Brilinta) 60mg tab oral twice daily.Review of R#1's Medication Administration Record for June 2026 reflected staff administered the 60mg Ticagrelor oral tablet by mouth two times daily from 06/01/26 at 8:00 a.m. through 6/15/26 at 8:00 a.m., from 6/18/26 at 8:00 p.m. through 6/19/26 at 8:00 p.m., and from 6/20/26 at 8:00 p.m. through 6/23/26 at 8:00 a.m. The medication was discontinued on 6/23/26 at 9:58 a.m. Review of R#1's Hospital Records, dated 6/23/26, reflected, Patient fell out of her wheelchair striking her head on a piano.noted to have a 4cm laceration to the left forehead, mild active bleeding.ED Laceration Face Stitches, follow-up with primary care doctor in 7 days for suture removal.return to the ER for any new or worsening symptoms.During a telephone interview with R#1's RP on 6/26/26 at 10:09 a.m., RP said R#1 often fell at home before she was admitted to the facility's memory care unit due to her severe dementia, severe cognitive impairment, and diminished capacity to make informed decisions. They said DON called and notified them on 6/11/26 that R#1 was walking fast without standby assistance, fell, hit her face and head on the floor, and sustained injuries to her head and face on 6/11/26 between 8:00 a.m. and 12:00 p.m. They did not know whether R#1's first fall was witnessed or not. They also said the DON also told them that a nurse assessed R#1, had an x-ray done, and the x-ray showed she did not sustain any fractures. They said the DON also called and notified them on 6/11/26 that she witnessed R#1 walking fast without standby assistance, fell and hit her face again on 6/11/26 between 1:00 p.m. and 6:00 p.m. They said R#1 was not sent to the hospital after the first and second fall on 6/11/26. They said they did not know why R#1 was not sent to the hospital. They also said they observed R#1 sitting at the nurse's station with a swollen eye and blood noticeable in her eyes on 6/13/26. They said R#1 was sent to the hospital on 6/15/26, was x-rayed again, CT scanned, the CT scan reflected she sustained internal bleeding to her eyes and brain and was sent to the ICU. They said R#1 was discharged from the hospital and returned to the facility with discharge paperwork and instructions from the hospital doctor to make sure she rest and not fall again on 6/18/26. They said the ADM and DON told them on 6/19/26 that the staff could not monitor her at all times. They said the ADM and DON did not mention anything to them about what interventions they were going to put in place to prevent and intervene when she fell. They said the DON called and notified them on 6/23/26 that R#1 wandered away during an activity, fell, hit her face and head on the floor, sustained a head laceration, bled, staff could not control her bleeding, and sent her to the hospital on 6/23/26. They said R#1 received stiches at the hospital and returned to the facility on 6/23/26. During an observation and interview of R#1 on 6/26/26 at 11:25 a.m., R#1 was sitting in her wheelchair at the memory care unit nurse's station. She had a dark red laceration on the left side of her forehead that had stiches. The (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	in condition policy, prepare an SBAR, notify the NP, and follow NP orders. He knew the importance of notifying the physician timely and following physician's orders and said, To treat the residents' change in condition. Residents could be at risk depending on what it is. He said LVN A notified him on 6/11/26 between 9:30 a.m. and 9:45 a.m. that R#1 had a bruise on her forehead. He explained that after he was notified, he had the Unit Manager initiate in-services on 6/11/26. He said he did not initiate in-services after the second incident on 6/11/26. He said the NP was also notified on 6/11/26, ordered a STAT x-ray, and instructed staff to closely monitor and report any worsening changes in the hematoma. He said the DON notified him on 6/11/26 that R#1 sustained a head injury and discoloration after a witnessed fall. He said the NP was also notified and did not know if the NP had new orders. He explained R#1's facial STAT x-ray results were received either the night of 6/11/26 or the morning of 6/12/26 and was unsure who reviewed the x-ray results. He said the NP was not notified of R#1's injury worsening from 6/12/26 through 6/14/26 and was not aware that staff did not notify the NP before 6/15/26. He said staff sent R#1 out to the hospital on 6/15/26 because her injuries worsened, R#1 sustained a subcranial hemorrhage, and the hospital did not recommend any new orders for treatments or care after she returned on 6/18/26. He said the IDT met after R#1's