STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325091	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Silver City Care Center	3514 Fowler Avenue Silver City, NM 88061

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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 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. Based on observation and interview, the facility failed to store food under sanitary conditions for all 64 residents who eat food from the kitchen (residents were identified by the resident matrix provided by the administrator on (01/05/26) when staff failed to label and date all items in the kitchen refrigerator. Failure to store food under safe and sanitary conditions could likely lead to foodborne illnesses in residents. The findings are: A. On 01/05/26 at 12:10 PM, an observation of the kitchen revealed the following: 1. The walk-in refrigerator had: a. Two butter blocks with no dates, b. Jello in large container no date, no cover, c. Chorizo dated 12/20/25, 4. Pears no date in container, 5. Peanut Butter bar dessert in container no date, 6. Ham sliced in a ziplock bag was open dated 01/01/25, 7. Baked crispy pineapple cake in the pantry storage area with no date. 2. The walk-in freezer had: a. Salsbury streak opened with no date, b. Chicken patties opened with no date, c. Lemon meringue pie with no date, d. Pie crusts opened with no date e. Corn tortillas were opened loosely and not tightly sealed with a date of 12/11/25. B. On 01/05/26 at 12:29 PM, during an interview with the Dietary Manager (DM), she stated she checks dates of food every day. The staff who unload the food truck are to date the boxes as soon as they come in before storing them. The staff are to date the food when opened. She confirmed that there was food in the refrigerator and freezer that had no dates, no covers on food containers, food was not tightly sealed and outdated dates on food. The DM stated that her expectation is that the staff date and mark foods and throw them away if outdated.

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 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** Based on observation, record review, and interview, the facility failed to ensure care plan revisions occurred for 4 (R #7, R #11, R #47, and R #71) of 4 (R #7, R #11, R #47, and R #71) residents when the staff failed to revise the care plan with the most current resident information. This deficient practice could likely result in the care plan not being updated with the most current resident conditions and appropriate interventions, staff being unaware of changes in care provided, and residents not receiving the care related to changes in their health status or healthcare decisions. The findings are: R #7 A. Record review of R #7's physician order, dated 12/31/25, revealed enteral feeding (delivering nutrients directly into the gastrointestinal tract (stomach or small intestine) using a soft tube, bypassing the mouth for inadequate oral intake at meals). Give 250 ml (milliliters) Jevity (name brand of fiber-fortified, complete nutritional liquid formula) 1.2 when resident eats less than 25% of meals. B. Record review of R #7's care plan, dated 04/22/25, revealed staff did not document R #7's enteral feed order and interventions for her enteral feed in her care plan. C. On 01/07/25 at 2:12 PM, during an interview, the DON confirmed that staff did not document R #7's enteral feeds or the interventions for the enteral feeds in the care plan. R #11 D. Record review of R #11's admission document, no date, revealed R #11 was admitted to the facility on [DATE]. E. On 01/06/26 at 11:03 AM, during an observation of R #11's toenails revealed her toenail were thick layered. F. Record review of R #11's physician orders revealed an order dated 11/14/25, to check fingernails and toenails. Trim and file as resident will allow as per guidelines every Tuesday and Friday and document resident refusals. G. Record review of R #11's care plan, dated 12/28/25, revealed staff did not document the following: 1. R #11's fingernail and toenail trimming. 2. Staff did not document how they manage care when R #11 refuses nail care and becomes combative. H. On 01/07/26 at 1:21 PM, during an interview with CNA #24, she stated R #11 toenails were thick layered. CNA #24 stated R #11 does not let staff file or trim her nails, she becomes combative. I. On 01/07/26 at 1:27 PM, during an interview with Unit Manager (UM), he stated that his expectation is that R #11 should be care planned for nail care and her behaviors. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R #47 K. Record review of R #47's physicians order, dated 12/29/25, revealed oxygen therapy as needed at 1-2 liters per minute via nasal canula (lightweight, flexible medical device used to deliver supplemental oxygen) for low oxygen. L. Record review of R #47's care plan, dated 09/08/25, revealed that R #47's oxygen and interventions for the oxygen were not care planned. M. On 01/08/26 at 2:46 PM, during an interview, the Administrator confirmed R #47's oxygen and interventions were not documented on his care plan. The Administrator stated that the oxygen should be documented on R #47's care plan.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete performance reviews at least every 12 months for 2 (CNA #16 and CNA #17) of 2 (CNA #16 and CNA #17) CNAs sampled for 12 hours of annual training. This deficient practice could likely result in staff being undertrained and providing inadequate care. The findings are: A. Record review of the employee files revealed the following: 1. CNA #16's hire date was 11/18/24. 2. The file did not contain any performance evaluations for CNA #16. 3. CNA #17's hire date was 09/20/24. 4. The file did not contain any performance evaluations for CNA #17. B. On 01/13/26 at 9:27 AM, during an interview, the administrator confirmed the following: 1. There were not any performance evaluations for CNA #16 and CNA #17. 2. Performance evaluations were expected to be completed at least annually on CNAs.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the consultant pharmacist's recommendations were reviewed and implemented by the physician and/or the physician provided documentation of a rationale (a set of reasons or a logical basis for a course of action or a particular belief) for not following the consultant pharmacist's recommendation in the residents' medical record for 4 (R #8, R #10, R #32 and R #63) of 5 (R #7, R #8, R #10, R #32 and R #63) residents reviewed for unnecessary medications. This deficient practice could likely result in residents receiving medications that are no longer necessary and may cause unnecessary drug interactions (changes to medication action caused by being combined with other foods, beverages, or drugs) or adverse side effects (unwanted, undesirable effects from medication). The findings are: R #8 A. Record review of R #8's admission document, no date, revealed the following: 1. R #8 was admitted to the facility on [DATE], 2. R #8 was diagnosed with the following diagnoses: a. Vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. b. Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (cognitive decline affecting daily life but lacks specific neuropsychiatric symptoms like agitation, hallucinations, depression, or severe worry, with severity mild, moderate, severe also not yet specified). c. Anxiety Disorder (feelings of fear, dread, and uneasiness that may occur as a reaction to stress), unspecified. d. Insomnia, unspecified (is a common sleep condition that involves consistent difficulty falling asleep, staying asleep, or achieving restorative, quality sleep despite having adequate opportunity and environment for sleep). B. Record review of R #8's physician's orders revealed an order dated 09/25/25 for Quetiapine Fumarate tablet 200 mg (is used to treat schizophrenia in adults and children who are at least [AGE] years old. It is also used alone or with divalproex or lithium to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods) give 1 tablet by mouth at bedtime for Dementia with psychotic disturbance. C. Record review of R #8's pharmacy recommendation summary report dated 10/28/25, revealed the following: 1. R #8 is currently receiving Quetiapine 200 mg by mouth once daily for dementia with psychotic disturbance. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Patients with dementia-related psychosis (involves hallucinations (seeing/hearing things not there) and delusions (false, unshakable beliefs) occurring) treated with atypical antipsychotics (second-generation antipsychotics) are newer medications for mental health conditions like schizophrenia, bipolar disorder, and severe depression) are at an increased risk of death compared to placebo (a medicine or procedure prescribed for the psychological benefit to the patient rather than for any physiological effect). An increased incidence of cerebrovascular accident (is the medical term for a stroke) and adverse events (including fatalities) has been reported in elderly patients with dementia-related psychosis. 