

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 455484	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER San Juan Nursing Home Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 300 N Nebraska San Juan, TX 78589	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to complete a significant change MDS assessment within 14 days after a significant change in the resident's mental and physical condition for 3 of 5 residents (Resident #12, #4, and #2) reviewed for assessments.1. The facility failed to complete a Significant Change in Status MDS Assessment after Resident #12 admitted to hospice services on [DATE].2. The facility failed to complete a Significant Change in Status MDS Assessment after Resident #2 had four new diagnoses changes: Klebsiella Pneumoniae ([DATE]), Urinary Tract Infection (UTI [DATE]), Do Not Resuscitate (DNR [DATE]), and Pleural Effusion ([DATE]).3. The facility failed to complete a Significant Change in Status MDS Assessment after Resident #4 had increasing symptoms of cough, congestion, and shortness of breath which began [DATE] and was still progressing through the last day of survey [DATE].These failures could place residents at risk of having inaccurate assessments, not having individual needs met, and decreased quality of life.Findings included:1. Record review of Resident #12's face sheet, dated [DATE], revealed Resident #12 was a [AGE] year-old male admitted to the facility on [DATE]. Pertinent diagnoses included Congestive Heart Failure (CHF - a chronic condition where the heart cannot pump enough blood to meet the body's needs, leading to fluid buildup and other various symptoms), Atrial fibrillation (AFib - an irregular heart rhythm which originates in the heart's upper chambers (the atria) and could lead to symptoms such as fatigue, heart palpitations, shortness of breath, and dizziness), and Encounter for Palliative Care (Palliative Care - a medical specialty which focuses on relieving the symptoms and stresses of a serious illness in order to maximize the quality of life, according to the patient's and family's goals and aspirations).Record review of Resident #12's physician orders, dated [DATE], revealed Resident #12 had an order to be admitted to hospice with a diagnosis of CHF. Record review of Resident #12's care plan, dated [DATE], revealed Resident #12 had a care plan for Hospice. Interventions included correlating care with hospice to ensure all needs were met on a daily basis; keep Resident #12 comfortable, repositioned, clean, and dry; monitor Resident #12 for changes in condition.Record review of Resident #12's EHR did not indicate a Significant Change in Status MDS Assessment was completed after Resident #12 was admitted to hospice services on [DATE]. There were no Significant Change in Status MDS Assessments in Resident #12's EHR for the entirety of their admission in the facility.2. Record review of Resident #4's face sheet, dated [DATE], revealed Resident #4 was a [AGE] year-old female initially admitted to the facility on [DATE], with a readmission on [DATE]. Pertinent diagnoses included Alzheimer's Disease (a progressive disorder which was the most common cause of dementia, characterized by memory loss, cognitive decline, and behavioral changes), Do Not Resuscitate, Klebsiella Pneumoniae (a bacterium which could cause serious infections, particularly in hospital settings, and was known for its antibiotic resistance), and Urinary Tract Infection (UTI - an infection in any part of the urinary system).Record review of Resident #4's progress note, dated [DATE], revealed chest x-ray impression revealed small faint infiltrate on the right lung (Infiltrated Lungs referred to the presence of abnormal substances, such as fluid or cells, within the lung tissue, often detected through imaging techniques). Progress note dated [DATE] revealed Resident #4 was started on Amoxicillin for UTI. Progress note dated [DATE] (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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FORM CMS-2567 (02/99) Event ID: Facility ID: If continuation sheet
 Previous Versions Obsolete 455484 Page 2 of 15

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	signs and symptoms of respiratory distress and report to the doctor; oxygen at 2 Liters via nasal cannula as needed for low oxygen saturations; check oxygen saturations as indicated or needed. Record review of Resident #2's electronic health record did not indicate a Significant Change in Status MDS Assessment was completed after Resident #2 progressively worsened with cough, congestion and shortness of breath which began [DATE]. Resident #2's Annual MDS Assessment, dated [DATE] and completed [DATE], did not reveal any oxygen therapy or treatments, or any suctioning therapy or treatments. There were no Significant Change in Status MDS Assessments in Resident #2's EHR for the entirety of their admission in the facility. In an interview on [DATE] at 9:36 am, MDS-C stated he made sure the MDS assessments were completed and filled out, then submitted. He also said there were 3 MDS nurses who worked on MDS assessments, but he was not the coordinator. MDS-C stated no one was tracking anything regarding the MDS assessments, then subsequently stated significant change MDS assessments were getting done in the facility because he was the one who did them. He stated a significant change was a change in the residents' diagnoses or care which was projected to last long term, longer than 14 days, and affected 2 or more care areas, such as residents being placed on hospice. MDS-C stated he found out about residents with changes in the morning meetings which were held twice per week, or when he ran the 24-hour report in the morning. He could not recall any residents in the