STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455753	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Brook Health Care Center	107 Stacy Dr. Whitehouse, TX 75791

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 interview and record review, the facility failed to ensure residents were provided reasonable access to receive their mail in a timely manner for 1 of 8 confidential residents (Confidential Resident #1) reviewed for resident rights. The facility failed to implement a system to distribute incoming mail daily and ensure residents promptly received their mail. This failure could place residents at risk of a delay in residents' personal correspondence, financial information, or other time-sensitive materials. The findings included: During a confidential group interview at an undisclosed date and time, Confidential Resident #1 indicated they did not receive their package that was delivered on a Saturday. The confidential resident stated the package arrived on a Saturday and sat by the front door until they retrieved it the following day. During an interview on 06/16/2026 at 2:52 PM, the BOM stated during the week she retrieved the mail, gave it to the AD, and the AD distributed it to the residents. The BOM stated on the weekends the weekend receptionist obtained the mail and delivered it to residents. During an interview on 06/17/2026 at 9:34 AM, the AD stated she had been working as the AD for 2 months and prior to that she worked as a receptionist. The AD stated that when she worked as a receptionist she would obtain the mail on the weekends and distribute it to residents. The AD stated that the facility hired a new weekend receptionist, Receptionist L. The AD stated that Receptionist L was responsible for distributing mail to residents on the weekend. During a telephone interview on 06/17/2026 at 9:37 AM, Receptionist L stated she was the weekend receptionist. Receptionist L stated she obtained the mail on the weekends but did not distribute any mail out to residents. Resident L stated she put resident mail in HR's office box because HR distributed it to residents on the weekends when she was at the facility. Receptionist L stated she did this because she was new to working at the facility and was not familiar with the residents. During an interview on 06/17/2026 at 9:46 AM, HR stated she did not distribute mail to residents on the weekends. HR stated she did come to the facility for personal reasons but stated Receptionist L was to distribute residents' mail. HR stated that Receptionist L was trained to obtain and deliver residents' mail on the weekends. HR stated she had not seen any resident mail in her office box. HR stated she was unaware why Receptionist L would state she put residents' mail in her box, but she might have said if she was unsure about any mail Resident L could slide it under her office door. During a telephone interview on 06/17/2026 at 9:50 AM, Receptionist L stated resident mail did come in on Saturdays. Receptionist L stated she was trained specifically to put resident mail in HR's office box. Receptionist L stated she had been working at the facility for 3 weeks and on the weekend she checked the mail and brought it in so it did not sit in the mailbox over the weekends and when HR came in HR would check the mail and distribute it to the residents. During an interview on 06/17/2026 at 11:29 AM, the DON stated the process for distributing residents' mail on the weekends was HR checked the mail, provided it to Receptionist L, and Receptionist L distributed it to the residents. The DON stated it was her expectation residents got their mail on Saturdays. The DON stated the inconsistency in determining responsibility for distributing mail was a communication error. The DON stated she did not see harm for residents for not receiving mail but acknowledged it was their right as a resident to get mail daily. A record review of the facility policy titled Resident Personal Mail dated 6/2017 indicated the following: Policy:It is the policy of this facility to ensure each resident is able to (continued on next page)

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

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

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	receive and send mail without interference from facility staff. Procedure: Mail that is received for individual residents at the facility will be delivered unopened to the resident for which it is intended. Resident mail is sorted and delivered to the resident's room.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents unable to conduct activities of daily living (ADLs) received the necessary services to maintain good grooming and personal hygiene for two of five residents (Resident # 5, Resident #25) reviewed for quality of life. The facility failed to ensure Resident #5 and Resident #25 received showers and facial hair care. This failure could place residents at risk for poor hygiene, dignity issues, and a decline in quality of life. Findings included: 1. A record review of a face sheet dated 06/17/2026 indicated Resident #25 was a [AGE] year-old female who admitted to the facility on [DATE]. She had diagnoses which included cerebral palsy (a group of disorders that affect a person's ability to move, maintain balance and posture) speech impediment, muscle wasting, dementia (a decline in mental health severe enough to interfere with daily life), Intellectual Disability (a developmental condition characterized by both intellectual functioning and adaptive behavior), and Hirsutism (in women, the growth of coarse, dark hair in a male-like pattern). A record review of a quarterly MDS assessment dated [DATE] indicated Resident #25 had a BIMS score of 12 indicating her cognition was moderately impaired. She was incontinent with bowel and bladder. She was dependent on staff for bathing and grooming care. Her speech was not easily understood. A record review of Resident #25's care plan dated 02/21/2024 indicated Resident #25 required assistance with ADLs and had facial hair. The care plan goals were for Resident #25 to maintain a sense of dignity by being clean, well groomed, and