STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455675	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Amarillo Rehabilitation and Nursing Ce	5601 Plum Creek Dr Amarillo, TX 79124

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all residents had a right to a dignified existence for 1 of 24 residents (Resident #56) observed for dining room experience when the facility failed to: Ensure Resident #56 was treated with respect, dignity and consideration when she failed to receive her noon meal at the same time as her table mates. This failure could place residents at risk of feeling neglected or ignored and could negatively impact residents' quality of life. Findings included:Resident #56 was a 95-y o female admitted to the facility on [DATE] with diagnoses of dementia (a decline in mental ability), diabetes (a condition causing high blood sugar due to insufficient insulin production), dysphagia- oropharyngeal type (difficulty initiating a swallow, moving food from the mouth to the throat), Vitamin B deficiency ((when the body lacks sufficient B vitamins needed for metabolism, red blood cell production and nerve function), Vitamin D vitamin deficiency causing weak or brittle bones, muscle weakness and chronic fatigue) and Vitamin D deficiency (when the body lacks sufficient Vitamin D causing weak or brittle bones, muscle weakness and chronic fatigue). A Care Plan dated 1/1/26 documented resident was independent in most ADLs, wanders and is at risk for falls. A Quarterly MDS dated [DATE] documented a BIMS score of 5 out of 15 which indicates cognition is severely impaired. The MDS documented Resident #56 usually understood what was said to her and was usually understood. The MDS documented Resident # 56 was 57 inches tall and weighed 108 pounds. Resident #56 had not had any weight loss in the past 6 months. In an observation on 3/24/26 at 12:00 pm, Resident #56 did not receive her food at the same time as her tablemates. Further observation revealed Resident #56 sat at the table at the same time the other 2 tablemates were seated. The other 2 tablemates received their trays and began eating. Resident # 56 was not served the lunch meal until after the 2 tablemates and 2 other tables of 4 residents each had gotten their food. In an interview on 3/25/26 at 2:50 pm Resident # 56 stated she was in the dining room and the residents at her table all had their food except her. She stated she felt left out and had been wondering why she did not get her food. She stated she thought she might not get to eat.In an interview on 3/26/26 at 10:15 am, the DM stated she had not been aware Resident #56 had not received her tray at the same time as the rest of the residents at her table. The DM stated all residents at a table should be served at the same time. She stated the consequences of not serving all residents at the table at the same time could be residents feeling left out of the group. Record review of the facility's policy titled, ' Nursing Responsibilities at Meal Service ' dated 2012, documented: A tray sequence is used in dining rooms so all residents at a table are served at the same time. Record review of the facility's policy titled, ' Resident Rights documented Residents have the right to be treated with dignity, courtesy, consideration and respect.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe and clean environment for 1 (Resident #59) of 17 residents reviewed for environment. -Resident #59 had soiled washcloths left in her room for 29 hours. This failure could place residents at risk for diminished quality of life due to the lack of a well-kept environment.Findings included:Record review of Resident #59's face sheet revealed she was a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), seizures (sudden, uncontrolled body movements and changes in behavior that occur because of abnormal electrical activity in the brain), hemiplegia (a condition characterized by sever or completed paralysis on once side of the body, typically resulting from brain damage), and depressive disorder (a common, serious mental health condition characterized by persistent sadness, loss of interest in activities, and low energy, lasting at least two weeks). Record review of Resident #59's quarterly MDS assessment completed 2/18/26 listing her with a BIMS of 07 indicating she was severely cognitively impaired, and she had a functionality of being dependent on staff for most of her activities of daily living. Record review of Resident #59's care plan with admission date of 9/01/24 revealed the following: Focus: Resident has a behavior problem: History of finger-painting feces Date Initiated: 05/01/2024Intervention: Check often for position/cleanliness. Date Initiated: 05/01/2024 During an observation on 03/24/2026 at 09:21 AM Resident #59 was in her room, in her bed under her covers. Resident #59 was awake and alert. Resident #59 had difficulty with speech but was able to report she was pleased with her care. Resident #59 then went back to watching TV and did not respond to any further questions. Several used washcloths were observed in a brown bin in the shower in her room. During an observation on 03/24/2026 at 11:37 AM the used washcloths continued to be in the bathroom in the brown bin. They were observed to be white washcloths with a slight brown discoloration. During an observation on 03/24/2026 at 1:54 PM Resident #59 was observed leaving her room by wheelchair with the assistance of a staff member. Upon observation, the used slightly brown stained washcloths