STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455536	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amistad Nursing and Rehabilitation Center	200 Riverside Drive Uvalde, TX 78801

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, 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 for food safety. Raisin bread and hamburger buns were stored in the facility's' kitchen pantry without labeled dates to indicate when the food was received and opened.Hamburger buns were stored in the facility's' kitchen pantry unsealed and open to air.The facility's' nutrition room refrigerator had resident foods which were not labeled to indicate when the food was received or when the food should be discarded.Food delivered by the food vendor was stored in cardboard cases upon the floor. These failures could place residents at risk for food borne illness.The findings included: During an observation and interview on 6/23/2026 at 11:00 AM revealed the facility's kitchen pantry stored 5 loaves of Raisin bread, packaged in the manufacturer's clear plastic wrap upon a wire rack. The loaves were all without any labeled date to indicate when the bread was received. A package of hamburger buns was opened and left open to air upon a wire rack. The package did not have any label to indicate when the food was received and when the food was opened. The FSM stated the food should be labeled with the date the food was received and when the food was opened. The FSM stated the dates indicated when the food should be discarded, food which has been opened should be discarded after 7 days. During an observation and interview on 6/23/2026 at 11:18 AM revealed the facility's residents' nutrition room located on the facility's 100-hall, had a refrigerator which stored resident foods. CNA C demonstrated the refrigerator which had a sign affixed to the refrigerator door which reflected, This refrigerator is for resident snacks and resident personal food items: place name of resident on items received. Date each item when received. Check date of best by or expiration each day and discard as needed. Notify resident, Representative, family, when items are discarded. CNA C demonstrated the refrigerator which stored multiple foods without the labels which could have indicated when the food was received and when the food should be discarded. Observations revealed the following foods:A plastic to-go container, which contained an enchilada dinner, with Resident #62's name written upon the container. No date was labeled on the container to indicate when the dinner was received or to indicate when the food should be discarded.A 10.6 ounce opened container of brand name cottage cheese without a label to indicate which resident the food belonged to, when the food was received, when the food was opened, and when to discard the food.CNA C confirmed the food should be labeled with the residents' names and dates to indicate when the food was received and when the food should be discarded. During an observation and interview on 6/26/2026 at 11:30 AM revealed the facility's' kitchen pantry, where foods were stored in cardboard boxes upon the floor. The FSM stated he had just received a food truck delivery from the food vendor and had placed the food, which was stored in cardboard boxes, on the floor. The FSM stated the practice was an oversight and he should not have placed the food on the floor. The FSM stated the failures could potentially place residents at risk for food borne illness. A record review of the facility's undated Food Safety policy revealed, We will insure all food purchased shall be wholesome and manufactured, processed, and prepared in compliance with all State, Federal, and local laws and regulations. Food shall be handled in a safe manner. Procedure: . 2. Food is to be (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	wrapped or sealed and covered in clean containers. Opened food shall be labeled, dated and stored properly. Perishable opened foods shall be used within 7 days or less, in compliance with the Texas Food Establishment rules. Non-perishable foods will be used as long as the quality of the product is maintained. 9. Do not keep potentially hazardous food in refrigerator past the labeled expiration date.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to ensure residents were provided a sanitary and comfortable environment for 1 of 3 shower areas (400-hall shower) reviewed for physical environment. The facility failed to ensure the 400-hall shower area was free from dirt and debris. This failure could result in decreased quality of life. Findings included: In an interview with a confidential resident on an undisclosed date/time, the resident said the shower room in the 400-hall was dirty, and the lack of cleanliness made the resident feel uncomfortable when bathing. In an observation on 6/23/2026 at 2:26 PM, the 400-hall shower was observed to have a wet, black substance between the tiles on the floor. The moveable shower chair had a similar, wet, black substance on the surface of the bottom panel and the fabric straps. In a second observation on 6/24/2026 at 10:45 AM, revealed the condition of the 400-hall shower area was unchanged. In an interview on 6/24/2026 at 10:45 AM, the HSKD said the shower areas were cleaned daily, and the shower chairs were deep cleaned with a pressure washer on the last Wednesday of every month. She said the facility ensured all the chairs were cleaned because they were all cleaned at the same time. She said they did not maintain a log of this activity. She said if the chairs required additional unscheduled cleaning the staff should notify the housekeeping department. She said the shower chair in the 400-hall shower should have received an additional cleaning due to the observed condition. In an interview on 6/24/2026 at 10:45 AM, the DON said the showers and shower chairs were cleaned between each resident by the CNA performing showers, and the expectation was the shower areas and equipment would be cleaned to maintain cleanliness, and the shower area and chair should have received additional cleanings. Record review of the facility policy titled Infection Control Plan: Obserview dated 2016, reflected the following: .3. Non-invasive resident care equipment is cleaned daily or as needed between use by the nursing assistant.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure residents had the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. These grievances included those with respect to care and treatment which had been furnished as well as those which had not been furnished, the behavior of staff and of other residents, and other concerns regarding their long term care (LTC) facility stay, for 3 of 8 residents (Residents #11, #12, and #30) reviewed for grievances. CNA A failed to file a grievance when Resident #11 reported to CNA G that someone stole $31 from her some days prior to 6/24/2026.The facility failed to take immediate action, per their grievance policy, to prevent further potential violations of any resident right while the alleged violations were being investigated when Resident #30's representative complained that LVN D was verbally abusive and neglectful. LVN D was allowed to work in the facility another 3 days after Resident #30's representative made the complaint. The facility failed to issue written grievance decisions to Resident #30, per the facility policy.The Administrator failed to document a grievance made by Resident #12 when he called the Administrators' cell phone on the evening of June 17th, 2026, when he alleged, he was left soiled in his bowel movement for longer than 1-2 hours. These failures could place residents at risk for not having their grievances heard and acted upon for resolution.The findings included. Resident #11A record review of Resident #11's admission record dated 6/26/2026 revealed an admission date of 9/28/2022 with diagnoses which included polyosteoarthritis (a chronic, degenerative joint disease that affects five or more joints simultaneously), chronic pain, and difficulty walking. A record review of Resident #11's quarterly MDS assessment dated [DATE] revealed Resident #11 was a [AGE] year-old female admitted for LTC supports which included assistance with transfers. Resident #11 was assessed with adequate vision, adequate hearing without hearing aid, the ability to understand others and the ability to make herself understood. Resident #11 was assessed with a BIMS score of 9 out of a possible 15 which indicated moderate cognitive impairment. A record review of Resident #11's care plan dated 6/5/2026 revealed a focus of Potential for alteration in mood / behavior due to depression and impaired cognition . Interventions: . monitor, record, report, to MD PN mood patterns signs and symptoms of depression, anxiety, sad mood, as per facility behavior monitoring protocols. A record review of the facility's grievance log for the period January 2026 through June 26, 2026, revealed no grievance recorded for Resident #11's alleged missing $31. During an interview on 6/25/2026 at 1:45 PM Resident #11 stated that, sometime last week, staff had stolen her $31, from her wallet, which she kept at her nightstand. Resident #11 stated she had reported the incident to CNA G. Resident #11 stated she had not received any information regarding the loss of her money and had just resolved to keep her money on her person and not trust any staff at the facility. During an interview on 6/25/2026 at 1:54 PM CNA G stated Resident #11 had reported to her that someone stole $31 from her room. CNA G stated she could not recall the specific day but that the report was some time last week. CNA G stated she had not reported the complaint because she believed the nurses knew about the complaint. Resident #30A record review of Resident #30's admission record dated 6/26/2026 revealed an admission date of 6/2/2026. Resident #30's diagnoses included emphysema (a progressive, irreversible lung disease where the tiny air sacs are gradually destroyed), cerebral infarction (stroke; a medical emergency that occurs when blood flow to an area of the brain is cut off or a blood vessel in the brain bursts), and cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body). A record review of Resident #30's admission MDS assessment dated [DATE] revealed Resident #30 was a [AGE] year-old female admitted for long term care with activities of daily life supports. Resident #30 was assessed with a BIMS score of 13 which indicated intact cognition. A record review of Resident (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#30's care plan dated 6/26/2026 revealed, potential for ineffective breathing pattern due to but not limited to history of respiratory infections and resident has emphysema with chronic bronchitis, . administer medications / treatments as per medical doctors' orders. A record review of Resident #30's physicians' orders dated 6/26/2026 revealed the physician prescribed for Resident #30 to receive ipratropium albuterol solution, for her emphysema, twice a day in the morning and again in the evening, via a nebulizer (a medical device used to turn liquid medicine into a fine mist). A record review of the