absent of facial hair. A record review of a Nurse Aide Assignment Sheet dated 06/10/2026 indicated Resident #25 was to receive a shower and be shaved on Mondays and Thursdays on the 7AM - 3PM shift. During an observation on 06/15/2026 at 09:07 AM, Resident #25 was observed asleep and lying in bed with the head of the bed slightly elevated. Resident #25 was observed to have approximately a 1-2-day growth of hair on her lower face and neck. During an observation and interview on 06/15/2026 at 03:51 PM, Resident #25 was observed lying in bed. She had not been shaved. When asked if she had received a shower on Monday, 06/15/2026, she said no by moving her head slightly from side to side. During an observation on 06/16/2026 at 10:50 AM, Resident #25 was observed sitting in a wheelchair and was being pushed down the hall. Resident #25 was placed against the wall at the beginning of Hall 2. She had what appeared to be a 2-3-day growth of dark hair on her lower face. She had not been shaved. During an interview on 06/16/2026 at 02:12 PM, CNA-P said she tried to shave Resident #25 that morning, but Resident #25 refused. CNA-P said if a resident refused care she would tell the nurse. During an observation on 06/17/2026 at 10:16 AM, Resident #25 was observed lying in bed. She had not been shaved. During an interview on 06/17/2026 at 10:20 AM, LVN-D said she was not told Resident #25 refused to be shaved on 06/16/2026. 2. A record review of a face sheet dated 06/17/2026 indicated Resident #5 was a [AGE] year-old male who admitted to the facility on [DATE]. He had diagnoses which included cerebrovascular accident (a stroke) with right-sided hemiparesis and hemiplegia (partial to total paralysis of the right side). A record review of a quarterly MDS dated [DATE] indicated Resident #5 had a BIMS score of 7 (seven) indicating his cognition was severely impaired. He was incontinent with bowel and bladder. The MDS indicated Resident #5 required maximum assistance with bathing and personal hygiene. A record review of Resident #5's care plan dated 04/02/2025 indicated Resident #5 required assistance with ADLs due to right-sided hemiparesis (partial paralysis). The care plan goal was for Resident #5 to maintain a sense of dignity by being clean and groomed. A record review of a Nurse Aide Assignment Sheet dated 06/10/2026 indicated Resident #5 was to receive a shower and be shaved on Mondays and Thursdays. During an observation on 06/15/2026 at 09:48 AM, Resident #5 was observed asleep and lying in bed with the head of the bed slightly elevated. Resident #5 was observed to have approximately a 1 (one) day growth of hair on his face with longer hairs underneath the lower lip extending the full length of the lower lip and a mustache. Long, thick hairs were noted extending out of his nose. During an (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observation and interview on 06/15/2026 at 03:45 PM, Resident #5 was observed lying in bed. He had not been shaved, nor had the nasal hairs been trimmed. Resident #5 replied no by turning his head from side to side when asked if he was growing a beard and mustache. When asked if he had received a shower on 06/15/2026 (Monday), he said he had not. During an observation on 06/16/2026 at 01:40 PM Resident #5 was observed lying in bed. He had not been shaved, nor had the nasal hairs been trimmed. During an observation and interview on 06/17/2026 at 09:45AM Resident #5 was observed lying in bed and being assisted to dress by CNA-N. He had not been shaved, nor had the nasal hairs been trimmed. CNA-N said she shaved Resident #5 on Sunday, 06/14/2026. She said she did not shave the mustache area. She said she missed shaving the area directly under his lower lip. She said she could not trim Resident #5's nasal hairs because she did not have anything to trim nasal hair with. CNA-N said Resident #5 liked to be shaved and would sometimes ask to be shaved. She said Resident #5 never refused his bath or shave that she knew of. CNA-N said it was important for the residents to get their showers and be shaved if they did not want a beard because it showed respect for them as a person. During an interview with Resident #5 on 06/17/2026 at 11:15 AM with the DON and ADON present, Resident #5 rubbed his right index finger over his upper lip and said, They missed that. When asked if wanted a shave, Resident #5 said he did not want to look like a wolf. During an interview on 06/17/2026 at 11:01 AM, the ADON said the nurses were responsible for monitoring the aides and ensuring the residents' bathing and grooming needs were met. During an interview with the DON on 06/17/2026 at 11:28 AM, she said the aides were supposed to shower and shave the residents according to the instructions on the Nurse Aides Assignment Sheet and turn in a completed shower sheet to the nurses. The DON said she could not find a shower sheet for Resident #25 for 06/15/2026. The DON said the shower sheet dated 06/15/2026 for Resident #5 was marked Bed Bath. The DON said showers and grooming were a basic part of ADLs and were important for promoting dignity and respect. A record review of the facility's policy dated 11/28/2017 and entitled Quality of Life: ADL Care Provided For Dependent Residents indicated the following: A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure medications were prepared and administered in a manner that prevented medication errors for 4 of 4 licensed nurse medication carts (Cart #1, Cart #2, Cart #3 and Cart #4) observed for controlled medications storage. The facility failed to Ensure MA (B) did not sign the controlled substance count sheets for the end of their shift at the beginning of their shift on Cart #1 and Cart #2, on 6/16/2026The facility failed to Ensure LVN C did not sign the controlled substance count sheets for the end of her shift at the beginning of her shift on Nurses Cart #3 and Cart #4, on 6/16/2026 These failures could place residents at risk of creating the potential for medication diversion, administration of incorrect medication, and compromised resident safety, and not receiving medications as ordered by the physicianFindings include:During an observation and