continued to be in the shower in her room. Between 03/24/2026 at 3:21 PM and 03/25/2026 at 1:45 PM the slightly brown stained washcloths were observed 3 times in Resident #59's shower in her room. During an observation on 03/25/2026 at 2:24 PM this surveyor observed Resident #59's room/shower with the CN and noted the soiled washcloth to be present in the shower. The CN stated the soiled washcloths were an issue, she did not even know why they were in the shower because this shower was not used for resident care, and they (the soiled washcloths) should have been removed. During an interview on 03/25/2026 at 2:48 PM LVN I (the nurse responsible for providing care for Resident #59 this shift) reported if a resident had dirty washcloths in their room and she saw them she would remove them. LVN I reported the soiled washcloths should have been removed because they were dirty. LVN I reported if they are not removed then cross-contamination can occur, germs can occur, and it was just nasty. During an interview on 03/26/2026 at 9:12 AM CNA H (the CNA responsible for providing care for Resident #59 this shift) reported they make rounds every 2 hours and they check the room for cleanliness. CNA H reported if the room was left unclean then the resident could develop an illness. During an interview on 03/26/2026 at 9:49 AM the DON reported staff, especially the CNAs, should make rounds every two hours and they should make sure that the resident's room was clean, tidy, and had no trash. The DON reported that if the room was not clean it could affect the resident's mental condition and violate infection control. Record review of the facility provided policy titled, Fundamentals of Infection Control Precautions Infection Control Policy & Procedure Manual undated, revealed the following: Linen and laundry:1. All soiled linen will be double bagged at the site that it was generated.2. Soiled linen will be transported to the laundry site by cart. Record review of the facility provided policy (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled, Resident Rights undated, revealed the following: The resident has a right to a dignified existence.The 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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the assessment accurately reflected the resident's status for 2 (Resident #18 and Resident #71) of 18 residents reviewed for accuracy of assessment.The facility inaccurately coded Resident #18 as having a bipolar diagnosis when he did not have a bipolar diagnosis.This failure could place residents at risk of receiving unnecessary care/medication or not receiving necessary care/medication.Findings Included:Record review of Resident #18's admission record dated 03/25/26 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Parkinson's disease (chronic and progressive movement disorder that initially causes tremors in one hand and stiffness or slowing of movement), dementia (a group of thinking and social symptoms that interferes with daily functioning), and anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life). The admission record did not reveal a diagnosis of bipolar disorder.Record review of Resident #18's significant change MDS assessment completed on 01/25/26 revealed a BIMS of 6 which indicated severely impaired cognition. Section I Active Diagnoses in the Last 7 Days revealed he had a diagnosis of bipolar disorder.Record review of Resident #18's care plan completed on 01/25/26 revealed no mention of bipolar disorder.Record review of Resident #18's diagnosis report dated 03/25/26 revealed no mention of bipolar disorder.During an interview on 03/26/26 at 08:58 AM RN D stated MDS RN was responsible for completing MDS assessments. She stated an inaccurate MDS assessment could negatively affect a resident because a lot of times the doctors use it and nurses use it and it can give you an incorrect clinical depiction of your resident. They might not be getting the care they need.During an interview on 03/26/26 at 09:03 AM ADON stated MDS RN was responsible for completing MDS assessments. She stated if an MDS assessment was inaccurate some level of care (for the resident) might be missed.During an interview on 03/26/26 at 09:05 AM DON stated MDS RN was responsible for completing MDS assessments. She stated if an MDS assessment was inaccurate it would cause the care plan to be inaccurate and residents might not receive needed care.During an interview on 03/26/26 at 09:09 AM ADM stated MDS RN was responsible for completing MDS assessments. She stated if an MDS assessment was inaccurate residents might not receive care or services they needed.During an interview on 03/26/26 at 9:10 AM CN stated MDS RN was responsible for completing MDS assessments. She stated if an MDS assessment was inaccurate residents might not receive the care they needed.During an interview on 03/26/26 at 09:17 AM MDS RN stated she was responsible for completing MDS assessments. She stated she used the RAI manual as her policy for completing MDS assessments. The MDS RN stated she was not sure why Resident #18 was coded as having bipolar disorder. MDS RN stated an inaccurate MDS assessment could affect facility funding. She stated she did not believe an inaccurate MDS assessment would negatively affect resident care because the facility would treat the resident regardless of funding.Record review of the facility provided policy titled, Documentation, revealed the following in part. Goal:1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets.Record review of the Long-Term Care Facility RAI 3.0 User's Manual Version 1.20.1 dated October 2025 revealed the following: . SECTION I: ACTIVE DIAGNOSES Intent: The items in this section are intended to code diseases that have a direct relationship to the resident's current functional status, cognitive status, mood, or behavior status, medical treatments, nursing monitoring, or risk of death. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status. Once a diagnosis is identified, it must be determined if the diagnosis is active. Active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to refer to the state designated authority all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment for 1 (Resident #9) of 18 residents reviewed for PASRR.The facility failed to refer Resident #9 to the state designated authority for a PASRR Evaluation due to his diagnosis of Major Depressive Disorder Recurrent Severe.This failure could place residents at risk of not receiving necessary services or of being harmed by residents who have not been screened properly for placement in a nursing home setting.Findings Included:Record review of Resident #9's admission record dated 03/25/26 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, personal history of traumatic brain injury and major depressive disorder recurrent severe (a mental disorder characterized by persistent low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities).Record review of Resident #9's diagnosis report dated 03/25/26 revealed he received a diagnosis of major depressive disorder recurrent severe on 02/28/25.Record review of Resident #9's quarterly MDS assessment completed on 02/02/26 revealed a BIMS score of 6 which indicated severely impaired cognition. Section I Active Diagnoses revealed he had a diagnosis of depression.Record review of Resident #9's care plan completed on 02/05/26 revealed no mention of major depressive disorder but did note Resident #9 was being monitored for side effects of several medications one of which was antidepressant medication.Record review of Resident #9's active orders dated 03/25/26 revealed no orders for antidepressant medication.Record review of Resident #9's discontinued, struck out, completed orders revealed the following antidepressant medication orders and corresponding start dates:02/28/25 Duloxetine HCl Capsule Delayed Release Particles 60 MG Give 1 capsule by mouth one time a day for depression related to MAJOR DEPRESSIVE DISORDER, RECURRENT SEVERE.03/28/25 Mirtazapine Oral Tablet 15 MG . Give 1 tablet by mouth at bedtime related to MAJOR DEPRESSIVE DISORDER, RECURRENT SEVERE .06/13/25 Mirtazapine Oral Tablet 30 MG . Give 1 tablet by mouth at bedtime for Depression07/11/25 Mirtazapine Oral Tablet 45 MG . Give 45 mg by mouth one time a day related to MAJOR DEPRESSIVE DISORDER, RECURRENT SEVERE .09/20/25 Sertraline HCl Oral Tablet 50 MG . Give 1 tablet by mouth one time a day related to MAJOR DEPRESSIVE DISORDER, RECURRENT SEVERE .10/31/25 Sertraline HCl Oral Tablet 100 MG . Give 100 mg by mouth one time a day related to MAJOR DEPRESSIVE DISORDER, RECURRENT SEVERE .Record review of Resident #9's EHR under the miscellaneous tab revealed one PASRR screening and no Form 1012 (a form used to determine if a resident is eligible for PASRR services based on a new diagnosis).Record review of Resident #9's PASRR Level 1 Screening dated 12/09/24 revealed he was negative for mental illness.During an interview on 03/26/26 at 08:58 AM RN D stated not having a new PASRR screening following a qualifying diagnosis could negatively impact resident care. She stated, We have to reassess and make sure we are meeting their needs.During an interview on 03/26/26 at 09:03 AM ADON stated MDS RN was responsible for ensuring PASRRs were completed. She stated not having a new PASRR screening following a qualifying diagnosis could probably negatively impact resident care. She stated, Their mental health or condition might be overlooked or misunderstood.During an interview on 03/26/26 at 09:05 AM DON stated MDS RN was responsible for ensuring PASRRs were completed. She stated not having a new PASRR screening following a qualifying diagnosis could negatively impact resident care. She stated the care plan might not be as good as it could be if a new PASRR screening was not completed.During an interview on 03/26/26 at 09:09 AM ADM stated MDS RN was responsible for ensuring PASRRs were completed. She stated not having a new PASRR screening following a qualifying diagnosis could negatively impact resident care due to missed care/missed (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services.During an interview on 03/26/26 at 09:10 AM CN stated not having a new PASRR screening following a qualifying diagnosis could negatively impact resident care. She stated, We could not provide all the services they might quality for.During an interview on 03/26/26 at 09:17 AM MDS RN stated she was responsible for ensuring PASRR screenings were done as needed after admission. She stated she did not think a resident's care would be negatively impacted if they did not receive a new PASRR screening because residents with mental illness received in-house treatment. Regardless of whether or not they have the positive on the PASRR they still receive the services in the building. MDS RN stated without a new PASRR screening the residents would not be offered the opportunity to get outside services.During an interview on 03/26/26 at 09:41 AM PC stated residents might not get needed care if they do not receive