| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455471 | A. Building<br>B. Wing | 03/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Mountain View Health & Rehabilitation | 1600 Muchison Rd<br>El Paso, TX 79902 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observations, interviews, and record review the facility failed to distribute and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for sanitation and food storage.-The facility failed to ensure dietary staff followed proper food safety practices for hand hygiene after contamination on 03/24/2026.This failure had the potential to place residents at risk for foodborne illness.Findings included:During an observation on 3/24/2026 at 11:58 AM, it was observed that [NAME] F collected all the used sanitizing towelettes and wrappers and discarded them in the trash without practicing hand hygiene before returning to work. At 12:10 PM [NAME] F was filling a bowl of pozole (Mexican pork stew) that overflowed and wet her left hand with dripping falling back into the steam table pozole insert, she proceeded to work without practicing hand hygiene. At 12:13 PM [NAME] F was filling another bowl of pozole that overflowed and wet her left hand with dripping falling back into the steam table pozole insert, she proceeded to work without practicing hand hygiene. No hand hygiene was observed to taken place for the next 10 minutes, before surveyor exited kitchen. Pozole was still served to residents following the observed cross-contamination.During an interview on 03/26/2026 at 2:18 PM with Dietary Aide D, she stated she worked the steam table serving food sometimes. She stated that she washed her hands throughout the day, after restroom, after breaks, and when reentering the kitchen. She stated that staff needed to wash their hands if it was exposed to the food during serving. She stated that staff should have stopped and washed their hands because it was potential for cross contamination if they didn't. She stated all staff were responsible for recognizing cross contamination and washing hands when soiled. She stated there was a system in place that provided the opportunity for the serving to continue and the staff member to wash their hands. She stated that the last in-service for hand washing was within the past week. During an interview on 03/26/2026 at 2:27 PM with [NAME] E, he stated you practice hand hygiene before beginning work, every time you move from the cooking area, whenever you touch an article that was not part of the cooking process (for example a door handle, the walk-in refrigerator), and when you grab a residents cup or plate. He stated he had worked the steam table line before, and if his hands were exposed to food, he would stop and wash his hands. He stated it was considered cross contamination if staff did not wash their hands. He stated he would wash hands immediately and would wash his hands if it happened again. He stated staff not washing their hands after contamination was not appropriate. He stated that the supervisors were responsible for ensuring staff were washing their hands when contaminated. He stated the last in-service for hand hygiene was a couple of weeks ago. He explained the hand-washing procedure included washing the nails, fingers, hand, and a little above you wrist for 20 seconds. During an interview on 03/26/2026 at 2:39 PM with The Dietary Supervisor, she stated hand hygiene needed to be practiced for every kitchen reentry, when staff grabbed an ingredient or meat, and was an ongoing task staff needed to complete. She explained that the hand-washing procedure included washing the exposed area below the wrists for 40 seconds each time. She stated that anyone in the kitchen could tell another staff member to wash their hands if a potential contamination was observed. She stated that she had worked at the steam table during serving before and added she had experienced food<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | touching her before. She stated in all instances she stopped what she was doing immediately to wash her hands. She stated this needed to be done because there was a potential for cross contamination of food. She stated that staff should wash their hands immediately to prevent a cross contamination and she needed to ask the cook for a replacement dish if the dripping landed back in the food. She stated the last in-service for hand hygiene was yesterday.During an interview on 03/26/2026 at 2:56 PM with the Dietary Director, he stated that staff needed to complete hand hygiene whenever they reenter the kitchen, encountered a raw ingredient or fridge handle, and before beginning a new task. He stated this needed to be adhered to because it could be considered cross contamination. He stated it would be an infection control issue if staff had a contaminant on their hands and continued meal service. He stated that staff should have stopped and completed hand hygiene if they encountered food while serving during mealtime. He stated everyone was responsible for completing hand hygiene and supervisors were responsible for providing in service and training on hand hygiene. He stated that residents could be exposed to symptoms related to food-borne illnesses if hand hygiene was not adhered to. He stated the last in service for hand hygiene was within the last month. He explained that the hand-washing procedure included washing palms, wrists, fingers, and back of hands for a minimum of 20 seconds. During an interview on 03/26/2026 at 3:43 PM with The Administrator, he stated dietary staff should be practicing hand hygiene at all times because it was a universal precaution. He stated proper hand hygiene provided infection control during meal service by minimizing cross contaminations for residents. He stated that the dietary manager, supervisors, and all staff could address hand hygiene concerns in the kitchen. He stated that if food came in contact during line service, staff needed to stop immediately and wash their hands to prevent cross contamination. He stated it affected residents by exposing them to cross contaminated food and added it messed up the quality of food. He stated that [NAME] F and any staff member who saw the mishandling should have instructed [NAME] F to practice hand hygiene. He stated there was no issue with staff stepping away from the meal service line to complete hand hygiene. Record review of the facility's policy titled, Fundamentals of Infection Control Precautions undated read in part, A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility (Hand Hygiene section) Hand hygiene continue to be the primary means of preventing the transmission of infection, The following is a list of some situations that require hand hygiene: -When coming on duty - When hands are visibly soiled . -Before and after or handling food |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain an infection prevention program designed to provide safe, sanitary, and prevent the development and transmission of communicable diseases and infections for 2 of 8 residents (Resident #8 and Resident #77) reviewed for transmission-based precautions.- The facility failed on 03/24/2026 to ensure an unattended IV saline syringe flush was not left on Resident #77' nightstand.- The facility failed on 03/24/2026 and 03/25/2026 to ensure Resident #8's Eternal Feeding Syringe was not uncovered on his nightstand or in his dresser.The failures placed residents at risk for developing a preventable infection during patient care.Findings Included:Findings Included:<br><br>1.Resident #8<br><br>Record review of Resident #8 face sheet dated 03/26/2026 revealed an [AGE] year-old male with an admission date on 08/11/2025.<br><br>Record review of Resident #8 Quarterly MDS dated [DATE] revealed the resident had a BIMS score of 13 indicating he was cognitively intact. Under Section K-swallowing/nutritional status revealed the resident had a feeding tube in place.<br><br>Record review of Resident #8's care plan dated 11/20/2025 revealed the resident had an enhanced barrier precaution in place. The care plan revealed a focus for tube feeding with interventions to check for tube placement and gastric contents/residual volume per facility protocol and record and a goal for Resident #8 to remain free of side effects or complications related to tube feeding.<br><br>Record review of Resident #8 health and physical dated 07/24/2025 revealed the resident was at the hospital emergency room with expressed concerns for swallowing and progressive weight loss ongoing for 2 weeks. Resident #8 was diagnoses with dysphagia (difficulty swallowing) with a PEG tube placement and Lewy body Dementia (causing cognitive decline, visual hallucinations, movement issues, and fluctuating alertness).<br><br>During an observation on 3/24/2026 at 3:49 PM, it was observed that Resident #8's external feeding syringe was placed on his nightstand only partially sealed with the original packaging the syringe came in but still exposed by the piston and half of the syringe.