second incident on 6/11/26, but he could not recall when. He said he was not aware that the NP wanted R#1's antiplatelet discontinued when she returned from the hospital on 6/18/26. He said the NP did not visit R#1 from 6/18/26 through 6/23/26. He said the DON notified him on 6/23/26 that she witnessed R#1's fall and he observed R#1 lying on the ground with the laceration to her head. He also said the DON and RN D were providing care to R#1. He said R#1 went out to the hospital on 6/23/26 because she was bleeding on her forehead, received stitches at the hospital, and returned to the facility the same day. During a telephone interview with LVN A on 6/29/26 at 12:58 p.m., she said the nurses who admitted residents were required to review the discharge orders and verify with the physician any new or changes. She knew the importance of reviewing discharge orders with the physician and said, For resident safety. To prevent further injury and to ensure resident received continuity of care and to make sure physician was aware of residents' condition and care. Residents could be at risk of receiving improper treatment and medication error, which could result in death. She said CNA N notified her on 6/11/26 that R#1 had a bump on one of the sides of her head, she did not know where the injury came from, she notified the ADON, DON and NP, and the NP ordered her to start R#1 on scheduled pain medication, order a facial x-ray and to initiate neurological checks because it was a head injury. She said R#1's head area did not worsen during the shift, but she had a fall later that day. She said R#1's fall was witnessed in the activity area, she completed an incident report on the witnessed fall, notified all appropriate parties, the x-ray order results came in after this fall, and she was expected to continue monitoring. She said R#1 was not sent out to the hospital and she did not notice the injuries worsening after the fall incident on 6/11/26. She also said the CNAs and nurses did not notify her of any worsening changes in R#1's injuries. She said she did not work with R#1 after she returned 6/18/26 because she was transferred to another hallway. Review of the facility's in-services from 6/1/26 through 6/26/26 reflected the Unit Manager trained staff on Abuse, Neglect and Exploitation, Incidents and Accidents, and Resident Rights on 6/11/26. RN E, LVN F and LVN G were not listed. The in-service roster for resident rights and accidents and incidents in-services were photocopies from abuse, neglect and exploitation in-service. Review of the facility's Change of Condition policy, reflected 10/1/25, reflected, A significant change in Resident's status is any sign or symptom that is: Acute or sudden onset A marked change (i.e., more severe) in relation to usual signs and symptoms New or worsening symptomsWhen a change in condition occurs, the Licensed Nurse will:.2. Notify the Physician of the change in condition.3. Document date, time Physician, Responsible Party was notified of findings from the evaluation and any new orders obtained.5. If it is determined that there is no improvement or resolution in the Resident's condition change, the nurse will notify the Physician for further guidance and document response in the EMR.Review of the facility's Provision of Physician Ordered Services policy, implemented 12/1/25, (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	reflected, .3. Qualified nursing personnel will receive and review the diagnostic test reports or consults and communicate the results to the ordering Physician, physician assistant, nurse practitioner or clinical nurse specialist within 24 hours of receipt unless the reports fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. Ordering Provider will be notified of results upon receipt if deemed critical and/or require immediate attention.4. Documentation of consultations, diagnostic tests, the results, and date/time of Physician notification will be maintained in the resident's clinical record.Review of the facility's Consulting Physician/Practitioner Orders policy, implemented 11/1/25, reflected, 2. For consulting physician/practitioner orders received in writing or via fax, the nurse in a timely manner will:a. Call the attending physician to verify the order.b. Document the verification order by entering the order and the time, date, and signature on the physician order sheet.c. Follow facility procedures for verbal or telephone orders including noting the order, submitting to pharmacy, and transcribing to medication or treatment administration record.These failures resulted in the identification of an IJ on 6/27/26 at 2:47 p.m. The