a new PASRR screening following a qualifying diagnosis. She stated the facility could enter a change of condition into the system rather than performing a new PASRR screening and that would alert her to call and find out what the change was and if it qualified the resident for services or not.Record review of an undated facility policy titled Form 1012 Policy and Procedure with Instructions revealed the following: . Form 1012 assists nursing facilities (NF) in determining whether a resident with a negative Preadmission Screening and Resident Review (PASRR) Level 1 (PL1) Screening form . needs further evaluation for Mental Illness (MI). When to Prepare The NF completes Form 1012 following: . An individual's diagnosis is changed. Depression, unless diagnosed as major depressive disorder in the medical record by the physician is not considered a mental illness.Record review of facility policy titled, PASRR Level 1 Screen Policy and Procedure and dated 03/06/19 revealed no information on what to do if an individual receives a qualifying diagnosis after admission.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to perform a preadmission screening for individuals with a mental disorder and individuals with intellectual disability for 1 (Resident #18) of 18 residents reviewed for preadmission screening.The facility failed to ensure an accurate PL1 for Resident #18 prior to her admission on [DATE]. She was coded as not having mental illness when she did have mental illness.This failure could place residents at risk of not receiving needed services.Findings Included:Record review of Resident #18's admission record dated 03/25/26 revealed a [AGE] year-old female admitted to the facility with diagnoses that included, but were not limited to, schizoaffective disorder bipolar type (mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder), generalized anxiety disorder (inability to control constant worrying), and major depressive disorder single episode (a mental disorder characterized by persistent low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities). The date of her schizoaffective disorder bipolar type diagnosis was 08/12/25. The date of her generalized anxiety disorder diagnosis was 08/14/25. The date of her major depressive disorder single episode diagnosis was 08/14/25.Record review of Resident #18's quarterly MDS completed on 01/24/26 revealed a BIMS of 12 which indicated moderately impaired cognition. Section I Active Diagnoses coded Resident #18 as having anxiety disorder, depression, and schizophrenia.Record review of Resident #18's care plan completed on 02/10/26 revealed the following: The resident has depression r/t SCHIZOPHRENIA . The resident requires antidepressant medication . The resident requires anti-psychotic medications . The resident uses anti-anxiety medications .Record review of Resident #18's active orders dated 03/25/26 revealed the following orders with corresponding start dates:03/11/26 Ariprazole Oral Tablet 30 MG . Give 30 mg by mouth at bedtime related to SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE .11/11/25 Divalproex Sodium ER Oral Tablet Extended Release 24 Hour 500 MG . Give 3 tablet by mouth at bedtime related to SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE .Record review of Resident #18's EHR under the miscellaneous tab revealed one PL1.Record review of Resident #18's PL1 revealed it was completed by her family member and she was coded as having no mental illness.During an interview on 03/26/26 at 08:58 AM RN D stated an inaccurate PL1 at admission could negatively impact resident care. She stated, We have to reassess and make sure we are meeting their needs.During an interview on 03/26/26 at 09:03 AM ADON stated MDS RN was responsible for ensuring PASRRs were completed. She stated an inaccurate PL1 at admission could probably negatively impact resident care. She stated, Their mental health or condition might be overlooked or misunderstood.During an interview on 03/26/26 at 09:05 AM DON stated MDS RN was responsible for ensuring PASRRs were completed. She stated an inaccurate PL1 at admission could negatively impact resident care. She stated the care plan might not be as good as it could be if the PL1 at admission was inaccurate.During an interview on 03/26/26 at 09:09 AM ADM stated MDS RN was responsible for ensuring PASRRs were completed. She stated an inaccurate PL1 could negatively impact resident care due to missed care/missed services.During an interview on 03/26/26 at 09:10 AM CN stated an inaccurate PL1 could negatively impact resident care. She stated, We could not provide all the services they might quality for.During an interview on 03/26/26 at 09:17 AM MDS RN stated she and AC were responsible for ensuring PL1s were completed at or prior to admission. She stated she did not think a resident's care would be negatively impacted if their PL1 was inaccurate because residents with mental illness received in-house treatment. Regardless of whether or not they have the positive on the PASRR they still receive the services in the building. MDS RN stated if a PL1 was inaccurate, residents would not be offered the opportunity to get outside services.During an interview on 03/26/26 at 09:26 AM AC stated she gets the PL1 from the RE and sends it with all of the other admission paperwork to MDS RN. AC stated she does not check the PL1 against the resident's diagnoses to ensure accuracy.During an interview on (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/26/26 at 09:41 AM PC stated residents might not get needed care if their PL1 was inaccurately coded.Record review of an undated facility policy titled Form 1012 Policy and Procedure with Instructions revealed the following: .Depression, unless diagnosed as major depressive disorder in the medical record by the physician is not considered a mental illness.Record review of facility policy titled, PASRR Level 1 Screen Policy and Procedure and dated 03/06/19 revealed the following: . Procedure 1. The Facility Admissions process will ensure a PL1 Screening Form is obtained from the RE on day of admission or prior to admission. 