<br><br>During a follow up observation on 03/25/2026 at 11:08 AM, an external feeding syringe was stored inside Resident #8's dresser unsealed and exposed to all the contents of the dresser.<br><br>During an interview on 03/25/2026 at 8:23 AM with Resident #8, he stated he had a gastric tube in place that staff used to provide feeding and hydration through. He stated they used a big purple syringe to assist in-between feedings and hydration. He stated staff provided feeding at a frequency of 3 times and quantity of 2 bottles per session. He added for hydration they came at a frequency of 5 times.<br><br>2.Resident #77<br><br>Record review of Resident #77 face sheet dated 03/26/2026 revealed a [AGE] year-old female with an admission date on 03/12/2026.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Record review of Resident #77 MDS dated [DATE] revealed the resident had a diagnosis of Sepsis (the body's extreme, overwhelming response to an infection, leading to tissue damage and organ failure). Under Section O-Special treatments, procedures, and programs the resident was coded for having a peripheral IV access site on admission<br><br>Record review of Resident #77 care plan dated 03/12/2026 revealed the resident was on enhanced barrier precautions with a goal to be free of transmission of infection from or to the resident. Further review revealed the resident had a focus are for the IV access site with interventions to flush the ports/lines as ordered and monitor for signs and symptoms of infection.<br><br>Record review of Resident #77 health and physical dated 3/12/2026 revealed the resident was diagnoses with Coronary Artery Disease (buildup of plaque in the arteries), Urological cancer post chemotherapy (cancer of the urinary excretion system post treatment).<br><br>During an observation on 3/24/2026 at 9:48 AM, it was observed a saline flush syringe was left unattended out of its package on Resident #77's nightstand.<br><br>During an interview and observations on 3/24/2026 at 10:50 AM with Resident #77, she stated she had just returned from PT. She stated she had not noticed the saline flush syringe on her nightstand and does not remember what staff member had provided it or when. She added she did not know what it was used for. She stated she did have an IV access site on her hand but it had been discontinued. She was unable to recite for how long the IV therapy had been discontinued.<br><br>During an interview on 03/26/2026 at 8:52 AM with CNA A, he stated if he found an unattended syringe out of its package, he would report it to the nurse immediately. He stated he did not know if it was okay to leave saline syringe flushes and external feeding syringe in the resident's room. He stated there was a hazard for leaving syringes in residents' rooms. He added it was an infection control issue because there was a possibility the syringe had encountered a resident's bodily fluids. He stated that the supervisors were responsible for ensuring staff were following infection prevention practices.<br><br>During an interview on 03/26/2026 at 9:14 AM with RN C, she stated that the saline syringe was used to flush an IV line and the big purple syringes were external feeding syringes used for feeding and flushing water for residents with PEG tubes. She stated the saline syringe was disposable after it was out of its package and the external feeding syringe could be reused up to 24 hours, but it had to be stored in a Ziplock bag to seal it off from contaminants when not in use. She stated it was not okay for the external feeding syringe to be stored on top of the dresser or in the resident's dresser. She started the saline syringe needed to be discarded if it was removed from its package but not used. She stated it was an infection control issue if the resident syringes were left out because they could develop mold, dust, bodily fluids, medication, or old feeding shakes. She stated the nurse would be responsible for upholding infection prevention, but anyone could report or address it if they observed it in a residents' room. She stated that the last in service she received for infection control was last week.<br><br>During an interview on 03/26/2026 at 3:47 PM with the Administrator, he stated that the external feeding syringe and saline syringes should not be stored in a resident's room when not in use. He stated if it was used, it should be discarded after. He stated that the external feeding syringe for Resident #8 should have stored and sealed away so that there was no potential for cross contamination and added it was not appropriate for it to be left in the Resident #8's dresser. He stated (continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | that the saline syringe left in Resident #77's room out of the package needed to be discarded. He stated every staff member could dispose of used medical equipment but typically it was nurse's responsibility. He stated the DON was the infection control specialist. He added it was expected the ADONs and nurses should adhere to infection control and prevention practices. He stated it affected residents by exposing them to other infections.<br><br>In an interview on 03/26/2026 at 3:48 p.m., with the DON revealed the feeding syringe needed to be placed back in the packaging after use to prevent contamination and to prevent bacteria from entering the PEG tube. She stated that the saline flush needed to be discarded after each use to prevent cross contamination that could possibly enter the residents blood stream through the IV. She stated that it was the responsibility of the nurses to ensure that all equipment was stored, discarded, and sanitized properly along with the DON and ADONs.<br><br>Record review of the facility's policy titled Eternal Nutrition undated, read in part, . (Procedure Section) The Nursing Services Department is responsible for all feeding equipment and the administration of tube feedings Problems with administration of the tube feeding are monitored and corrected by nursing<br><br>Record review of the facility's policy titled, Fundamentals of Infection Control Precautions undated read in part, A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility (Resident Care Equipment and Articles Section) Non-invasive resident care equipment is cleaned daily or as needed between use by the nursing assistant A documentation system will be maintained of the cleaning Any resident care equipment/article that is visibly contaminated with blood or body fluids will be immediately be cleaned with an approved disinfectant |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents were provided services with reasonable accommodation of needs and preferences for 3 of 28 residents (Residents #13, #56 and #87) reviewed for call lights. The facility failed to ensure resident call lights were within reach for Residents #13, #56 and #87 on 03/24/2026. This failure placed residents at risk of having their needs unmet when they were unable to contact staff.Findings include:Resident #13Record review of Resident #13's face sheet dated 3/26/2026, revealed a [AGE] year-old female with an admission date of 1/13/2023.Record review of Resident #13's quarterly MDS dated [DATE] revealed BIMS score of 14 indicating cognitively intact. Section GG-Functional Abilities notated Resident #13 was unable to complete oral hygiene, bathing, upper/lower body dressing, rolling to side, and bed/toilet/wheelchair transfers due to medical conditions. Resident was dependent meaning the helper does all the effort required to complete activities for daily living.Record review of Resident #13's care plan dated 1/29/2026 revealed the resident was at risk for falls with an intervention in place to ensure the call light was within reach. The care plan had a focus to address Resident #13's uncontrolled pain with interventions in place to monitor and anticipate the resident's need for pain relief.Record review of Resident #13's Health and Physical dated 3/3/2026 revealed the resident had diagnoses of cerebral palsy (a group of permanent movement and posture disorders), quadriplegic with chronic lower extremity contractures (a person with paralysis or severe weakness in all four limbs), and seizure disorder (unprovoked seizures caused by abnormal electrical activity in the brain).During an observation and interview on 3/24/2026 at 4:22 PM, Resident #13 was sitting in her wheelchair while the call light touch pad was on her bed. Resident #13 stated that she was dependent on staff for everything she needed and added the call light was not accessible to her because she could not move her wheelchair herself to obtain the call light. Resident #13 was approximately 6 feet away from her call light touch pad.Resident #56Record review of Resident #56's admission Record dated 03/26/2026 revealed a [AGE] year-old male with an admission date of 05/23/2024.Record review of Resident # 56's History and Physical