record review on 06/16/2026 at 1:11 PM, 4 of 4 medication carts indicated MA B was signing on and off of hall one and hall two narcotic count checklists at the same time she signed on at shift count for the controlled drugs on hand. During an observation on 6/16/2026 at 1:57 PM, of 4/4 medication carts, LVN C had not signed for receiving at the beginning of her shift on the count sheet, The controlled drugs on hand. During an observation on 6/16/26 at 1:58 PM, of 4/4 med carts, it was discovered that hall one and hall two had missing signatures on: 06/03/2026,06/04/2026, and 06/08/2026 During an observation on 6/16/26 at 2:00 PM, of 4/4 med carts, it was discovered that hall one and hall two had missing signatures on: 06/04/2026, 06/05/2026, and 06/16/2026 outgoing or incoming nurse simply forgot to sign the log after confirming the count, failed to complete the count sheet form.During an interview on 6/16/2026 at 2:10 PM, MA B said she always signed both coming/going slots on the Nurse on and Nurse off at the same time so he would not forget at the end of his shift, she said she thought this was ok to do so she would not forget to sign at the end of her shift, she said she never thought of if something happened to her during her shift what the consequences would be.During an interview on 6/16/2026 at 2:15 PM, LVN C said she almost always signs the controlled count sheet when receiving control off the count, she just forgot to do so today, she said, I simply forgot. LVN C said she knew she should sign because she was now responsible for that medication cart and the narcotics it contained and she was responsible if something happened during her shift.During an interview on 6/16/2026 at 2:30 PM, the DON said all nurses were to sign the Drug Administration Record Controlled Drug Count Record at the time coming on to their shift and at the time they were going off their shift. The DON said she had in serviced all nurses on the procedure and she was ultimately responsible for monitoring and making sure it was done correctly.Record review of a policy and procedure titled, Controlled Substances, dated 2001, indicated, Med-Pass revised December 2012. The facility shall comply with all laws, regulations, and other requirements related to handling, storage disposal and documentation of Schedule II and other controlled substances.8. Nursing staff must count controlled medication at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the director of Nursing Services.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure the menu was followed for 2 of 2 meals (lunch meals 06/15/2026 and 06/16/2026) reviewed for menus and nutritional adequacy. Dietary staff did not serve bread during the noon meals on 06/15/26 and 06/16/2026 to any residents eating mechanical soft diets.This failure could place residents who eat food from the kitchen at risk of not having their nutritional needs met. Findings included: Record review of the planned menu dated 06/15/2026, indicated for the noon meal was beef fried rice, egg rolls, Oriental vegetable blend, fudge cookie.During an observation and interview of the kitchen on 06/15/2026 at 9:35 A.M., the DM said the residents receiving mechanical soft diets were not being served the egg rolls because they were the bread item. The DM said nothing was substituted for the bread on mechanical soft diets. She said she would give them an extra vegetable and put some carrots on to heat. She said speech therapy told them last year no residents receiving a mechanical soft diet could have any bread. She said they did not receive slices of bread, rolls, biscuits, bread products or pie crusts. She said there were no substitutions made regarding the bread items. She said they just did not receive it. She was observed looking up the caloric value for the egg rolls on her computer, and the caloric value was 234 calories for the 2 small egg rolls. She said every resident receiving a mechanical soft diet would be losing 234 calories from their meal. She said the RD did not get back to her on what to do about not giving the bread and she never followed up with the RD. She said what was confusing to her was although speech therapy said residents receiving mechanical soft diets could not have any bread, some of the residents were allowed a soft sandwich, which was made of bread.Record review of the planned menu, dated 06/16/2026, indicated the noon meal was Dorito Casserole, mixed vegetables, Mexican rice, slice of bread, and chocolate chip muffin. Residents ordered a mechanical soft diet received fruit for dessert instead of the muffin and no bread. There was nothing extra given in place of the bread.During an interview on 06/17/2026 at 7:50 A.M., the DM said the RD was in contact with her quite often but had the RD not talked with speech therapy about the mechanical diets to her knowledge. She said the speech therapist came last year to the dietary department and informed them the mechanical soft diets were to no longer receive bread products. She said she did not receive an explanation so she could understand the change. She said it was discussed with the RD at that time, but she had not received any guidance as to what to substitute for the bread offered at every meal. She said she remembered the residents getting very upset about not being able to get sandwiches. She said the residents in the facility loved and ate a lot of sandwiches daily. She said the DON spoke with speech therapy and they decided some residents on mechanical soft could have soft sandwiches and some could not. She said it was placed on the dietary slip if they could have a soft sandwich which would consist of either pimiento cheese, egg salad, chicken salad, tuna salad or peanut butter and jelly. She said the speech therapists arrive in the evening so she never got to speak with them so never had her questions answered. She said when they offer an entree that was a pot pie with pie crust, the mechanical soft diets included the inside but not the crust. She said sometimes she compensated with serving mashed white or sweet potatoes. She said she had no guidance from the RD as to what else she could do and she said she