3. The Facility will review the PL1 Screening Form for completion and correctness prior to admission . review each item on the PL1 to ensure accuracy and prevent a regulatory problem. 7. The facility will maintain PL1 Best Practices as follows: . Review the PL1 form for completion and correctness before admission.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who required respiratory care were provided such care consistent with professional standards of practice for 1 (Resident #5) of 18 residents reviewed for respiratory care.Resident #5 did not have physician orders for oxygen therapy. This failure had the potential to affect residents by placing them at risk for respiratory compromise and associated complications, including shortness of breath, confusion, respiratory failure, infection, and exacerbation of their condition.Findings included: Record review of Resident #5's clinical record revealed a [AGE] year-old female resident admitted to the facility on [DATE] with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD refers to a group of diseases that cause airflow blockage and breathing-related problems), type 2 diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), dementia (a group of thinking and social symptoms that interferes with daily functioning), myocardial infarction (heart attack), acute on chronic diastolic (congestive) heart failure (heart failure where the heart muscle is stiff and cannot fill properly) and morbid obesity. Record review of Resident #5's clinical record revealed the most recent MDS, a significant change assessment completed 03/12/2026 indicated a BIMS score of 10, reflecting moderate cognitive impairment. The assessment further indicated that the resident required substantial to maximal assistance with most activities of daily living. Section O (Special Treatments, Procedures, and Programs) documented that Resident #5 was not receiving oxygen therapy while a resident. Record review of the Order Summary, printed on 03/25/2026, revealed no physician orders for oxygen therapy.Record review of the Medication Administration Record, printed on 03/26/2026 for the period of 03/01/2026 through 03/31/2026, revealed no orders or documentation for oxygen administration, including flow rate or dosage.Record review of the O2 Saturation Summary, printed on 03/25/2026 and covering the period of 12/25/2025 through 03/25/2026, revealed documentation on 03/21/2026 through 03/25/2026 indicating oxygen was administered via nasal cannula.Record review of Resident #5's care plan, last reviewed on 03/24/26, revealed the following: Focus: resident has shortness of breath at times related to COPD. Interventions: Give oxygen therapy as ordered by the physician. During an observation and attempted interview on 03/24/26 at 9:17 AM, Resident #5 was observed sitting in a recliner receiving O2 via a N/C at 2 lpm and was unable to answer questions. During an observation on 03/24/26 at 12:05 PM, Resident #5 was observed at lunch receiving O2 via N/C. During an observation on 03/25/26 at 2:52 PM, Resident #5 was observed lying in bed, on her back asleep, receiving O2 via a N/C at 2 lpm. During an observation on 03/26/26 at 9:37 AM Resident #5 was observed lying in bed receiving O2 via a N/C. During an interview on 03/26/26 at 9:39 AM, CNA F stated that she had been working at the facility since 2022 and nurses were responsible for setting flow rates. She stated a potential negative outcome for administering O2 without orders included the resident receiving too much or too little oxygen. During an interview 03/26/26 at 9:41 AM LVN E stated there were no orders for O2 for Resident #5 and that the resident was just put on hospice which may be why there was not an order. She stated that O2 was considered medication and physicians orders were required. LVN E further stated staff would not know the correct flow rate without orders and would be unable to appropriately monitor the resident.During an interview on 03/26/2026 at 9:47 AM, LVN G stated she was the charge nurse for the unit that Resident #5 resided on currently. She stated a potential negative outcome of administering oxygen without an order included adverse reactions due to the absence of a baseline for comparison.During an interview on 03/26/2026 at 9:55 AM, the DON stated oxygen was considered a medication and should not be administered without a physician's order. The DON stated a potential negative outcome included unnecessary oxygen use and possible dependency.Record review of the facility provided policy titled, Oxygen Administration, not dated, revealed the following: The amount of oxygen by percent of concentration or lpm, and the method of administration, is ordered by the (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Amarillo Rehabilitation and Nursing Ce	5601 Plum Creek Dr Amarillo, TX 79124