dated 03/19/2026 revealed a diagnosis of generalized muscle weakness.Record review of Resident #56's comprehensive MDS dated [DATE] revealed a BIMS score of 13 indicating intact cognitive function. Section GG indicated Resident needed partial/moderate assistance meaning the helper does less than half the effort. Helper lifts or holds, or supports trunk or limbs, but provides less than half the effort when going from sitting to standing position.Record review of Resident #56's care plan revised 03/17/2026 revealed Resident # 56 was a risk for falls. Interventions included to ensure the residents call light was within reach and encouraging the resident to use it for assistance as needed.An observation on 03/24/2026 at 3:38 p.m., revealed Resident #56 asleep in bed. The call light was hanging on a sharps container that was to the right of the resident's bed above the head of the bed.Resident #87Record review of Resident #87's admission Record dated 03/26/2026, revealed a [AGE] year-old female with admission date 05/17/2019.Record review of Resident #87's History and Physical dated 03/26/2026 revealed a medical history of Dementia (a syndrome characterized by a decline in cognitive function, affecting memory, thinking, behavior, and the ability to perform everyday activities), muscle wasting and atrophy (muscle atrophy is when muscles appear smaller than usual due to a lack of muscle tissue), and Muscle Weakness. Record review of Resident #87's Quarterly MDS dated [DATE] revealed a BIMS score of 0, indicating severe cognitive impairment.Record review of Resident #87's care plan with revision date 09/30/2021, revealed Resident #87 had a cognitive communication problem with staff intervention to ensure a safe environment including providing the call light within resident reach.An observation was made on 03/24/2026 at 10:08 AM of Resident #87's call light on the floor under the resident's bed and out of her reach. Resident #87 did not answer any of the surveyor's questions.In an interview on 03/26/2026 at 2:47 PM with RN H, he stated the purpose of call lights<br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | was for residents to call staff for their needs. He stated the nursing staff rounded on residents every 2 hours which included ensuring the call light was within the residents' reach. He stated the risks for residents not having their call light within reach, included possible falls or not having their needs met. RN H stated residents not having their call light within reach was not safe for the resident.During an interview on 3/26/2026 at 3:24 PM with The Administrator, he stated that a call light was used for residents to contact the staff to provide customer service and care. He stated the call light needed to be within reach for the resident to utilize. He stated everybody in the facility can place a call light within reach for the resident. He added any staff member could respond to an illuminated call light but would be dependent on the staff member's position for what services they could provide . He stated that it affected residents who needed assistance by not having their needs met like a brief change and delayed time response from staff. He was unable to recall the last in service for call lights and did not provide documentation before exiting on 3/26/2026 at 5:45 PM.In an interview on 03/26/2026 at 3:43 PM with the DON, she stated all staff were responsible for ensuring the call light was within the residents' reach. She stated CNAs and Nurses round on residents throughout their shifts. She stated ADONs round on residents 3-4 times on their shift to ensure residents have call lights within reach. The DON stated the potential risk of residents not having the call light within reach included residents being unable to call for help or not having their needs met.On 03/26/2026 at 9 AM, the Administrator stated there was no call light policy. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** ased on interview and record review, the facility failed to ensure assessments accurately reflected the status for 1 of 8 residents reviewed for MDS assessments. (Resident #63).-The facility did not accurately code Resident #63's MDSs for a pressure ulcer on the Sacrum that had resolved 11/30/2026. This failure could place the census of 133 residents at risk of not receiving adequate care and services to meet their needs. Findings include:Record review of Resident #63's admission Record dated 03/26/2026 revealed a [AGE] year-old female with admission date 11/07/2025.Record review of Resident #63's History and Physical dated 03/06/2026 revealed a medical history of Type II Diabetes Mellitus (a chronic condition that happens when the body cannot use insulin correctly and sugar builds up in the blood).Record review of Resident #63's Quarterly MDS dated [DATE] revealed a BIMS score of 11, indicating moderate cognitive impairment. Section M- Skin Conditions noted Resident #87 had a Stage II pressure ulcer and had pressure ulcer/injury care.Record review of Resident #63's Care plan revised 11/12/2025, and resolved date 03/26/2026 after surveyor intervention, revealed the resident had a pressure ulcer or potential for pressure ulcer development: Stage 3 to Sacrum (just above the buttocks and at the base of the spine). The staff interventions included Administering treatments as ordered and monitored for effectiveness.Record review of Resident #63's Weekly Skin assessment dated [DATE] noted Resident #63 did not have any pressure, venous, arterial, or diabetic ulcers during assessment. It noted Resident #63 did not have any bruising, skin tears, abrasions (scrape or graze), lacerations (a rip or tear in or on the body), rashes, or moisture-associated skin damage.In an interview on 03/26/2026 at 1:00 PM with Resident #63 revealed she was admitted to the nursing facility last year with a wound which was resolved in the facility months ago. She denied having any wounds at the moment.In an interview on 03/26/2026 at 1:05 PM with MDS Nurse L, he stated Resident #63 had her pressure ulcer to her Sacrum resolved since 11/30/2025. He stated he did not believe there was a potential risk of the resident's MDS having resolved Resident #87's wound as active in the MDS but it was his mistake as the MDS Nurse. He stated that MDS Nursing was responsible for monitoring and confirming that the MDS was updated with resident's information correctly. MDS Nurse L stated MDS Nursing monitored on a quarterly basis and as needed for significant changes.In an interview on 03/26/2026 at 3:37 PM with the DON, she stated floor nursing staff initiated the initial or baseline MDS upon admission. She stated MDS Nursing composed the comprehensive MDS and were responsible for the MDS. She stated she did not believe there was a potential risk for residents having an active wound and wound care noted in the MDS.Record review of the facility's policy Resident Assessment, with no date, read in part: A comprehensive assessment will be completed within 14 days of admission and annually on each resident. It continued to read, 4. The facility will examine each resident and review the minimum data set expanded core elements specified in RAI no less than once every three (3) months and as appropriate. Results must be recorded to assure continued accuracy of the assessment. 5. The results of the assessment are used to develop, review, and revise the resident's comprehensive plan of care. |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to incorporate the recommendations from the PASRR Level II determination and PASRR evaluation report into the resident's assessment, care planning, and transitions of care for 1 of 7 (Resident #149) residents reviewed for PASRR services.