ADM and DON were notified of the IJ and provided the IJ template on 6/27/26 at 2:54 p.m.The POR was approved on 06/28/26 at 6:52 p.m. and reflected the following, On 6/26/2026 an abbreviated survey was initiated at the facility. On 6/27/2026, the surveyor provided an Immediate Threat (IT) Template notification that the Regulatory Services has determined that the condition at the facility constitutes an immediate threat to resident health and safety.The notification of Immediate Threat states as follows: The facility failed to ensure residents received treatment and care in accordance with professional standards of practice.1.) The facility failed to notify the NP when Resident #1 had had two incidents on 06/11/26 in which she hit her head and her injuries worsened 6/12/26 through 6/14/26. The NP sent her to the hospital on [DATE] where she was diagnosed with a traumatic subarachnoid hemorrhage and subsequently led to her needing care in the ICU.2.) The facility failed to follow the physician's instruction and hospital discharge orders by not discontinuing her blood thinner medication when she returned to the facility on 6/18/26, which subsequently resulted in another hospital visit on 6/23/26 requiring stitches to her forehead when staff could not stop the bleeding from Resident #1's laceration after sustaining another fall.Action: The nurse practitioner had been notified of the incidents on 6/11/2026, as evidenced by NP documentation on chart dated 6/11/26 (page 7 of 8) where facial x-ray was ordered. Another meeting with physician and NP was also conducted yesterday with administrator and director of nursing to review the case and as part of ad hoc QAPI.[PH15.1][SB15.2] A head-to-toe assessment and medication reconciliation was completed on 6/27/26. No additional findings were noted.Start Date: 6/27/26Completion Date: 6/27/26Responsible: Administrator and Director of NursingAction: The Director of Nursing and Assistant Director of Nursing will initiate a 100% audit of all residents who admitted /readmitted within the last 14 days to ensure orders were entered correctly by reconciling against the hospital discharge medication list, the provider and patient representative will be notified of any discrepancies.Start Date: 6/27/2026Completion Date: 6/27/2026Responsi

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for 1 (R#1) of 7 residents reviewed for pain management. The facility failed to accurately assess R#1's pain levels. This failure could place residents at risk of functional decline, untreated physiological complications and mental health deterioration. Findings include: Review of R#1's admission Record, dated 6/26/26, reflected she was admitted to the facility on [DATE]. She had medical diagnoses of traumatic subarachnoid hemorrhage (bleeding in the fluid-filled space between the brain and the skull), difficulty walking, lack of coordination, muscle weakness, and Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory and thinking skills).Review of R#1's Quarterly MDS Assessment, dated 5/29/26, reflected she had a BIMS of 3, which indicated she had severe cognitive impairment. She also received a scheduled pain medication regimen. Review of R#1's Care Plan, revised 6/26/26, reflected she was at risk for pain and rarely/never understood in ability to express ideas and wants. Staff were required to assess for presence of pain at frequent routine intervals and before/after specific activities. Review of R#1's Order Summary Report, dated 6/26/26, reflected staff were required to assess for pain every shift by using non-verbal/noncognitive signs of pain to determine R#1's pain score. The report also reflected R#1's pain intensity score could not be verbalized and she had a cognizant deficit. Review of R#1's Pain Summary, dated 6/26/26, reflected staff used a pain numerical scale to assess R#1's pain levels on 6/1/26 at 11:16 a.m., 6/8/26 at 9:46 a.m., 6/19/26 at 11:27 p.m., 6/20/26 at 4:28 p.m., 6/22/26 at 3:40 p.m., 6/23/26 at 2:48 p.m. and 9:59 p.m., 6/24/26 at 3:49 p.m. and 6/25/26 at 1:11 a.m. and 1:12 p.m. The rest of the pain assessments performed from 6/1/26 through 6/25/26 were conducted using a PAINAD. During a telephone interview with R#1's RP on 6/26/26 at 10:09 a.m., RP said R#1 had severe dementia, severe cognitive impairment, and a diminished mental capacity. They explained R#1 was unable to verbalize and express her pain levels. During an observation and interview of R#1 on 6/26/26 at 11:25 a.m., R#1 was sitting in her wheelchair at the memory care unit nurse's station. She had a dark red laceration on the left side of her forehead that had stiches. The