facility in the past 3-6 months who he had performed a Significant Change MDS Assessment on. In an interview on [DATE] at 10:30 AM, the DON stated Resident #2 recently had a significant change in which he had to continuously be placed on Oxygen due to low Oxygen saturation levels. The DON stated a significant change was something which deviated from the baseline which required treatment or monitoring, such as a change in the residents' care, and the fact Resident #2 had not consistently used Oxygen previously, but it was currently being utilized continuously, would be considered a significant change. The DON stated if there was a change in condition, the floor nurses assessed the situation and put it in a progress note, but they did not do an actual assessment of the residents such as a focused assessment or SBAR assessment for a change in condition, but he saw how it would be needed, and the nurses should have been doing focused assessments, SBARs, or significant change assessments, which should trigger the MDS to do the Significant Change in Condition MDS assessments, but they were not being done. He stated the progress notes or changes got relayed back to MDS-C in the morning meetings or in their group communication text/chat. The DON stated MDS-C had not been doing significant change assessments, except when there was a big change, such as new hospice orders. In an interview on [DATE] at 1:30 PM the Administrator stated the MDS coordinator did MDS assessments in conjunction with the other MDS staff and the speech therapist. She stated since the facility was a non-profit, they did not get help from people such as regional nurses or regional MDS. She stated it was up to them to figure out what needed to be done. She stated staff had been trained in MDS assessments, so they should have known when and how to complete significant change assessments, but she was not sure if they had been doing it. In an interview on [DATE] at 2:15 pm, MDS-B (the MDS Coordinator) stated she used to be the DON for this facility, but she moved over to the MDS coordinator position. She stated she had been trained on how to complete MDS assessments and forms, and the MDS was the actual comprehensive assessment to meet all the needs of the residents and establish a plan of care. MDS-B stated MDS-C was the one who did the actual MDS assessment, and she just signed off on them once they were completed. She stated she had not actually checked for accuracy or to make sure the proper assessments were completed. She stated it was just her job to sign off the MDS had been completed. MDS-B stated in-house acquired pressure ulcers could be considered significant changes if it affected two or more care areas or lasted longer than 14 days, as well as progressive cough and congestion and use of Oxygen could be considered a significant change if it affected 2 or more care areas or lasted longer than 14 days, but she was not sure who in the facility had actually had recent significant changes warranting assessments to be completed. Record review of the facility's Change in a Resident's Condition or Status policy, revised (continued on next page)		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE], revealed A significant change of condition is a decline or improvement in the resident's status which: a. will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; b. Impacts more than one area of the resident's health status; c. required interdisciplinary review and/or revision to the care plan; d. ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument and 42 CFR 483.20(b)(ii).Record review of the facility's Assessment Schedule for the RAI, revised [DATE], revealed Page 2-7, a significant change in status assessment is not required in a case where the resident's condition is expected to return to baseline within a short period of time, such as one to two weeks. If the condition does not return to baseline, the assessment should be completed as soon as needed to provide appropriate care to the residents, but in no case later than 14 days after the determination was made which a significant change occurred. The amount of time which would be appropriate for a facility to monitor a resident depends on the clinical situation and severity of symptoms experienced by the resident. Generally, if the condition has not resolved within approximately 2 weeks, staff would begin a comprehensive RAI assessment.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to coordinate assessments with the Pre-admission Screening and Resident Review (PASRR) program to the maximum extent practicable to avoid duplicative testing and effort for 5 of 16 residents reviewed for PASRR. (Residents #2, 7, 8, 9, and 11) 1. The facility failed to refer Resident #2 for PASRR Level II assessment when the facility incorrectly coded his PASRR Level I assessment. 2. The facility failed to refer Resident #7 for PASRR Level II assessment when the facility incorrectly coded her PASRR Level I assessment. 3. The facility failed to refer Resident #8 for PASRR review following new mental illness diagnosis. After admission, he was diagnosed with mood disorder due to known physiological condition, delusional disorders, and insomnia. 4. The facility failed to refer Resident #9 for PASRR review following new mental illness diagnosis. After admission, she was diagnosed with major depressive disorder, recurrent, severe with psychotic symptoms. 