-The facility failed to submit a complete and accurate request for nursing facility specialized services in the LTC Online Portal within 20 business days after the date of the Interdisciplinary Team meeting from 12/18/2025This failure placed the PASRR residents at risk from not receiving services identified by the IDT in a timely manner.Findings include:Record review of Resident #149's face sheet dated 3/26/2026 revealed a [AGE] year-old female with an admission date of 07/08/2025 and a discharge date of 02/25/2026.Record review of Resident #149's Quarterly MDS dated [DATE], Section C-Cognitive Patterns revealed the resident did not have a BIMS score because the resident was rarely/never understood. Section GG-Functional Abilities notated Resident #149 was unable to complete oral hygiene, bathing, upper/lower body dressing, rolling to side, and bed/toilet/wheelchair transfers due to medical conditions. Resident was dependent, meaning the helper does all the effort required to complete activities for daily living.Record review of Resident #149's Care plan dated 12/18/2025 revealed a focus for Resident #149's Parkinson diagnosis with interventions of PT, OT treatment as ordered. An additional focus area was identified for PASRR services with interventions of providing specialized services will be provided per IDT recommendations: PT/OT/ST 3X WEEK and Habilitation Coordination.Record review of Resident #149's Health and Physical dated 2/24/2026 revealed the resident had diagnoses of volvulus of sigmoid colon (a serious condition where the sigmoid colon twists around its stomach fold causing closed-loop bowel obstruction,), large bowel obstruction (blockage of the colon preventing waste passage), advance Parkinson disease (characterized by severe, disabling symptoms-including extreme rigidity, significant balance issues, freezing, and cognitive decline), and debilitated (general weakness, lack of stamina, and functional decline, often linked to advanced age or multiple comorbidities).Record review of the complaint intake dated 3/10/2026 read in part, Attached is the spreadsheet of nursing facilities (NFs) that have been contacted. These NFs were informed that per 26 TAC Chapter 554, Subchapter BB S554.2704 (i)(7). The resident has not received a Medicaid service because of the following: The NF was notified and instructed to submit a NFSS Request by a specific deadline but failed to do so. The NFSS Request submittal by the NF was denied and there was not a follow up submittal to ensure the request was approved to provide specialized services for PASRR for the resident (Resident #149).Record review of Resident #149's PCSP dated 12/18/2025 revealed the meeting was a Local Authority update due to a change in service (Section: A0900) and Resident #149 was Medicaid confirmed payer source (Section A0810). Under Section A2800-Nursing Facility Specialized Services, it was identified as a new finding that Resident #149 required a PT and OT assessment and therapy services.Record review of Resident #149's PCSP dated 01/15/2026 revealed under Section A2800- Nursing Facility Specialized Services, it was identified the findings for related for PT and OT assessment and therapy services was still coded as new. At the time, Resident #149 had a new identified need for ST assessment and therapy services.Record review of the documents titled NFSS Therapist, Referring Physician and NF Administrator Therapy Signature page for Resident #149, revealed the Physical Therapist, Occupational Therapist, Physician, and Administrator signed their portion of the document on 1/15/2026.During an interview on 3/25/2026 at 2:13 PM with the Director of Rehabilitation, she stated she was aware of Resident #149 was PASRR positive (an individual who was identified for having a mental health or intellectual and developmental disorder who required additional screening and services upon entry into a nursing facility) and was present during her care plan meetings. She stated the resident was PASRR 1 positive before admission and transferred from skilled nursing<br>(continued on next page) |

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| | 455471 | A. Building<br>B. Wing | 03/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Mountain View Health & Rehabilitation | 1600 Muchison Rd<br>El Paso, TX 79902 |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | services, then to long term care, then into Hospice. She stated that MDS would provide her with the paperwork and the therapists and herself would complete the assessments in 20 days. She stated the specialized services were PT, OT and ST. She stated the services were initiated on 1/15/2026 following the therapists' signatures. She stated that for PASRR, the authorization from the state had to be provided before providing the services and treatment. She added, once approval came in then the services could begin and authorization was good for 6 months. She stated it was shared responsibility amongst the whole team to meet the NFSS deadlines. She stated if services were delayed, the resident would not see improvement in their condition and would cause a restart after a delay. She stated she recalled a delay in Resident #149's therapy services but could not remember the cause of delay and did not recall being aware of the conditions being vocalized on 12/18/2025 during the PCSP meeting.During an interview on 3/25/2026 at 2:29 PM with the DON, she stated she remembered Resident #149 but was not aware of her PASRR situation and was not aware of any delay in services. She stated that PASRR was comprised of PT, OT, ST, Director of Rehabilitation, The LMHA/LIDDA, Social Worker, and the MDS Nurses. She stated that MDS typically coordinated the PASRR. She stated she could not recall completion of the PASRR 1 or 2 (an individual who was identified for having a mental health or intellectual and developmental disorder who required additional screening and services upon entry into a nursing facility) for Resident #149. She stated she could not recall the specialized services she required for Resident #149. She stated that MDS completed all the documentation in the health record software and conversed with LMHA/LIDDA. She stated she would be notified by MDS if there was any participation required on her part. She stated she was not aware of the timelines for NFSS. She stated that herself, ADON, MDS needed to adhere to the timelines and monitor to ensure they were completed before required deadlines. She stated the delay in services would negatively affect the resident and added she could not elaborate based on limited clinical knowledge on therapy. During an interview on 3/25/2026 at 2:42 PM with MDS Nurse A, she stated she recalled Resident #149 and her PASRR situation. She stated Resident #149 was screened PASRR 1 positive on 7/18/2025. She stated that the resident was screened for PASRR 2 on 7/14/2025 and was positive by LMHA/LIDDA under the IDD portion of the PASRR assessment. She stated Resident #149 did not have any specialized services identified because she was Medicaid pending. She stated that PASRR services stopped when Medicaid was pending. She stated that PASRR specialized services were only for individuals on Medicaid. She stated the family was indecisive on continuing or stopping PASRR for therapy services or admitting Resident #149 into Hospice. She stated that she was confused with the LMHA/LIDDA representative because during the care plan meeting on 12/18/2025 they had clarified with LMHA/LIDDA representative that all specialized services were not going to be provided until January 2026 during the next care plan meeting. She stated that the specialized services for PT and OT were not provided from 12/18/2025 to 01/15/2026. She stated that the therapy department completed notes in their system. She stated that when LMHA/LIDDA provided services, it was documented in an external program. She stated that therapy department, MDS, and clinical team had access to the external program. She identified herself as the individual who was responsible for meeting the NFSS timelines. She stated that the state needed to know within 20 days of specialized services being identified. She stated that the timeline for Resident #149's specialized services identification and therapists' signature was not within the 20-day NFSS requirement. She stated it affected residents who received a delay in services that they would not receive the physical, occupational, and speech therapy needed for improvement. She stated there could be a decline in a resident's wellbeing. During an interview on 3/26/2026 at 10:43 AM with the Physical Therapist, she stated she evaluated Resident #149 on 1/6/2026. She stated the resident was very fragile and required total assistance for bed mobility, had a PEG tube in place, contracture on her right knee, contracture hip abductor bilaterally (both sides), left plantar flexion (downward movement of the foot and ankle) contractions, bilateral (both sides) hand contractions, chronic contractions to the neck. She stated that the findings on 7/29/2025 (continued on next page) |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | evaluation had the same findings as those in 1/6/2026. She stated the contractures were too severe for Resident #149 to participate in a PT restoration program and was more focused on providing maintenance for Resident #149. She stated her portion of the PASRR was to complete a document when requested and clarified she did not participate in the care plan meetings. She stated that the Director of Rehabilitation would present the PASRR documents to her when a resident needed to have one completed for specialized services. She stated that the NFSS form came after the 6 of January and was not signed until 1/15/2026. She stated she was not familiar with the PASRR process. She stated she recommended stretching for physical therapy for passive range of motion and tolerate semi-upright in bed with head elevated for Resident #149. She stated she documented her service delivery in an external program and added she did not know who else had access to the external program. She stated that services delayed could result in worsening conditions for residents. During