facility's grievance dated 6/6/2026 revealed Resident #30's Representative made a grievance against LVN D, (Resident #30's Representative) reported that (Resident #30) stated that she had not received her AM nebulizer medication. (Resident #30's Representative) went to the nurse's station and asked (LVN D) if he could administer the neb treatment and (LVN D) was very rude according to (Resident #30's Representative) and LVN E. (Resident #30's Representative) reported that LVN D stated (Resident #30) could administer the medication herself. (LVN D) did eventually administer the nebulizer treatment after (Resident #30's Representative) asked for it. The nebulizer treatments are scheduled for AM and PM. LVN D administered the medication around 1130-noon. The DON documented, (LVN D) was late administering a neb treatment and was rude to (Resident #30's Representative) after she asked for the neb treatment to be administered. (LVN D) showed poor customer service. LVN D was coached on medication administration and customer service. An employee disciplinary record was requested from corp. the grievance document revealed a meeting was held with Resident #30's Representative and the grievance was confirmed and resolved. The DON documented Resident #30's Representative received a resolution report in a one-to-one discussion. A record review of an email from Resident #30's Representative to the Administrator dated 6/6/2026 at 4:57 PM revealed, Resident #30's Representative made a complaint that LVN D had not administered Resident #30's medications as the prescriber had ordered, that LVN D was rude and verbally abusive, and Resident #30's Representative requested a formal investigation with a written report per the facility's policy; Subject: formal complaint regarding medication and treatment administration. To nursing home administration, I am writing to formally document concerns regarding the care provided to (Resident #30) and specifically the repeated issues involving medication and treatment administration by one of the nursing staff members, (LVN D). I informed (LVN D) that (Resident #30) had not received her morning nebulization treatment. (LVN D's) response was, Okay, I'll do it right now. I then asked for clarification, stating that my understanding was that the treatment was ordered for morning and evening administration. (LVN D) confirmed that was correct. When I asked why it had not been given that morning, (LVN D) stated that (Resident #30) had the nebulizer medication in her room and could administer it herself. I respectfully request: a formal investigation into these incidents; a review of (Resident #30's) medication and treatment administration records to determine whether other prescribed doses or treatments have been missed or administered incorrectly; education or corrective action as appropriate regarding adherence to physician orders; a written response outlining the findings of the investigation and any steps being taken to prevent similar issues in the future. after composing this notification, I learned that (LVN D) went into (Resident #30's) room after I left the building and told (Resident #30) she could administer it herself and that she probably didn't even need it because (LVN D) had not heard (Resident #30) coughing. During an interview on 6/26/2026 at 1:30 PM Resident #30 and Resident #30's Representative stated they were disappointed that they still had not received a written report on the investigative findings of the abuse and neglect claims made on the 6th of June 2026. Resident #30 and Resident #30's Representative stated they had spoken with the DON and learned LVN D had missed Resident #30's albuterol treatments and had not returned to care for Resident #30 since June 6th, 2026. Resident #30 and Resident #30's Representative stated to check with LVN E who was a witness to the incident on 6/6/2026. Resident #30 stated she was intimidated by LVN D's care when on 6//6/2026 in the evening LVN D confronted Resident #30 and accused her of being able to self-administer her own medications and was not even sick because she was not coughing. During an interview on 6/26/2026 (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 2:20 PM LVN E stated she was receiving a nurse-to-nurse report from LVN D on 6/6/2026 around 2:00 PM when she witnessed LVN D state to Resident #30's Representative that he had not administered Resident #30's morning nebulizer treatment and Resident #30 could administer her nebulizer herself. LVN E stated she was surprised at LVN D's rude response. LVN E stated she had not reported the complaint to the leadership because she heard Resident #30's Representative state they were going to report LVN D. Resident #12A record review of Resident #12's admission record dated 6/26/2026, revealed an admission date of 5/8/2026. Resident #12 had diagnoses which included neuromuscular dysfunction of the bladder (occurs when damage to the brain, spinal cord, or nerves disrupts the signals required to hold and release urine), a history of falling, and depressive disorders (persistent feelings of sadness, emptiness, and a loss of interest in activities). A record review of Resident #12's admission MDS assessment dated [DATE] revealed Resident #12 was a [AGE] year-old male admitted for LTC supports for activities of daily life. Resident #12 was assessed with adequate vision with eyeglasses, adequate hearing without hearing aids, clear speech, the ability to understand others and the ability to make himself understood. Resident #12 was assessed with a BIMS score of 12 which indicated moderate cognitive impairment. A record review of Resident #12"s care plan dated 6/26/2026 revealed, Resident is incontinent of bowel and requires assistance with toileting tasks due to but not limited to decreased mobility and impaired cognition. Potential for with history of constipation / loose stools. History of colon rectal cancer. check resident frequently throughout the day and as required / requested and assist with toileting as needed. toilet use: requires extensive x1 staff assistance. resident is incontinent of bowel and bladder. potential for skin breakdown due to but not limited to decreased mobility, incontinence and impaired condition, the resident needs assistance to turn, reposition, frequently throughout the day and as requested. During an interview on 6/24/2026 at 9:20 AM Resident #12 stated on June 17th, 2026, he was left in his feces for 2 hours. Resident #12 stated the time was after dinner and he became soiled with feces and ignited his call light. Resident #12 stated he had become frustrated and upset when he was left in that condition with no one responding to his calls when he recalled the Administrator had given him her cell phone number. Resident #12 stated he used his cell phone to call the Administrator. Resident #12 stated the Administrator received his call and within some minutes a CNA entered his room and confronted Resident #12 by stating you got me in trouble! and proceeded to provide rough hurried incontinent care. During an observation and joint interview on 6/24/2026 at 9:40 AM, revealed, the Administrator in Resident #30's room documenting Resident #30's interview. Resident #30 stated he used his cell phone to call the Administrator to notify her when he was left soiled in his feces for 2 hours. The Administrator stated Resident #30 called her on the evening of 6/17/2026 and stated he was left with his call light on for some time. A record review of the facility's grievance log for the period of June 2026 revealed no grievance entry for Resident #12. The log was sent via an email dated 6/24/2026 at 9:47 AM. A record review of the administrators' email dated 6/24/2026 at 1:42 PM to the survey team revealed the Administrator stated she had made a correction to the grievance log. A record review of the corrected log for June 2026 revealed the Administrator had written in a new entry dated 6/17/2026 for Resident #12. A record request was made for the actual grievances listed on the log. A record review of Resident #12's grievance dated 6/24/2026 revealed an incident date of 6/17/2026. The Administrator documented, (Resident #12) was waiting for someone to change him. I quickly thanked him for letting me know and made sure someone went to take care of his needs. During an interview on 6/26/2026 at 3:35 PM the Administrator stated the process for documenting formal grievances when residents or Representatives presented concerns was, if it required an investigation then it was documented into a formal grievance, one of the things that we fail on is giving ourselves credit for things we address and fix, it's very easy to fix things on the spot, but there are those that take a little longer. We have to do in-services and do documentation on because it's serious. so, if it requires an investigation then it's turned into a formal grievance. A record review of the facility's policy titled Grievances dated 11//2/2016 revealed, The resident has the right to voice (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents; and other concerns regarding their LTC facility stay. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have. The grievance official of this facility is the administrator or their designee.3. The grievance official will: Oversee the grievance process Receive and track grievances to their conclusion Lead any necessary investigations by the facility Maintain the confidentiality of all information associated with grievances Issue written grievance decisions to the resident Coordinate with state and federal agencies as necessary4. As needed, the facility will take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated5. All grievances involving alleged violations of neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the abuse preventionist.6. All written grievances decisions will include: The date the grievance was received A summary statement of the resident's grievance The steps taken to investigate the grievance A summary of the pertinent findings or conclusions regarding the resident's concern(s) A statement as to whether the grievance was confirmed or not confirmed Any corrective action taken or to be taken by the facility as a result of the grievance The date the written decision was issued.