3. A benefit/risk analysis of current therapy warrants a continuation at the present dose. 4. R #8's physician did not provide a benefit/risk analysis with patient specific information as to why R #8 needed to remain on medication. R #10 D. Record review of R #10's admission document, no date, revealed the following: 1. R #10 was admitted to the facility on [DATE], 2. R #10 was diagnosed with the following diagnoses: a. Alzheimer's Disease (is the biological process that begins with the appearance of a buildup of proteins in the form of amyloid plaques and neurofibrillary tangles in the brain). b. Dementia, unspecified severity, with other behavioral disturbance, (cognitive decline affecting daily life but lacks specific neuropsychiatric symptoms like agitation, hallucinations, depression, or severe worry, with severity mild, moderate, severe also not yet specified). E. Record review of R #10's physician's orders revealed an order dated 07/01/25 for Quetiapine 25 mg, oral tablet (is used to treat schizophrenia in adults and children who are at least [AGE] years old. It is also used alone or with divalproex or lithium to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods) give 1 tablet by mouth 25 mg, two times a day for Dementia with psychotic disturbance. F. Record review of R #10's pharmacy recommendation summary report dated 10/28/25, revealed the following: 1. R #10 is currently receiving Quetiapine 25 mg by mouth twice daily for dementia with psychotic disturbance. 2. Patients with dementia-related psychosis (involves hallucinations (seeing/hearing things not there) and delusions (false, unshakable beliefs) occurring) treated with atypical antipsychotics (second-generation antipsychotics) are newer medications for mental health conditions like schizophrenia, bipolar disorder, and severe depression) are at an increased risk of death compared to placebo. An increased incidence of cerebrovascular adverse events (including fatalities) has been reported in elderly patients with dementia-related psychosis. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. A benefit/risk analysis of current therapy warrants a continuation at the present dose. 4. R #10's physician did not provide a benefit/risk analysis with patient specific information as to why R #10 needed to remain on medication. R #32 G. Record review of R #32's admission document, no date, revealed the following: 1. R #32 was admitted to the facility on [DATE], 2. R #32 was diagnosed Dementia, unspecified severity, with Agitation, (is used specifically for documenting cases of unspecified dementia, a condition characterized by a decline in cognitive function without a clearly identified cause. It includes varying severities and can be recorded with or without accompanying behavioral, psychotic, mood, or anxiety disturbances). H. Record review of R #32's physician's orders revealed an order dated 12/17/25 for Rexulti oral tablet 1.5 mg (as an adjunctive therapy to antidepressants for the treatment of major depressive disorder (MDD) in adults, treatment of schizophrenia in adults and pediatric patients ages 13 years and older, treatment of agitation associated with dementia due to Alzheimer's disease) give 1 tablet by mouth one time a day. I. Record review of R #32's pharmacy recommendation summary report dated 12/27/25, revealed the following: 1. R #32 is currently receiving the atypical antipsychotic Rexulti 2 mg by mouth once daily by mouth in the evening for Dementia with Behavioral disturbance and agitation. 2. Patients with dementia-related psychosis (involves hallucinations (seeing/hearing things not there) and delusions (false, unshakable beliefs) occurring) treated with atypical antipsychotics (second-generation antipsychotics) are newer medications for mental health conditions like schizophrenia, bipolar disorder, and severe depression) are at an increased risk of death compared to placebo. An increased incidence of cerebrovascular adverse events (including fatalities) has been reported in elderly patients with dementia-related psychosis. 3. A benefit/risk analysis of current therapy warrants a continuation at the present dose. 4. R #32's physician did not provide a benefit/risk analysis with patient specific information as to why R #32 needed to remain on medication. J. On 01/09/2026 at 12:33 PM, during an interview with the DON regarding the resident benefit risk analysis for medication for R #8, R #10, and R #32. DON stated she does see in the chart where it is documented specifically benefit risk analysis for the medications. DON's expectation is that the physician document in the chart the benefit risk analysis. R #63 K. Record review of R #63's admission document, no date, revealed the following: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. R #63 was admitted to the facility on [DATE], 2. R # 63 was diagnosed with the following diagnoses: a. Depression (a mood disorder that causes persistent feelings of sadness and a loss of interest in activities, affecting how a person thinks, feels, and acts), unspecified. b. Dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (cognitive decline affecting daily life but lacks specific neuropsychiatric symptoms like agitation, hallucinations, depression, or severe worry, with severity mild, moderate, severe also not yet specified). c. Anxiety disorder (Feelings of fear, dread, and uneasiness that may occur as a reaction to stress), unspecified. L. Record review of R #63's physician's orders revealed the following orders: 1. An order dated 08/11/25 for Escitalopram Oxalate (major depressive disorder and generalized anxiety disorder) give 15 mg by mouth one time a day for depression. 