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician.Goals:1. The resident will maintain oxygenation with safe and effective delivery of prescribed oxygen. Record review of the facility provided policy titled, Documentation, not dated, revealed the following in part. Goal:1. The facility will maintain complete and accurate documentation for each resident on all appropriate clinical record sheets.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to prepare, and serve foods using methods to ensure palatability and flavor for 1 of 4 residents with a pureed diet (Resident #56) when they failed to: A. Ensure facility staff prepared pureed foods for meal service using standardized recipes, and nutritive methods to ensure palatability, flavor and meal satisfaction. These failures placed Reside1 of 4 residents who ate food that was pureed and served by the kitchen at risk of meal dissatisfaction and potential weight loss. Findings included: In an interview and observation on 3/24/26 at 11:00 am, [NAME] C measured 4 servings of green beans with juice, 7 ladles of gravy and 6 slices of bread into the blender. During the puree process another 3 slices of bread were added to the puree. [NAME] C pureed the beans then added 2 more slices of bread to the puree before completing the puree. During a taste test of the green beans the green beans tasted like bread with a hint of gravy to this writer. [NAME] C was asked to taste the green beans. She reluctantly tasted the green beans and stated, They are ok. When asked what she would normally use to thicken the food she stated she used gravy because it was already made. [NAME] C stated the thickener made the food taste funny. She stated she used bread to thicken most foods, so the food tasted better. When asked if she reviewed the puree recipes, she said no. An observation of the kitchen preparation area revealed there were no recipes out for review at the time of the food being pureed. In an observation and interview on 3/24/26 at 11:15 am, [NAME] C pureed the BBQ chicken. [NAME] C added more than 4 servings of BBQ chicken and turned the bottle of BBQ sauce upside down into the chicken and added an unmeasured amount of BBQ sauce. [NAME] C pureed the chicken and then added more BBQ sauce and 3 slices of bread to the chicken. [NAME] C pureed the meat again. [NAME] C added more BBQ sauce and 4 more slices of bread before completing the puree. During a taste test the BBQ had a strong overwhelming taste of BBQ sauce. [NAME] C appeared to reluctantly taste the chicken and stated it was ok. In an observation and interview on 3/24/26 at 11:35 am, [NAME] C stated she had finished pureeing the foods for the noon meal. [NAME] C was asked about pureeing the honey kissed rolls that were listed on the menu and that were observed sitting on the counter. [NAME] C stated, They (residents on a pureed diet) don't ask for bread. This writer asked [NAME] C if all the residents should get the same food listed on the menu as all residents on a regular diet. [NAME] C hesitated then stated yes, they should. [NAME] C then got a package of premade rolls and microwaved the package. [NAME] C then put the whole package of rolls into the blender, added 7 scoops of gravy to the rolls and pureed the rolls. [NAME] C added 5 more scoops of gravy and pureed the rolls again. During a taste test the bread tasted like gravy. [NAME] C stated she used gravy because it was already made. When asked what else she could use to puree the bread she stated she would use chicken broth. [NAME] C was asked if she had ever used milk to puree bread and she stated she had not. [NAME] C tasted the bread and stated she thought the bread tasted ok. The pureed bread tasted like gravy. In an interview on 3/25/26 at10:25 am, the RD stated purees should be thinned with chicken broth for chicken, juice from green beans or chicken broth. She stated bread should have milk added to it for thinning. She stated she was not sure about using gravy for green beans or bread. She stated that was not a usual thinner. She stated she was not sure about the taste of the food if gravy had been used. The RD stated measured amounts of liquids should be used to thin a puree only as needed and after an initial puree was conducted. She stated added liquids should be a last resort. The RD stated if green beans were drained properly there would be no need to add gravy or bread. She stated the cooks should use the fork test for consistency. In an interview on 3/25/26 at 2:50 pm Resident # 56, who had a pureed lunch meal, stated the bread had tasted like gravy and the chicken had too much BBQ sauce. She stated she did not like the green beans but ate them anyway. She stated the green beans had tasted like bread. In an interview on 3/26/26 at 10:15 am, the DM stated she had trained all cooks to pureed foods and to taste food after it is prepared to ensure quality. She stated she expected the cooks to taste the food after it was prepared to ensure the quality and taste (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was palatable. She stated she expected staff to take pride in serving quality meals to all residents. She stated foods should be pureed first with no added liquid and then small, measured amounts of liquid could be added as needed. The DM stated milk should be used for bread when pureeing bread. The DM stated it is preferable that the juices from the cooked foods should be used when possible before bread or gravy was used to ensure flavors were as close as possible to the food cooked. She stated the consequences of not preparing purees properly could be weight loss and meal