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures, for 3 of 8 residents (Residents #11, #12, and #30) reviewed for reporting suspicions of abuse, neglect, exploitation or mistreatment CNA G failed to report an allegation of misappropriation of property to the Administrator, when Resident #11 reported to CNA G that, someone stole $31 from her some days prior to 6/24/2026.The Administrator and the DON failed to report to the State Agency an allegation of neglect and verbal abuse on 6/6/2026, when Resident #30 and her Representative alleged LVN D had neglected to administer medications and was verbally abusive.The Administrator failed to report to the State Agency an allegation made by Resident #12 that he was left soiled in his bowel movement for longer than 1-2 hours. These failures could place residents at risk for not having their allegations and suspicions of abuse, neglect, exploitation and mistreatment reported to the Administration and the State Agency.The findings included: Resident #11A record review of Resident #11's admission record dated 6/26/2026 revealed an admission date of 9/28/2022 with diagnoses which included polyosteoarthritis (a chronic, degenerative joint disease that affects five or more joints simultaneously), chronic pain, and difficulty walking. A record review of Resident #11's quarterly MDS assessment dated [DATE] revealed Resident #11 was a [AGE] year-old female admitted for LTC supports which included assistance with transfers. Resident #11 was assessed with adequate vision, adequate hearing without hearing aid, the ability to understand others and the ability to make herself understood. Resident #11 was assessed with a BIMS score of 9 out of a possible 15 which indicated moderate cognitive impairment. A record review of Resident #11's care plan dated 6/5/2026 revealed a focus of Potential for alteration in mood / behavior due to depression and impaired cognition . Interventions: . monitor, record, report, to MD PRN mood patterns signs and symptoms of depression, anxiety, sad mood, as per facility behavior monitoring protocols. A record review of the state of Texas website, Texas Unified Licensure Information Portal for the facility's account, accessed 6/23/2026 revealed no report of alleged abuse, neglect, exploitation, or mistreatment on behalf of Resident #11 for the period of 6/1/2026 through 6/23/2026. During an interview on 6/25/2026 at 1:45 PM Resident #11 stated that, sometime last week, staff had stolen her $31, from her wallet, which she kept at her nightstand. Resident #11 stated she had reported the incident to CNA G. Resident #11 stated she had not received any information regarding the loss of her money and had just resolved to keep her money on her person and not trust any staff at the facility. During an interview on 6/25/2026 at 1:54 PM CNA G stated Resident #11 had reported to her that someone stole $31 from her room. CNA G stated she could not recall the specific day but that the report was some time last week. CNA G stated she had not reported the complaint because she believed the nurses knew about the complaint. Resident #30A record review of resident #30's admission record dated 6/26/2026 revealed an admission date of 6/2/2026 with diagnoses which included emphysema (a progressive, irreversible lung disease where the tiny air sacs are gradually destroyed), cerebral infarction (stroke; a medical emergency that occurs when blood flow to an area of the brain is cut off or a blood vessel in the brain bursts), and cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body). A record review of Resident #30's admission MDS assessment dated [DATE] (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed Resident #30 was a [AGE] year-old female admitted for long term care with activities of daily life supports. A record review of Resident #30's care plan dated 6/26/2026 revealed, potential for ineffective breathing pattern due to but not limited to history of respiratory infections and resident has emphysema with chronic bronchitis, . administer medications / treatments as per medical doctors' orders. A record review of Resident #30's physicians' orders dated 6/26/2026 revealed the physician prescribed for Resident #30 to receive ipratropium albuterol solution, for her emphysema, twice a day in the morning and again in the evening, via a nebulizer (a medical device used to turn liquid medicine into a fine mist). A record review of the state of Texas website, Texas Unified Licensure Information Portal for the facility's account, accessed 6/23/2026 revealed no report of alleged abuse, neglect, exploitation, or mistreatment on behalf of Resident #30's for the period of 6/1/2026 through 6/23/2026. A record review of the facility's grievance dated 6/6/2026 revealed Resident #30's Representative made a grievance against LVN D, (Resident #30's Representative) reported that (Resident #30) stated that she had not received her AM nebulizer medication. (Resident #30's Representative) went to the nurse's station and asked (LVN D) if he could administer the neb treatment and (LVN D) was very rude according to (Resident #30's Representative) and LVN E. (Resident #30's Representative) reported that LVN D stated (Resident #30) could administer the medication herself. (LVN D) did eventually administer the nebulizer treatment after (Resident #30's Representative) asked for it. The nebulizer treatments are scheduled for AM and PM. LVN D administered the medication around 1130-noon. The DON documented, (LVN D) was late administering a neb treatment and was rude to (Resident #30's Representative) after she asked for the neb treatment to be administered. (LVN D) showed poor customer service. LVN D was coached on medication administration and customer service. An employee disciplinary record was requested from corp. the grievance document revealed a meeting was held with Resident #30's Representative and the grievance was confirmed and resolved. The DON documented Resident #30's Representative received a resolution report in a one-to-one discussion. A record review of an email from Resident #30's Representative to the Administrator dated 6/6/2026 at 4:57 PM revealed, Resident #30's Representative made a complaint that LVN D had not administered Resident #30's medications as the prescriber had ordered, that LVN D was rude and verbally abusive, and Resident #30's Representative requested a formal investigation with a written report per the facility's policy; Subject: formal complaint regarding medication and treatment administration. To nursing home administration, I am writing to formally document concerns regarding the care provided to (Resident #30) and specifically the repeated issues involving medication and treatment administration by one of the nursing staff members, (LVN D). I informed (LVN D) that (Resident #30) had not received her morning nebulization treatment. (LVN D's) response was, Okay, I'll do it right now. I then asked for clarification, stating that my understanding was that the treatment was ordered for morning and evening administration. (LVN D) confirmed that was correct. When I asked why it had not been given that morning, (LVN D) stated that (Resident #30) had the nebulizer medication in her room and could administer it herself. I respectfully request: a formal investigation into these incidents; a review of (Resident #30's) medication and treatment administration records to determine whether other prescribed doses or treatments have been missed or administered incorrectly; education or corrective action as appropriate regarding adherence to physician orders; a written response outlining the findings of the investigation and any steps being taken to prevent similar issues in the future. after composing this notification, I learned that (LVN D) went into (Resident #30's) room after I left the building and told (Resident #30) she could administer it herself and that she probably didn't even need it because (LVN D) had not heard (Resident #30) coughing. During an interview on 6/26/2026 at 1:30 PM Resident #30 and Resident #30's Representative stated they were disappointed that they still had not received a written report on the investigative findings of the abuse and neglect claims made on the 6th of June 2026. Resident #30 and Resident #30's Representative stated they had spoken with the DON and learned LVN D had missed Resident #30's albuterol treatments and had not returned to care for (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455536	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amistad Nursing and Rehabilitation Center	200 Riverside Drive Uvalde, TX 78801

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #30 since June 6th, 2026. Resident #30 and Resident #30's Representative stated, check with LVN E who was a witness to the incident on 6/6/2026. Resident #30 stated she was intimidated by LVN D's care when on 6//6/2026 in the evening LVN D confronted Resident #30 and accused her of being able to self-administer her own medications and was not even sick because she was not coughing. During an interview on 6/26/2026 at 2:20 PM LVN E stated she was receiving a nurse-to-nurse report from LVN E on 6/6/2026 around 2:00 PM when she witnessed LVN D state to Resident #30's Representative that he had not administered Resident #30's morning nebulizer treatment and Resident #30 could administer her nebulizer herself. LVN E stated she was surprised at LVN D's rude response. LVN E stated she had not reported the complaint to the leadership because she heard Resident #30's Representative state they were going to report LVN D. Resident #12A record review of Resident #12's admission record dated 6/26/2026, revealed an admission date of 5/8/2026 with diagnoses which included neuromuscular dysfunction of the bladder (occurs when damage to the brain, spinal cord, or nerves disrupts the signals required to hold and release urine), a history of falling, and depressive disorders (persistent feelings of sadness, emptiness, and a loss of interest in activities) A record review of Resident #12's admission MDS assessment dated [DATE] revealed Resident #12 was a [AGE] year-old male admitted for LTC supports for activities of daily life. Resident #12 was assessed with adequate vision with eyeglasses, adequate hearing without hearing aids, clear speech, the ability to understand others and the ability to make himself understood. Resident #30 was assessed with a BIMS score of 12 which indicated moderate cognitive impairment. A record review of Resident #12"s care plan dated 6/26/2026 revealed, Resident is incontinent of bowel and requires assistance with toileting tasks due to but not limited to decreased mobility and impaired cognition. Potential for with history of constipation / loose stools. History of colon rectal cancer. check resident frequently throughout the day and as required / requested and assist with toileting as needed. toilet use: requires extensive x 1 staff assistance. resident is incontinent of bowel and bladder. potential for skin breakdown due to but not limited to decreased mobility, incontinence and impaired condition, the resident needs assistance to turn, reposition, frequently throughout the day and as requested. A record review of the state of Texas website, Texas Unified Licensure Information Portal for the facility's account, accessed 6/23/2026 revealed no report of alleged abuse, neglect, exploitation, or mistreatment on behalf of Resident #12 for the period of 6/1/2026 through 6/23/2026. During an interview on 6/24/2026 at 9:20 AM Resident #12 stated on June 17th, 2026, he was left in his feces for 2 hours, Resident #12 stated the time was after dinner and he became soiled with feces and ignited his call light. Resident #12 stated he had become frustrated and upset when he was left in that condition with no one responding to his calls when he recalled the Administrator had given him her cell phone number. Resident #12 stated he used his cell phone to call the Administrator. Resident #12 stated the Administrator received his call and within some minutes a CNA entered his room and confronted Resident #12 by stating you got me in trouble! and proceeded to provide rough hurried incontinent care. During an observation and joint interview on 6/24/2026 at 9:40 AM, revealed, the Administrator in Resident #30's room documenting Resident #30's interview. Resident #30 stated he used his cell phone to call the Administrator that he was left soiled in his feces for 2 hours. The Administrator stated Resident #30 called her on the evening of 6/17/2026 and stated he was left with his call light on for some time. A record review of Resident #12's grievance dated 6/24/2026 revealed an incident date of 6/17/2026. The Administrator documented, (Resident #12) was waiting for someone to change him. I quickly thanked him for letting me know and made sure someone went to take care of his needs. During a joint interview on 6/26/2026 at 3:35 PM with the DON and the Administrator; the DON responded to the question, what is the policy/process on reporting allegations of abuse/neglect/exploitation? the DON responded, the staff know to report immediately to the abuse coordinator and then the abuse coordinator immediately reports to the state; and the Administrator responded, We follow the state guidelines. The DON responded to the question are there any incidents/grievances/ allegations/ suspicions of abuse, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	neglect, or exploitation, that have not been reported? The DON responded, No, I think everything that should have been reported has been reported. The Administrator responded, With Resident #11, we weren't aware of her missing money, but we did report it once we knew. Resident #11 will tell everybody, she's very vocal and everybody knows. We find it odd that she didn't tell either of us because we've both spent time with her. The DON added, She spends a lot of time with the ADON and I talked to her on Friday and she didn't say anything about missing money. But it would have been reported, and we did report it yesterday. We interviewed CNA G, and she said in her statement but in her mind she thought it was from way back when, not that it had just happened. So, she thought it was in the past, like a long time ago. A record review of the facility's undated Abuse / Neglect policy revealed, The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the residents' medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, . it is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property, and situations that may constitute abuse or neglect to any resident in the facility. Reporting: . Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property, or injury of unknown source to the facility Administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of provider letter 2024-14 dated 8/29/2024. If the allegations involve abuse or result in serious bodily injury, the report is to be made within two hours of the allegation. If the allegation does not involve abuse or serious bombing injury, the report must be made within 24 hours of the allegation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation were verified appropriate corrective actions must have been taken, for 3 of 8 residents (Residents #11, #12, and #30) reviewed for reporting suspicions of abuse, neglect, exploitation or mistreatment. The facility failed to investigate and provide the State Agency with a report no later than 5 days after the alleged abuse, neglect, exploitation, mistreatment, and misappropriation of property was received for:A reported allegation of misappropriation of property, when Resident #11 reported to CNA G that someone stole $31 from her.A reported allegation of verbal Abuse and neglect when Resident #30 and her Representative alleged LVN D had neglected to administer medications and was verbally abusive.A reported allegation of neglect when Resident #12 alleged he was left soiled in his bowel movement for longer than 1-2 hours. These failures could place residents at risk for not having their allegations and suspicions of abuse, neglect, exploitation and mistreatment investigated and reported to the Administration and the State Agency.The findings included: Resident #11A record review of Resident #11's admission record dated 6/26/2026 revealed an admission date of 9/28/2022 with diagnoses which included polyosteoarthritis (a chronic, degenerative joint disease that affects five or more joints simultaneously), chronic pain, and difficulty walking. A record review of Resident #11's quarterly MDS assessment dated [DATE] revealed Resident #11 was a [AGE] year-old female admitted for LTC supports which included assistance with transfers. Resident #11 was assessed with adequate vision, adequate hearing without hearing aid, the ability to understand others, and the ability to make herself understood. Resident #11 was assessed with a BIMS score of 9 out of a possible 15 which indicated mild cognitive impairment. A record review of Resident #11's care plan dated 6/5/2026 revealed a focus of Potential for alteration in mood / behavior due to depression and impaired cognition . Interventions: . monitor, record, report, to MD PRN mood patterns signs and symptoms of depression, anxiety, sad mood, as per facility behavior monitoring protocols. A record review of the State of Texas' website, the Texas Unified Licensure Information Portal for the facility's account, accessed 6/23/2026 revealed no investigation report for the alleged abuse, neglect, exploitation, or mistreatment on behalf of Resident #11 for the period of 6/1/2026 through 6/23/2026. During an interview on 6/25/2026 at 1:45 PM Resident #11 stated staff had stolen her $31 sometime last week. Resident #11 stated she had reported the incident to CNA G. Resident #11 stated she had not received any information regarding the loss of her money and had just resolved to keep her money on her-person and not trust any staff at the facility. During an interview on 6/25/2026 at 1:54 PM CNA G stated Resident #11 had reported to her that someone stole $31 from her room. CNA G stated she could not recall the specific day but that the report was some time last week. CNA G stated she had not reported the complaint because she believed the nurses knew about the complaint. Resident #30A record review of resident #30's admission record dated 6/26/2026 revealed an admission date of 6/2/2026 with diagnoses which included emphysema (a progressive, irreversible lung disease where the tiny air sacs are gradually destroyed), cerebral infarction (stroke; a medical emergency that occurs when blood flow to an area of the brain is cut off or a blood vessel in the brain bursts), and cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body). A record review of Resident #30's admission MDS assessment dated [DATE] revealed Resident #30 was a [AGE] year-old female admitted for long term care with activities of daily life supports. A record review of Resident #30's care plan dated 6/26/2026 revealed, potential for ineffective breathing pattern due to but not limited to history of respiratory infections and resident has emphysema with chronic bronchitis, . administer medications / treatments as per medical doctors' orders. A record review of (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #30's physicians' orders dated 6/26/2026 revealed the physician prescribed for Resident #30 to receive ipratropium albuterol solution, for her emphysema, twice a day in the morning and again in the evening, via a nebulizer (a medical device used to turn liquid medicine into a fine mist). A record review of the State of Texas' website, the Texas Unified Licensure Information Portal for the facility's account, accessed 6/23/2026 revealed no investigation report for the alleged abuse, neglect, exploitation, or mistreatment on behalf of Resident #30, for the period of 6/1/2026 through 6/23/2026. A record review of the facility's grievance dated 6/6/2026 revealed Resident #30's Representative made a grievance against LVN D, (Resident #30's Representative) reported that (Resident #30) stated that she had not received her AM nebulizer medication. (Resident #30's Representative) went to the nurse's station and asked (LVN D) if he could administer the neb treatment and (LVN D) was very rude according to (Resident #30's Representative) and LVN E. (Resident #30's Representative) reported that LVN D stated (Resident #30) could administer the medication herself. (LVN D) did eventually administer the nebulizer treatment after (Resident #30's Representative) asked for it. The nebulizer treatments are scheduled for AM and PM. LVN D administered the medication around 1130-noon. The DON documented, (LVN D) was late administering a neb treatment and was rude to (Resident #30's Representative) after she asked for the neb treatment to be administered. (LVN D) showed poor customer service. LVN D was coached on medication administration and customer service. An employee disciplinary record was requested from corp. the grievance document revealed a meeting was held with Resident #30's Representative and the grievance was confirmed and resolved. The DON documented Resident #30's Representative received a resolution report in a one-to-one discussion. A record review of an email from Resident #30's Representative to the Administrator dated 6/6/2026 at 4:57 PM revealed, Resident #30's Representative made a complaint that LVN D had not administered Resident #30's medications as the prescriber had ordered, that LVN D was rude and verbally abusive, and Resident #30's Representative requested a formal investigation with a written report per the facility's policy; Subject: formal complaint regarding medication and treatment administration. To nursing home administration, I am writing to formally document concerns regarding the care provided to (Resident #30) and specifically the repeated issues involving medication and treatment administration by one of the nursing staff members, (LVN D). I informed (LVN D) that (Resident #30) had not received her morning nebulization treatment. (LVN D's) response was, Okay, I'll do it right now. I then asked for clarification, stating that my understanding was that the treatment was ordered for morning and evening administration. (LVN D) confirmed that was correct. When I asked why it had not been given that morning, (LVN D) stated that (Resident #30) had the nebulizer medication in her room and could administer it herself. I respectfully request: a formal investigation into these incidents; a review of (Resident #30's) medication and treatment administration records to determine whether other prescribed doses or treatments have been missed or administered incorrectly; education or corrective action as appropriate regarding adherence to physician orders; a written response outlining the findings of the investigation and any steps being taken to prevent similar issues in the future. after composing this notification, I learned that (LVN D) went into (Resident #30's) room after I left the building and told (Resident #30) she could administer it herself and that she probably didn't even need it because (LVN D) had not heard (Resident #30) coughing. During an interview on 6/26/2026 at 1:30 PM Resident #30 and Resident #30's Representative