5. The facility failed to refer Resident #11 for PASRR Level II assessment when the facility incorrectly coded her PASRR Level I assessment. Further, and after admission, her diagnoses included anxiety disorder, major depressive disorder, recurrent, severe without psychotic features, mood disorder due to known physiological condition, vascular dementia, depression, bipolar disorder, and delusional disorders. These failures could place residents at risk of not receiving needed assessments (PASRR Evaluation), individualized care, and specialized services to meet their needs. Findings include: 1. Record review of face sheet dated 11/05/24 indicated Resident #2 was a [AGE] year-old male admitted on [DATE]. His diagnoses (all dated 11/05/24) included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Mood disorder due to known physiological condition with mixed features, and anxiety disorder due to known physiological condition with mixed features, and cognitive communication deficit. Resident #2's Annual Minimum Data Set (MDS) assessment dated [DATE] indicated his Brief Interview for Mental Status (BIMS) score was 12 out of 15 showing moderate cognitive impairment. He was coded as having depression, required staff dependence for all ADL's, and was always incontinent of bowel. He had a urinary catheter and a feeding tube. His active diagnoses included progressive neurological conditions, Diabetes, stroke, anxiety disorder, and bipolar disorder. He was taking psychotropic medications. Record review of Resident #2's PL1 dated 11/05/24 was negative for MI, ID, or DD. There were no other PASRR screenings. 2. Record review of Resident #7's electronic face sheet dated 04/12/24 reflected the resident was an [AGE] year-old female originally admitted to the facility on [DATE]. Her diagnoses included Parkinson's (a brain disorder that slows down movement, causes tremors, stiffness, and balance problems, making everyday tasks difficult. It is a progressive disease where brain cells die, affecting control over the body, worsening over time) (04/12/24), Psychotic disorder with hallucinations due to known physiological condition (12/11/23), unspecified dementia (11/30/23), depression, and functional quadriplegia (the complete inability to move the arms and legs due to severe frailty or debility without actual physical damage or injury to the brain or spinal cord). Record review of Resident #7's quarterly MDS assessment dated [DATE], revealed a BIMS score of 00, indicating severely impaired cognition. She had no functional abilities and was dependent on staff for all ADL's and was always incontinent of bowel. She had a urinary catheter and a feeding tube. Her active diagnoses included depression, Parkinson's, and psychotic disorder. She was taking antidepressant and antipsychotic medications, and was on continuous oxygen therapy. Record review of Resident #7's PL1 dated 11/30/23 was negative for MI, ID, or DD. There were no other PASRR screenings. 3. Record review of face sheet dated 06/19/24 indicated Resident #8 was a [AGE] year-old male admitted on [DATE]. His diagnoses dated 06/19/24 included unspecified dementia; unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, anxiety, depression, Parkinson's, and lack of coordination. On 08/14/24, he was (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnosed with mood disorder due to known physiological condition, delusional disorders, and insomnia. Record review of Resident #8's quarterly MDS assessment dated [DATE], revealed a BIMS score of 02, indicating severely impaired cognition. He had physical behavioral and/or verbal symptoms (hitting, kicking, pushing, scratching, grabbing, abusing others sexually and/or threatening others, screaming and/or cursing at others) directed towards others occurring 1-3 days a week. He was dependent on staff for all ADL's and was always incontinent of bladder and bowel. His active diagnoses included non-Alzheimer's dementia, mood disorder, progressive neurological conditions, stroke, Parkinson's, anxiety, depression, psychotic disorder and heart failure. He was taking antidepressant and antipsychotic medications. He was receiving oxygen therapy. Record review of Resident #8's PL1 dated 06/18/24 was negative for MI, ID, or DD. There were no other PASRR screenings. 4. Record review of face sheet dated 06/19/24 indicated Resident #9 was an [AGE] year-old female admitted on [DATE] with an original admission date of 03/15/24. Her diagnoses dated 03/15/24 included unspecified dementia; unspecified severity, with other behavioral disturbance, anxiety disorder, major depressive disorder, recurrent, and insomnia. On 03/22/24, she was diagnosed with major depressive disorder, recurrent, severe with psychotic symptoms. She was also dependent on dialysis, had heart failure, chronic respiratory failure and was dependent on oxygen. Record review of Resident #9's annual MDS assessment dated [DATE], revealed a BIMS score of 15, indicating no impaired cognition. She utilized a manual wheelchair and could self-propel. She was independent of staff for all ADL's except set-up and verbal or touching cues. She was occasionally incontinent of bladder and always continent of bowel. Her active diagnoses included non-Alzheimer's dementia, progressive neurological conditions, anxiety, depression, respiratory failure, end stage renal disease, and heart failure. She was taking antidepressant medications. She was receiving oxygen therapy. She was on dialysis. Record review of Resident #9's PL1 dated 03/15/24 was negative for MI, ID, or DD. There were no other PASRR screenings. 