STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325057	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lovington Health Care	1600 West Ave I Lovington, NM 88260

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50207 Based on record review and interview, the facility failed to ensure the Pre-Admission Screening and Resident Review (PASRR; a screening to help ensure that individuals are not inappropriately placed in nursing homes for long term care) assessment was accurate for 1 (R #36) of 2 (R #36 and R #40) residents reviewed for PASRR accuracy. This deficient practice is likely to result in the residents not receiving the services they need. The findings are: A. Record review of R #36's face sheet revealed R #36 was admitted to the facility on [DATE] with the following diagnoses: 1. Major depressive disorder (depression; a mood disorder that causes a persistent feeling of sadness and loss of interest), 2. Post-traumatic stress disorder (PTSD; a mental health condition triggered by a terrifying event, causing flashbacks, nightmares, and severe anxiety), 3. Schizoaffective disorder (a mental condition that causes both psychosis and mood problems), bipolar type (a disorder associated with episodes of mood swings). B. Record review of R #36's PASRR dated 07/12/22, revealed staff documented that R #36 does not have a diagnosis or suspected mental illness. C. On 05/07/25 at 10:10 am, during an interview with the Interim Director of Nursing (IDON), she stated R #36 does has been diagnosed with major depressive disorder, PTSD, and schizoaffective disorder, bipolar type which are listed as a mental illnesses on the first question of section C on the New Mexico PASRR Level 1 Identification Screen form and confirmed that R #36's PASRR was incorrect.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325057	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lovington Health Care	1600 West Ave I Lovington, NM 88260

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 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** 51616 Based on record review, observation, and interview, the facility failed to develop comprehensive a care plan for 1 (R #214) of 1 (R #214) resident reviewed when staff failed to develop a comprehensive care plan for oxygen therapy. This deficient practice is likely to result in staff not being aware of the residents' care needs and preferences, and residents not receiving the needed care. The findings are: A. Record review of R #214's face sheet revealed she was admitted to the facility on [DATE] with the following diagnoses: 1. Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation (a progressive lung disease that makes it difficult to breathe with worsening symptoms, typically lasting for several days, requiring changes in treatment), 2. Pleural Effusion (a condition where excessive fluid accumulates the area between the lungs and the chest wall), 3. Acute And Chronic Respiratory Failure with Hypoxia (respiratory failure involving a condition where the body doesn't get enough oxygen), 4. Anxiety Disorder (excessive worry and fear that significantly interfere with daily life). B. Record review of R #214's care plan dated 05/04/25 revealed the following: 1. Focus are of The resident has oxygen therapy related to diagnosis of COPD and respiratory therapy. 2. Interventions include monitor for signs and symptoms of respiratory distress and report to provider as needed. The care plan does not include person centered interventions, baseline vital signs nor description of oxygen therapy to include frequency and indication of use of oxygen. C. On 05/06/25 at 12:55 pm, during an observation of R #214's room, an oxygen concentrator sat on the floor next to R #214's bed and she was wearing a nasal canula (a thin flexible tube used to deliver oxygen through your nose). D. Record review of R #214's electronic health records (EHR) revealed the resident did not have an order for the use of oxygen. E. On 05/06/25 at 12:55 pm, during an interview with Certified Medication Aid (CMA) #1, she confirmed R #214 was wearing a nasal canula with oxygen in use. F. On 05/07/25 at 10:25 am, during an interview with the Interim Director of Nursing (IDON), she confirmed R #214's care plan did not meet her expectations of person-centered interventions for oxygen therapy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325057	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lovington Health Care	1600 West Ave I Lovington, NM 88260