stated they were disappointed that they still had not received a written report on the investigative findings of the abuse and neglect claims made on the 6th of June 2026. Resident #30 and Resident #30's Representative stated they had spoken with the DON and learned LVN D had missed Resident #30's albuterol treatments and had not returned to care for Resident #30 since June 6th, 2026. Resident #30 and Resident #30's Representative stated, check with LVN E who was a witness to the incident on 6/6/2026. Resident #30 stated she was intimidated by LVN D's care. During an interview on 6/26/2026 at 1:45 PM the facility's Human Resources (HR) Director stated she was asked by her leadership to develop and implement an employee disciplinary (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	record for LVN D related to his misconduct on 6/6/2026 with Resident #30. The HR Director stated a record review of LVN D's employee time records revealed LVN D worked the next 3 days after he was alleged to have been misappropriate with Resident #30, (LVN D) worked 6/7/2026, 6/8/2026, and 6/9/2026 8 hours each day and prior to receiving his employee disciplinary action on 6/9/2026 he left the building and never returned. During an interview on 6/26/2026 at 2:20 PM LVN E stated she was receiving a nurse-to-nurse report from LVN E on 6/6/2026 around 2:00 PM when she witnessed LVN D state to Resident #30's Representative that he had not administered Resident #30's morning nebulizer treatment and Resident #30 could administer her nebulizer herself. LVN E stated she was surprised at LVN D's rude response. LVN E stated she had not reported the complaint to the leadership because she heard Resident #30's Representative state they were going to report LVN D. Resident #12A record review of Resident #12's admission record dated 6/26/2026, revealed an admission date of 5/8/2026 with diagnoses which included neuromuscular dysfunction of the bladder (occurs when damage to the brain, spinal cord, or nerves disrupts the signals required to hold and release urine), a history of falling, and depressive disorders (persistent feelings of sadness, emptiness, and a loss of interest in activities) A record review of Resident #12's admission MDS assessment dated [DATE] revealed Resident #12 was a [AGE] year-old male admitted for LTC supports for activities of daily life. Resident #12 was assessed with adequate vision with eyeglasses, adequate hearing without hearing aids, clear speech, the ability to understand others and the ability to make himself understood. Resident #30 was assessed with a BIMS score of 12 which indicated moderate cognitive impairment. A record review of Resident #12"s care plan dated 6/26/2026 revealed, Resident is incontinent of bowel and requires assistance with toileting tasks due to but not limited to decreased mobility and impaired cognition. Potential for with history of constipation / loose stools. History of colon rectal cancer. check resident frequently throughout the day and as required / requested and assist with toileting as needed. toilet use: requires extensive x 1 staff assistance. resident is incontinent of bowel and bladder. potential for skin breakdown due to but not limited to decreased mobility, incontinence and impaired condition, the resident needs assistance to turn, reposition, frequently throughout the day and as requested. A record review of the State of Texas' website, the Texas Unified Licensure Information Portal for the facility's account, accessed 6/23/2026 revealed no investigation report for the alleged abuse, neglect, exploitation, or mistreatment on behalf of Resident #12 for the period of 6/1/2026 through 6/23/2026. During an interview on 6/24/2026 at 9:20 AM Resident #12 stated on June 17th, 2026, he was left in his feces for 2 hours, Resident #12 stated the time was after dinner and he became soiled with feces and ignited his call light. Resident #12 stated he had become frustrated and upset when he was left in that condition with no one responding to his calls when he recalled the Administrator had given him her cell phone number. Resident #12 stated he used his cell phone to call the Administrator. Resident #12 stated the Administrator received his call and within some minutes a CNA entered his room and confronted Resident #12 by stating you got me in trouble! and proceeded to provide rough hurried incontinent care. During an observation and joint interview on 6/24/2026 at 9:40 AM, revealed, the Administrator in Resident #30's room documenting Resident #30's interview. Resident #30 stated he used his cell phone to call the Administrator that he was left soiled in his feces for 2 hours. The Administrator stated Resident #30 called her on the evening of 6/17/2026 and stated he was left with his call light on for some time. A record review of Resident #12's grievance dated 6/24/2026 revealed an incident date of 6/17/2026. The Administrator documented, (Resident #12) was waiting for someone to change him. I quickly thanked him for letting me know and made sure someone went to take care of his needs. During a joint interview on 6/26/2026 at 3:35 PM with the DON and the Administrator; the DON responded to the question, what is the policy/process on reporting allegations of abuse/neglect/exploitation? the DON responded, the staff know to report immediately to the abuse coordinator and then the abuse coordinator immediately reports to the state; and the Administrator responded, We follow the state guidelines. The DON responded to the question are there any (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incidents/grievances/ allegations/ suspicions of abuse, neglect, or exploitation, that have not been reported? The DON responded, No, I think everything that should have been reported has been reported. The Administrator responded, With Resident #11, we weren't aware of her missing money, but we did report it once we knew. Resident #11 will tell everybody, she's very vocal and everybody knows. We find it odd that she didn't tell either of us because we've both spent time with her. The DON added, She spends a lot of time with the ADON and I talked to her on Friday and she didn't say anything about missing money. But it would have been reported, and we did report it yesterday. We interviewed CNA G, and she said in her statement but in her mind she thought it was from way back when, not that it had just happened. So, she thought it was in the past, like a long time ago. A record review of the facility's undated Abuse / Neglect policy revealed, The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the residents' medical symptoms. Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, . it is each individual's responsibility to recognize, report, and promptly investigate actual or alleged abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property, and situations that may constitute abuse or neglect to any resident in the facility. Reporting: . Facility employees must report all allegations of: abuse, neglect, exploitation, mistreatment of residents, misappropriation of resident property, or injury of unknown source to the facility Administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of provider letter 2024-14 dated 8/29/2024. If the allegations involve abuse or result in serious bodily injury, the report is to be made within two hours of the allegation. If the allegation does not involve abuse or serious bombing injury, the report must be made within 24 hours of the allegation.

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure at the time each resident was admitted , the facility had physician orders for the resident's immediate care, for 1 of 8 residents reviewed (Resident #30) for medications needed upon admission. Resident #30 was discharged from the hospital and admitted to the facility on [DATE] with an immediate need for anticoagulant medication which was not prescribed per the physicians' and manufactures' recommendations and resulted in Resident #30 missing 4 doses. This failure could place residents at risk of not receiving medications upon admission.The findings included: A record review of Resident #30's admission record dated 6/26/2026 revealed an admission date of 6/2/2026. Resident #30 had diagnoses which included emphysema (a progressive, irreversible lung disease where the tiny air sacs are gradually destroyed), cerebral infarction (stroke; a medical emergency that occurs when blood flow to an area of the brain is cut off or a blood vessel in the brain bursts), and cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body). A record review of Resident #30's admission MDS assessment dated [DATE] revealed Resident #30 was a [AGE] year-old female admitted for long term care with activities of daily life supports after a hospitalization for a suspected cardiovascular accident (a stroke). A record review of Resident #30's care plan dated 6/26/2026 revealed, Resident is on anticoagulant therapy . administer medications per medical doctor's orders. A record review of Resident #30's hospital medication discharge orders dated 6/2/2026 revealed the hospital physician prescribed for Resident #30 to receive an apixaban started pack upon admission to the facility. A record review of the medication apixaban's manufacturers website:https://www.eliquis.com/eliquis/hcp/dosing/dvt-peaccessed 6/26/2026, revealed an apixaban started pack was for patients to receive 2, 5mg tablets twice a day for 7 days and then to receive 1, 5mg tablet twice a day for the duration of their anticoagulant therapy. A record review of Resident #30 medication orders and the medication administration record for the period from 6/2/2026 through 6/23/2026 revealed that Resident #30 was not prescribed the apixaban as recommended by the physician and the manufactures' recommendations which resulted in Resident #30 missing 4 doses of apixaban 10mg on the following dates and times:On 6/3/2026 Resident #30 was not administered the morning 10mg dose.On 6/4/2026 Resident #30 was not administered the morning 10mg dose and evening 10mg dose.On 6/5/2026 Resident #30 was not administered the morning 10mg dose. During an interview on 6/26/2026 at 3:35 PM the DON was asked about the admission process to ensure newly admitted residents received their immediate need medications; the DON stated, there was a chart check that was performed by the ADON, and they follow a list of checks, so it covers the diet and things like that. The DON stated the ADON received the documents from the hospital and compared them with the facility physician orders, and if there was anything that needed to be clarified, then it would be clarified. The DON responded to the question How did the apixaban get missed?; the DON Responded, I wasn't involved in that . I wasn't aware that it had been missed. The DON stated the admission nurse was responsible for accurate transcribing of physicians' admission orders and the ADON was the second set of eyes to review the accuracy of physicians' orders. A record review of the facility's undated Resident Rights policy revealed, The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this policy. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life.