surveyor attempted to interview R#1, but she was unable to answer any questions.During a telephone interview with the NP on 6/26/26 at 3:20 p.m., he said he expected staff to use PAINAD for R#1 and said, Because a dementia resident could not tell you their numerical pain value. He also said he knew the importance of using the proper pain assessment when assessing residents for pain and said, Because the resident could have a new injury. Residents could be at risk of not having their pain assessed and managed.During an interview with the DON on 6/26/26 at 3:51 p.m., she said she expected staff to use PAINAD when evaluating R#1's pain levels because she was not able to verbalize her pain level. She also said she was not aware that staff used a pain numerical scale when assessing R#1's pain levels instead of PAINAD. She knew the importance of using the proper pain assessment when evaluating residents' pain levels and said, So their pain could be accurately assessed and treated.During an interview with the ADM on 6/26/26 at 11:22 a.m., he said he expected staff to evaluate residents like R#1 using PAINAD. He explained he expected staff to evaluate and identify nonverbal cues for pain for R#1. He also said he was not aware that staff used a pain numerical scale when assessing R#1's pain levels instead of PAINAD. He knew the importance of using the proper pain assessment when evaluating residents' pain levels and said, To determine if residents need further treatment and to treat the pain. Residents could be at risk of pain being unnoticed and facility not being aware of residents' pain. During an interview with LVN I on 6/29/26 at 11:17 a.m., she said the nurses assessed, treated and documented pain. She explained that staff used appropriate pain evaluation based on residents' BIMS. She said she was trained on pain administration. She said she would switch to PAINAD when evaluating R#1's (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pain levels. She also said R#1 sometimes could answer using a numerical pain scale. She said she knew the importance of using the proper pain assessment when evaluating residents' pain levels and said, It's important because to tell staff what the resident's pain level was. Residents could be at risk of pain. During an interview with the ADON on 6/29/26 at 11:43 p.m., she said nurses assess residents' pain levels. She also said nurses determined pain evaluation type based on residents' BIMS score and cognitive impairment. She said she knew the importance of using the proper pain assessment when evaluating residents' pain levels and said, So residents could communicate or staff could determine pain levels. Residents could be at risk of their pain levels not accurately being evaluated.During a telephone interview with LVN A on 6/29/26 at 12:58 p.m., she said nurses evaluated residents' pain. She also said nurses determined evaluations for pain based on residents being alert, oriented, their BIMS and verbal communication. She said she knew the importance of using the proper pain assessment when evaluating residents' pain levels and said, So we can get the correct assessment, evaluation and treatment for the resident. Residents could be at risk of not being effectively treated for injuries. Review of the facility's Pain Management policy, implemented 12/1/25, reflected, Facility staff will observe for nonverbal indicators which may indicate the presence of pain.The facility will use a pain assessment tool, which is appropriate for the resident's cognitive status, to assist staff in consistent assessment of a resident's pain.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interview and record review, the facility failed to administer in a manner that enables it to resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 13 of 19 staff reviewed for in-services. The facility failed to in-service who were assigned to work in the memory care unit on 6/11/26 on abuse, neglect and exploitation, incidents and accidents and resident rights on 6/11/26. This failure could place residents at risk of repeat safety failures, escalating neglect, and sustaining avoidable injuries. Findings include: Review of the facility's in-services from 6/1/26 through 6/26/26 reflected the Unit Manager trained staff on Abuse, Neglect and Exploitation, Incidents and Accidents, and Resident Rights on 6/11/26. The in-service roster for resident rights and accidents and incidents in-services were photocopied from the abuse, neglect and exploitation in-service. There were no other in-services given to staff in June 2026. Review of the facility's staff schedules, as of 6/26/26, reflected the