thought they probably got very tired of mashed potatoes. She did not know if allowing them to have soft sandwiches also meant they could have the other bread products.During an interview on 06/17/2026 at 9:15 AM the DOR said mechanical soft diets could not have bread or bread products. She said since it could be individualized to every resident she said she had 2 speech therapists and 1 of them was at the facility 4 evenings every week. She said the speech therapist could do a bedside evaluation over a couple of days to see if a resident could tolerate and eat bread safely. She said nursing service was supposed to let the DOR know with a request for a bedside evaluation when they had a resident on a mechanical soft diet. She said for a resident to upgrade from a mechanical soft (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diet to a regular texture diet a speech therapist had to do the evaluation. She said the same was true for allowing certain food products individualized to each resident. She said some residents receiving a mechanical soft diets may be able to tolerate bread or other foods and the bedside evaluation would indicate that ability. She said speech therapy would communicate with nursing if a resident could tolerate soft sandwiches and nursing would send a communication to the dietary department. During an interview on 06/17/2026 at 9:45 AM the DON said residents receiving mechanical soft diets can have bread or sandwiches if speech therapy had done a bedside evaluation. She said once the resident was approved to be able to eat a sandwich safely a communication form would be sent to the dietary department so it could be added to the meal ticket for that particular resident and they could have soft sandwiches and bread. She said it would be placed in the resident's clinical record as a physician order for a mechanical soft diet with variations. She said speech therapy were the ones who would write the sandwich orders in the clinical record and then it was communicated to nursing service the order had been written so they could tell the dietary department.During an interview on 06/17/2026 at 11:00 AM the DM said the RD had not communicated a substitute for the missed bread items at every meal and acknowledged residents could be losing 300-500 calories a day depending on what foods were being served. She said she needed further clarification from speech if residents receiving soft sandwiches could also have other bread products being offered or did they still have no bread, buns, biscuits, pie crusts and only soft sandwiches. She said she wanted the residents to receive everything they were allowed to have safely.]A review of Mechanical Soft Diet eating plan dated 06/12/2025 provided by the DOR indicated the following: A typical sandwich presents several textural challenges for someone a mechanical soft diet.bread.is a primary obstacle. Fillings like deli meats, raw vegetables, and crunchy condiments pose further difficulties.The goal is to find a bread option that easily falls apart in the mouth with minimal chewing.The fillings of the sandwich are just as important as the bread. Hard, chunky, or stringy ingredients should be avoided. Instead focus on soft, moist, and easily manageable fillings.Avoid tough and chewy meats.raw vegetables are generally not appropriate due to texture, but soft-cooked vegetables are all viable options. Be sure to remove any skins or seeds.avoid chunky or seedy condiments like relish or whole grain mustard. Smooth condiments like mayonnaise, butter, hummus or avocado puree are generally safe choices.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 serve food that was palatable and at an appetizing temperature for 1 of 1 meal (noon meal 06/15/2026) and 9 of 9 residents (Resident #s 2, 23, 30, 37, 56, 59, 67, 81, and 84) reviewed for food palatability. The facility did not provide palatable and appetizing food for the residents for the 06/15/2026 noon meal.Resident #s 2, 23, 30, 37, 56, 59, 67, 81, and 84 complained the food was cool or cold, poorly or not seasoned and was not appealing in appearance. This failure could place residents who received food from the kitchen at risk for diminished meal satisfaction and potential weight loss due to poor meal intake.Findings included:During an observation on 06/15/2026 at 12:16 PM the test trays left the kitchen on the last hall cart. On 06/15/2026 at 12:35 PM, the test trays were tasted after the last resident had been served and indicated the following:*Regular tray- Beef Fried Rice, Egg Rolls, Oriental mixed vegetables, fudge cookie. The beef fried rice appeared very dark. The rice and beef mixture was very bland and had no soy sauce or oriental flavor. It was room temperature. The egg roll was tough and slightly doughy and difficult to chew and swallow because it was dry. The Oriental vegetable blend was mushy and had no seasoning or taste and it was lukewarm in temperature. The fudge cookie was a commercially prepared treat in a wrapper and was chewy and fudgy in flavor and tasted good.*Alternate tray- Chicken and dressing and green beans. Carrots were also included by request since it was offered to the mechanical soft textured diets on the main meal. The chicken and dressing was warm and very flavorful and tasted good. The green beans tasted as if they had been poured from the can and heated. There was no seasoning or spices of any kind, they were bland and were barely warm. The carrots tasted bland with no flavor.During an interview on 06/15/2026 at 12:17 PM, Resident #23 said he did not want the regular lunch. Resident #23 said it did not look good and he did not want to eat it. Resident #23 requested a peanut butter and jelly sandwich as an alternative. During an interview on 06/15/2026 at 12:20 PM Resident #67 said her vegetables were way too soft and did not taste very good. She said the egg rolls were tough and difficult to bite through. The resident said she had snacks she was going to eat.During an interview on 06/15/2026 at 12:22 PM Resident #84 said the vegetables were way too soft and mushy and the main dish did not taste like stir fry and did not look appetizing. She ate some but