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	455536	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amistad Nursing and Rehabilitation Center	200 Riverside Drive Uvalde, TX 78801

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **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 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 3 of 5 residents (Residents #5, #76, and #77) reviewed for transmission-based precautions. The facility failed to ensure staff wore required PPE when providing assistance for Residents #76 and #77. The facility failed to ensure staff performed proper hand-hygiene when providing personal care for Resident #5. This failure could lead to the spread of infection. Findings included: 1.Record review of Resident #76's admission Record dated 6/24/2026 reflected a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included other diseases of stomach and duodenum [digestive tract]. Record review of Resident #76's Order Summary Report dated 6/24/2026 reflected the following physician's order dated 4/17/2026:Currently on transmission-based precautions related to positive test for clostridium difficile [a highly contagious bacterial infection of the digestive tract]. one time a day [sic]The resident is in a room by themselves, remained in their room and all care and services have been performed in the residents [sic] room during the last 24 hours? [sic] Record review of Resident #77's admission Record dated 6/25/2026 reflected a [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included malignant neoplasm of lateral wall of bladder [cancerous tumor in the bladder]. Record review of Resident #77's Order Summary Report dated 6/25/2026 reflected the following physician's order dated 6/24/2026:Currently on transmission-based precautions related to Diagnoses [sic] of Shingles [an infectious viral illness] every shift The [sic] resident is [NAME] room by themselves, remained in their room and all care and services have been performed in the residents [sic] room during the last 24 hours? [sic] In an observation on 6/25/2026 at 12:26 PM, Residents #76 and #77 were observed to have signage on their respective room doors that indicated both residents were on contact level of isolation. The signage instructed all staff to apple PPE, including a gown and gloves, prior to entering the room. CNA C was seen entering Resident #76 and #77's rooms at this time to deliver the lunch trays without donning PPE. CNA C entered Resident #76's room a second time to deliver a set of disposable silverware and assist Resident #77 with setting up her lunch tray. In an interview on 6/25/2026 at 12:30 PM, CNA C said she had delivered the lunch trays to Residents #76 and #77, and she said both residents required contact level of isolation precautions. She said she did not have to wear a gown or gloves when entering the rooms because contact isolation precautions allowed for staff to enter the room without PPE as long as close contact care was not being provided, such as when delivering a lunch tray. She said she had received training regarding PPE and transmission-based precautions during new hire training. She said the potential risk of not wearing PPE appropriately was the spread of infection. In an interview with the ADON on 6/25/2026 at 12:35 PM, she said all staff should don PPE prior to entering a room on contact level of isolation precautions, including delivering a lunch tray. In an Interview on 6/25/2026 at 1:00 PM with LVN J stated Resident #77 was on contact precautions and staff need to wear PPE to enter the room. Record review of the facility policy titled Transmission-based Precautions dated 2010 reflected the following: . Contact precautions require the use of appropriate PPE, including a gown and gloves upon entering the contact precaution room . 2. Record review of Resident #5's admission Record dated 6/26/2026 reflected a [AGE] year-old male admitted to the facility on [DATE]. Diagnoses included obstructive and reflux uropathy [difficulty or inability to completely eliminate urine from the body due to physical blockage]. Record review of Resident #5's quarterly MDS dated [DATE] reflected a BIMS score of 07, which indicated moderately impaired cognition. Section H0100A of the MDS indicated Resident #5 had an indwelling catheter at the time of the assessment. Record review of Resident #5's Order Summary Report dated 6/26/2026 reflected a physician's order dated 11/26/2024 that read as follows:Provide catheter care, clean perineal area with soap and water, pat dry every shift. Record (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of Resident #5's Care Plan Report undated/printed 6/26/2026 reflected the following focus area initiated 11/07/2024:Resident is on enhanced barrier precautions In an observation on 6/26/2026 at 12:10 PM, LVN B was observed performing indwelling catheter care for Resident #5. After donning PPE, including a disposable gown, disposable face mask, and disposable gloves, LVN B then lowered Resident #5's blankets and under garments to expose Resident #5's pelvis. LVN B did not change gloves or perform hand hygiene before touching Resident #5's genitals and catheter tubing. In an interview on 6/26/2026 at 12:24 PM, LVN B said he should have changed his gloves and sanitized his hands prior to initiating the care of the catheter. He said failing to do so could result in the spread of infection. He said he had received training on transmission-based precautions and hand hygiene but had forgotten to change gloves because he was nervous. In an interview with the DON on 6/26/2026 at 3:35 PM, she said the facility expectation is that staff will perform hand hygiene before beginning care of an indwelling catheter, including touching linens and repositioning a resident. She said the potential harm was the spread of infection. Record review of the facility policy titled Fundamentals of Infection Control Precautions dated 2016 reflected the following: . The following is a list of some situations that require hand hygiene: Before and after assisting a resident with personal care Before and after assisting a resident with toileting After handling soiled or used linens, dressings, bedpans, catheters and urinals .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observations, interviews, and record reviews, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition, for 1 of 1 facility kitchen reviewed for essential equipment. The facility's 1 of 1 dishwashing machine had a faulty temperature gauge which indicated safe operating temperatures.The facility's 1 of 1 plate warmer was malfunctioning and not operational for longer than a week. This failure could place residents at risk for food borne illness and cold food.The findings included: During an observation and interview on 6/23/2026 at 11:00 AM, revealed the kitchen's 1 of 1 electrical plate warmer was plugged into the electrical outlet but had room temperature plates stored within. DA H and [NAME] G stated the plate warmer was malfunctioning and had not warmed plates since last week or maybe prior. The FSM stated that the plate warmer had been documented in the facility's maintenance care program which alerted the Maintenance Director to the needed repair. During an observation and interview on 6/24/2026 at 11:37 AM, revealed the kitchen's 1 of 1 dishwasher had a temperature gauge which read 110F during operation and after operation. The FSM utilized a temperature gauge and demonstrated that the water temperature during operation was 122F . The FSM stated that the safe operating temperature was for the water to be over 120F . The FSM stated the temperature gauge was faulty, and he would have the Maintenance Director address the faulty gauge. During an interview on 6/24/2026 at 12:55 PM, the Maintenance Director stated he had not been notified of the faulty kitchen equipment. The Maintenance Director stated he reviewed the maintenance care database for the month of June 2026 which revealed no entries for the kitchen's plate warmer or the faulty dishwasher gauge. The Maintenance Director stated the state agency's observations he would take action to address the faulty equipment. The Maintenance Director stated that the potential negative impact to residents was cold plates and a faulty dishwasher temperature gauge. A record review of the facility's undated Preventive Maintenance policy revealed, The facility will ensure that a comprehensive preventive maintenance program is in place for essential operating equipment. Preventive maintenance will completed routinely and according to protocol by the Maintenance Supervisor or qualified designee. The facility will maintain documentation of all preventive maintenance.1. Preventive maintenance will be completed according to protocol outlines.