STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455684	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longview Hill Nursing and Rehabilitation Center	3201 N Fourth St Longview, TX 75605

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interviews and record reviews, the facility failed to ensure residents received mail delivered to the facility for 3 of 3 confidential residents reviewed for right to communication.The facility failed to ensure residents received their mail unopened and on Saturdays.This failure could place residents at risk of potentially being denied their rights and receiving and opening mail in a timely manner and a diminished quality of life.Findings included:During a confidential group interview on undisclosed date and time, 3 of 3 residents interviewed said their supplies and mail would come to them open. A resident said every piece of mail he had received was open. Another resident reported he had received his bank card through the mail, and the staff had removed the bank card and brought it to him. He was concerned with someone getting his personal information from the card. The residents interviewed stated they did not receive mail on Saturdays.During an interview on 3/18/2026 at 8:55 AM, Receptionist H said she received mail and packages through multiple carriers. She said the packages were stored across the hall near the Administrators office. She said she sorts the mail and places the mail in the department head trays. She stated the bills go to the Business Office Manager. Receptionist H said she opens all the mail. She stated if there was a check in the mail, she would make a copy of it and place it back in the envelope and give it to the Business Office Manager. She said she opened all mail. Receptionist H recanted and stated that she only opened magazine mail. She said she did not know when the residents received their mail. She said the Activity Director gets the cards and she did not know who delivers the mail on Saturdays.During an interview on 3/18/2026 at 11:20 AM, the Assistant Activity Director said the mail was delivered to the front receptionist area. She said she does not open the residents' mail unless one of the nurses opens the mail. The Assistant Activity Director said she does not deliver the mail on Saturdays because she forgot. She said her activity schedule was full of activities. She said she could not recall the last time she delivered mail on Saturdays. During an interview on 3/18/2026 at 2:31 PM, the Business Office Manager said the mail goes to the receptionist. She said if there was mail from Health and Human Services, she opened it. She said it would have her name or the facility's name on it. The Business Office Manager said she did not open the mail unless the Power of Attorney asked them to open the mail because the family asked them to open it for the financial renewal. She said the resident mail goes to the tray and the Activity Director delivers the mail. She said the mail should not be opened. The Business Office Manager said no one delivered mail on Saturdays that she was aware of. She rephrased and stated she was not sure who delivered mail on Saturday. The Business Office Manager said no one had reported to her that their mail had been opened. She did not know who was responsible for ensuring the mail was delivered on Saturdays. She said it could make a resident upset.During an interview on 3/18/2026 at 2:42 PM, the ADON said the mail came to the front receptionist and then it goes to the Business office and then the Activity Director hands out the resident mail. She said the mail should not be opened by any staff member. She said a resident could get upset if someone opened their mail. She said no one had reported their mail being opened. The ADON said if the post office is open, then the mail should be delivered to the residents.During an interview on 3/18/2026 at 3:16 PM, the DON said the Activity Director passes out the mail. She said the residents open their own mail. The DON said the resident rights would be violated if someone opened their mail. She said there was a manager (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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on duty on the weekends. She said she was not sure who delivered the mail on the weekends.During an interview on 3/18/2026 at 3:30 PM, the ADM said he had one resident who alleged their mail was open. He stated the facility wrote a grievance on a resident who received a letter from a family member. He said if the resident's bank card or statement were addressed to the facility and resident, it would go to the business office. He said he did not know how a resident would feel. He said they may get upset if their mail was open. The ADM said he talked to the Activity Director, and she did not open the mail. He said you could assume it came damaged but understood the concern. The ADM said the receptionist received the mail on Saturday and put the mail in the box. The ADM said the mail should be delivered on Saturdays.Record review of a policy titled Resident Personal Belongings dated 10/24/2022 indicated .It is the policy of this facility to protect the resident's right to possess personal belongings.7. The facility will exercise reasonable care for the protection of the resident's property from loss or theft.Requested review of a policy on mail delivery and resident rights but was only provided Resident Personal Belongings.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion for 3 of 12 residents with limited range of motion (Resident #64, Resident #103 and Resident #53).1. The facility failed to ensure Resident #53 had hand roll on right hand and palm guard splint on left hand for up to 8 hours during the day on 03/16/26, 03/17/26 and 3/18/26.2. Resident #64 had limited range of motion to upper right extremity with no services to prevent further decrease in range of motion.3. The facility failed to ensure Resident #103 had a contracture prevention device in place for the treatment of his left-hand contracture on 03/16/26 and 03/17/26.These failures could place residents at risk of not having their individualized needs met, decreased range of motion and a decline in their quality of care and life.1. Record review of Resident #53's face sheet, dated 3/17/26, indicated a [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #53 had diagnoses which included cerebral infarction (a serious medical emergency where a blood clot blocks blood vessels supplying the brain, causing tissue death), contracture, left hand (a permanent or long-lasting tightening, shortening, or hardening of muscles, tendons, skin, or joint tissue, restricting movement and causing deformity) contracture, right hand, aphasia (a neurological disorder that impairs a person's ability to communicate) and anxiety disorder. Record review of Resident #53's nursing home comprehensive MDS assessment, dated 12/8/25, indicated Resident #53 was rarely/never understood by others and usually understood others. There was not a brief interview for mental status completed on Resident #53. Resident #53 was dependent on ADLs. Restorative nursing program indicated no splint or brace assistance for Resident #53. Record review of Resident #53's care plan, dated 10/4/25, indicated Resident #53 has limited physical mobility related to bilateral hand contractures and neurological deficits. Interventions included, monitor, document, report as needed any signs and symptoms of immobility, contracture forming or worsening, thrombus (a stationary blood clot) formation, skin breakdown and fall related injury. Record review of progress notes dated from 2/15/26 to 3/18/26 did not indicate Resident #53 refused to wear hand roll on right hand and palm guard splint on left hand for up to 8 hours. Review of occupational therapy discharge summary signed 10/03/2025 indicated; Long term goal: Patient will safely wear hand roll on right hand and palm guard splint on left hand for up to 8 hours with minimal signs and symptoms of redness, swelling, discomfort or pain in order to manage contracture and prevent skin breakdown. During an observation on 3/16/26 at 11:26 A.M., Resident #53 was lying in bed with feeding running with bed in lowest position. Resident #53's right and left hand were contracted; there was no palm guard splint or hand roll in place. During an observation on 3/16/26 at 2:03 P.M., Resident #53 was lying in bed watching T.V. Resident #53 could not speak. Resident #53's right and left hand were contracted; there was no palm guard splint or hand roll in place. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 3/17/26 at 10:41 A.M., Resident #53 was sitting in a broda chair (specialized medical seating) resting. Resident #53 had contractures to right and left hand and no palm guard splint or hand roll was applied. During an observation on 3/17/26 at 2:13 P.M., Resident #53 was sitting up in a broda chair (specialized medical seating) in her room and there was no palm guard splint or hand roll in place. During an observation on 3/17/26 at 4:19 P.M., Resident was lying in bed resting. Resident #53 did not have a palm guard splint or hand roll applied to bilateral contracted hands. During an observation on 3/18/2026 at 10:48 A.M., Resident #53 was lying in bed asleep. Resident #53 did not have a palm guard splint or hand roll applied to bilateral contracted hands. During an interview on 3/17/26 at 4:26 P.M., CNA L said Resident #53 fought and she would not let staff put the hand roll and palm guard splint in her hands. She said the nurse went to Resident's room to attempt to apply the splint and hand roll but was not successful. She said usually the CNAs tried to apply the splints and hand rolls first. She said Resident #53 wears the splints, because both of her hands are contracted. She said usually, the therapy people came and in-serviced the CNAs and nurses on who had splints and hand rolls and how to apply them to the residents. She said the CNAs did not document applying or refusal of palm guard splint or hand roll. She said CNAs just notified the nurse of the refusal. She said a risk with the resident's hands being contracted could cause an opened area to the hands. During an interview on 3/17/26 at 5:08 P.M., LVN P said Resident #53 does not have her palm guard splint and hand roll in because she was combative. She said a family member of Resident #53'shad her palm guard splint and hand roll; she said a family member of Resident #53's took the items home to wash them. She said she honestly did not know how long Resident #53 had been without the splint and hand roll. She said the nurse or a family member of Resident #53's usually put on the palm guard splint and hand roll. She said the nurses know what residents had contractures, because it was in their orders. She said the nurses usually document in a progress note or where they click off the tasks in the point click care (electronic health records). She said the hand palm guard splint and hand roll prevent Resident #53's fingers from digging into her skin. She said the risk of Resident #53 not wearing the palm guard splint and hand roll was potential for infection; she could cut her hand, and she could dig a wound in her hands. During an interview on 3/18/26 at 1:50 P.M., PTA N said if therapy applied a palm guard splint or hand roll depends on the resident. She said if the resident was on therapy services, therapy usually ensured the resident's splints or hand rolls were in place, but after therapy was completed, the nurses were responsible for applying the splints and hand rolls. She said the palm guard splint and hand roll was to keep the resident's hand from completely closing. She said the negative effect of not using the palm guard splint or hand roll could cause a wound and it could also cause an infection with the hands being closed and not cleaned; bacteria could set up in the area. During an interview on 3/18/26 at 2:18 P.M., ADON K said Resident #53 refused most care. She said she knew a family member of Resident #53's took her things home to wash them. She said sometimes Resident #53 would let staff do things for her, but that was very seldom. She said the nurses should be documenting that Resident #53 refused the palm guard splint and hand roll. She said if staff could get Resident #53 to wear the palm guard splint and hand roll, they should apply them. She said the nursing staff were responsible for applying the palm guard splint and hand roll. She said the risk of (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #53 not wearing the palm guard splint and hand roll was infection. During an interview on 3/18/26 at 2:41 P.M., the Director of Nursing said she expected all staff to apply palm guard splint and hand roll to the residents with contractures. She said the nurses were responsible for applying the palm guard splint and hand rolls. She said a risk was it could lead to worsening of the contractures. During an interview on 3/18/26 at 2:58 P.M., the Administrator said he expected the staff to apply the palm guard splint and hand rolls to the residents with contractures. He said the nurses and therapy were responsible for applying the palm guard splint and hand roll. He said the risk depended on the baseline of the resident with the contracture; the condition could get worse without the palm guard splint or hand roll. He said the facility did not have a policy for contractures. The findings included: 2. Record review of the face sheet dated 08/31/2019 indicated Resident #64 was [AGE] years old and was initially admitted on [DATE] and most recently re-admitted on [DATE] with diagnoses including Contracture Right Hand (a condition where the palmar fascia thickens, forming cords that pull one or more fingers into a bent position), Muscle Wasting and Atrophy (Muscle atrophy is the loss of muscle tissue, causing reduced muscle mass and strength, usually resulting from inactivity, aging, or disease), Atrial Fibrillation (the most common type of treated heart arrhythmia, characterized by a rapid, irregular heartbeat caused by chaotic electrical signals in the heart's upper chambers.) Record review of Resident #64's Quarterly MDS dated [DATE] indicated Resident #64 was understood and understood others. The MDS indicated a BIMS score of 04 indicating Resident #64 had severe cognitive impairment. The MDS indicated that Resident #64 had a contracture. The MDS indicated that Resident #64 did not reject care. Record review of a care plan revised on 01/03/2026 revealed a lack of care planning regarding Resident #64's contracture. There was no information listed regarding Resident #64's contracture. Record review of Resident #64's diagnosis sheet revealed a diagnosis of a contracture dated 10/29/2024. Record review of Resident #64's Occupational Therapy Plan of Treatment showed that she received treatment for her contracture by occupational therapy from 2/18/25 to 2/27/25. Shows that Resident #64 successfully went from 2 minutes of using her hand splint to 4 hours using her hand splint. During an observation on 3/16/26 at 10:38 a.m. Resident #64's right hand was observed contracted. Her pinky and ring finger was touching her palm. Resident #64 did not have a hand splint in her hand to open her hand. During various observations throughout the day on 3/17/26 Resident #64 did not have a hand splint in her hand. During an interview on 3/17/26 at 1:20 p.m. Resident #64 said that she used to have a hand roll in her hand daily. She said that it must have been 6 months since the last time she had a hand roll in her hand. She said that the hand roll really helped her so that she could keep her hand open more. She said she does not know why she does not have the hand roll anymore. She said that she could not (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	open her pinky or ring finger anymore and it stayed closed. It was observed that Resident #64's pinky and ring finger was touching the palm of her hand and she was unable to fully open her hand. During an interview on 03/17/2026 at 1:40 p.m. the Director of Rehab said that Resident #64 was most recently on speech therapy, but she did receive occupational therapy for her contracture starting on 2/18/25 and met her goals ending occupational therapy on 2/27/25. He said that Resident #64 had