said she would ask for a snack or eat what she already had in her room.During an interview on 06/15/2026 at 12:35 PM Resident #30 said she got her lunch tray, took the lid off, and tried a bite or two, but did not eat it. She said the vegetables were mushy and had no salt or other seasoning. She said the brown stuff did not look good and did not taste good and everything was barely warm. During an interview on 06/15/2026 at 12:40 PM Resident #81 said lunch was not good. She said everything was cold. She said the green beans and carrots tasted like they came straight from the can with no salt or anything else added. She said she did not try any of the rice and meat stuff because it just did not look good. She said she ate the cookie and drank her tea and asked them to bring her a sandwich. During an interview on 06/15/2026 at 12:30 PM Resident #2 refused his lunch tray said he did not like the stir-fried rice with meat or the vegetables with carrots however he said his meal was hot and requested a sandwich. During an interview on 06/15/2026 at12:35 PM Resident #37 said the stir fried looked like leftovers and was not appealing. She ate about 40% of her meal and refused a sandwich.During an observation and interview on 06/15/2026 at 12:40 PM Resident # 59 was observed picking at the food and only ate 1.5 of the 2 eggrolls. She said she did not like the rice and ground meat fried rice entree and said there was not enough meat and it was tasteless and the vegetables were watery with no taste. A sandwich was offered but said she did not want the sandwich. During an observation and interview on 06/15/2026 at 12:45 PM Resident # 56 ate 25-30% of the meal. She said she did not like the lunch meal and said the ground meat and rice were too spicy. She said she did not like the eggrolls and said the eggroll was hard. She said she did not like carrots. During an interview on 06/15/2026 at 1:10 PM the DM said the dietary department does not put any salt or pepper in the foods they prepare. She said the beef fried (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rice looked pale to her and she added soy sauce to the mixture and it gave it the dark brown color. She said she did not taste it. She said the beef mixture had been prepared with a bag of prepared frozen vegetable rice mixture (rice, peas, corn) and hamburger meat had been cooked and added to the rice mixture. She said she did not think the cook added any spices to the beef rice mixture. She said a lot of residents complain about too much salt or pepper and she said they did not add any salt. She said she buys other spices and flavorings for the cooks to use but they have their way of cooking and do not use the spices or will use one spice blend on everything they cook. She said some use a lot of garlic powder and some of the residents did not care for the garlic. She understood why the residents would say the food was bland because she agreed it was. She said she bought salt free butter and said it could also be added to vegetables for extra flavoring but she had long term staff that just did not listen to her. Review of the undated recipe for Beef Fried [NAME] indicated to serve approximately 90 residents the dietary department was to 1. [NAME] 20 lbs. of hamburger meat and set aside, 2. Heat 18 lbs. of the pre-cooked rice and vegetable medley, 3. Combine ground meat and rice and vegetable medley, 32 ozs. of chicken broth, 2 qts. low-sodium soy sauce, onion powder to taste, garlic powder to taste, and chicken bouillon base, and 1/4 cup of sugar, 4. Heat to temperature and hold.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 3 of 3 residents (Resident #6, Resident #47, and Resident #30) reviewed for infection control. The facility failed to ensure RN A wore PPE when providing intravenous care to Resident #6. The facility failed to ensure LVN D wore PPE when providing enteral feeding to Resident #47.CNA-M failed to remove PPE and discard prior to leaving resident 's room after providing perineal care, incontinent care for Resident #30. These failures could place residents at risk for cross contamination, spread of infection and sepsis, in violation of infection prevention and control requirements. Finding included: During an observation on 6/15/2026 at 10:30 A.M., RN A was in Resident #6's room providing intravenous medication (abbreviated as IV therapy) is a medical process that administers fluids, medications and nutrients directly into a person's vein. RN A was not wearing a mask or gown. There was signage indicating EBP was to be used, and PPE was present at the room entrance area. During an interview on 6/15/2026 at 12:45 PM, RN A said he didn't notice that he had not put on a gown for Resident #6, but was aware of the EBP and what he should have done when doing care a resident with an IV; The EBP signage read: When providing care for dressing, bathing/showering, transferring, changing linens, changing briefs or assisting with toileting, device care or use: central line(A central line is a long, flexible tube inserted into a large vein near the heart to deliver medications, fluids, or nutrition and to monitor blood parameters safely over an extended period), urinary catheter(Urinary catheters are medical devices that drain urine from your bladder if you have a condition that makes it difficult or impossible to urinate), feeding tube(A feeding tube is a medical device that delivers nutrition, fluids, and medications directly into the stomach or small intestine when a person cannot eat or swallow safely), tracheostomy(tracheostomy is a surgical procedure that creates an opening in the neck to facilitate breathing when the usual airway is obstructed or compromised), wound care any skin opening requiring a dressing. During an observation on 6/15/2026 at 1:46 PM, LVN D was observed in Resident #47 's room doing an enteral feeding and not wearing a mask or gown. There was signage indicating EBP was to be used, and PPE was present at the room entrance area. During an interview on 6/15/2026 at 2:15 PM, LVN D said she did not realize that she did not have a gown and mask on but knew she had gloves on. A record review of a face sheet dated 