2. An order dated 10/02/25 for Zyprexa (to treat certain mental health conditions) give 1 tablet by mouth one time a day for dementia with psychotic disturbances. M. Record review of R #63's pharmacy recommendation summary report dated 10/26/25, revealed the following: 1. R #63 is currently receiving Zyprexa 5 mg by mouth once daily at bedtime for dementia with psychotic disturbance, consider gradual dose reduction (GDR). 2. Patients with dementia-related psychosis (involves hallucinations (seeing/hearing things not there) and delusions (false, unshakable beliefs) occurring) treated with atypical antipsychotics (second-generation antipsychotics) are newer medications for mental health conditions like schizophrenia, bipolar disorder, and severe depression) are at an increased risk of death compared to placebo. An increased incidence of cerebrovascular adverse events (including fatalities) has been reported in elderly patients with dementia-related psychosis. 3. A benefit/risk analysis of current therapy warrants a continuation at the present dose. 4. R #63's physician did not provide a benefit/risk analysis with patient specific information as to why R #63 needed to remain on medication. N. Record review of R #63's pharmacy recommendation summary report dated 12/26/25, revealed the following: 1. R R #63's is currently receiving Escitalopram (a prescription antidepressant medication) 15 mg by mouth once daily, consider gradual dose reduction (GDR). 2. R #63's physician did not provide rationale with patient specific information as to why a GRD was not done. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	O. On 01/09/26 at 11:27 AM, during an interview, the DON confirmed that a rationale and benefit/risk analysis is not documented in R #63's medical record. The DON stated that her expectation is that a rationale should be provided and that an analysis should be completed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure medical records were complete and accurate for 4 (R #5, R #10, R #11, and R #16) of 4 (R #5, R #10, R #11, and R #16) residents reviewed accuracy of documentation when staff failed to: 1. Accurately document R #5's dental assessment. 2. Accurately document activity participation for R #10 and R #11. 3. Accurately document R #16's skin assessment. These deficient practices have the potential to negatively impact the care staff provide to meet residents' needs due to inaccurate records. The findings are: R #5 A. Record review of R #5's admission documents, no date, revealed R #5 was admitted to the facility on [DATE]. B. On 01/06/26 at 9:42 AM, during an observation and interview with R #5, the following was revealed: 1. R #5 stated that she had several broken teeth that needed to be pulled. 2. R #5 had several of her teeth broken with discoloration on the top and bottom of her mouth. C. Record review of R #5's admission assessment, dated 11/17/25, revealed staff documented R #5 had no natural teeth or tooth fragments and was edentulous (lacking teeth). D. On 01/07/26 at 2:50 PM, during an interview, LPN # 16 observed R #5 in her room and confirmed that R #5 was not edentulous. E. On 01/08/26 at 3:10 PM, during an interview, the DON confirmed the following: Staff documented on R #5's admission assessment that she was edentulous. R #5's admission assessment was inaccurate. Staff were expected to ensure resident dental status was assessed and documented accurately. R #10 F. Record review of R #10's admission document, no date, revealed that R #10 was admitted to the facility on [DATE]. G. On 01/05/26 at 3:06 PM, during an interview with family member (FM), she stated R #10 wants to (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	go to Christian Church service and it is not offered. FM stated the manager in secure unit, said there is Catholic services offered here with activities, and they can't take him out due to his wandering. FM further stated that she doesn't know if activities are offered at the facility because, when FM visits R #10 she does not see activities going on in the secure unit. H. Record review of the facility's activities participation record for October 2025-December 2025 revealed no documentation for attending church services for R #10. I. On 01/07/26 at 1:35 PM, during an interview with the Unit Manager (UM), he stated R #10 likes to hear music and reads his bible. He stated R #10 goes off unit with activities staff for church service. UM stated he couldn't provide documentation of residents going to church services