a splint that she was supposed to be wearing daily since she was currently on the active contracture list. He said he was not sure how long it had been since she wore the hand splint. He said that nursing may know more if she was allowing staff to place the hand roll in her hand. During an interview on 3/17/26 at 2:10 p.m. the [NAME] President of Operations said that he was looking into the issue with Resident #64's contracture. He said he will look into why her contracture was not listed on her care plan or orders. He said his staff will do a sweep of the building to ensure every resident's needs with contractures were being met. During an interview on 3/18/26 at 1:40 p.m. the Administrator said that it was the responsibility of nursing staff to ensure that residents on the contracture list are receiving appropriate care. He said that residents could be placed at a risk of decreased quality of life if they did not receive all the services and care they require. During an interview on 3/18/26 at 1:50 p.m. the Director of Nursing said that residents on the contracture list should be receiving services to prevent further complications of their contractures. She said that it was the responsibility of nursing staff and therapy to ensure that Resident #64 had a splint in her hand. She said that residents who do not receive all the services they need could be placed at risk of a lower quality of life. 3. Record review of the face sheet, dated 03/17/26, reflected Resident #103 was a [AGE] year-old male who admitted to the facility on [DATE] with a diagnosis of contracture (permanent tightening, shortening, or stiffening of muscles, tendons, ligaments, or skin, causing joints to become fixed in a bent or twisted position) to left hand. Record review of the quarterly MDS assessment, dated 02/04/26, reflected Resident #103 had unclear speech, was understood, and was usually able to understand others. Resident #103 had a BIMS score of 13, which indicated no cognitive impairment. He had no behaviors or refusal of care during the look-back period. The MDS reflected Resident #103 had functional limitation in range of motion that interfered with daily functions or placed him at risk for injury to one side of his upper and lower extremity. Record review of Resident #103's comprehensive care plan, dated 03/17/26, did not address contracture management. Record review of the order summary report, dated 03/17/26, reflected Resident #103 had no orders for a contracture management device or splint. Record review of Resident #103's ADL task list, reflected there were no tasks for contracture management or application of contracture device for range of motion. Record review of the occupational therapy Discharge summary, dated and signed on 12/24/25, reflected Resident #103 was discharged from occupational therapy for contracture management. The (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	goals included Resident #103 will tolerate wearing of resting hand splint to left hand 8 hours. During an observation and interview on 03/16/26 beginning at 10:58 a.m., Resident #103 was sitting in his wheelchair. His left hand was curled up in a fist. He had no splint or devices on his left hand or arm. Resident #103 stated he was unable to extend his left hand because of an accident that caused a brain bleed. Resident #103 stated he did not wear a splint on his left arm or hand. During an observation on 03/17/26 at 11:13 a.m., Resident #103 was sitting in his wheelchair in the therapy room. He had no splint to his left hand or arm. During an observation and interview on 03/17/26 at 11:45 a.m., Resident #103 was sitting in the doorway of his room. Resident #103 had no splint or device to his left arm or hand. He said that he did not wear a splint or brace, even during the night. During an interview on 03/18/26 at 11:01 a.m., CNA B stated when residents had contractures to their hands, she would have washed their hands and looked for a device or hand roll. She stated if there were no devices or hand rolls available in the room, she would have rolled up a washcloth and placed it gently in their hand. CNA B stated Resident #103 had a splint for his left hand contracture. She stated therapy staff were the ones who put on his splint. She stated therapy explained it was okay to wear his left hand splint when he was sitting up but it should have been taken off while in the bed. CNA B stated she was unsure why Resident #103 had not worn his splint on 03/16/26 or 03/17/26. CNA B stated there was no place to document or sign-off on application or removal of contracture devices or splints. CNA B stated she depended on therapy to communicate when residents had contractures or needed splints. During an interview on 03/18/26 at 11:05 a.m., the Director of Rehabilitation stated when residents had new or discovered contractures, he would perform a screening and evaluation and pick them up on services. He said if he was aware of the contractures, he periodically re-evaluated the residents and picked them up as needed. He said when the residents were discharged from therapy, nursing staff were responsible for picking up and maintaining the contractures or applying any contracture management devices. He said that in-service education was provided in the past when residents came off of therapy services, but he was unsure if in-service education had been provided in the past year. He said during the past year, he had just verbally communicated with the nursing staff when residents were coming off of therapy services. He said he communicated the contracture management device needed and instructions for use. The Director of Rehab stated Resident #103 was not currently on therapy services for contracture management. He stated nursing was responsible for applying Resident #103's resting hand splint. He stated Resident #103 should have been wearing it for at least 8 hours per day. He stated he applied Resident #103's hand splint today, because he noticed he did not have it on. The Director of Rehab stated it was important to ensure contracture management devices were applied as directed to prevent hand deformities or prevent the contracture from getting worse. He stated it could have caused skin breakdown and decreased hygienics. During an interview on 03/18/26 at 11:11 a.m., LVN C stated she worked as needed at the facility and did not work regularly. LVN C stated when contractures were identified the nurses assessed the extent of the contracture, made sure the contracture was kept clean, and followed orders for contracture management or devices. She stated contracture management devices should have been placed in the orders and then been included in the care plan. She stated the orders and care plan were how she determined what contracture management devices were needed and how often. LVN C stated she was aware Resident #103 had a contracture to his left hand. She said she was unsure if he (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	required the use of a hand splint. She stated it was important to ensure contracture management devices were used to prevent worsening of the contracture and maintain the resident's independence for as long as possible. During an interview on 03/18/26 at 1:54 p.m., the DON stated when residents had contractures, therapy performed a screening, then reported the contracture management care or devices to the nursing staff. She said the nursing staff should have placed the order into the computer, then updated the care plan. She said the nursing staff were responsible for applying the device and maintaining the contracture after the residents were discharged from therapy. She stated the nurses were responsible for monitoring to ensure contracture management devices were utilized. She stated it was important to ensure contracture management devices were used to prevent a decrease in range of motion and prevent worsening of the contracture. During an interview on 03/18/26 at 1:57 p.m., the Administrator stated he expected the nursing staff to ensure contracture management devices were used as directed. The Administrator stated nursing staff were responsible for monitoring to ensure contracture management devices were used. He stated it was important for the resident's quality of life and to maintain the resident's independence. During an interview on 03/18/26 at 4:12 p.m., the DON stated the facility did not have a policy on contractures or contracture management.