6/16/2026 revealed resident #47 was a [AGE] year-old female admitted to facility on 4/11/2013 with diagnosis of severe dementia, major depression and anxiety and dysphagia (difficulty swallowing) and gastrostomy. Resident #47 was unable to voice any concerns. During an interview on 6/16/2026 at 3:00 PM, the DON/IP (Infection Preventionist Nurse) stated potential negative outcomes for staff's failure to observe EBP for at-risk residents was cross contamination, spread of infection and sepsis, resulting from violation of infection prevention and control requirements. A record review of the facility's policy, dated 04/1/2024 and titled, Enhanced Barrier Precautions, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated the following: The policy of this facility is to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. The initiation of Enhanced Barrier Precautions will be obtained for residents with any of the following: Wounds (e.g., Bed-linen changes, chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers), and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes). A record review of a face sheet dated 06/16/2026, revealed Resident # 30 was a [AGE] year-old female admitted [DATE]. She had diagnoses which included hypokalemia (lower-than normal blood potassium levels), cellulitis (bacterial skin infection that affects the skin's deeper layer underlying tissues), gastro-esophageal reflux disease, acute myocardial infarction (heart attack), rheumatoid arthritis, cerebral infarction (stroke), candidiasis (a fungal infection), osteomyelitis (infection and inflammation of the bone tissue), hyperlipidemia (having too many lipids (fats), such as cholesterol), depressive disorder, anxiety disorder, hypertension, and type 2 diabetes mellitus. During an observation on 6/16/2026 at 9:50 A.M., CNA-M was observed performing perineal care and changing Resident #30's brief. CNA-M put on appropriate PPE, infection control practices were followed throughout providing perineal care/incontinent care. Upon completion of Perineal Care/Incontinent Care, CNA-M exited the room before removing PPE gown and gloves and discarded the gown and gloves in the hallway trash can. CNA M returned to Resident #30's room and said she forgot to remove the grown and gloves before leaving the room after providing care. CNA-M said she should have removed and discarded the PPE gown and gloves prior to exiting the resident's room. She stated the PPE should have been disposed of in the trash receptacle with the blue liner located in the resident's bathroom. During an interview on 06/16/2026 at 02:30 P.M., with the DON and ADON/IP Nurse, the DON said CNA's received training on the facility's EBP policy. The DON said staff were required to wear appropriate PPE during resident care, such as perineal care and linen changes, and remove and discard PPE before exiting the resident's room to help prevent the spread of pathogens. Both the DON and ADON said proper skill performance of hand hygiene, PPE use, and incontinent care technique were important for preventing the spread of infection. During an interview on 6/16/2026 at 3:00 PM, the ADON/IP (Infection Preventionist Nurse) stated failure of staff to follow EBP for at-risk residents could result in cross contamination, spread of infection and sepsis (a life-threatening response to an infection), due to noncompliance with infection prevention and control practices. During an interview on 6/17/2026 at 10:00 A.M., the DON stated the staff in the building were all trained and retrained on EBP. The DON further said failure of staff to follow EBP for at-risk residents could result in cross contamination, transmission of infection and sepsis (a life-threatening response to an infection), and would be a violation of the facility's infection prevention and control program. A record review of the facility's policy dated 04/1/2024 and titled, Enhanced Barrier Precautions, indicated the following: The policy of this facility is to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. The initiation of Enhanced Barrier Precautions will be obtained for residents with any of the following: Wounds (e.g., Bed-linen changes, chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers), and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes).

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary and comfortable environment for four of five rooms (Rooms 201, 203, 205, and 208) reviewed for environment. The facility failed to maintain clean and sanitary conditions in rooms 201, 203, 205, and 208 which had a yellowish liquid substance and brownish-black sticky residue present throughout the rooms along the seams of the vinyl flooring with dirt, debris and food particles adhering to the substance and residue. This failure could place residents at risk of living in an unsafe, unsanitary and uncomfortable environment.Findings included: During an observation on 06/15/2026 at 9:35 A.M. room [ROOM NUMBER] and at 9:58 A.M. room [ROOM NUMBER] had brownish-black raised sticky spots on the floor with dirt and food particles adhered to the substance. The substance appeared to be emerging from the seams of the vinyl flooring. During an observation and interview on 06/16/2026 at 9:10 A.M., Resident #84 stated that maintenance had attempted to clean the brownish-black sticky substance; however, the substance returned. She stated that her feet adhered to the floor and that the substance was transferred to her shoes and other belongings. There was brownish-black sticky residue around the seams of the vinyl flooring, ranging in size from a dime to a quarter. Shoes adhered to the floor while walking across the room. During an interview 06/16/2026 at 9:15 A.M., Resident #67 stated that the brownish-black sticky substance had been present on her floor since she moved into the room in the past month and that dirt adhered to the substance. During an interview on 06/16/2026 at 9:25 A.M., CNA-E stated that rooms on Hall 2 had experienced both the brownish-black sticky substance and a yellowish glue-like liquid emerging from the seams of the vinyl flooring since she began employment in October 2025. She stated the