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure the resident has a right to be treated with respect and dignity for 1 of 8 (Resident #51) residents reviewed for personal hygiene in that: Resident #51 had long strands of facial hair on upper lip and chin area, and she did wanted them shaved. This failure could affect all residents that did not want facial hair and could result in low self-esteem. The Findings: Record review of Resident #51's admission Record dated June 25, 2026, documented she was admitted on [DATE]. Her diagnoses included Parkinson's disease, muscle weakness, lack of coordination, dementia and anxiety. Record review of Resident #51's Quarterly MDS dated [DATE] documented she was usually able to make self- understood, she usually understands others and had a BIMs score of 9/15 (meant she was moderately cognitively impaired). She had impairment on one side to her upper extremity, she scored 8/8 for personal hygiene (meant not attempted due to medical condition or safety concerns). Record review of Resident #51's Care plan dated 4/16/2026 documented, The resident has an ADL Self Care Performance Deficit related to but not limited to Dementia, Parkinson's.Intervention, Personal Hygiene: the resident requires extensive assistance x1 assistance with personal hygiene care. The resident had impaired visual function and required eyeglasses. Intervention monitor for/record confounding problems: decline in cognitive status, decline in ADL. In an observation on 6/23/2026 at 11:45 AM, Resident #51's face had long facial hairs on her upper lip and chin area. In an observation on 6/24/2026 at 10:00 AM Resident 51's face had long facial hairs on her upper lip and chin area. In an observation on 6/25/2026 at 10:11 AM Resident #51's face had long facial hairs on her upper lip and chin area. In an interview on 6/25/2026 at 10:12 AM with Resident #51 stated she wanted her upper lip and chin to be shaved. Resident #51 stated she was not aware she had facial hair. Resident #51 stated staff have not offered to shave her upper lip or chin area. Resident #51 stated it made her feel like a man and does not want to have facial hair. She did not recall when the last time her facial hair was shaved by staff. In an interview on 6/26/2026 at 2:26 PM with the DON stated facial hair should be offered to be shaven and hair removed for both men and women by CNA's. The DON stated staff were to provide care and make sure this was in the care plan. The DON stated the harm for residents could be that it affects their self-image, insecurity and feeling clean. The DON was not aware of the facial hair for Resident #51. In an interview 06/25/2026 at 10:14 AM with CNA C confirmed Resident #51 had long strands of hair on her upper lip and chin hairs. CNA C stated she had not worked with Resident #51 for a while. CNA C stated she had offered to shave Resident #51 in the past. In an interview on 6/25/2026 at 5:41 PM with MDS LVN I stated Resident #51 was a 1 person assistance. MDS LVN I, I stated the grooming was making sure residents were clean, put deodorant on them, cleansing skin, clean face, oral care, personal hygiene, brushing hair, brushing teeth, and staff need to offer hair removal, if residents want it. MDS LVN, I stated oral or hygiene was important because residents have right to have their own grooming preferences. Record review of the policy on, Shaving, electrical/Safety Razors, (no date) documented Shape of the male (female) resident can be performed within metric for safety razor depending on the preference and availability of equipment. It is usually done as part of a daily personal hygiene, although every other day is sufficient for some based on the beard (hair) growth period it is done to promote cleanliness and a positive body image. Usually, the resident or staff person staff member performs the procedure, but the nurse can shave the resident illness and disability prevents independence. Goals: 1. the resident will experience cleanliness and comfort. 2.the resident will be free from infection 3. The resident will maintain intact skin integrity. Record review of the policy on, admission packet, dated November 20121, documented, Resident rights, residents of Texas nursing facilities have all the rights, benefits, responsibilities, and privileges granted by the constitution and laws of the state and the United States. They have the right to be free of (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interference, coercion, discrimination, and reprisal and exercising these rights as citizens of the United States. Dignity and respect, you have the right to; be treated with dignity, courtesy, consideration and respect. Freedom of choice, you have the right to; make your own choices regarding personal affairs, care, high benefits and services., refused to perform services for the person or facility providing services. Participation in your care, you have the right to; refuse treatment, care, or services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment for 4 of 8 (Residents #10, #51, #62, #75) residents reviewed for care plans. The facility failed to ensure Resident #10's care plan had discharge plans.The facility failed to ensure Resident #51's care plan had discharge plans.The facility failed to ensure Resident #62's care plan had discharge planThe facility failed to ensure Resident #75's care plan had discharge plans.This could affect residents and could result in residents not being educated on indwelling catheter positioning and residents not having a discharge plan or goal to set. The Findings: 1.Record review of Resident #10's admission Record dated 6/26/2026 revealed the resident was admitted on [DATE]. Resident #10 had diagnoses of paraplegia (paralysis of both lower limbs), lack of coordination, recurrent depressive disorder and moderate protein-calorie malnutrition. Record review of Resident #10's Comprehensive MDS dated [DATE] documented his BIMs score was 12/15 (moderate cognitive impairment). Record review of Resident #10's care plan dated 4/27/2026 did not include a discharge or staying at facility planning. 2.Record review of Resident #51's admission Record dated June 25, 2026, documented she was admitted on [DATE]. Resident #51 had diagnoses of Parkinson's disease, (a progressive neurodegenerative disorder characterized by tremors, muscular rigidity, postural instability, and loss of dopamine-producing neurons in the substantia nigra, often with Lewy bodies present in the brainstem) muscle weakness, lack of coordination, dementia and anxiety. Record review of Resident #51's Quarterly MDS dated [DATE] documented she was usually able to make self- understood, she usually understands others, BIMs score of 9/15 (moderately cognitively impaired). Record review of Resident #51's Care plan dated 4/16/2026 did not include a care plane for discharge or staying at facility planning. 3. Record review of Resident #62's admission Record dated 6/25/2026 documented she was admitted on [DATE] and re-admitted on [DATE]. Resident #62 had medical diagnoses of muscle wasting, dementia, diabetes II, (a chronic condition where the body does not produce enough insulin or the cells become resistant to insulin,) and chronic kidney disease. Record review of Resident #62's Comprehensive MDS dated [DATE] documented her BIMS score was 7/15 (sever cognitive impairment).Record review of Resident #62's Care Plan dated 6/24/2026 did not include a care plan for discharge or staying at facility planning. 4. Record review of Resident #75's admission Record dated 6/26/2026 documented she was admitted [DATE], re-admitted [DATE]. Her diagnoses included diabetes II, weakness, lack of coordination, and dependence of renal dialysis. Record review of Resident #75's Quarterly MDS dated [DATE] revealed her BIMS score was 8/15 (moderate cognitive impairment).Record review of Resident #75's care plan dated 5/5/2026 did not include a care plan for discharge or staying at facility planning. Interview on 6/25/2026 at 5:58 PM with MDS nurse stated she was not sure why Residents #10, # 51, 62 and #75 did not have care plan for discharge or staying at facility care planning. MDS stated all residents should have documented discharge or staying at facility planning.In an interview on 6/26/2026 at 2:26 PM with the DON stated all residents should have documented for discharge or staying at facility planning. The DON stated could result in staff not knowing resident preference.Record review of policy, The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan will describe the following: The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's goals for admission and desired outcomes, and the resident's preference and potential for future discharge. Discharge plans in the comprehensive care plan, as appropriate.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain grooming, and personal and oral hygiene for 1 of 8 (Resident #51) residents reviewed for personal hygiene in that: 1.Resident #51 had long strands of facial hair on upper lip and chin area, that she wanted staff to shave her.2. Resident #51 had not cleaned her teeth in the last 3 days of surveyor observations. This failure could affect all residents that did not want facial hair, wanted to have clean teeth and could result in low self-esteem. The Findings:Record review of Resident #51's admission Record dated June 25, 2026, documented she was admitted on [DATE]. Resident #51 had diagnoses of Parkinson's disease, (a progressive neurodegenerative disorder characterized by tremors, muscular rigidity, postural instability, and loss of dopamine-producing neurons in the substantia nigra, often with Lewy bodies present in the brainstem) muscle weakness, lack of coordination, dementia and anxiety. Record review of Resident #51's Quarterly MDS dated [DATE] documented she was usually able to make self- understood; she usually understands others and had a BIMs score of 9/15 (meant she was moderately cognitively impaired). She had impairment on one side to her upper extremity; she scored 8/8 for personal hygiene (meant not attempted due to medical condition or safety concerns). Record review of Resident #51's Care plan dated 4/16/2026 documented, The resident has an ADL Self Care Performance Deficit related to but not limited to Dementia, Parkinson's.Intervention, Personal Hygiene: the resident requires extensive assistance x1 assistance with personal hygiene care. The resident had impaired visual function and required eyeglasses. Intervention monitor for/record confounding problems: decline in cognitive status, decline in ADL. In an observation on 6/23/2026 at 11:45 AM, Resident #51's face had long facial hairs on her upper lip and chin area. In an observation on 6/24/2026 at 10:00 AM Resident 51's face had long facial hairs on her upper lip and chin area. In an observation on 6/25/2026 at 10:11 AM Resident #51's face had long facial hairs on her upper lip and chin area. In an interview on 6/25/2026 at 10:12 AM with Resident #51 stated she wanted her upper lip and chin to be shaved. Resident #51 stated she was not aware she had facial hair. Resident #51 stated staff have not