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure an accurate MDS was completed for 1 of 5 residents (Resident #49) reviewed for PASRR services. The facility did not ensure Resident #49's significant change MDS assessment was accurately coded to reflect his level II PASRR status for intellectual and developmental disabilities. This failure could place residents at risk of not receiving care and services to meet their needs. The findings included: Record review of the face sheet, dated 03/18/26, reflected Resident #49 was a [AGE] year-old male who admitted to the facility on [DATE] with a diagnosesis of Down syndrome (a genetic condition caused by the presence of an extra copy of chromosome 21, leading to developmental delays and distinct physical features), severe intellectual disabilities (developmental condition characterized by significant limitations in intellectual functioning and adaptive behavior, requiring daily support for basic self-care and communication), and neurofibromatosis (group of genetic conditions involving the development of tumors that may affect the brain, spinal cord, and the nerves that send signals between the brain and spinal cord and all other parts of the body). Record review of the significant change MDS assessment, dated 05/20/25, reflected Resident #49 was not currently considered by the state level II PASRR process to have serious intellectual disability or related condition. Record review of the comprehensive care plan, dated 09/01/25, reflected Resident #49 was PASRR positive for intellectual or developmental disabilities. Record review of the PASRR Evaluation (level II), dated 08/15/24, reflected Resident #49 had intellectual and developmental disabilities and was eligible for PASRR services. During an interview on 03/18/26 at 1:34 p.m., MDS Coordinator D stated she was the one who completed the significant change MDS assessment for Resident #49. She stated Resident #49 had readmitted to the facility for skilled services during the time he readmitted to the facility. She stated she just overlooked the PASRR section in section A and miscoded the significant change MDS assessment. She said Resident #49 was clearly PASRR positive and was currently receiving services in the facility. She stated it was important to ensure MDS assessments were coded accurately so residents received the care and services they needed. During an interview on 03/18/26 at 1:57 p.m., the Administrator stated he expected the MDS assessments to be coded accurately. The Administrator stated the care management staff were responsible for monitoring to ensure the MDS assessments were coded correctly. He said it was important to ensure MDS assessments were coded correctly to develop the care plan and to ensure residents received the care and services they needed. Record review of the Assessments Frequency/Timeliness policy, dated 10/24/22, did not address MDS accuracy. During an interview on 03/18/26 at 4:12 p.m., the DON stated the Assessments Frequency/Timeliness policy was the policy used for MDS accuracy.

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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 records reviews, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 (Resident #20 and Resident #111) of 18 residents reviewed for care plans. 1. The facility failed to ensure Resident #20 had a comprehensive care plan for limited range of motion to her lower extremity.2. The facility failed to ensure Resident # 111 had a comprehensive care plan for limited range of motion to her lower extremity. These failures could place residents at risk of not having their individualized needs met, falls, decreased range of motion and a decline in their quality of care and life.Findings included: 1.Record review of the face sheet, dated 03/18/2026, reflected Resident #20 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of dementia (a general term for a decline in mental ability-such as memory loss, impaired reasoning, and behavioral changes-severe enough to interfere with daily life), diabetes type II (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar) and COPD (a progressive, treatable lung disease-commonly caused by smoking or pollution-that blocks airflow and causes long-term breathing difficulties, including emphysema and chronic bronchitis). Record review of the quarterly MDS assessment, dated 02/23/2026, reflected Resident #20 had a BIMS of 05, which indicated a severe memory impairment. Resident #20 had limited range of motion to her lower extremities on one side and a history of left hip fracture. Record review of Resident #20's comprehensive care plan, dated 03/17/2026, reflected no care plan related to limited range of motion to her lower extremities and no interventions to prevent worsening. 2.Record review of an undated face sheet revealed Resident #111 was an [AGE] year-old female admitted on [DATE] with diagnoses of dementia (a general term for a decline in mental ability-such as memory loss, impaired reasoning, and behavioral changes-severe enough to interfere with daily life), diabetes type II (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar) and left femur fracture (broken hip). Record review of the quarterly MDS assessment, dated 02/23/2026, reflected Resident #111 had a BIMS of 01, which indicated a severe memory impairment. Resident #111 had limited range of motion to her lower extremities on one side and a history of left hip fracture. Record review of Resident #111's comprehensive care plan, dated 03/18/2026, reflected no care plan related to limited range of motion to her lower extremities and no interventions to prevent worsening. During an interview on 03/18/2026 at 12:40 p.m., the MDS Coordinator stated care plans were to include all things that were coded on the MDS. She stated the care plan should be reviewed by the nursing staff to know the individual care instructions for each resident. The MDS Coordinator stated items such as falls, high risk medication usage, hospice services, and diagnoses should be care planned for resident safety. She stated not care planning an important item with the interventions could result in the staff not knowing what is needed for the management of the individual resident condition. She stated the MDS Coordinator was responsible for comprehensive care plans and the administrative nurses were responsible for acute care planning. During an interview on 03/18/2026 at 1:00 p.m., the DON stated it was the floor nurse and the administrative nurses' responsibility to ensure that staff were educated about interventions for all aspects of the resident's care. She stated all major diagnoses, conditions, medications, and falls should be care planned with interventions to alert the staff of the potential of these situations recurring and to give instructions on what to do in those cases. The DON stated not care planning important information could lead to the residents not receiving personalized care. During an interview on 03/18/2026 at 1:30 p.m., the Administrator stated he expected the staff to follow the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions decided on by the MDS Coordinator and interdisciplinary team. He stated the interventions were in place, so all residents received the best quality of care possible in their situation. He stated not having the care items planned could potentially lead to the residents not receiving individualized care. Record review of the Care Plans, Comprehensive Person-Centered policy, dated April 2021, reflected A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.the interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.the comprehensive, person-centered care plan includes measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment;.and which professional services are responsible for each element of care; includes the resident's stated goals upon admission and desired outcomes; builds on the resident's strengths; and reflects currently recognized standards of practice for problem areas and conditions.the interdisciplinary team reviews and updates the care plan. at least quarterly.