an interview on 3/26/2026 at 3:55 PM with The Administrator, he stated he was familiar with Resident #149 and was aware she was a skilled nursing resident and transferred to LTC with Medicaid pending, then entered Hospice care. He stated when a resident was Medicaid pending, it was difficult to get new services approved. He stated that there was a possibility the facility failed to start PASRR services due to human error from payor source. He stated that there was a pending signature from the Hospice RN that resulted in the delay of care. He stated that he was not familiar when Resident #149 was PASRR 1 positive. He stated he did not know when Resident #149 was screened for PASRR 2. He stated he was not aware of any specialized services Resident #149 required under PASRR. He stated that the MDS reviewed delivery of services for PASRR on a daily and quarterly basis. He stated that the IDT team and MDS were responsible for ensuring the NFSS timelines were met. He stated that ADLs could decline during the period of no service provided. He stated that the IDT needed to report it within 20 days and was unaware if the facility met the requirement for specialized services for Resident #149.Record review of Resident #149's document titled PASRR Level 1 Screening revealed it was completed on 07/08/2025 and that the facility had identified evidence in the resident for a mental illness and a developmental disability.Record review of Resident #149's document titled PASRR Evaluation revealed it was completed on 07/14/2025 by the LMHA/LIDDA representative. Further review revealed Resident #149 presented positive screening for findings under Section B for IDD with identified assistance for nutritional support. coordinating medical treatments. ADLs. development to include social/recreational activities and relationships with othersA policy for PASRR care and treatment was requested at end of day on 3/25/2026 and was not fulfilled before exit on 3/26/2026. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs for 1 resident (Residents #63) of 6 residents reviewed for care plans.The facility failed to have a comprehensive person-centered care plan for Resident #63 by showing a resolved wound as active.These failures could affect residents and put them at risk for not receiving care and services to meet their needs.Record review of Resident #63's admission Record dated 03/26/2026 revealed a [AGE] year-old female with admission date 11/07/2025.Record review of Resident #63's History and Physical dated 03/06/2026 revealed a medical history of Type II Diabetes Mellitus (a chronic condition that happens when the body cannot use insulin correctly and sugar builds up in the blood).Record review of Resident #63's Quarterly MDS dated [DATE] revealed a BIMS score of 11, indicating moderate cognitive impairment. Section M-Skin Conditions noted Resident #87 had a Stage II pressure ulcer and had pressure ulcer/injury care.Record review of Resident #63's Care plan revised 11/12/2025, and resolved date 03/26/2026 which was during survey, revealed the resident had a pressure ulcer or potential for pressure ulcer development: Stage 3 to Sacrum (just above the buttocks and at the base of the spine). The staff interventions included Administering treatments as ordered and monitored for effectiveness.Record review of Resident #63's Weekly Skin assessment dated [DATE] noted Resident #63 did not have any pressure, venous, arterial, or diabetic ulcers during assessment. It noted Resident #63 did not have any bruising, skin tears, abrasions (scrape or graze), lacerations (a rip or tear in or on the body), rashes, or moisture-associated skin damage.In an interview on 03/26/2026 at 1:00 PM with Resident #63 revealed she was admitted to the nursing facility last year with a wound which was resolved in the facility months ago. She denied having any wounds at the moment.In an interview on 03/26/2026 at 1:04 PM with MDS Nurse L, he stated Resident #63 had her pressure ulcer to her Sacrum resolved since 11/30/2025. He stated there was no potential risk to the resident having an active Pressure Wound diagnosis in the care plan, though it was an error and his mistake. He stated that MDS Nursing was responsible for monitoring and confirming that the care plan was updated correctly. MDS Nurse L stated MDS Nursing monitored on a quarterly basis and as needed for significant changes.In an interview on 03/26/2026 at 2:43 PM with RN H, he stated care plans were started by floor nursing staff and the MDS Nursing were responsible for monitoring the care plan. He stated that MDS Nursing monitored the care plan quarterly. RN H stated potential risks of care plans not reflecting accurate resident information, would include the risk of utilizing or supplying equipment that were no longer needed if the intial issue was resolved.He stated that the ADONs and the DON monitored care plans, but unsure how often.In an interview on 03/26/2026 at 3:36 PM with the DON, she stated floor nurses were responsible for composing the baseline care plan and as needed for acute changes. She stated the comprehensive care plan was monitored every 3 months by MDS Nursing. The DON stated she did not think there was a potential risk of having resolved diagnosis included in the care plan as active, including the care plan noting a resident had a wound and required wound care when they did not.Record review of the facility's policy Comprehensive Care Planning, with no date, read in part: The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. It also read, The comprehensive care plan will reflect interventions to enable each resident to meet his/her objectives. Interventions are the specific care and services that will be implemented. When developing the comprehensive care plan, facility staff will, at a minimum, use the Minimum Data Set (MDS) to assess the resident's clinical condition, cognitive and functional status, and use of services. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 1 of 4 residents ( Resident #40) reviewed for ADL care.- The facility failed on 3/24/2026 to ensure Resident #40's fingernails were trimmedThis failure could place residents who required assistance with ADLs at risk for unmet care needs.Findings include:Resident #40Record Review of Resident #40's admission Record dated 03/26/2026 revealed a [AGE] year-old female with an initial admission date of 01/12/2023 and a readmission date of 10/13/2025.Record review of Resident #40's History and Physical dated 03/05/2026 revealed a diagnosis of a cerebral vascular accident (blood flow to a part of the brain is interrupted or reduced) and chronic vegetative state.Record review of Resident #40's Quarterly MDS dated [DATE] revealed no BIMs score. Section GG revealed personal hygiene tasks were not attempted due to medical condition or safety concerns.Record review of Resident #40's care plan revised on 03/18/2026 revealed Resident #40 had an ADL self-care deficit; interventions included resident required total assistance with personal hygiene care.An observation on 03/24/2026 at 10:13 a.m., revealed Resident #40's right hand fingers to be contracted with fingernails digging into the palm of the hand, and fingernails were observed to be long. Resident was awake but not alert or oriented, and she was not able to answer questionsDuring an interview on 03/26/2026 at 8:41 AM with CNA B, he stated if he saw a resident with long toenails, he would consult with the nurse to see if the resident was diabetic or scheduled with the podiatrist already. He stated that he was restorative CNA so he did not have a routine to look at the toenails in his responsibilities but would notify the nurse for any concerns he observed or heard. He stated when he was on the floor staff would review the toenails every day when providing care and ADLs. He stated if a resident requested nail service, then he would inform the nurse and gain clarification to see if it was a service he could provide based on the resident's condition. He stated that residents could be affected by infection, fungus development, and ingrown nails if they did not receive routine nail care. He stated it was all nursing staffs' responsibility to ensure residents' nails were regularly groomed. He stated the last in-service he received for ADLs was in February 2026.In an interview on 03/26/2026 at 1:40 p.m., with CNA I revealed fingernails were trimmed on Sundays and as needed. She stated that CNAs and nurses were responsible for ensuring that nails were trimmed. She stated a possible risk of long fingernails was injury due to scratching and could possibly be an infection control issue.In an interview on 03/26/2026 at 2:00pm with RN H revealed fingernails were trimmed as needed, when they were observed to be long or when the resident asked for a trimming. He stated that a potential risk would be injury by scratching or cutting themselves. He stated that the nurses were responsible for cutting the fingernails and ensuring that