5. Record review of face sheet dated 03/14/18 indicated Resident #11 was a [AGE] year-old female admitted on [DATE]. Her diagnoses dated 03/14/18 included anxiety disorder, diabetes, arthritis, heart failure, and anemia. On 11/17/20, she was diagnosed with major depressive disorder, recurrent, severe without psychotic features. On 01/27/22 she was diagnosed with mood disorder due to known physiological condition. On 10/01/22 she was diagnosed with vascular dementia. On 01/10/23 she was diagnosed with depression, bipolar disorder, and delusional disorders. Record review of Resident #11's quarterly MDS assessment dated [DATE], revealed a BIMS score of 00, indicating severely impaired cognition. She was dependent on staff for all ADL's and was always incontinent of bladder and bowel. Her active diagnoses included anemia, heart failure, progressive neurological conditions, diabetes, non-Alzheimer's dementia, anxiety disorder, bipolar disorder, psychotic disorder and asthma. She was taking antianxiety medications. She was receiving oxygen therapy and under hospice care. Record review of Resident #11's PL1 dated 03/13/18 was negative for MI, ID, or DD. There was a form 1012 signed by the physician dated 11/24/2020 but was never filed. There were no other PASRR screenings. In an interview with MDS C on 12/11/25 at 9:36 am, he said MDS B documented the care plans and diagnoses. He said his job was to make sure the MDS's were filled out and signed and he submitted them to an electronic portal. He said the PL1's got updated when there was a new diagnosis. He said he for sure did not have any other PASRR documents for Resident #2, 7, 8, 9, or 11. He said he would send the 1012 form to the MDS people in a nearby town, but after Covid, meetings were by phone-it was one of those things. He said Resident #11 went on hospice and he did not know why. He said the facility had three MDS coordinators, and he was not one of them, but since he had worked there for 15 years, he received the brunt of it. He said MDS B worked on the diagnoses and care plans. He said no one was tracking anything. He said MDS B was the coordinator and she was responsible for PASRR. He said right now the facility was changing titles and cutting staff. For example, he would remain as MDS for LTC (long term care). He said MDS F would be doing therapy and MDS B was taking over the care plan's. He said he had not followed up with any PASRR since (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed and 1 of 1 nutrition rooms for storage, preparation, and sanitation. The facility failed to discard damaged pans and utensils. The facility failed to keep food products in the refrigerators and freezers sealed properly. The facility failed to follow a cleaning schedule. These failures could place residents at risk for food contamination and foodborne illness. Findings include: Initial tour and observation of the kitchen on 12/09/24, beginning at 8:15 am revealed 4 of 7 non-stick type coated frying pans were flaking. Three of the pans were completely bare, except for the sides. There were 2 large spatulas with chunks of plastic missing around the edges in the use bin. The underside of the shelf directly over the food on the steam table had chunks of removable red, brown, and black substances. There was a removable fuzzy black substance on and around the gaskets and on the doors of the 2-compartment bread refrigerator. There were tomatoes with fuzzy black spots on them, and they were leaking juices in the walk-in refrigerator. There were 7 large limp carrots with fuzzy black spots on them. The carrots were inside a large box touching more large carrots. There was an unsealed zip-type bag of cut cabbage that was open to air in the walk-in refrigerator. There was a large open plastic bag labeled sausage slices in the walk-in freezer. The sausage slices had ice on them. In an interview with DA G on 12/09/25 at 8:20 am, she said she did not know the pans were damaged, and she could not throw them out because the DM had to do that. She said the cooks and the DM were in charge of the refrigerators and freezers. In an interview with DA H on 12/09/25 at 8:40 am, she said she was unaware of the flaking non-stick coating on the pans. She said the bits of the coating could get into the food and make residents sick. In an interview with the [NAME] on 12/09/25 at 8:50 am, she said the non-stick coating from the pans were like that because they used metal utensils in them. She said they did not use the pans. She said the pans were hanging on the clean rack. She said the DM was the only one allowed to discard damaged utensils. She said the damaged spatulas were used in the puree machine. She said she guessed the broken-off pieces were in the food. She said the residents could ingest the particles of the spatulas, pans, and whatever was on the underside of the steam table shelf. She said whoever unloaded the truck deliveries was responsible for storing the items properly. She said she did not know who stacked the boxes to the ceiling in the walk-in freezer. She said the DA's and the cooks were responsible for properly storing leftover food in the refrigerators and freezers. She said she did not know who had left food open. She said that when kitchen staff came across bad food, such as the tomatoes and carrots, they threw them out as soon as they saw them. She said leaving the tomatoes and carrots in the state they were in could cause cross-contamination and make residents sick. She said the DM did not come in until 8 or 9 am. His presence was requested at this time. During a return visit to the kitchen and an interview with the DM on 12/10/25 at 2:00 pm, he said he did not come to work until 8 or 9 am in the morning. He said he was at the facility yesterday and knew the state was in the building. He shrugged his shoulders when asked why he did not speak with this state surveyor yesterday. He said he was responsible for everything in the kitchen. He said there was a cleaning schedule, but the kitchen had not been cleaned properly for over nine months. He said there had been staffing shortages, so he had to cut some things out. He said not cleaning the kitchen properly could compromise the cleanliness of the kitchen and make residents sick. He said there was mold around both of the bread