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an ongoing program of activities based on the comprehensive assessment to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 1 of 6 residents reviewed for activities. (Resident #108)The facility failed to provide Resident #108 with consistent, scheduled, one-on-one activities.This failure could place residents at risk of not having activities to meet their interests or needs and a decline in their physical, mental, and psychosocial well-being.Findings included:Record review of a face sheet dated 3/17/2026 indicated Resident #108 was an [AGE] year-old female who admitted on [DATE] with the diagnoses of Alzheimer's disease (a progressive mental deterioration that can occur in middle or old age, due to degeneration of the brain), chronic atrial fibrillation (a type of heart arrhythmia characterized by an irregular and often rapid heartbeat), protein-calorie malnutrition (an imbalance between the nutrients your body needs and nutrients it gets) and diverticulosis of intestine (a condition characterized by the formation of small pouches in the colon and depression (a common and serious mood disorder characterized by persistent feelings of sadness, loss of interest and a range of emotional and physical problems.) Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #108 usually understood and usually was understood by others. Resident #108's vision was impaired. The MDS indicated Resident #108's BIMS score was 7 indicating severe cognitive impairment. The MDS indicated Resident #108 required motorized wheelchair and required substantial assistance with transfers.Record review of the care plan initiated on 5/17/2025 and last revised on 11/24/2025 indicated Resident #108 was dependent on staff for emotional, intellectual, physical, and social needs due to physical limitations. Interventions included all staff converse with residents while providing care, invite residents to scheduled activities. The Care plan also included the resident prefers the following radio stations: gospel, oldies but goodies and preferred activities included music, bingo with help and trivia. The care plan indicated Resident #108 required assistance and escort to activities.During an interview and observation on 3/16/2026 at 10:51 AM, Resident #108 was lying in bed with no activities. Resident stated the staff do not offer to get her out of bed to go to activities. She said she would like to be out of bed. Resident #108 did not have her TV on or any music playing in her room.During an observation on 3/16/2026 at 12:07 PM, Resident #108 was lying in bed in the same position. Resident #108 was yelling she needed help. There were no observed activities in room during observation. During an observation on 3/18/2026 at 8:33 AM, Resident #108 was sitting up in bed. There were no observed activities during observation.During an interview on 3/18/2026 at 1:46 PM, CNA E said Resident #108 was blind. CNA E said she would get up to eat but she would want to go back to bed. CNA E said she got Resident #108 up on 3/17/2026 for lunch and took her to the dining room and Resident #108 complained that her back was hurting and went back to bed. CNA E said Resident #108 enjoyed bingo and she would help her. CNA E said she enjoyed getting her nails done. CNA E said Resident #108 would tell staff what she wants. CNA E said Resident #108 would say You know I can't see. CNA E said Resident #108 does not like the TV and wanted it off. CNA E said Resident #108 likes to sleep when she was in her room. CNA E said the nurse should encourage Resident #108 more and CNA E was responsible for getting the residents up. She said a resident could become depressed if she did not have activities available.During an interview on 3/18/2026 at 2:03 PM, RN F said Resident #108 did not get out of bed yesterday for lunch. RN F said Resident #108 enjoyed going to Bingo. RN F said Resident #108 would hear the loudspeaker for bingo and she wanted to go. RN F said the Activity Director would go around and ask each resident if they wanted to attend. RN F said Resident #108 liked to be by herself and did not like to be bothered. RN F said Resident #108 did not like music or TV. RN F said Resident #108's preferences would be on her care plan. RN F said she reviewed the care plan when there was a change in condition. She said all staff were responsible for ensuring (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #108's preferences were being honored. RN F said Resident #108 had days she was ready to get up and then she wanted to go back to bed. RN F said not having activities could make a resident bored, lonely or make them feel nobody cared about them.During an interview on 3/18/2026 at 2:20 PM, the Activity Director said Resident #108 participated in bingo. She said Resident #108 sat next to her. The Activity Director said she did not do any activities with Resident #108 this week. She said Resident #108 was yelling in the dining hall yesterday and did not want to eat, so Resident #108 returned to bed. The Activity Director said Resident #108 enjoyed small talk, music and loved to sing. The Activity Director said Resident #108's preferences were care planned. The Activity Director said Resident #108 was able to tell staff what she wanted and at times would refuse. The Activity Director said she was responsible for ensuring residents participated in activities, but the CNAs assisted the residents up for the activities. The Activity Director said in-room activities were on Monday, Wednesday, and Fridays. She said a resident could get depressed if they were in their room all day.During an interview on 3/18/2026 at 2:42 PM, the ADON said Resident #108 enjoyed getting her nails done and played bingo. The ADON said Resident #108 was blind but could tell you what she wanted. The ADON said the staff brought Resident #108 to the dining room yesterday, but she wanted to return to bed. The ADON said Resident #108's preferences would be care planned. She said the Activity Director was responsible for activities. The ADON said the residents should be asked every day if they wanted to participate in activities. She said not having activities could make a resident feel isolated or depressed.During an interview on 3/18/2026 at 3:16 PM, the DON said the care plan would have the residents' preferences with activities. The DON said the Activity Director should offer activities daily. She said she expected the staff to play music or turn the TV on if those were the residents' preferences. The DON said residents should be able to participate if they wanted up. The DON said a resident could have psychosocial issues and prolong a resident's time in bed, which could cause skin breakdown. The DON said the Activity Director was responsible for activities.During an interview on 3/18/2026 at 3:30 PM, The ADM said activities should be based on resident preferences. He said she may not want to do anything. He said Resident #108 should be offered based off her preferences listed. The ADM said the preference should be on the residents' care plan. The ADM said he did not know what kind of negative impact could have on the residents if activities were not provided.The facility was unable to provide a policy related to activities when requested on 3/18/2026.