the residents had trimmed nails.During an Interview on 3/26/2026 at 3:28 PM with the Administrator, he stated that podiatry visited the facility 1 to 2 times a month. He added if a resident was requesting toenail trimming beyond the scope of nurses, it should be reported to the nurse to contact podiatry. He stated that the podiatrist had a list of residents they saw during their visits. He stated it affected residents who did not receive toenail care because they could experience pain and ingrown nails. He stated that the ADON, DON, and floor nurses were responsible for following up on toenail care. He stated fingernails were trimmed as needed. He stated that nurses and CNAs were responsible for trimming the fingernails. He stated that the nurses, DON and ADONs were responsible for ensuring that residents' fingernails were being trimmed. He stated that long nails were a potential risk of injury due to scratching. He stated he was not aware of a monitoring/tracking system in place for residents that required podiatry and referred to DON for further information. During an interview on 03/26/2026 at 4:24 PM with the DON, she stated that during showers staff recorded the conditions of the toenails and fingernails and reported it to the Podiatrist to provide services to the residents. She (continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | stated that it could be uncomfortable for a resident because there could be infections from ingrown nails and fungus. She stated that the nursing staff and supervisors monitored and tracked the condition of residents' toes and fingernails daily with rounds and assessments throughout the day. She stated that when the resident was diabetic or had a bleeding disorder, they would be referred to the podiatrist. She stated that the podiatrist comes as needed and once a month on routine. She stated there was a list that the facility kept of residents serviced when podiatry came; podiatry service census documentation was provided before exit on 3/26/2026. She stated that fingernails were trimmed during shower days. She stated that fingernails were trimmed by CNAs and nurses and it was the responsibility of the nurses and CNAs to ensure that fingernails were kept trimmed and clean.Record review of the facility's documents titled podiatry list dated on 12/09/2025, 02/03/2026, and 03/06/2026 revealed Residents #40 and #119 were not on the list of residents who received services through podiatry for the past 3 months.Record review of the facility's policy titled Nail care undated, read in part, Nail management is the regular care of the toenails and fingernails to promote cleanliness, and skin integrity issues, to prevent infection, and injury from scratching by fingernails and pressure of shoes on toenails. It includes cleansing, trimming, smoothing, and cuticle are and is usually done during the bath NAIL CARE, ESPEECIALLY TRIMMING IS PERFORMED BY A PODIATRIST IN THOSE WITH DIABETES AND PERIPHERAL VASCULAR DISEASE (Goals section) Nail care will be performed regularly and safely. The resident will be free from abnormal nail conditions (Procedure section) . Nails that are ingrown, thickened, or infected should be cared for by a podiatrist. Report conditions immediately to the primary nurse. The nurse will ensure a referral to the podiatrist. |

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| F 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate foot care.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, the facility failed to ensure that resident receive proper treatment and care to maintain mobility and good foot health for 1 of 1 residents (Resident #119) reviewed for foot care.The facility failed on 3/24/2026 to ensure Resident #119's toenails were trimmedThis failure could place residents who required specialized foot care at risk for unmet care needs, infections, and health complications.Resident #119Record review of Resident #119's face sheet dated 3/26/2026 revealed a [AGE] year-old female with an original admission date on 04/01/2020 and a readmission date on 11/13/2023.Record review of Resident #119's quarterly MDS dated [DATE] revealed the resident had a BIMS score of 15 indicating the resident was cognitively intact. Section GG - Functional Abilities revealed the resident could not complete lower body dressing, personal hygiene, oral hygiene, upper body dressing, putting on/removing footwear, and transfers due to medical conditions or safety concerns.Record review of Resident #119's care plan dated 01/13/2026 revealed the resident needed assistance with ADLs and mobility due to hemiplegia/hemiparesis (A neurological condition causing one-sided body weakness) to the right side of her body. Further review revealed Resident #119 had an age-related physical debility (a state of general weakness or lack of stamina) and required extensive assistance with ADLs with intervention for 1 person to assist with personal hygiene.Record review of Resident #119's Physical and Health dated 3/19/2026 revealed the resident had diagnoses of peripheral vascular disease (progressive circulation disorder involving narrowing, blockage, or spasms in blood vessels outside the heart and brain, most commonly in the legs and feet), Parkinsons (disease is a progressive neurodegenerative movement disorder), legally blind, and type 2 diabetes mellitus with hyperglycemia (chronic metabolic disease where the body becomes resistant to insulin).Record review of Resident #119's Orders revealed the resident had an active order from the Physician dated 02/26/2024 for, podiatrist consultation for foot care.During an observation and interview on 03/24/2026 at 3:36 PM with Resident #119 she stated she did not like the length of her toenails and would like someone to cut them. She stated that she had asked the direct care staff already but was unable to recall when and who she asked. Observation of Resident #119's exposed right foot revealed long and thickened toenails with a yellow hue under the nail.During an interview on 03/26/2026 at 8:41 AM with CNA B, he stated that he was restorative CNA so he did not have a routine to look at the toenails in his responsibilities but would notify the nurse for any concerns he observed or heard. He stated when he was on the floor staff would review the toenails every day when providing care and ADLs. He stated if a resident requested nail service, then he would inform the nurse and gain clarification to see if it was a service he could provide based on the resident's condition. He stated that residents could be affected by infection, fungus development, and ingrown nails if they did not receive routine foot care. He stated it was all nursing staffs' responsibility to ensure residents' nails were regularly groomed. He stated the last in-service he received for ADLs was in February 2026.During an interview on 03/26/2026 at 9:02 AM with RN C, she stated she would review with the resident to see if she can cut their toenails and any related diagnosis like diabetes and vascular circulation. She stated if a resident had fungus and diabetes they would be referred to podiatry for further care. She stated that the toenails should be reviewed every shift by the charge nurse and CNAs. She added a resident could potentially be reviewed minimum of 3 times by 3-6 different people. She stated the nurse would be responsible for completing the nail assessment. She stated residents could develop an ingrown nail, could result in infection, and fungus development. She stated if a resident vocalized wanting their toenails cut and there was no underlying condition she would do it immediately. She added if she was not able to she would consult with DON for podiatry as the alternative or contact the nurse practitioner to see if she could provide nail trimming services. She stated the last in-service for ADLs was 1 to 2 weeks ago.During an Interview on 3/26/2026 at 3:28 PM with the Administrator, he stated<br>(continued on next page) |