dissatisfaction. She stated residents could also have poor meal experiences. Record Review of the facility recipe from Menu Manager titled Pureed [NAME] Beans documented:Measure number of servings. Drain well to minimize the use of thickener to obtain appropriate consistency. Puree. Add liquid if needed. Record Review of the facility recipe from Menu Manager titled Pureed BBQ Chicken documented:Measure number of servings. Drain well to minimize the use of thickener to obtain appropriate consistency. Puree. Add liquid if needed. Record Review of the facility recipe from Menu Manager titled Honey Kissed Rolls documented:Measure number of servings. Drain well to minimize the use of thickener to obtain appropriate consistency. Puree. Add liquid if needed. Record review of the facility's policy titled, ' Menus ' dated 2012, documented:Menus are planned to meet the Recommended Dietary Allowances of the Food and Nutrition al Board. The menus will be prepared as written using standardized recipes. Record review of the facility's policy titled, ' Resident Menus ' dated 2012, documented: The menus will be prepared as written using standardized recipes. The DM and cook are trained and responsible for the preparation and service of therapeutic diets as prescribed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, and serve food under sanitary conditions in 1of 1 kitchen when they failed to: Ensure facility staff wore hair restraints and beard guards while in the kitchen.These failures placed all residents who ate food served by the kitchen at risk of cross contamination and food-borne illness. Findings included: In an observation on 3/24/26 at 8:15 am, a sign posted on the main door of the kitchen stated, A hairnet must be worn at all times in the kitchen. Do not enter without putting on a hairnet. Do not cross the threshold without one. No Exceptions. In an observation and interview on 3/24/26 at 10:00 am, [NAME] A walked through the kitchen with his beard and sideburns sticking out of his beard cover. The beard cover did not cover the mouth, sideburns or the upper part of his bushy beard. He stated as far as he knew he was supposed to have a beard cover and hair net on while in the kitchen. When asked if the hairnet was supposed to cover all parts of the hair on his face he stated What am I supposed to do about that? In an observation and interview on 3/24/26 at 12:05 pm, [NAME] B walked into the kitchen from the front door and through the kitchen to the staff changing room with no hairnet or beard cover on. When asked he stated I just walked through the kitchen. I am not sure I am supposed to put it on. In an interview on 3/25/26 at 10:25 am, the RD stated she expected all staff to wear hairnets, and beard covers at all times while in the kitchen. She stated she expected hairnets, and beard covers to cover all hair. She stated the consequences of all issues would be food borne illness. In an interview on 3/26/26 at 10:15 am, the DM stated she had trained the staff in their kitchen duties She stated she expected all staff to wear hairnets and beard covers. She stated she was aware all staff had to keep hair, moustache and beards covered while in the kitchen. She stated she had been aware the beard cover had not covered [NAME] B's beard and moustache very well. She stated she had drilled it into everyone's heads not to come to the kitchen without a hairnet. She stated that food borne illness could result from all these issues. Record review of the facility policy titled ' Preventing Foodborne Illness- Employee Hygiene and Sanitary Practices' dated 2001 documented: Hairnets and beard restraints are worn when cooking, preparing or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens. Record review of the facility's policy titled, ' Dietary Food Service Personnel Policy and Procedures ' dated 2012 documented:Hairnets or hats covering the hairline are worn at all times. [NAME] guards are required for facial hair. Record review of the facility's policy titled, ' Infection Control ' dated 2012, documented:Clean hair is required. It is to be covered with an effective hair restraint. Facial hair is to be closely trimmed and is to be covered with a hair restraint.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, 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 1 (Resident #65) of 17 residents observed for infection control. -Resident #65's oxygen nasal cannula was left on the floor for 23 hours. This deficient practice has the potential to affect residents by exposing them to the spread of infections, tissue breakdown, and feelings of isolation related to poor hygiene.Findings include: Record review of Resident #65's face sheet revealed he was a [AGE] year-old male resident admitted to the facility originally on 11/26/2024 and readmitted on [DATE] with diagnoses to include chronic respiratory failure (a long-term condition lasting over a month where the lungs cannot adequately supply oxygen to the flood or removed carbon dioxide, often resulting from chronic diseases like COPD), asthma (a chronic disease in which the bronchial airways in the lungs become narrowed and swollen, making it difficult to breathe), cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), and dementia (a group of thinking and social symptoms that interfere with daily functioning). Record review of Resident #65's clinical record revealed his last MDS was a quarterly completed 1/30/2026 listing him with a BIMS score of 15 indicating he was cognitively intact and he had a functionality of requiring