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50207 Based on observation, record review, and interview, the facility failed to ensure staff revised the care plan for 5 (R #4, R #10, R #14, R #15, and R #28) of 5 (R #4, R #10, R #14, R #15, and R #28) residents reviewed when staff failed to: 1. Revise R #4's care plan to include information regarding mobility bars (safety devices designed to provide additional support and stability for people with limited mobility or balance), 2. Revise R #10's care plan to include information regarding positioning rails (rails used to assist in maintaining an object's location or position), 3. Revise R #14's care plan to remove information regarding positioning rails, 4. Revise R #15's care plan to remove information regarding pain interventions, 5. Revise R #28's care plan to remove information regarding psychotropic medication when the medication was discontinued. These deficient practices are likely to result in residents' care and needs not being addressed if care plans are not updated. The findings are: R #4 A. Record review of R #4's admission record revealed R #4 was admitted to the facility on [DATE]. B. Record review of R #4's electronic health record (EHR) revealed the following: 1. A Safety Device Evaluation assessment completed on 04/29/25 for bed mobility bars. 2. An order entered on 04/29/25 for bed mobility bars. 3. A consent form completed on 04/29/25 for bed mobility bars. 4. The care plan did not include the use of bed mobility bars. C. Record review of R #4's care plan revised on 04/23/25, revealed R #4 did not have a care plan for bed mobility bars. D. On 05/04/25 at 1:40 pm during an observation of R #4's room, the bed contained mobility bars on both sides of the bed. E. On 05/04/25 at 1:40 pm during an interview with R #4, he stated he used the bed mobility bars for positioning. He stated he requested the mobility bars to assist him in positioning himself in bed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325057	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lovington Health Care	1600 West Ave I Lovington, NM 88260

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. On 05/07/25 at 10:45 pm, during an interview with the Interim Director of Nursing (IDON), she confirmed R #4 currently requires the use of mobility bars. The IDON confirmed the revision of the care plan for R #4 was not revised and should have been. R #10 G. Record review of R #10's admission record revealed that she was admitted to the facility on [DATE]. H. Record review of R #10's current medical orders revealed an order dated 04/13/25 for positioning rails to both sides of R #10's bed. I. Record review of R #10's care plan dated 01/07/25 revealed the care plan did not contain any information regarding R #10's use of positioning rails. J. On 05/07/25 at 10:10 am during an interview with the Interim Director of Nursing (IDON), she confirmed that R #10 does use positioning rails on both sides of her bed. The IDON stated that R #10's care plan should have been revised when the positioning rails were added to R #10's bed. R #14 K. Record review of R #14's admission record revealed R #14 was admitted to the facility on [DATE]. L. Record review of R #14's electronic health record (EHR) revealed the following: 1. The record did not contain an assessment for repositioning bars. 2. The record did not contain an order for the repositioning bars. 3. The record did not contain a consent for the repositioning bars. M. On 05/04/25 at 9:23 am during an observation of R #14's room, there was not repositioning bars on her bed. N. Record review of R #14's care plan revised on 02/17/25, revealed R #14 had a care plan for bed mobility that stated, R #14 uses repositioning bars to maximize independence with turning and repositioning in bed. O. On 05/04/25 at 9:23 am during an interview with R #14, she stated she used to have repositioning bars but does not have them anymore. R #14 did not know why she no longer had them nor how long ago they had been removed. P. On 05/07/25 at 10:25 am, during an interview with the Interim Director of Nursing (IDON), she confirmed R #14 does not require the use of repositioning bars. The IDON confirmed the revision of the care plan for R #14 was not revised and should have been. R #15 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325057	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lovington Health Care	1600 West Ave I Lovington, NM 88260

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Q. Record review of R #15's admission record revealed R #15 was admitted to the facility on [DATE]. R. Record review of R #15's care plan initiated on 01/23/25 and revised on 04/09/25, revealed a care plan for actual pain with interventions to administer pain medication as prescribed. S. Record review of R #15's Electronic Health Record (EHR) revealed there were no orders for pain medication. T. Record review of R #15's Medication Administration Record (MAR) dated February 2025, March 2025, April 2025 and May 2025, revealed: 1. Pain medication was not administered. 2. Daily pain monitoring scored at a zero (no pain). U. On 05/04/25 at 9:57 am during an interview with R #15, he stated that he sometimes has pain, but does not get any pain medication. R #15 could not confirm if he notified the facility of any pain. V. On 05/07/25 at 10:25 am during an interview with the Interim Director of Nursing (IDON), she stated the care plan was created as a preventative with the expectation that R #15 may require an order for pain medication soon after admission. R #15 has not complained of any pain since admission and therefore has not required a request for pain medications. The IDON confirmed the care plan for R #15 was not revised to remove interventions for pain medication use and should have been. R #28 W. Record review of R #28's admission record revealed she was admitted to the facility on [DATE]. X. Record review of R #28's care plan revised on 02/17/25 revealed that R #28 takes a psychotropic medication. Y. Record review of R #28's current medical orders revealed no order for a psychotropic medication. Z. On 05/07/25 at 10:10 am, during an interview with the Interim Director of Nursing (IDON) she confirmed that R #28's psychotropic medication was discontinued in April 2025. The IDON stated she expects R 28's care plan to be revised when needed to ensure it is accurate to reflect R #28's current medical needs. 51616 51657