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| F 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | that podiatry visited the facility 1 to 2 times a month. He added if a resident was requesting toenail trimming beyond the scope of nurses, it should be reported to the nurse to contact podiatry. He stated that the podiatrist had a list of residents they saw during their visits. He stated it affected residents who did not receive toenail care because they could experience pain and ingrown nails. He stated that the ADON, DON, and floor nurses were responsible for following up on toenail care. He stated fingernails were trimmed as needed. He stated that nurses and CNAs were responsible for trimming the fingernails. He stated that the nurses, DON and ADONs were responsible for ensuring that residents' fingernails were being trimmed. He stated that long nails were a potential risk of injury due to scratching. He stated he was not aware of a monitoring/tracking system in place for residents that required podiatry and referred to DON for further information. During an interview on 03/26/2026 at 4:24 PM with the DON, she stated that during showers staff recorded the conditions of the toenails and fingernails and reported it to the Podiatrist to provide services to the residents. She stated that it could be uncomfortable for a resident because there could be infections from ingrown nails and fungus. She stated that the nursing staff and supervisors monitored and tracked the condition of residents' toes and fingernails daily with rounds and assessments throughout the day. She stated that when the resident was diabetic or had a bleeding disorder, they would be referred to the podiatrist. She stated that the podiatrist comes as needed and once a month on routine. She stated there was a list that the facility kept of residents serviced when podiatry came; podiatry service census documentation was provided before exit on 3/26/2026. She stated that fingernails were trimmed during shower days. She stated that fingernails were trimmed by CNAs and nurses and it was the responsibility of the nurses and CNAs to ensure that fingernails were kept trimmed and clean.Record review of the facility's documents titled podiatry list dated on 12/09/2025, 02/03/2026, and 03/06/2026 revealed Residents #40 and #119 were not on the list of residents who received services through podiatry for the past 3 months.Record review of the facility's policy titled Nail care undated, read in part, Nail management is the regular care of the toenails and fingernails to promote cleanliness, and skin integrity issues, to prevent infection, and injury from scratching by fingernails and pressure of shoes on toenails. It includes cleansing, trimming, smoothing, and cuticle are and is usually done during the bath NAIL CARE, ESPEECIALLY TRIMMING IS PERFORMED BY A PODIATRIST IN THOSE WITH DIABETES AND PERIPHERAL VASCULAR DISEASE (Goals section) Nail care will be performed regularly and safely. The resident will be free from abnormal nail conditions (Procedure section) . Nails that are ingrown, thickened, or infected should be cared for by a podiatrist. Report conditions immediately to the primary nurse. The nurse will ensure a referral to the podiatrist. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455471 | A. Building<br>B. Wing | 03/26/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Mountain View Health & Rehabilitation | 1600 Muchison Rd<br>El Paso, TX 79902 |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to ensure the resident's environment remained as free of accident hazards as was possible for 1 of 7 residents (Resident #123) reviewed for Accidents-the facility failed from 03/24/2026 to 03/26/2026 to ensure Resident #123 did not have a mini fridge resting on top of a wobbly table.This failure placed the resident at risk for injury from a foreseeable and avoidable hazard.Findings include:Record review of Resident #123's face sheet dated 03/26/2026 revealed a [AGE] year-old female with an original admission date on 08/03/2021 and a readmission date on 02/16/2023.Record review of Resident #123's Quarterly MDS dated [DATE] revealed BIMS score of 14 indicating cognitively intact. Revealed under Section GG-Functional Abilities the resident utilized a manual wheelchair for mobility needs. Under section I- Active Diagnoses, the resident was coded for muscle wasting and atrophy in multiple sites, unsteadiness on feet, and other abnormalities of gait and mobility.Record review of Resident #123's care plan dated 02/03/2026 revealed the resident had a focus area to treat ADL self-care performance deficits with interventions to receive 1 person assist for all ADLs. Resident #119 also had interventions to keep furniture in a locked position to address the risk of falls.Record review of Resident #123's Health and Physical dated 01/15/2026 revealed the resident had diagnoses of Transient Ischemic Attack (a temporary blockage of blood flow to the brain that causes stroke-like symptoms-such as weakness, confusion, or vision changes), Degenerative Joint Disease (when cartilage in joints breaks down over time, causing pain, stiffness, and decreased mobility), Peripheral Artery Disease (chronic circulatory condition where narrowed arteries reduce blood flow to the limbs), and Autonomic Neuropathy (nerve damage affecting involuntary bodily functions like blood pressure, heart rate, digestion, and bladder control).During an observation and interview on 03/24/2026 at 4:13 PM, Resident #123 was sitting in her wheelchair in front of her mini-fridge and TV, approximately 2-3 feet away. It was observed that the table (approximately 3 feet tall) her mini fridge was resting on had a wobbly front left leg that rendered the table uneven; tucked underneath the left leg was a folded cardboard. She stated the table was hers that she brought into the facility. She stated that the table was not always wobbly and staff had fixed the table by placing the folded cardboard under the front left leg. She was unable to recall when and what staff member placed the cardboard under the left leg. She stated she had not notified the facility of the condition of her table. A photo was captured of the mini fridge resting on top of the table with the cardboard support under the front left leg. Follow-up observations completed on 03/25/2026 at 9:00 AM and 03/26/2026 at 10:31 AM, revealed the mini-fridge was still resting on the wobbly table with folded cardboard supporting the front left leg. During an interview on 03/26/2026 at 8:45 AM with CNA B, he stated that a hazard could be furniture not in the right place, cluttered floor, or privacy curtain obstructing passage. He stated all the furniture needed to be in proper and good use condition. He stated if a resident brought in their own furniture that was not in proper condition, it needed to be reported to the nurse immediately. In reference to the photo captured, he stated it needed to be reported because the table could fall on the resident or their roommate. He stated that when residents provided their own furniture, the nurse would review the furniture first to ensure it was not a hazard. He stated it was a hazard for the mini fridge to sit on a table with an uneven table and added it needed to be reported immediately. He stated it affected residents if staff was not reviewing the environment for hazards because there could be potential for injuries. He stated the last in-service he received for environmental hazards was in February 2026.During an interview on 3/26/2026 at 9:08 AM with RN C, she stated to identify hazards in the room she would look for extra electrical cords not approved by the facility, tripping hazards in the form of clutter on the floor, or unnecessary equipment in place like a wheelchair properly stored. She stated the integrity of the furniture was the housekeeping team's responsibility because they would<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | inspect the furniture daily during cleaning chores. She stated they moved the furniture around daily. She stated that a table with cardboard support on a wobbly leg with a mini fridge on top was a hazard. She stated that she estimated a mini fridge to weigh 20 pounds at minimum and would affect the resident by injury if it fell on them. She stated that every employee was responsible for addressing the environmental hazards in resident's rooms. She stated that the maintenance director was responsible for reviewing the integrity of furniture brought in by residents. She stated she does not recall when the last in-service was for identifying environmental hazards.During an interview on 3/26/2026 at 1:58 PM with the Maintenance Supervisor, he stated the process for when a resident provided their own furniture was to enter it through the front entrance for maintenance to log it in their system and complete a brief review of the furniture. He stated any staff member can move furniture around the room with the resident's permission. He stated he had not declined any furniture due to safety concerns. He stated furniture could be removed for the resident in the event it possessed a potential hazard to the resident. He stated putting a cardboard under a wobbly table was not an approved solution by the facility. In reference to the photo captured of the mini fridge on top of a wobbly table, he stated that this was a potential risk for the resident. He stated any staff member could have notified him, and there were QR codes throughout the facility for anyone to report concerns to him. He stated he had not provided an in-service for identifying environmental hazards. He stated he was the one who set up the table for Resident #123 when she brought it in. He added it was not wobbly at the time of installation, and the cardboard was added later by an unknown staff member. During an interview on 03/26/2026 at 3:32 PM with The Administrator, he stated he could not remember the last in-service training for