to check with activities staff. J. On 01/07/26 at 1:46 PM, during an interview, Activities Director (AD) stated activities aide goes to the secure unit on Thursdays at 10:00 AM to take R #10 to church services. AD stated activities staff does not document activity participation for the secure unit, and the manager of the secured unit should be documenting R #10's activity attendance. K. On 01/07/26 at 2:09 PM during an interview with the Administrator, she stated she is the supervisor for the UM and AD. Administrator stated that the UM oversees the secure unit. The Administrator stated her expectation is that the UM documents the activities that residents attend on and off the secure unit. R #11 L. Record review of R #11's admission document, no date, revealed that R #11 was admitted to the facility on [DATE]. M. Record review of R #11's care plan dated 06/12/25 revealed a goal that staff will encourage resident to participate in facility activities and provide one to one, programs as needed through next review date. N. Record review of the facility's activities participation record for October 2025-December 2025 revealed no documentation for one-to-one activities for R #11. O. On 01/07/26 at 1:32 PM, during an interview with the UM, he stated R #11 does receive one-to-one activities at least once a day. The staff read her books and magazines, she enjoys a slinky object on her arm, and staff take R #11 outside weather permitting. His expectation is that staff complete the activity participation record when activities occur. R #16 P. Record review of R #16's admission documents, no date, revealed R # #16 was admitted to the facility on [DATE]. Q. On 01/05/26 at 2:45 PM, during an observation of R #16 by the nurses' station, the following was revealed the following: 1. R #16 had blood on his right elbow. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. LPN #17 cleansed R #16's right elbow and placed a bandage over the wound. R. On 01/08/26 at 9:46 AM, during an observation and interview of R #16 in the hallway, the following was revealed: 1. R #16 had a dressing that was falling off his right elbow that appeared to have dried blood on it. 2. R #16 stated that staff had not changed the bandage since he got the wound on 01/05/26. S. Record review of R #16's skin assessment, dated 01/08/26, revealed staff documented that R #16 had no skin issues. T. On 01/08/26 at 9:57 AM, during an interview, the wound care nurse stated the following: 1. She was not aware R #16 had a wound on his right elbow. 2. She observed R #16's elbow and confirmed he had a wound on his right elbow. 3. She confirmed that on 01/08/26, staff documented that R #16 had no skin issues 4. She confirmed that R #16's skin assessment was inaccurate. T. On 01/08/26 at 3:04 PM, during an interview, the DON confirmed that staff were expected to assess resident skin condition at least weekly and were expected to document accurately on the skin assessment form.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, and interview, the facility failed to have reasonable accommodations for 1 (R #61) of 1 (R #61) resident sampled for environment, when they failed to put R #61's call light in a place he could reach it. This deficient practice could likely result in residents not being unable to notify staff when they are in need of assistance. The findings are: A. On 01/06/26 at 12:54 PM, during an observation of R #61's room revealed R #61's call light was hanging over the light above his bed. The light fixture is approximately 6 feet from the floor. B. On 01/06/25 at 12:56 PM, during an interview, CNA #8 confirmed that R #61's call light was hanging from the light fixture above his bed. CNA #8 confirmed that R #61 could not reach the call light. C. On 01/07/25 at 2:24 PM, during an interview, the Administrator confirmed that residents should be able to reach their call lights.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure the MDS assessment was accurate for 2 (R #5 and R #9) of 8 (R #5, R #6, R #9, R #13, R #33, R #51, R #62 and R #80) residents reviewed for accurate MDS assessments. This deficient practice could likely result in the facility not having an accurate assessment of the resident's current health status and being unable to meet the resident's current needs. The findings are: R #5 A. Record review of R #5's admission documents, no date, revealed she was admitted to the facility on [DATE]. B. On 01/06/26 at 9:42 AM, during an observation and interview with R #5, revealed the following: 1. R #5 stated that she had several broken teeth that needed to be pulled. 