refrigerator doors and gaskets. He said the damaged non-stick pans were not being used and did not know why they were hanging on the clean rack. He said he was in charge of discarding damaged utensils, so he knew when to replace them. When asked at what point non-stick pans were considered damaged, he said when the coating started coming off. He said the coating was toxic, and the pieces probably got into the food and could make the residents sick, but he had not heard about anyone getting sick. He (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said the particles on the underside of the shelf above the steam table probably got into the food. He said all food in the refrigerators and freezers should be tightly sealed, labeled, and dated. He said the cooks and DA's were responsible for storing food. He said the rotten tomatoes and carrots should not be in the same box as the good ones because whatever was on the bad ones could cross-contaminate the good ones and make residents sick. He said the personal items on the carts in the kitchen should not be there because of cross-contamination. He said the kitchen staff had a place to store their personal items. He said the carts were not a designated area for staff belongings. He said kitchen staff were not responsible for the nutrition refrigerators, and he did not know who was. He said staff should know not to stack boxes in the walk-in refrigerators to the ceiling. He said it could impede the sprinklers if there was a fire. He said the ice accumulation on the condenser hose was always like that. He said that was why he did not report it to anyone. In an interview with the DON on 12/11/25 at 12:13 pm he said nurses were responsible for cleaning, labeling, and dating resident belongings in the designated resident refrigerator. He said labeling and dating food and beverages were required to prevent cross-contamination and potential illness from expired products. He said all staff were responsible for cleaning, labeling, and dating personal belongings in the designated employee refrigerator. He said he did not check the refrigerators because he assumed staff were. In an interview with MDS B on 12/11/25 at 2:15 pm she said the ICP took care of the nutrition rooms. In an interview with the ADM on 12/11/25 at 2:30 pm, she said she was unaware there was anything going on with the kitchen. She said she had been there before but was not sure what to look for. Record review of the facility's 4-page cleaning schedules for 2025 revealed: Page 1, Mondays and Tuesdays, weeks 1-5. Mondays covered freezers, walk-in cooler, pantry, bathroom, walk-in curtain, juice machine & tubes, coffee station, hand washer, bread refrigerator, small refrigerator, wipe ice machine, toaster/can opener. Tuesdays covered can opener, garbage cans, dust pans, veggie sink, dish machine, wash room, wipe ice machine, bathroom, hand washer, dish room curtain, coffee station. Page 2, Wednesdays covered juice machine & tubes, plate cart, cabinets, walls, windows, coffee station, hand washer, toaster/can opener, wipe ice machine, bathroom, walk-in curtain. Thursdays covered all heated carts, serving carts, plate cart, stove hood, clean utensil rack, wipe ice machine, bathroom, dishroom curtain, can opener, hand washer, coffee station. Page 3, Friday and Saturday. Fridays covered juice machine & tubes, garbage cans, cabinets, hand washer, coffee station, mop closet, toaster/can opener, wipe ice machine, bathroom, walk-in curtain, and blue carts. Saturday covered ovens, dishmachine, doors, walls, toaster/can opener, wipe ice machine, bathroom, dishroom curtain, hand washer, coffee station, ice machine-1st Saturday of the month clean ice machine/empty ice/wash the scoop. Page 4, Sundays covered plate cart, all parts of stove, floor mats, bathroom, wipe ice machine, walk-in curtain, cabinets, can opener, hand washer and kitchen floor. There were no check-offs for any days in December 2025. November 2025, only Page 3, Saturday, week 2 was checked off. October 2025, page 3, Saturday week 3 and page 4, Sunday week 3 were checked off. No days in September 2025. August page 1, Tuesday, week 4, Wednesday page 2, week 3 and 4 were checked off. July page 2 Wednesday week 1 and Thursday week 1 were checked off. June 2025 page 1 Monday week 2, Tuesday week1 Wednesday weeks 1 and 2, and Thursday week 4 were checked off. Record review of the facility policy revised on 04/06/25, titled, Sanitation Inspection revealed under Policy: It is the policy of this facility ,as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary, and in compliance with applicable state and federal regulations. 4. Sanitation inspections will be conducted in the following manner: a. Daily: Food service staff shall inspect refrigerators/coolers, freezers .b. Weekly: The dietary manager shall inspect all food service areas weekly to ensure the areas are clean and comply with sanitation and food service regulations. Record review of the facility policy revised 04/06/25, titled, Food Safety Requirements revealed under Policy: .Food will be stored, prepared, distributed, and served in accordance with professional standards for food service safety. 1. Food safety practices shall be followed throughout the facility's entire food handling process. 1 b. Storage of food in a manner that (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	helps prevent deterioration or contamination of the food, including from growth of microorganisms. 1 e. Equipment used in the handling of food, including dishes, utensils, and other equipment that comes in contact with food. 3 c. Refrigerated storage .Practices to maintain safe refrigerated storage include: iv. Labeling, dating, and monitoring refrigerated food, including but not limited to leftovers, so its use-by date, or frozen/discarded v. Keeping foods covered or in tight containers. 