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for 2 of 5 residents (Resident #4 and Resident #14) reviewed for skin integrity. The facility failed to ensure Resident #4 and Resident 14's pressure- redistribution mattress (is designed to distribute the patient's body weight over a broad surface area and help prevent skin breakdown) was on the correct settings. This failure could place residents at risk for developing pressure ulcers and could contribute to developing avoidable pressure ulcers. Findings include: 1. Record review of Resident #4's face sheet, dated 3/17/26, indicated a [AGE] year-old female initially admitted to the facility on [DATE]. Resident #4 had diagnoses which included cerebral infarction (a serious medical emergency where a blood clot blocks blood vessels supplying the brain, causing tissue death), hemiplegia (paralysis affecting one side of the body) and hemiparesis (neurological condition characterized by mild to moderate muscle weakness), muscle wasting and atrophy (the wasting away of body tissue, muscles or organs), pressure ulcer of right buttocks, stage 3 (a full thickness skin injury extending into subcutaneous tissue). Record review of Resident #4's nursing home comprehensive MDS assessment, dated 1/21/26, indicated Resident #4 understand others and made herself understood. Resident #4's BIMS score was 14, which indicated cognition was intact. Resident #4 was dependent on ADLs. Resident #4 weighed 162 pounds. Resident #4 was at risk of pressure ulcer/injuries. Resident #4 received a pressure-reduced device for bed. Record review of Resident #4's care plan, dated 9/5/23, indicated Resident #4 has history of pain related to diabetic neuropathy and pressure ulcers. Interventions include notify physician if interventions are unsuccessful or if current complaint is a significant change from resident's past experience of pain. Record review of Resident #4's physicians order, dated 2/18/26, indicated low air loss mattress, every shift. Record review of Resident #4's physicians order, dated 3/16/26, indicated low air loss mattress for pressure redistribution mattress, ensure mattress is functioning properly, every shift. Record review of Resident #4's weight record, dated 3/17/26, indicated: *3/10/26 - 169.0 pounds *2/10/26 - 167.4.0 pounds *2/3/26 - 167.4 pounds *1/10/26- 162.1 pounds *12/17/25- 165.9 pounds During an observation on 3/16/26 at 11:18 A.M., revealed Resident #4 was lying in bed watching television. Resident #4's pressure redistribution mattress weight setting was 250 pounds. During an observation on 3/17/26 at 10:31 A.M., revealed Resident #4 was lying in bed resting. Resident #4's pressure redistribution mattress weight setting was 250 pounds. During an observation on 3/17/26 at 2:15 P.M., revealed Resident #4 was lying in bed. Resident #4's pressure redistribution mattress weight setting was 250 pounds and the mattress was unplugged. Resident #4 said her bed was not comfortable, because the bed was too hard. During an observation on 3/17/26 at 4:24 P.M., Resident #4 was lying in bed resting. Resident #4's pressure redistribution mattress weight setting was 250 pounds. 2. Record review of Resident #14 face sheet, dated 3/16/26, indicated an 85-years-old female initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #14 had diagnoses which included mild protein-calorie malnutrition, muscle wasting and atrophy (the wasting away of body tissue, muscles or organs), cognitive communication deficit and muscle weakness (generalized). Record review of Resident #14's care plan, dated 2/23/26, indicated Resident #14 has potential for pressure ulcer development related to reduced mobility sacrum stage 2 (a partial-thickness injury, appearing as a shallow, open pink/red wound over the tailbone). Interventions included educating the resident/family/caregivers as to causes of skin breakdown including transfer/positioning requirements, importance of taking care during ambulating immobility, good nutrition and frequent repositioning. Record review of Resident #14's nursing home comprehensive MDS assessment, dated 2/21/26, indicated Resident #14 usually understood others and usually made herself understood. Resident #14's had a BIMS score of 11, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	which indicated moderate cognitive impairment. Resident #14 was dependent on ADLs. Resident #14 weighed 161 pounds. Resident #14 was at risk of pressure ulcer/injuries. Resident #14 received a pressure reducing device for bed. Record review of Resident #14's physicians order, dated 2/19/26, indicated mattress: pressure redistribution mattress, every shift. Record review of Resident #14's weight record, dated 3/17/26, indicated: *3/10/26 - 169.7 pounds *2/10/26 - 160.5 pounds *1/10/26 - 174.3 pounds *12/30/25- 174.0 pounds *12/23/25- 174.0 pounds During an observation and interview on 3/16/26 at 1:53 P.M., revealed Resident #14 was lying in bed resting. Resident #14's pressure redistribution mattress weight setting was greater than 350 pounds. Resident #14 said her bed was uncomfortable and she needed another mattress, because that mattress hurt her butt. Resident #14 said she has a sore between her rectum and private area. During an observation and interview on 3/17/26 at 10:35 A.M., revealed Resident #14 was lying in bed resting. Resident #14's pressure redistribution mattress weight setting was 210 pounds. Resident #14 said her bed was not comfortable and she wanted another mattress. During an observation on 3/17/26 at 2:20 P.M., revealed Resident #14 was lying in bed asleep. Resident #14's pressure redistribution mattress weight setting was 200 pounds. During an interview on 3/18/26 at 10:51 A.M., Treatment Nurse said the bed should be set to the resident's weight. She said the nurses were responsible for checking the bed setting of the residents. She said if the residents' beds were set too high that meant the beds were too firm. She said the risk was more of a potential to cause pressure injury to a resident. During an interview on 3/18/26 at 1: 58 P.M., LVN M said the nurses were responsible for monitoring the settings on the low air loss mattresses of the residents. She said she thought the setting should be set according to the resident's weight, give or take 5 to 10 pounds. She said the negative effect of the bed set too high was it would be too firm and a risk for pressure injury. During an interview on 3/18/26 at 2: 18 P.M., ADON K said the low air loss mattress beds should be set at the resident's weight. She said it was brought to her attention that the hospice aides were turning up the pressure setting of the residents' beds to make the mattress firmer to make the bed harder to perform care. She said there was a malfunction with Resident #14's bed, but hospice provided her with a new mattress. She said the risk of not having the redistribution mattress set at the correct setting was pressure and it could cause wounds. During an interview on 3/18/26 at 2:41 P.M., the Director of Nursing said she expected the resident's pressure redistributing mattress to be on the correct settings. She said the mattress should be set according to the resident's weight. She said the nurses were responsible for monitoring the bed settings. She said the risk was increased skin breakdown. During an interview on 3/18/26 at 2:58 P.M., the Administrator said he expected the resident's redistribution beds to be set in the correct setting. He said the nurses were responsible for ensuring the settings were set for the pressure redistribution mattress. He said the risk was skin breakdown. Record review of the facility's Pressure Injury Prevention and Management policy, dated 8/15/2022, indicated .The facility is committed to the prevention of avoidable pressure injuries and the promotion of healing of existing pressure injuries. 4. Interventions for Prevention and to Promote Healing: c. Evidence-based interventions for prevention will be implanted for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: Redistribute pressure (such as reposition, protecting and/or offloading heels, etc.) Provide appropriate, pressure-redistributing, support surfaces.