following staff were assigned to work in the memory care unit and were not in-serviced: 6/11/26 6a-6p: CNA N, RN E, RA, ADON, RN R, MDS coordinator, Staffing Coordinator, DON, and Treatment Nurse 6/11/26 6p-6a: CNA N, CNA O, CNA P, CNA Q and LVN GDuring an interview with RN D on 6/26/26 at 11:29 a.m., he said RN R in-serviced him within the last week on abuse and neglect. During an interview with RN E on 6/26/26 at 11:43 a.m., she said she was in-serviced on abuse and neglect on 6/25/26. She could not recall who in-serviced her. During an interview with CNA L on 6/26/26 at 11:57 a.m., she said she could not remember who, what and when she was most recently in-serviced. During an interview with CNA H on 6/26/26 at 12:01 p.m., she said the Unit Manager in-serviced her on abuse and neglect within this week or last week. During an interview with CNA S on 6/26/26 at 12:04 p.m., she said the Unit Manager in-serviced her on abuse and neglect on 6/22/26 or 6/24/26. During an interview with RN D on 6/26/26 at 1:49 p.m., he said he could not recall how many in-services he signed and could not recall signing 3 in-services on 6/11/26. During an interview with CNA H on 6/26/26 at 1:59 p.m., she said she could not recall how many in-services she signed and could not recall signing 3 in-services on 6/11/26.During an interview CNA L on 6/26/26 at 2:00 p.m., she could not recall how many in-services she signed and could not recall signing 3 on 6/11/26. She also did not know if she worked on 6/11/26. During a telephone interview with the NP on 6/26/26 at 3:20 p.m., he said he expected all staff to be reeducated after an incident or accident. During an interview with the DON on 6/26/26 at 3:51 p.m., she said she asked the Unit Manager to [PH22.1][SB22.2]reeducate the staff in the memory care unit on resident rights, abuse and neglect, and incidents and accidents. She said she was there when the Unit Manager in-serviced the staff on 6/11/26. She said she was not aware the Unit Manager made photocopies of the in-service roster. She explained she asked the Unit Manager to split up the in-services on three separate sheets. During an interview with the ADM on 6/27/26 at 1:22 a.m., he said the Unit Manager initiated in-services on 6/11/26. He was not aware the Unit Manager made photocopies of the in-service roster. He knew the importance of in-servicing all staff and said, So in-services were fresh in staff's mind, they know the procedures and know how to act. Residents were not at risk as long as staff followed protocols.During an interview with LVN I on 6/29/26 at 11:17 a.m., she said the Unit Manager, ADON, DON, or ADM in-serviced staff whenever there was a concern or after an incident. She knew the importance of in-servicing all staff and said, Because we all make mistakes and to remind staff of protocols and new protocols. Residents could be at risk of staff not providing appropriate care and services.During a telephone interview with LVN A on 6/29/26 at 12:58 p.m., she said the Unit Manager, ADON, DON, and ADM in-serviced staff often. She knew the importance of in-servicing all staff and said, To make sure everyone was properly trained to take care of residents in a productive and safe manner. Residents could be at risk of incidents happening again and harm if staff were not in-serviced or properly trained. Review of the facility's Training Requirements policy, implemented 1/1/26, reflected, It is the policy of this facility to develop, implement, and maintain an effective (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. 3.Competencies and skill sets for all new and existing staff, and individuals providing services must be consistent with their expected roles.4.Facility staff needs to be trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program. 5.Training requirements should be met prior to staff independently providing services to residents, annually, and as necessary based on the facility assessment.6.Training content includes, at a minimum:b.Resident rights and facility responsibilities for caring of residents.h.Abuse, neglect, and exploitation prevention.7.It is the responsibility of each employee to complete required training.a.The facility offers a variety of training methods and times to accommodate individuals.b.An individual's failure to complete required training in a timely manner will result in removal from schedule until compliant or termination of employment.8.In-service training is provided by qualified personnel (in house or outside entities) in a variety of formats (e.g., facilitated training, computer-based training, self-directed learning, mentoring and/or coaching, etc.).