offered to shave her upper lip or chin area. Resident #51 stated it made her feel like a man and does not want to have facial hair. She did not recall when the last time her facial hair was shaved by staff. In an interview on 6/26/2026 at 2:26 PM with the DON stated facial hair should be offered to be shaven and hair removed for both men and women by CNA's. The DON stated staff were to provide care and make sure this was in the care plan. The DON stated the harm for residents could be that it affects their self-image, insecurity and feeling clean. The DON was not aware of the facial hair for Resident #51. In an interview 06/25/2026 at 10:14 AM with CNA C confirmed Resident #51 had long strands of hair on her upper lip and chin hairs. CNA C stated she had not worked with Resident #51 for a while. CNA C stated she had offered to shave Resident #51 in the past. In an interview on 6/25/2026 at 5:41 PM with MDS LVN I stated Resident #51 was a 1 person assistance. MDS LVN I, I stated the grooming was making sure residents were clean, put deodorant on them, cleansing skin, clean face, oral care, personal hygiene, brushing hair, brushing teeth, and staff need to offer hair removal, if residents want it. MDS LVN, I stated oral or hygiene was important because residents have right to have their own grooming preferences. Record review of the policy on, Shaving, electrical/Safety Razors, (no date) documented Shape of the male (female) resident can be performed within metric for safety razor depending on the preference and availability of equipment. It is usually done as part of a daily personal hygiene, although every other day is sufficient for some based on the beard (hair) growth period it is done to promote cleanliness and a positive body image. Usually, the resident or staff person staff member performs the procedure, but the nurse can shave the resident illness and disability prevents independence. Goals: 1. the residents will experience cleanliness and comfort. 2.the resident will be free from infection 3. The resident will maintain intact skin integrity. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the policy on, admission packet, dated November 20121, documented, Resident rights, residents of Texas nursing facilities have all the rights, benefits, responsibilities, and privileges granted by the constitution and laws of the state and the United States. They have the right to be free of interference, coercion, discrimination, and reprisal and exercising these rights as citizens of the United States. Dignity and respect, you have the right to; be treated with dignity, courtesy, consideration and respect. Freedom of choice, you have the right to; make your own choices regarding personal affairs, care, high benefits and services., refused to perform services for the person or facility providing services. Participation in your care, you have the right to; refuse treatment, care, or services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455536	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Amistad Nursing and Rehabilitation Center	200 Riverside Drive Uvalde, TX 78801

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 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 drugs used in the facility were labeled in accordance with currently accepted professional principles for 1 of 4 medication carts (E-Hall medication cart) reviewed for medication storage. The facility failed to ensure 2 insulin pens in the E-Hall medication cart were labeled with the date opened. This failure could result in residents receiving expired insulin, leading to uncontrolled blood sugar levels. Findings included:In an observation and interview on [DATE] at 10:01 AM, 2 insulin pens were observed in the E-Hall medication cart without dates indicating when they were opened. MA A said she thought the pens were removed from the refrigerator storage by the overnight nurse because all of the pens were dated when she worked the day prior. She said the facility policy was to date all insulins at the time they are removed from the fridge, and the potential harm was not knowing if the insulin is expired. In an interview with the DON on [DATE] at 3:35 PM, she said the facility policy is to date all insulins immediately upon removal from the refrigerator. She said the potential harm was administration of expired insulin to residents. Record review of the facility policy titled Medication Labels dated 2025 reflected the following:Medications are labeled in accordance with facility requirements, state, and federal laws.

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	455536	A. Building B. Wing	06/26/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews of the facility failed to ensure therapeutic diets must be prescribed by the attending physician for 1 resident of 1 (Resident #62) in that: Resident #62 did not have her ice cream cup with her meal tray. This could affect all residents that get a meal tray and could cause residents to lose weight. The Findings: Record review of Resident #62's admission Record dated 6/25/2026 revealed she was admitted on [DATE] and re-admitted on [DATE]. Resident #62 had medical diagnoses of muscle wasting, dementia, diabetes II, and chronic kidney disease. Record review of Resident #62's Comprehensive MDS dated [DATE] revealed her BIMS score was 7/15 (severe cognitive impairment), and she required supervision or touching assistance with eating; and had no weight loss. Record review of Resident #62's consolidated orders for June 2026 revealed she had a regular diet with mechanical soft, ground texture, and ice cream for lunch and dinner. Record review of Resident #62's Care Plan dated 6/24/2026 revealed, Potential for altercation in nutrition and weight loss due but not limited to resident requires a therapeutic and mechanically altered diet. History of significant weight loss. Interventions serve diet as ordered, and regular diet, Mechanical ground meat texture, regular consistency ice cream with lunch and dinner. In an observation and review on 6/23/2026 at 12:15 PM during lunch, revealed Resident #62's lunch card had typed on it a 4 oz ice cream cup. Resident #62 did not have ice cream on her lunch tray. In an observation on 6/23/2026 at 12:16 PM revealed LVN J helping her cut her steak. The resident did not have an ice cream cup on her plate. Interview on 6/23/2026 at 12:17 PM with LVN J confirmed that Resident #62 did not have an ice cream on her lunch tray as ordered. In an observation on 6/25/2026 at 2:24 PM revealed Resident #62 was not served ice cream with her lunch meal.In an interview on 6/25/2026 at 2:54 PM the FSM stated ice cream should be on the tray for Resident #62 when served her meal. The FSM stated he would talk to staff to make sure Resident #62 gets her ice cream with her meal tray. Interview on 6/26/2026 at 2:26 PM the DON stated Resident #62 should have ice cream on her meal tray and ordered ice cream for weight loss. The DON stated this could cause residents to not get what the physician ordered. Record review of policy, Dietary [NAME] Policy and Procedures [NAME] 2012 revealed to ensure correct understanding our interpretation of therapeutic diets, all diets are ordered as stated in the diet menu. The physician will prescribe diets in accordance with concrete diet meaning. A written order must appear on the medical record before the resident may be served.

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	455536	A. Building B. Wing	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure the facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from Each resident's bedside for 1 of 8 (#51) resident with call system in that: Resident #51's call light was not working when she was lying in bed. This failure could affect all residents with call lights at bedside and could result in call light not being answered and causing further harm. The Findings: Record review of Resident #51's admission Record dated 06/25/2026 revealed she was admitted on [DATE], with diagnoses of Parkinson's disease, muscle weakness, lack of coordination, dementia and anxiety. Record review of Resident #51's Quarterly MDS dated [DATE] revealed she was usually able to make herself- understood, she usually understood others and her BIMs score was 9/15 (meant she was moderately cognitively impaired). Resident #51 used a wheelchair to mobilize and she had impairment on one side to her upper extremity. Record review of Resident #51's care plan dated 4/16/2026 revealed, The resident has an ADL Self Care Performance Deficit related to but not limited to Dementia, Parkinson's. The resident had impaired visual function and required eyeglasses. Intervention monitor for/record confounding problems: decline in cognitive status, decline in ADL, deterioration, oral motor function, poor fitting/missing dental appliances, and ensure/provide a safe environment: call light in reach, be sure resident call light within reach and encourage resident to use it for assistance as needed. In an observation on 6/25/2026 at 10:12 AM revealed that Resident #51 pushed the call light, and it did not work when resident pushed it. Further observations, revealed the light on the hall did not light up. In an interview on 6/25/2026 at 10:13 AM Resident #51 stated sometimes staff did not come when she pushed the call light, this did not cause harm. In an interview on 6/25/2026 at 10:14 AM CNA C confirmed when she pushed the call light it was not working. In an interview on 6/25/2026 at 2:45 PM the Maintenance Supervisor stated he was not aware Resident #51's call light was not working. In an interview on 6/26/2026 at 2:26 PM the DON stated she was not aware that Resident #51 call lights did not work. The DON stated because Resident #51's call light did not work that could cause a decrease in care and staff not being aware residents needed assistance. Record review of an email from the ADM, dated 6/26/2026 at 1:10 PM, revealed there was no policy for call lights.