environmental hazards. He stated that environmental hazards needed to be reported to maintenance immediately with a QR code. He stated that the QR codes are located throughout the facility. He identified examples of environmental hazards could be a loose cord, water on the floor, exposed electricity, air conditioning malfunction, or anything that affected a resident in a negative way. He stated that the only restrictions on resident's furniture were that it couldn't take up their neighbor's space or if a chair wasn't fire retardant. He stated the Maintenance Supervisor needed to review the furniture to ensure the article would not place residents in danger. He stated that the facility would provide notice to the family or resident if there was a concern or repair the furniture if it was possible. He stated that the mini fridge on the wobbly table was a hazard because it was unstable surface. He stated any resident who attempted to open the refrigerator would be at risk for the mini fridge falling on them. He stated there was potential for injury and staff needed to address it immediately. During an interview on 3/26/2026 at 4:30 PM with the DON, she stated she was not familiar with the review process for resident's personal furniture but suspected it was maintenance supervisor who would review furniture. She stated an example of environmental hazard would be clutter, rugs, and cords on the floor. She added having multiple things plugged into an outlet or a chair in the passageway. She stated that residents had dressers, tables, mini fridges, and closets in their room. She stated it was not appropriate for the fridge to be on top of a wobbly table because the support could be dislodged and affected the residents or staff in the room. She stated it needed to be reported immediately, and it could be reported by anyone who utilized the QR codes located throughout the building. She stated that it was not appropriate for a staff member to resolve a wobbly table with a folded cardboard under a table leg. She stated there was potential for injury for anyone in front of the fridge. A policy for environmental hazards was requested at the end of day on 03/25/2026. The policy provided on 03/26/2026 was titled Communication of Hazards to Employees undated, and focused on biological hazards, bodily fluids, and soiled linens. The policy did not provide insight to concerns about compromised furniture. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation and interview the facility failed to ensure drugs and biologicals were stored and labeled in accordance with currently accepted professional principles for 1 of 4 medication carts (500 Hall nurse cart) reviewed for cleanliness.The facility failed to ensure bottles of liquid medication (milk of magnesia and lactulose), stored in medication cart on the 500 hall did not have dried drippings on the sides of the bottles.This failure could affect residents by placing them at risk of cross contamination. The findings included:An observation of the medication cart in the 500 hall and interview on 03/26/2026 at 11:50p.m., with LVN I revealed medication 1 bottle of lactulose, and one bottle of milk of magnesia to have dried drippings on the side of the bottles. [NAME] colored spots were observed on the side of the medication drawer and on the lids of one bottle of MiraLAX, and 3 bottles of lactulose. LVN I stated that medication bottles were to be cleaned after each use. He stated the bottles could be wiped down with the wipes available in the cart. He stated that it was the nurses responsibility to ensure the bottles were clean after each use. He stated that there could be a possible risk of cross contamination and drippings/ stains did not give off a good look.In an interview on 3/26/2026 at 3:48 p.m., with the DON revealed medication bottles were to be cleaned after every use to prevent cross contamination and from bacteria forming on the dried drippings. She stated that it was the responsibility of the nurses to ensure all bottles were cleaned.In an interview on 03/26/2026 at 4:21 p.m., with the Administrator revealed all medication bottles were to be cleaned after every use to prevent cross contamination. He stated there was a possible risk of infection to the resident if medication was poured out of dirty bottles. He stated that the nurse pouring the medication was responsible for ensuring the bottles were cleaned. He stated that it was also the responsibility of all nurses to ensure medication cart and bottles were kept clean.Review of facility policy titled Medication Storage in the Facility dated 2025 read in part . outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediatly removed from stock,disposed of according to the procedures for medication destruction, and reordered from the pharmacy, if current order exists. Medication storage areas are kept clean, well-lit and free of clutter. |

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| F 0810<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide special eating equipment and utensils for residents who need them and appropriate assistance.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals for 1 of 8 (Residents #12) residents reviewed for special eating equipment.-The facility failed to provide Resident #12's physician ordered cup with lid for drinking fluids on 03/24/2026, 03/25/2026 and 03/26/2026.This failure could place residents at risk for harm by weight loss, diminished independence, and self-esteem.Findings included:Record review of Resident #12's admission Record dated 03/26/2026 revealed a [AGE] year-old male with an original admit date of 06/03/2021 and a readmission date of 12/08/2025.Record review of Resident #12's History and Physical dated 12/08/2025 revealed a diagnosis of chronic schizophrenia (mental disorder characterized by disruptions in though process), and polyneuropathy(neurological condition characterized by numbness, tingling weakness and burning pain).Record review of Resident #12's Psychiatric Subsequent assessment dated [DATE] revealed a diagnosis of drug induced subacute dyskinesia (involuntary repetitive movements to include tremors appearing days to weeks after starting antipsychotic medications).Record review of Resident #12's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 11 indicating moderate cognitive impairment. Section GG-Functional Abilities revealed Resident #12 needed supervision or touching assistance while eating meaning helper provided verbal cues and or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.Record Review of Resident #12's Care plan revised on 11/14/2025 revealed Resident #12 had a regular diet. Interventions included the use of a sippy cup with meals.Record review of Resident #12's Physician Orders revealed an active order for a sippy cup to drink dated 12/08/2025. An observation on 03/24/2026 at 12:15 p.m. revealed Resident #12 drinking coffee from a cup without a lid with his lunch meal. He was noted to have a mild tremor to upper extremity. An observation on 03/25/2026 at 12:25 p.m. revealed Resident #12 drinking coffee from a cup without a lid with his lunch meal, he was observed to spill coffee on his left hand and on the table.An observation on 03/26/2026 at 12:17 p.m. revealed Resident #12 drinking coffee from a cup without a lid with his lunch meal.In an interview on 03/26/2026 at 1:46 p.m. with CNA G revealed that the purpose of a sippy cup was to prevent the resident from spilling liquids, on themselves, and to make it easier for residents to drink their liquids. She stated that the risk of the residents not using the sippy cup would be possible injury due to spilling hot liquids on themselves. She stated it was the responsibility of the staff supervising dining to ensure that all residents were using adequate drinkware.In an interview on 03/26/2026 at 2:00 p.m. with RN H revealed the purpose of the sippy cup was for safety reasons so that residents would not burn themselves with hot liquids. He stated that the CNAs observing the dining room were responsible for ensuring that the residents had adequate drinkware. He stated that a risk would be the possibility of a burn if it was a hot liquid. In an interview on 03/26/2026 at 3:48 p.m. With the DON revealed the purpose of a sippy cup was to protect the residents from spilling liquids on themselves. She stated that it was the responsibility of all staff members to ensure that all residents were using the correct drinkware as ordered. She stated a possible risk would be the resident getting burned if drinking a hot liquid.In an interview on 03/26/2026 at 4:21 p.m., with the Administrator revealed the purpose of the sippy cup was an adaptive aid that residents used to prevent liquid from spilling on them, especially hot liquids. He staed that it was the responsibility of all staff members to ensure that all residents were provided with the adequate aids needed.The facility did not provide a policy regarding adaptive aids before exit. |