supervision/touching assistance to partial/moderate assistance with his activities of daily living. Record review of Resident #65's care plan with admission date of 02/13/2025 revealed the following: Focus: The resident has Oxygen Therapy. Date Initiated: 02/03/2026. Record review of Resident #65's Order Summary Report with Active Orders as of 3/26/2026 revealed the following order:- Oxygen LPM: 2-5 L Via: N/C every shift for keep O2 SATS GREATER THAN 88% Assess O2 Sat, Resp. Rate, Pulse, Breath sounds Verbal Active 01/29/2026. Record review of Resident #65's O2 Sats Summary revealed the following: 3/26/2025 02:00AM 92.0% Oxygen via Nasal Cannula 3/23/2025 04:17AM 92.0% Oxygen via Nasal Cannula 3/22/2025 02:09AM 92.0% Oxygen via Nasal Cannula 3/21/2025 04:25AM 92.0% Oxygen via Nasal Cannula During an observation on 03/24/2026 at 08:56 AM Resident #65 was not in his room. Resident #65's nasal cannula was on the floor next to his oxygen concentrator and his bedside dresser with the nasal prongs touching the floor. During an observation on 03/24/2026 at 10:03 AM Resident #65 was observed on the unit, up in his wheelchair. Resident #65 reported no issues. Observation of his room revealed his nasal cannula continued to be on the floor in the same position. During an observation on 03/24/2026 at 11:35 AM of Resident #65's room revealed his nasal cannula continued to be on the floor and the trashcan had been placed over the nasal cannula after the trashcan had been emptied. During an observation and interview on 03/24/2026 at 11:38 AM Resident #65 was observed sitting on the unit in his wheelchair dressed well for the day and he appeared in good condition. Resident #65 reported he had pneumonia about a month ago and required oxygen but only used it at night now. The staff provide for all his needs to include his oxygen care. During an observation on 03/24/2026 at 1:50 PM Resident #65 was in his bed sleeping peacefully with the HOB elevated and not wearing his oxygen. His nasal cannula was still on the floor under his trash can next to the oxygen concentrator. During an observation on 03/24/2026 at 3:20 PM Resident #65's nasal cannula continued to be on the floor under his trash can. During an observation on 03/25/2026 at 8:08 AM Resident #65 had been taken to therapy by staff in his wheelchair and when this surveyor checked his room his nasal cannula was still on the floor with the nasal prongs touching the floor in the same area next to his bedside dresser and his oxygen concentrator, but the trash can had been removed. During an observation and interview on 03/25/2026 at 1:20 PM Resident #65 was observed in his bed with the HOB elevated and he was watching TV. He was noted to have a new nasal cannula in a bag hanging from his oxygen concentrator. Resident #65 reported the nurse discovered the nasal cannula and replaced it. Resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#65 reported he did not need the oxygen last night, he only needs it occasionally, and if he needs it, he will just let the staff know and they will put it on him. Resident #65 was not aware the nasal cannula had been on the floor but reported he was glad it was replaced. During an interview on 03/25/2026 at 2:48 PM LVN I (the nurse providing care for Resident #65 this shift) reported staff should make rounds every 2 hours and they should check the resident's oxygen tubing to make sure it was stored correctly in a bag off the floor. LVN I reported if staff do find the tubing on the floor, then they should replace the tubing before putting it on the resident. LVN I reported she had not replaced Resident #65 oxygen tubing but had replaced his nebulizer tubing, that she would immediately check his room and ensure his oxygen tubing was replaced. LVN I reported Resident #65 will wear oxygen at night but only requires it when his oxygen saturation was below 90%. LVN I did confirm the oxygen tubing and nasal cannula on the floor should have been caught by staff when doing rounds. LVN I reported if a resident used a nasal cannula that had been on the floor, then they could get germs especially if the dirty nasal cannula was not removed and a new one put on. During an interview on 03/26/2026 at 9:12 AM CNA H (the CNA providing care for Resident #65 this shift) reported staff make rounds every 2 hours. CNA H reported if the room had oxygen, then the oxygen tubing and cannula need to be stored off the floor so the residents will not develop an illness. During an interview on 03/26/2026 at 9:49 AM the DON reported staff, especially the CNA's, should make rounds every two hours and they should check the oxygen and make sure the nasal cannula and tubing are stored in a bag off the floor. The DON reported if the nasal cannula and tubing were not stored correctly then it could be contaminated, damaged, or the resident could get caught up in it and trip resulting in a fall. During an interview on 03/26/26 at 09:32 AM the CN stated the facility did not have a policy or procedure specific to nasal cannula storage. The CN provided the Oxygen policy which had no information related to nasal cannula/O2 tubing storage.Record review of the facility provided policy titled, Fundamentals of Infection Control Precautions undated, revealed the following:-A variety of infection control measures are used for decreasing the risk of transmission of microorganisms in the facility.6. Resident care equipment and articles 3. Non-invasive resident care equipment is cleaned daily or as need between use by nursing assistant.