2. R #5 had broken teeth, and her mouth was discolored on the top and bottom. C. Record review of R #5's admission MDS assessment dated [DATE], revealed staff documented R #5 was edentulous (lacking teeth). D. On 01/07/26 at 2:50 PM, during an interview, LPN #16 observed R #5 in her room and confirmed that R #5 was not edentulous. E. On 01/08/26 at 3:10 PM, during an interview, the DON confirmed the following: 1. Staff documented on R #5's admission MDS that she was edentulous. 2. R #5's admission MDS was inaccurate, and staff should not have documented that R #5 was edentulous. 3. Staff were expected to ensure that MDS assessments were accurate. R #9 F. Record review of R #9's admission record (no date) revealed the following: 1. R #9 was admitted to the facility on [DATE]. 2. Diagnosis included cerebral infarction unspecified (type of stroke caused by blockage of the vessels that affect blood flow to the brain that can lead to significant disability or death). G. Record review of R #9's medical record revealed the following: Computed tomography angiography (CTA) of the neck (specialized imaging that creates detailed images of the blood vessels in the neck and is used to evaluate conditions that can lead to serious complications like stroke) dated 02/13/25 results: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Complete occlusion of the right common carotid (serious condition in which there is total blockage of the artery/major blood vessels which supply oxygen-rich blood to the brain, head and neck). b. Greater than 70 % stenosis of the left proximal internal carotid artery (significant narrowing of the artery/major blood vessels which supply oxygen-rich blood to the brain, head and neck). c. Recommend neurovascular evaluation (a specialized and comprehensive assessment with a doctor that specializes in diagnosing and treating conditions related to the blood vessels in the brain and spinal cord, particularly cerebrovascular [group of disorders that affect blood flow to the brain] diseases like stroke). H. Record review of R #9's provider progress note dated 02/14/25 revealed the following: Diagnosis, assessment and plan: a. Stenosis of the left internal carotid artery b. Occlusion of the right internal carotid artery. c. Plan: Discussed results of CTA of neck with resident. Discussed seriousness of findings. Answered all questions. Resident preferring not to go to the emergency department today but waiting for follow-up with vascular specialist. Verbalized understanding of seriousness of the findings and risks associated with waiting for follow-up care including death. I. Record review of R #9's Quarterly MDS assessment dated [DATE] revealed Section I, active diagnoses: Did not include the diagnoses from the CTA dated 02/13/25. J. On 01/08/26 at 3:31 PM an interview with the MDS coordinator revealed the following: 1. She was unaware of the diagnoses for R #9 after he had the CTA on 02/13/25. 2. The medical team liaison (MTL) will usually notify her of new diagnoses. 3. R #9's diagnoses from the CTA on 02/13/25 should have been added to R #9's MDS.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and interview, the facility failed to meet professional standards of practice for 1 (R #63) of 2 (R #7 and R #63) residents reviewed for physician's orders, when staff did not update an order for R #63's enteral feed. This deficient practice could likely lead to the resident having adverse (unwanted, harmful, or abnormal result) side effects or not receiving the desired therapeutic effect of the medication. The findings are: A. On 01/06/26 at 2:38 PM, during an interview, LPN #8 stated that R #63 only gets his Jevity (a brand of fiber-fortified, complete nutritional liquid formula) through his Percutaneous Endoscopic Gastrostomy (PEG- a flexible feeding tube placed through the abdominal wall directly into the stomach to deliver nutrition) tube when R #63 eats less than 50% of his meals by mouth. B. Record review of R #63's physician's orders revealed the following: 1. An order dated 11/08/25 for enteral feed (delivering liquid nutrition directly into the gastrointestinal tract (stomach or small intestine) via a soft tube when someone can't eat enough by mouth) four times a day Jevity 1.2 via PEG tube. 2. An order dated 12/01/25 for regular/liberalized diet puree texture, (a dietary modification consisting of foods that have been blended, strained, or pressed into a smooth, cohesive, pudding-like consistency that requires no chewing) thick liquids-Nectar consistency, allow sandwiches and soft snacks with supervision of intake. C. On 01/07/26 at 1:07 PM, during an interview, LPN #9 stated R #63 doesn't get the PEG tube feeding any more. LPN #9 stated that the resident is eating 100% by mouth of his meals. LPN #9 stated that R #63 had been eating on his own for a long time. D. On 01/07/26 at 1:12 PM, during an interview, the Nurse Practitioner (NP) stated R #63 is eating by mouth. The NP confirmed that the order for his PEG tube feeding 4 times a day was not updated to the current status of R #63 getting his PEG tube feeding only if R #63 eats less than 50% of his food by mouth. The NP stated that the order should be updated to document the most current treatment. E. On 01/07/26 at 1:25 PM, during an interview, the DON confirmed R #63's order was not updated. The DON stated that the order should be updated to clarify that R #63 should be fed via the PEG tube if he eats less than 50% of his meal by mouth.