8. Additional strategies to prevent foodborne illness include, but are not limited to: a. Preventing cross-contamination of foods. References: FDA Food Code 2022 Ch. 2-102.20 Food Protection Manager Certification 2-103 Duties 2-103.11 Person in Charge. The PERSON IN CHARGE shall ensure that: (E) EMPLOYEES are visibly observing FOODS as they are received to determine that they are from APPROVED sources, delivered at the required temperatures, protected from contamination, UNADULTERED, and accurately presented, by routinely monitoring the EMPLOYEES' observations and periodically evaluating FOODS upon their receipt 2-4 Hygienic Practices 2-401 Food Contamination Prevention 2-401.11 Eating, Drinking, (A) Except as specified in (B) of this section, an EMPLOYEE shall eat, drink, only in designated areas where the contamination of exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES; or other items needing protection cannot result. (B) A FOOD EMPLOYEE may drink from a closed BEVERAGE container if the container is handled to prevent contamination of: (1) The EMPLOYEE'S hands; (2) The container; and (3) Exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. Ch. 3-305 Preventing contamination from the premises 3-305.11 Food Storage FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination. Ch. 4-202 Cleanability 4-202.11 Food-Contact Surfaces. (A)Multiuse FOOD-CONTACT SURFACES shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections; (3) Free of sharp internal angles, corners, and crevices; (4) Finished to have smooth welds and joints 4-5 Maintenance and Operation 4-501 Equipment 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. 4-602 Frequency 4-602.11 Equipment Food-Contact Surfaces and Utensils. (A) Equipment food-contact surfaces and utensils shall be cleaned: (5) At any time during the operation when contamination may have occurred. (C) Except as specified in (D) of this section, if used with TIME/TEMPERATURE CONTROL FOR SAFETY FOOD, EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be cleaned throughout the day at least every 4 hours.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored in locked compartments for 1 of 6 medication carts (Nurse Med-Cart, [NAME] Wing, Long Hall) reviewed for labeling and storage. The facility failed to ensure the Nurse Medication Cart for the long hall in Wing 1 was locked and secured. This failure could place the residents at risk of gaining access to unlocked medications which were not prescribed to them. Findings included: Observation on 12/09/2025 at 9:42 AM revealed an unlocked med-cart parked down from the nurse's station in the long hall on Wing 1 with no nurses or other staff around it. The keys for the medication cart were hanging from the lock of the medication cart. There were residents noted to be walking and passing by. The med-cart lock was popped out, and all drawers were able to be opened and accessed. The med-cart was full of medications, including narcotics. In an interview on 12/09/2025 at 9:45 AM, LVN-D stated it was her med-cart, and she had forgotten to lock it and pull the keys out of it before she walked away. She stated the med-cart should always be locked when not in use because if left unlocked, anyone, including residents, could get into it and get medications out which did not belong to them, and this could cause harm. She stated the keys left in the med-cart contained the regular med-cart key, the narcotic box key, a key to the medication room, a key to the lock box in the medication room, as well as many other keys which she was not sure what they went to because she had never had to use them, but she thought they may have belonged to the other medication carts. LVN-D stated it was the responsibility of the nurse who was working the med-cart this shift to keep up with the keys for this med-cart and to ensure the med-cart remained locked when not in use. In an interview on 12/11/2025 at 10:30 AM, the DON stated he was not aware any of the nurses had left their medication cart unlocked. He stated it was the nurse of the med-carts responsibility to keep up with the keys for their med-cart, as well as be sure the med-cart was locked every time they stepped away from it. He stated if the med-carts were not kept locked, residents or anyone else could have gained access to the cart and taken medication which did not belong to them. He stated he was not sure exactly what keys were on LVN-D's key ring, but for sure there was the med-cart key, the narcotic box key, and the key to the medication room. He stated he was starting an in-service today with the nurses and medication aides regarding their med-cart keys and locking the med-carts. In an interview on 12/11/2025 at 1:30 PM, the Administrator stated it was the nurse's responsibility to keep her medication cart locked and keep up with the keys which went to her medication cart. She stated if medication carts were left unlocked, anyone could have gotten into the cart and taken medication, and it could have harmed them. She stated the nurses and medication aides knew this because it was discussed in their annual training, and they had been in-serviced regarding this as well. Record review of the facility's Storage of Medication Policy, revised April 2007, revealed 2. The nursing staff shall be responsible for maintaining medication storage and preparation area in a clean, safe, and sanitary manner. 7. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review the facility failed to develop a QAPI plan that described the process for conducting quality assessment and assurance activities, including the process on how the committee would identify and correct quality deficiencies for 3 of 16 residents. The facility did not have a QAPI plan process for conducting change in condition assessments. This failure could place residents at risk of not receiving quality care and services. The findings include: In an interview on 12/11/25 at 10:08 AM, the ADM stated a significant change was a change in the resident's condition and was something that deviates from the resident's baseline that would require treatment or monitoring. The ADM stated if an injury or accident occurred; nurses would document a progress note but not complete an actual assessment. The ADM stated the floor nurses should be doing an assessment with any changes the resident has had, such as a focused assessment or an SBAR but was unsure if the nurses were completing any assessments. The ADM stated since significant changes were not being made, the facility was not able to track and trend resident changes, and it was not a part of QAPI. In an interview on 12/11/2025 at 10:30 AM, the DON stated if there was a change in condition with a resident, the floor nurses assessed the situation and put it in a progress note, but they did not do an actual assessment of the residents such as a focused assessment or SBAR assessment for a change in condition, but he saw how it would be needed. The DON stated the nurses should have been doing focused assessments, SBARs, or significant change assessments, which would trigger the MDS to do the Significant Change in Condition MDS assessments, but they were not being done. The DON stated significant changes in residents were not being tracked and trended. Record review of QAPI confirmed significant changes were not being tracked. In an interview on 12/11/2025 at 2:15 pm, MDS B (the MDS Coordinator) stated she used to be the DON for this facility, but she moved over to the MDS coordinator position. She stated she had been trained on how to complete MDS assessments and forms, and the MDS was the actual comprehensive assessment to meet all the needs of the residents and establish a plan of care. MDS B stated MDS C was the one who did the actual MDS assessment, and she just signed off on them once they were completed. She stated she had not actually checked for accuracy or to make sure the proper assessments were completed. She stated it was just her job to sign off the MDS had been completed. MDS B stated administration meets twice a week, Mondays and Wednesdays to discuss anything going on in the facility and with residents, but they were not tracking and trending significant changes or monitoring them. Record review of the facility's Quality Assurance Performance Improvement policy dated 02/12/25 reflected: Policy: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care quality of life and addresses all the care and unique services the facility provides. Policy Explanation and Compliance Guidelines: 3. The QAPI plan will address the following elements: c. Process addressing how the committee will conduct activities necessary to identify and correct quality deficiencies, Key components of the process include, but are not limited to, the following: i. Tracking and measuring performance. ii. Establishing goals and thresholds for performance improvements. iii. Identifying and prioritizing quality deficiencies. V. Developing and implementing corrective action or performance improvement activities. Program Development Guidelines: 1. Program Design and Scope - b. At a minimum, the QAPI program will: i. Address all systems of care and management practices. 3. Program Feedback, Data Systems, and Monitoring - c. Data is collected from all departments and is used to develop and monitor performance indicators. i. Facility staff are responsible for following department procedures for data collection. ii. Department heads are responsible for ensuring data is collected appropriately and performance metrics are monitored in accordance with facility policy.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to establish and maintain an infection prevention and control program, designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections, for one of six Residents (Resident #5) that were reviewed for infection control and transmission-based precautions policies and practices. 1) The facility failed to ensure LVN performed hand hygiene after removing gloves prior to and after setting up Resident #5's wound care supplies. 2) The facility failed to ensure LVN used a sterile, individually wrapped applicator to apply medication to Resident #5's wound. 3) The facility failed to maintain an infection and prevention control program that included, at a minimum, a system for preventing and controlling Legionella through a program that identifies areas in the water system where Legionella bacteria can grow and spread. These failures could place residents at risk of infection through cross contamination of pathogens and infectious diseases. Findings include: Record review of Resident #5's face sheet dated 12/11/25 reflected an [AGE] year-old-female with an original admission date of 08/01/25. Diagnoses included hypertension (high blood pressure), type 2 diabetes (insufficient insulin production in the body), end stage kidney disease (kidneys can no longer maintain the body's balance of fluids, electrolytes, and waste products), and cerebral infarction (blood flow to part of the brain is obstructed, leading to the death in brain cells). Record review of Resident #5's physician orders dated 11/11/25 reflected: Stage IV Pressure Ulcer (full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage, or bone): Cleanse with Vashe (wound cleanser), pat dry with 4x4 gauze, apply collagen powder (promotes new tissue growth), apply Silvadene (topical antibiotic cream), cover with dry 4x4 gauze, cover with ABD pad, and