yellow glue-like substance adhered to shoes and dried into a sticky residue. She further stated that approximately three weeks prior she almost fell due to her shoes sticking to the floor and had reported the incident to the SW. During an interview on 06/16/2026 at 9:26 A.M., Resident #55 stated that the brownish-black sticky substance was always present and the housekeeping staff attempted to remove it. She reported that she attempted to wipe up what she could when she noticed the yellowish liquid coming up. During an observation 06/16/2026 at 9:36 A.M., room [ROOM NUMBER] had pieces of plastic bags, food particles, and dirt adhered to the floor by the brownish-black sticky substance. The substance was present throughout the room along the seams of the vinyl flooring. A 3-foot by 5-foot rug on the B side of the room was adhered to the floor and could not be moved. The rug contained dark sticky spots and appeared unmaintained not being washed. Additional dime- to pea-sized areas of brownish-black sticky residue were observed near the room's entrance. During an interview on 06/16/2026 at 9:40 A.M., the SW stated the facility was in the process of cleaning and replacing the flooring but was unable to provide documentation of a corrective action plan and was unaware when the issue was reported to administration. During an interview on 06/16/2026 at 9:50 A.M., the Housekeeping Supervisor stated the flooring was installed approximately one year earlier. She stated she notified the Maintenance Supervisor of the issue. She said although maintenance had cleaned the floors, the substance repeatedly returned. She stated housekeeping swept and mopped daily; however, the sticky substance remained and debris continued to accumulate. During an interview on 06/16/2026 at 10:00 A.M., HSK-F stated that foot traffic caused a yellowish liquid substance to emerge from the flooring seams, which later dried into a brownish-black sticky residue. She reported that the substance could not be removed by sweeping or mopping and that housekeeping scraped it from the floor, only for it to return by the following day. She stated maintenance was aware of the issue in the Hall 2 rooms for approximately two to three months. During an observation and interview on 06/16/2026 at 10:15 A.M., Resident #60 stated that despite cleaning efforts, the sticky brownish-black substance remained. She reported glue was coming up through the flooring seams and stated that when she attempted to clean (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the substance, her paper towel adhered to the floor. She stated the floor remained sticky and never appeared clean. The floor in room [ROOM NUMBER] had pea-sized areas of yellowish glue-like substances around the seams of the flooring in three separate locations, along with brownish-black sticky residue containing dirt and food particles. During an observation and interview on 06/16/2026 at 12:20 P.M., Resident #20 stated that her family had placed a rug in her room because glue was coming up from beneath the flooring and causing the floor to be sticky. The floor in room [ROOM NUMBER]B had brownish-black sticky substance on both the rug and flooring. During an interview on 06/16/2026 at 12:30 P.M., the MS stated he was aware of the sticky floor issue in room [ROOM NUMBER] but was unaware of similar concerns in other rooms. He stated issues would only come to his attention if entered on the maintenance board. During an interview on 06/16/2026 at 12:35 P.M., the SW stated staff conducted Angel Rounds (department supervisors' daily rounds though facility to check for issues to be addressed) daily Monday through Friday and that maintenance concerns should be identified during those rounds and entered onto the maintenance board for correction. During observations on 06/16/2026 at 2:30 P.M.-2:40 P.M., rooms [ROOM NUMBER] revealed yellowish liquid substance and brownish-black sticky residue throughout the rooms along the seams of the vinyl flooring. Record review of the Maintenance Log, dated 05/07/2026 through 06/01/2026, revealed only one maintenance entry related to sticky flooring in room [ROOM NUMBER]. The entry, dated 05/10/2026, indicated the issue was resolved and was marked completed. During an observation on 06/17/2026 at 9:04 A.M. of room [ROOM NUMBER] the yellowish liquid substance and brownish-black sticky residue remained present despite previous cleaning efforts. During an observation 06/17/2026 at 9:25 A.M., room [ROOM NUMBER] had a yellowish liquid substance emerging from the seams of the vinyl flooring and when pressure was applied by walking across the floor a quarter-sized pool of yellow liquid and multiple pea-sized areas were observed emerging. Brownish-black sticky residue was also present throughout the room along the flooring seams. During an observation and interview on 06/17/2026 at 9:32 AM, the Housekeeping Supervisor observed room [ROOM NUMBER] and stated she believed the substance was glue. She stated the condition had existed since the flooring was installed more than one year earlier and occurred daily in several rooms. She stated housekeeping used a Swiffer to remove wet material and scrapers to remove dried residue. During an interview on 06/17/2026 at 9:33 A.M., the DON stated she believed the substance was glue coming up through the flooring and that the condition had existed since the rooms were retiled more than one year earlier. During an observation and interview on 06/17/2026 at 11:11 A.M., the MS observed rooms [ROOM NUMBERS] and stated a yellowish milky liquid substance was emerging between the vinyl floor tiles. He stated the substance was glue and reported that he rolled the flooring to force the glue upward and cleaned up substance and then waxed the floors. He stated maintenance concerns were communicated through the maintenance board. A record review of facility policy titled, Maintenance Service, revised December 2009, indicated the following: Policy Statement:Maintenance service shall be provided to all areas of the building, grounds, and equipment. Policy Interpretation and Implementation:2.The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.