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325057	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lovington Health Care	1600 West Ave I Lovington, NM 88260

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51616 Based on record review, observation, and interview, the facility failed to provide respiratory care in accordance with professional standards for 1 (R #214) of 2 (R #23, and R #214) residents reviewed for respiratory care when the facility failed to ensure there was a physician order for use of oxygen. This deficient practice is likely to result in residents' care and needs not being met if staff are not aware of the indication for use. The findings are: A. Record review of R #214's face sheet revealed she was admitted to the facility on [DATE] with the following diagnoses: 1. Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation (a progressive lung disease that makes it difficult to breathe with worsening symptoms, typically lasting for several days, requiring changes in treatment), 2. Pleural Effusion (a condition where excessive fluid accumulates the area between the lungs and the chest wall), 3. Acute And Chronic Respiratory Failure with Hypoxia (respiratory failure involving a condition where the body doesn't get enough oxygen), 4. Anxiety Disorder (excessive worry and fear that significantly interfere with daily life). B. On 05/06/25 at 12:55 pm, during an observation of R #214's room, an oxygen concentrator sat on the floor next to R #214's bed and she wore a nasal canula (a thin flexible tube used to deliver oxygen through your nose). C. On 05/06/25 at 12:55 pm, during an interview with Certified Medication Aid (CMA) #1, she confirmed R #214 was wearing a nasal canula with oxygen in use. D. Record review of R #214's electronic health records (EHR) revealed the resident did not have an order for the use of oxygen. E. On 05/07/25 at 10:25 am, during an interview with the Interim Director of Nursing (IDON), she confirmed that R #214 uses oxygen. The IDON confirmed R #214 did not have an order for use of oxygen and should have.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325057	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lovington Health Care	1600 West Ave I Lovington, NM 88260

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51616 Based on observation and interview, the facility failed to ensure food was prepared and served under sanitary conditions when staff failed to: 1. Follow safe food handling practices. 2. Properly label food items in the refrigerator. 3. Properly wear hair nets while in the kitchen. These deficient practices are likely to affect all 59 residents listed on the resident census list provided by the Administrator on 05/03/25 and are likely lead to foodborne illnesses in residents if safe food handling practices are not adhered to and stored properly. The findings are: A. On 05/03/25 at 12:35 pm, an observation of dining revealed transportation personnel (TP) #1 improperly serving residents cups by touching the rim with his bare hands. B. On 05/03/25 at 12:40 pm, during an interview with the MDS Coordinator (MDS), she confirmed TP #1 should not handle residents cups by the rim, the expectation is that staff serve and handle cups by gasping around the sides and avoiding to touch the rim. C. On 05/03/25 at 11:00 am, an observation of the kitchen revealed a drink pitcher filled with brown liquid was in the main refrigerator and did not have a label indicating the contents or date it was prepared. D. On 05/03/25 at 11:10 am, during an interview with Dietary Aide (DA) #1, she pulled the sticker/label out of her pocket that was labeled with sweet tea and the date of 05/03/25 with a time of 10:30 am. She stated she had forgotten to place it on the pitcher before she put the pitcher back in the refrigerator. E. On 05/03/25 at 11:12 am an observation of the kitchen revealed Dishwasher (DW) #1's hair hung out of the hairnet. The hair net did not cover all of her hair. DW #1 confirmed that all of her hair should be up in the hairnet. F. On 05/05/25 at 11:53 am, a random observation of the kitchen revealed DW #1 not properly wearing hair net as evidenced by her hair hanging past the hair net. G. On 05/03/25 at 11:55 am during an interview with the Dietary Supervisor (DS) #1, she confirmed that DW #1 was not properly wearing the hairnet. She stated her expectation is for all staff to properly wear hairnets while in the kitchen or serving food. 51657

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325057	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lovington Health Care	1600 West Ave I Lovington, NM 88260