secure with tape, every day and night shift. Record review of Resident #5's quarterly MDS dated [DATE] a BIMS of 00 (severe cognitive impairment). During an observation on 12/10/25 at 1:16 PM, LVN A sanitized the wound care tray, removed gloves and put on new gloves without sanitizing or washing hands. During an observation on 12/10/25 at 1:19 PM, LVN A removed a wooden applicator from a shared cup containing multiple applicators located on the medication cart and placed it on the tray. The applicators were stored together in an open container, were not individually wrapped, and were not sterile. During an observation on 12/10/25 at 1:25 PM, LVN A removed gloves after prepping Resident #5's wound care supplies and put on new gloves without sanitizing or washing hands. In an interview on 12/10/25 at 1:47PM, LVN A stated it was important to wash or sanitize hands after every glove removal to prevent cross-contamination. LVN A stated Resident #5's wound could get infected and get worse if introduced to bacteria. LVN A stated he was nervous and forgot some of the steps. LVN A stated that the orders did not state what to use when applying the medication and just thought he could use one of the wooden applicators located on the medication cart. LVN A stated he probably should have used an individual sealed applicator since it would be sterile. LVN A stated since he used a non-sterile wooden applicator, Resident #5's wound could possibly not heal or become infected. In an interview on 12/11/25 at 2:03 PM, the IP stated hand sanitizer could be used after glove removal and hand washing should take place when hands are visibly soiled. The IP stated it was important to ensure hands were cleaned before staff moved on to the next resident to prevent cross contamination. The IP stated by using a non-sterile applicator, Resident #5's wound could obtain an organism and could become septic since the resident's immune system was low. The IP stated that hand hygiene skills were done continuously throughout the year. In an interview on 12/11/25 at 2:56 PM, the ADON stated she frequently would do spot checks on wound care, but she had no process for tracking and trending wounds. The ADON stated it was important to ensure hands were sanitized or washed after every glove removal to prevent cross contamination. In an interview on 12/11/25 at 3:07 PM, the DON stated all staff should be washing their hands after every glove removal to prevent infection and the spread of germs. The DON stated (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the ADON would do spot checks on wound care but did not have a process to track and trend competency. The DON stated LVN A should have used a sterile, individualized wrapped applicator to prevent the spread of infection. The DON stated Resident #5's wound could not heal or become worse. During an interview on 12/11/25 at 11:22 AM, the MD stated he was new to the Maintenance Director position and had not established any preventions to monitor and prevent Legionella. The MD stated he was unsure what the previous MD was doing and since he has become the MD, nothing had been done to the water system other than the replacement of 3 water heaters due to them not working. The MD stated it was important to monitor and try to prevent Legionella because the residents could become very sick if the water became contaminated. The MD stated he was going to start working on a prevention strategy immediately. In an interview on 12/11/25 at 12:39 PM, the IP stated she was aware of the organism Legionella but was not aware or trained on the prevention of it. The IP stated if the water became contaminated, the residents could experience pneumonia and possible rheumatic fever. In an interview on 12/11/25 at 12:47 PM, the DON stated it was important for the facility to monitor and have prevention strategies in place to prevent Legionella. The DON stated it could cause illness not only to the population but to guests as well. The DON stated the MD was working on a prevention strategy to implement immediately. Record review of the facility's Handwashing/Hand Hygiene policy dated April 2010 reflected: Policy Statement This facility considers hand hygiene the primary means to prevent the spread of infections. Polic Interpretation and Implementation 5. Employees must wash their hands for at least fifteen (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: k. Before and after changing a dressing; u. After removing gloves or aprons; and v. After completing duty. 7. Hand hygiene is always the final step after removing and disposing of personal protective equipment. Record review of the facility's Wound Care policy dated October 2010 reflected: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. The following equipment and supplies will be necessary when performing this procedure. 7. Use no-touch technique. Use sterile tongue blades and applicators to remove ointments and creams from their containers. Record review of the facility's Legionella Surveillance policy dated 02/12/25 reflected: Policy: It is the policy of this facility to establish primary and secondary strategies for the prevention and control of Legionella infections. Policy Explanation and Compliance Guidelines: 1. Legionella surveillance is one component of the facility's water management plans for reducing the risk of Legionella and other opportunistic pathogens in the facility's water systems. c. Physical controls: i. Cooling towers and potable water systems shall be routinely maintained. ii. Non-potable water systems shall be routinely cleaned and disinfected. d. Temperature controls: i. Cold water shall be stored and distributed below 68 F. ii. Hot water shall be stored above 140 F and circulated at a minimum return temperature of 124 F.		