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were offered sufficient fluid intake to maintain proper hydration and health for 1 of 1 resident (Resident #108) reviewed for fluid intake.The facility failed to ensure Resident #108's water pitcher was in reach on 3/16/2026 and 3/17/2026.This failure could place residents at risk of dehydration.Findings included: Record review of a face sheet dated 3/17/2026 indicated Resident #108 was an [AGE] year-old female who admitted on [DATE] with the diagnoses of Alzheimer's disease (a progressive mental deterioration that can occur in middle or old age, due to degeneration of the brain), chronic atrial fibrillation (a type of heart arrhythmia characterized by an irregular and often rapid heartbeat), protein-calorie malnutrition (an imbalance between the nutrients your body needs and nutrients it gets) and diverticulosis of intestine (a condition characterized by the formation of small pouches in the colon and depression (a common and serious mood disorder characterized by persistent feelings of sadness, loss of interest and a range of emotional and physical problems.) Record review of the Quarterly MDS assessment dated [DATE] indicated Resident #108 usually understood and usually was understood by others. Resident #108's vision was impaired. The MDS indicated Resident #108's BIMS score was 7 indicating severe cognitive impairment. The MDS indicated Resident #108 required setup assistance to bring food or liquid to mouth once the were placed before the resident.Record review of the care plan initiated on 5/17/2025 and last revised on 11/24/2025 indicated Resident #108 had potential for impairment to skin integrity related to bowel and bladder incontinence and fragile skin. Interventions included good nutrition and hydration to promote healthier skin.Record review of the consolidated physician orders dated 3/18/2026 indicated Resident #108 was ordered mechanical soft texture with regular liquid consistency. There was no fluid restrictions ordered.During an observation and interview on 3/16/2026 at 10:51 AM, Resident #108 said she was treated well, and she was able to use her call light. Resident #108 was observed to have her water pitcher out of reach, and she said she was blind. Resident #108 said she did not know where her water pitcher was and she was thirsty and her mouth was dry. Resident #108 said she did not have any swallowing issues and was not on any restrictions. She said she did use a straw.During an observation on 3/16/2026 at 12:07 PM, Resident #108 was observed lying in bed and water was out of reach on the bedside tray. Resident was yelling for help, and a staff member was located to provide assistance to Resident #108.During an observation on 3/17/2026 at 8:33 AM, Resident #108 had her water pitcher out of reach and an empty cup of orange juice on her bedside table. RN G came in the room and removed the empty cup of orange juice and placed Resident #108's water pitcher within reach and made her aware of the location.During an interview on 3/18/2026 at 4:46 PM, CNA E said Resident #108 was blind. CNA E said she fills Resident #108's water pitcher twice a shift. CNA E said Resident #108 liked her water at room temperature. She stated that Resident #108 did not like water. She said Resident #108 liked her bedside tray to the left or right of her and not over her bed. CNA E said she placed her water pitcher next to her so she could reach it. CNA E said everyone was responsible for ensuring the water pitcher was within reach of the resident. CNA E said Resident #108 had a call light and she knew how to use it to call for assistance. CNA E said Resident #108 pushes her table away because she likes to move her bed up and down.During an interview on 03/18/2026 at 2:03 PM, RN F said the aides go around every 2 hours. RN F said the water pitcher should be kept within reach of her. RN F said Resident #108 was not fully blind and stated she had cataracts. RN F said Resident #108 could see someone coming in. She said a resident could get dehydrated. RN F said she had never complained of dry mouth but indicated she loved suckers.During an interview on 3/18/2026 at 2:42 PM, the ADON said the water pitcher should be located within reach. The ADON said Resident #108 did not like water right now. The ADON said the CNA would tell her where everything was located on her table. The ADON said the nurses and aides were responsible for ensuring the water pitcher was within reach. (continued on next page)

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	455684	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Longview Hill Nursing and Rehabilitation Center	3201 N Fourth St Longview, TX 75605

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADON said residents could become dehydrated if they were not able to reach their water.During an interview on 3/18/2026 at 3:16 PM, the DON said she expected nursing staff to keep water pitcher within resident reach. She said a resident could get dehydrated. The DON could not recall if Resident #108 were blind. The DON said the water should be within reach.During an interview on 3/18/2026 at 3:30 PM, the ADM said he expected nurses and staff to keep water pitcher within reach of resident. He said nursing was responsible for ensuring the water was within reach. He said it could negatively impact a resident because they would not be able to reach their water.The facility was unable to provide a policy related to hydration when requested on 3/18/2026.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide pharmaceutical services to include procedures that assured the accurate dispensing and administering of all drugs to meet the needs of 1 of 1 residents (Resident #95.)The facility medication aide failed to ensure that Resident #95 took his medication before leaving the room. This deficient practice could affect residents and place them at risk of not receiving the therapeutic dosage and drug diversion. Findings included:Record review of the face sheet dated 11/14/23 indicated Resident #95 was [AGE] years old and was admitted on [DATE] with diagnoses including Paraplegia (impairment or loss of motor and sensory function in the lower extremities and sometimes the torso, generally caused by spinal cord injury or disease below the neck), Cognitive Communication Deficit (a communication impairment resulting from underlying cognitive issues rather than primary language deficits, often caused by brain injuries, strokes, or dementia), and Muscle Weakness (a reduced ability to contract muscles, resulting in decreased strength). Record review of Resident #95's Quarterly MDS dated [DATE] indicated Resident #95 was understood and understood by others . The MDS indicated a BIMS score of 15, indicating Resident #95 was cognitively intact. Record review of a care plan revised on 09/20/23 indicated Resident #95 had an activity of daily living self-care deficit. Showed that Resident #95 needed assistance with most of his activities of daily living . During an interview and observation on 3/16/26 at 9:55 a.m. Resident #95 was observed with a small plastic pill cup with approximately 4-6 pills inside. Upon approaching Resident #95 he took the cup of pills, put them into his mouth and swallowed them. He said that the med aide gave him his meds a few minutes ago. He asked why he was being asked about his medications and stated he did not want to speak to the surveyor. During an interview on 3/16/26 at 10:09 a.m. MA A said that she just passed medications in the hall Resident #95 was located in. She said that she was supposed to watch residents actually take their medications so she could document whether they took the medication or not. She said she would then be able to notate if the resident refused.During an interview on 03/18/26 at 1:40 p.m., the Administrator said the medications left at the bedside of Resident #95 could place other residents and Resident #95 at risk for harm. He said that he expects that the medication aides ensure that Residents take their medication before leaving the room. He said that residents can either refuse their medications or take them, but medications should not be left in residents' rooms. During an interview on 03/18/26 at 1:50 p.m., the Director of Nursing said she would have expected that medication aides would ensure that residents took their medications before leaving their room. She said that there could be risk that other residents could get ahold of medications that did not belong to them, take them and cause harm. She said that it also put residents at risk as they could not document whether the resident actually took their medication or not. Record review of a facility policy titled, Medication Administration' dated 10/24/22 shows that the purpose of this policy was to, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in the state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection Observe resident consumption of medication.