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, record review, and interview, the facility failed to ensure residents received quality treatment and care for 1 (R #16) of 4 (R #4, R #5, R #16, and R #80) residents reviewed for wound treatment when staff failed to: 1. Document R #16 had a wound on his right elbow. 2. Notify the provider and obtain orders for wound treatment for R #16 wound on his right elbow. 3. Provide wound care for R #16's wound on his right elbow. These deficient practices could likely lead to residents needs not being met and/or a worsening of their wounds. The findings are: A. Record review of R #16's admission documents, no date, revealed R #16 was admitted to the facility on [DATE]. B. On 01/05/26 at 2:45 PM, during an observation of R #16 by the nurses' station, revealed the following: 1. R #16 had blood on his right elbow. 2. LPN #17 cleansed R #16's right elbow and placed a bandage over the wound. C. On 01/05/26 at 2:46 PM, during an interview, LPN #17 stated she was placing a bandage on R #16 wound on his right elbow because R #16 had scraped his right elbow on the wheel of his wheelchair. D. On 01/08/26 at 9:46 AM, during an observation and interview of R #16 in the hallway, revealed the following: 1. R #16 had a dressing that was falling off his right elbow that appeared to have dried blood on it. 2. R #16 stated that staff had not changed the bandage since he got the wound on 01/05/26. E. On 01/08/26 at 9:57 AM, during an interview, the wound care nurse stated the following: 1. She was not aware that R #16 had a wound on his right elbow. 2. She observed R #16's elbow and confirmed he had a wound and a dressing that was falling off his right elbow. 3. When a new wound was identified, staff were expected to: a. Assess the wound. b. Notify the provider and resident family about the new wound. c. Document in the medical record regarding the new wound and who was notified regarding the wound. e. Enter orders to complete wound care on the wound. f. She confirmed there was no documentation in the medical record regarding R #16's wound on his right elbow or whether the provider was notified. g. She confirmed R #16's medical record did not have wound care orders for R #16's wound on his right elbow. h. She confirmed there was no documentation that R #16's dressing had been placed. F. On 01/08/26 at 3:04 PM, during an interview, the DON confirmed the following: 1. When a new wound was identified, staff were expected to evaluate and clean the wound, notify the provider and resident family, and enter wound care orders. 2. Staff did not document any information regarding R #16's wound on his right elbow. 3. Staff did not notify the provider or R #16's family that R #16 had a wound on his right elbow. 4. Staff did not enter any orders for wound care for R #16's wound on his right elbow.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide respiratory care in accordance with professional standards for 1 (R #3) of 2 (R #3 and R #47) residents reviewed for respiratory care when staff failed to follow the physician's order for oxygen use. This deficient practice could likely result in residents receiving too much or not enough oxygen and can lead to worsening of their condition. The findings are: A. Record review of R #3's admission documents, no date, revealed the following: 1. R #3 was admitted to the facility on [DATE]. 2. R #3 had the following diagnoses: a. Chronic respiratory failure with hypoxia (a long-term condition where the lungs can't get enough oxygen into the blood, causing low blood oxygen). b. Chronic obstructive pulmonary disease (COPD, a progressive lung condition causing airflow obstruction, making breathing difficult). c. Tracheostomy (a surgical procedure that creates an opening (stoma) in the neck into the windpipe (trachea) to provide an airway). B. Record review of R #3's physician's order, dated 08/12/25, revealed an order for Oxygen concentrator to be set at 3 liters per minute (LPM, flow rate of oxygen) every day and night shift. C. On 01/06/26 at 4:32 PM, during an observation and interview with R #3, the following was revealed: 1. R #3's oxygen concentrator (a medical device that provides supplemental oxygen by taking in ambient air, filtering out nitrogen, and delivering concentrated, purified oxygen (typically 90-95% pure) to the user through a nasal cannula or mask) was set at 4 LPM. 2. R #3 stated his oxygen is usually set at 3 LPM. 3. R #3 stated a couple of days before the interview (was unsure of the date), his oxygen saturation (the percentage of hemoglobin (the iron-rich protein in red blood cells that carries oxygen from your lungs to the rest of your body) in your red blood cells that is carrying oxygen, indicating how well your body's tissues are receiving oxygen from the lungs) was at 72% and staff increased his oxygen concentrator to 4 LPM. D. Record review of R #3's medical record, no date, revealed staff did not document the following: 1. When R #3's oxygen concentrator was increased to 4 LPM. 2. A respiratory assessment (a systematic evaluation of the respiratory system using inspection, palpation, percussion, and auscultation to check breathing patterns, chest movement, lung sounds (like crackles, wheezes), oxygenation, and signs of distress to diagnose issues and monitor lung health) that indicated why R #3's oxygen concentrator was increased to 4 LPM. 3. Whether the provider was notified that R #3's oxygen concentrator was increased. E. On 01/07/26 at 9:05 AM, during an observation of R #3 in his room, revealed R #3's oxygen concentrator was set at 4 LPM. F. On 01/07/26 at 9:06 AM, during an interview, LPN #16 stated the following: 1. She confirmed R #3's oxygen concentrator was set at 4 LPM. 2. She confirmed R #3's physicians order was for R #3's oxygen concentrator to be set at 3 LPM. 3. She was not aware why R #3's oxygen concentrator had been increased to 4 LPM. 4. She confirmed R #3's medical record did not have any documentation regarding why R #3's oxygen was increased or that the provider was notified about increasing R #3's oxygen concentrator to 4 LPM. G. On 01/08/26 at 3:25 PM, during an interview, the DON confirmed the following: 1. If a resident had a change in their respiratory status that required a change in their oxygen concentration, staff were expected to: a. Document an assessment regarding the residents' change in condition. b. Notify the provider and resident's family regarding the change in the resident's condition. c. Enter new orders to increase the resident's oxygen concentrator level. staff did not document in R #3's medical record that R #3 had a change in condition that required his oxygen concentrator to be increased. 2. Staff did not document that a provider was notified about a change in R #3's respiratory status. 3. Staff did not use the communication application to communicate with on-call providers did not contain any messages regarding a change in R #3's respiratory status or the need to increase his oxygen concentration.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on interview and record review the facility failed to ensure residents obtained dental services for 1 (R #7) of 3 (R #5, R #7 and R #63) residents sampled for dental services, when they failed to ensure residents receive routine dental care to include an annual inspection of the mouth for signs of disease, dental cleaning, fillings, or minor partial or full denture adjustments. This deficient practice is likely to cause the resident unnecessary pain, embarrassment over the condition/appearance of teeth, and potential dental or oral complications. The findings are: A. Record review of R #7's medical record revealed an admission date of 04/10/25. B. On 01/06/26 at 1:26 PM, during an interview with R #7's Family Member (FM) #1, he stated that R #7 had not been to see a dentist since she had been at the facility. R #7's FM #1 stated that R #7 does have missing teeth. C. On 01/09/26 at 11:55 AM, during an interview, R #7 stated that she had not been to the dentist. R #7 stated she would like to go to the dentist. D. On 01/09/26 at 12:02 PM, during an interview the Social Services confirmed that the resident has not been to the dentist since she was admitted to the facility.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and interview, the facility failed to ensure CNAs received the required in-service training of 12 hours per year for 2 (CNA #16 and CNA #17) of 2 (CNA #16 and CNA #17) CNAs reviewed for required in-service training. This deficient practice is likely to result in the CNAs not receiving the necessary training to meet the care needs of the residents. The findings are: A. Record review of the employee files revealed the following: 1. CNA #16's hire date was 11/18/24. 2. The file did not contain any documentation of in-service trainings for CNA #16. 3. CNA #17's hire date was 09/20/24. 4. The file did not contain any documentation of in-service trainings for CNA #17. B. On 01/13/26 at 9:27 AM, during an interview, the administrator confirmed the following: 1. There was no documentation of in-service trainings for CNA #16 and CNA #17. 2. CNAs were expected to have at least 12 hours of in-service training annually.