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 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** 50207 Based on observation, interview, and record review, the facility failed to maintain proper infection prevention measures by not changing the oxygen tubing and cannula as ordered and having unbagged oxygen tubing and cannulas on the floor and on the back of wheelchairs for 2 (R #5 and R #21) of 3 (R #5, R #21, and R #35) residents reviewed. This deficient practice could likely cause the spread of infections and illnesses to the residents. The findings are: R #5 A. Record review of R #5's admission record revealed that he was admitted to the facility on [DATE] with the following diagnoses: 1. Chronic Obstructive Pulmonary Disease (COPD; respiratory disease), 2. Anxiety Disorder (fear and worry that interferes with daily activities), 3. Anemia (not enough hemoglobin (a protein in red blood cells that carries oxygen to the lungs to breathe) to carry oxygen to the body's tissues. B. On 05/02/25 at 10:30 am, during an observation of R #5 the oxygen tubing date and time were missing on the concentrator tubing and the portable oxygen tubing. C. On 05/03/25 at 12:30 pm during a random observation of the lunch meal revealed R#5 in the dining area. R #5 was wearing oxygen, and the oxygen tubing and cannula were not dated or in a bag. R #21 D. Record review of R #21's admission record revealed that she was admitted to the facility on [DATE] with the following diagnoses: 1. Cerebral palsy (a disorder of movement, muscle tone, and posture), 2. Diabetes mellitus (DM; metabolic disease) 3. Seizure Disorder (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), 4. Acute Respiratory Failure with hypoxia (condition that occurs when lungs cannot get enough oxygen into the blood or remove carbon dioxide from the blood). E. Record review of R #21's quarterly Minimum Data Set (MDS; a federally mandated assessment instrument completed by facility staff) dated 03/15/25, revealed the following: 1. A Brief Interview for Mental Status (BIMS; a screening for cognitive impairment) score of 00, severe impairment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325057	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lovington Health Care	1600 West Ave I Lovington, NM 88260

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R #21 was dependent and required the use of oxygen. F. On 05/03/25 at 11:20 am, an observation of R #21's room revealed the oxygen tubing that was connected to the oxygen concentrator that was located by R #21's bed was on the floor and dated 04/28/25 as indicated as the date written on a piece of tape. The oxygen tubing and cannula were not in a bag. G. On 05/03/25 at 12:30 pm a random observation of the lunch meal revealed R #21 in the dining area. R #21 was wearing oxygen, and the oxygen tubing and cannula were not dated or in a bag. H. On 05/03/25 at 12:56 pm, during an interview with the MDS Coordinator (MDS) she confirmed that R #5's and R #21's oxygen tubing and cannulas were not dated or placed in bags. She stated that her expectation is for all tubing and cannulas to be changed out weekly as ordered and they should be kept in bags, not on the floor or on the back of wheelchairs. 51616

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325057	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lovington Health Care	1600 West Ave I Lovington, NM 88260

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50207 Based on observation and interview, the facility failed to ensure the hallway in the 100 hall was accessible for residents. This deficient practice is likely to affect all 22 residents residing on the 100 hall as identified on the resident census provided by the Administrator on 05/03/25. This deficient practice could likely result in residents living in an unsafe environment, could increase their risk for injuries, and decrease their quality of life. The findings are: A. On 05/03/25 at 1:00 pm during a random observation of the 100 hall revealed the following: 1. A mechanical lift on the right side of the hallway near rooms [ROOM NUMBERS], 2. A mechanical lift on the left side of the hallway near rooms [ROOM NUMBERS], 3. A housekeeping cart on the right side of the hallway near the shower room and room [ROOM NUMBER], 4. A medication cart on the left side of the hallway near rooms [ROOM NUMBERS]. B. On 05/04/25 at 9:00 am during a random observation of the 100 hall revealed the following: 1. A mechanical lift on the right side of the hallway near rooms [ROOM NUMBERS], 2. A mechanical lift on the left side of the hallway near rooms [ROOM NUMBERS], 3. A housekeeping cart on the left side of the hallway near room [ROOM NUMBER], 4. A medication cart on the left side of the hallway near rooms [ROOM NUMBERS]. C. On 05/04/25 at 9:10 am during an interview with Receptionist (REC) #1, she confirmed there were objects on both sides of the hallway blocking the residents' path. She stated that everything should be on one side of the hallway, so residents had a clear path.