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe and sanitary storage of residents' food items for 1 of 12 resident personal refrigerators reviewed for food safety (Resident #11). The facility failed to ensure the refrigerator and dry storage foods for Resident #11 was inspected for expired food and expired food disposed of. This failure could place residents at risk for food borne illnesses.Findings include: Record review of a face sheet dated 11/23/2025 indicated Resident #11 was an [AGE] year-old male, admitted to the facility on [DATE] with diagnoses including Urinary Tract Infection (an infection in any part of the urinary system—most commonly the bladder and urethra—often caused by bacteria, resulting in pain, burning, and a persistent urge to urinate), Major Depressive Disorder (a serious, common mood disorder characterized by at least two weeks of persistent, low mood, sadness, and loss of interest in activities), Chronic Obtrusive Pulmonary Disease (a progressive, incurable lung disease—primarily caused by smoking—that restricts airflow, causing severe breathing problems, chronic cough, and mucus production). Record review of the MDS dated [DATE] indicated Resident #11 understood others and made himself understood. The MDS indicated Resident #11 was cognitively intact with a BIMS score of 15. The MDS indicated Resident #11 did not reject evaluation or care. Record review of a care plan for Resident #11 dated 03/12/2026 revealed Resident #11 required assistance with activities of daily living. During an observation on 3/16/26 at 9:53 a.m. Resident #11 had a bag of shredded cheddar cheese in his personal refrigerator with an expiration date of September 20, 2024. Salsa observed in Resident #11's room expiration dated August 2, 2025, and peanut butter expiration date of January 22, 2024. Resident was not in the room to interview. During an interview on 3/17/26 at 10:15 a.m. Resident #11 said that he does eat the food in his room that he buys. He said that he orders the food to be delivered from a local grocery store. He said that he does not check the expiration dates on his food before he eats it. He said no one comes into his room to check the expirations of his food. He said he did not realize that he had food that expired nearly 2 years ago. During an interview on 03/18/2026 at 1:40 p.m. with the Administrator he said it was the responsibility of department heads to ensure that personal refrigerators were clean of expired foods. He said that residents could get sick if they ate cheese or peanut butter that was decomposing or moldy. During an interview on 03/18/2026 at 1:50 p.m. the Director of Nursing said that department heads were responsible to clean out the personal refrigerators for residents. She said that residents could be placed at risk for foodborne illness if they ate expired or moldy food. She said she expected department heads to clean out the personal refrigerators of all residents and dispose of expired food. Record review of a facility document titled, Resident Refrigerators dated 7/3/23 shows that the purpose of this policy was to, This facility does not provide a refrigerator in a resident's room. However, it is the policy of this facility to ensure safe and sanitary use of any resident-owned (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refrigerators.The refrigerator is inspected by maintenance personnel and deemed safe prior to use and upon routine inspections. The refrigerator maintains proper temperatures.A thermometer shall remain in the refrigerator. It shall be calibrated prior to use and periodically thereafter. Temperatures will be at or below 41 degrees Fahrenheit, and freezers will be cold enough to keep foods frozen solid to the touch (or in accordance with state regulations). If temperatures are out of range, staff shall notify nursing department to discard any foods that require refrigeration and take measures to remedy the problem. If problems persist with maintaining proper temperatures, the refrigerator shall be removed from use and the resident/family notified.Staff shall clean the refrigerator weekly and discard any foods that are out of compliance. Nursing staff shall clean up spills as needed or refer to housekeeping staff.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and record review the facility failed to maintain all essential equipment in a safe operating condition, for 1 of 4 refrigerators in a medication room reviewed for food service in that: The facility failed to ensure the refrigerator in medication room on hall 4 was cleaned, defrosted and food stored at an appropriate temperature on 3/17/26. This failure could place residents at risk for food borne illnesses.Findings include: Record review of the refrigerator temperature log sheet indicated the refrigerator should be 40 degrees Fahrenheit or below.During an observation on 3/17/26 at 5: 22 P.M., the med room on hall 4 with RN Q. The refrigerator in the medication room was used to store food for residents that did not have refrigerators in their rooms was covered in the inside with a brown substance splatter throughout. The refrigerator had a large buildup of ice on the cooling element, and the thermometer reading was on the red level at 42 degrees Fahrenheit. The refrigerator contained sour cream packets, yogurt, cranberry juice, strawberry shake, coffee creamer, can of coke, salad dressing and protein liquid container.During an interview on 3/17/26 at 5:28 P.M., RN Q said the refrigerator did not look good to her and it was not sanitary to eat the food in the refrigerator. She said housekeeping was responsible for keeping the refrigerators in the medication room and resident rooms clean. She said she needed to address the issue of the refrigerator. She said she would not want her refrigerator to look like that. She said a risk of the condition of the refrigerator was the food could be freezer burnt and it could introduce bacteria to the resident. During an interview on 3/18/26 at 2:10 P.M., the Environmental Supervisor said she was not responsible for ensuring the refrigerators in the medication rooms were cleaned and defrosted. She said the nurses were responsible for ensuring the refrigerators in the medication rooms were cleaned and defrosted. She said the refrigerator in the medication room on hall 4 needed to be cleaned. She said the housekeeping staff were not allowed in the medication rooms unless the nurse were present. She said a negative effect of the refrigerator not being clean, needing to be defrosted and elevated temperature was spoiled food. During an interview on 3/18/26 at 2:18 P.M., ADON K said the nurses were responsible for the refrigerators in the medication rooms and she expected the refrigerators to be clean. She said the refrigerator in the medication room on hall 4 needed to be pulled and checked to see why it was freezing over. She said staff should be making sure everything was within date in the refrigerator. She said the refrigerators should be checked daily. She said a negative effect of the condition of the refrigerator was that the food could be spoiled. During an interview on 3/18/26 at 2:41 P.M., the Director of Nursing said the refrigerator on hall 4 in the medication room was unacceptable in the condition it was in. She said the nurses and unit managers were responsible for ensuring the refrigerators were cleaned, defrosted and functioning at the appropriate temperature in the medication rooms. She said a negative effect from the refrigerator was the food in it could make the residents sick.During an interview on 3/18/2026 at 2:58 P.M., the Administrator said he excepted for the staff to keep the refrigerators clean, defrosted and at a safe storage temperature in the medication rooms. He said the unit manager, Director of Nursing and nursing services were responsible for ensuring the refrigerators were cleaned, defrosted and safe temperature. He said a negative effect was possible food spoilage.