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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 a resident who needed respiratory care was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences for 1 of 2 residents (Residents #59) reviewed for respiratory care. 1.The facility failed to ensure Resident #59's nasal cannula was changed and dated in accordance with facility policy that required weekly replacement. 2. The facility failed to ensure Resident #59's humidifier bottle was changed and dated in accordance with facility policy that required weekly replacement. This deficient practice could place residents at risk for respiratory-related infections Findings included: Record review of a face sheet dated 06/16/2026 revealed Resident # 59 was an [AGE] year-old female, admitted [DATE]. She had diagnoses which included fracture of right femur, cardiac pacemaker, chronic kidney disease, hyperlipidemia (having too many lipids(fats), such as cholesterol), dementia, psychotic disturbance, anxiety disorder, congestive heart failure, presence of cardiac pacemaker, spinal stenosis (narrowing of the spaces within your spine), dyspnea (shortness of breath), hypertension, and type 2 diabetes mellitus. A record review of Resident #59's quarterly MDS assessment, dated 03/19/2026 revealed a BIMS score of 15, which indicated cognitively intact. Section GG-Functional Abilities indicated Resident #59 required substantial/maximal assistance. A record review of Resident #59's physician orders dated 06/1/2026-06/30/2026 revealed an active physician order, initiated on 05/05/2026 for oxygen at 2 liters per minute by nasal cannula as needed for shortness of breath. Nebulizer-Change tubing every week on Wednesday 7:00 A.M. to 3:00 P.M., remember to date and initial tubing/applicator. During an observation on 06/15/2026 at 9:20 A.M., Resident #59's oxygen concentrator humidifier bottle was labeled and dated 6/2/2026. Further observation revealed Resident #59's nasal cannula tubing was labeled and dated 6/2/2026. During an interview on 06/15/2026 at 10:30 A.M., MA-B said the nursing staff were responsible for changing the oxygen concentrator humidifier bottle and the nasal cannula tubing for all residents who used oxygen, which was normally done weekly on Wednesdays. During an observation and interview on 06/16/2026 at 2:20 P.M., the ADON observed Resident #59's oxygen concentrator humidifier bottle, and nasal cannula tubing were labeled and dated 6/2/2026. ADON said the humidifier bottles and oxygen tubing were routinely changed weekly on Wednesdays by the charge nurses. She observed the equipment was not changed as scheduled and could not explain why. The ADON said she would immediately replace the humidifier bottle and oxygen tubing and applied updated labels and dates. She stated this failed practice could increase respiratory infections. During an interview on 06/17/2026 at 1:30 P.M., LVN-D said the charge nurses on each hallway were responsible for changing oxygen concentrator's pre-filled humidifier bottles and nasal cannula tubing weekly, typically on Wednesdays, and documented in the TAR. LVN-D said nursing staff received training and in-service education regarding weekly replacement of oxygen nasal cannula tubing and humified distilled water bottle, and the DON or ADON normally provided training. During an interview on 06/17/2026 at 1:45 P.M., the ADON said she and the DON were responsible for monitoring compliances with changing oxygen concentrator's humidifier bottles and nasal cannula tubing weekly. She further stated staff were informed and trained on the humidifier bottles and oxygen tubing change policy and that she normally completed the in-services. During an interview on 06/17/2026 at 1:45 P.M., the DON said the charge nurses were responsible for changing the oxygen tubing, the humidifier bottles and nasal cannula tubing weekly. The DON further said the ADON and DON were responsible for training and monitoring charge nurses to ensure compliance with facility policies. However, DON was unable to provide the facility's process for monitoring or ensuring staff compliance with the weekly oxygen equipment changes. A record review of the facility's policy titled, Administration of Oxygen, un-dated, indicated: .16. Change distilled water in humidifier weekly. Water in humidifier should be maintained and changed as necessary. Oxygen cannula, tubing and humidifier bottles should be changed weekly and as needed.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure all mechanical, electrical, and patient care equipment was in safe operating condition for 1 of 6 (Resident #65) reviewed for environment. The facility failed to repair or replace Resident #65's bed after the bed remote jammed and the foot of the bed frame creaked and abruptly dropped during operation. This failure could place residents at risk for impaired positioning, discomfort, and a reduced quality of life due to the use of malfunctioning equipment. The findings included: A record review of Resident #65's undated face sheet indicated a [AGE] year-old female admitted [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (partial or complete weakness on the left side of the body following a blockage in the brain), unspecified lack of coordination, torticollis (involuntary contraction of the neck muscles, causing the head to tilt to one side while the chin points to the opposite side), primary generalized osteoarthritis (a joint disease characterized by the breakdown of cartilage in multiple joints, leading to pain, stiffness, and decreased mobility), cognitive communication deficit (a disruption in mental processes essential for communication), and restless leg syndrome (a neurological disorder characterized by an irresistible urge to move the legs). A record review of Resident #65's most recent Quarterly MDS dated [DATE] indicated a BIMS of 10, which indicated moderate cognitive impairment. The MDS indicated Resident #65 required substantial/maximum assistance for rolling from lying on her back to the left and right side and returning to lying on her back on the bed and was dependent for transferring from the bed to a chair. The MDS indicated Resident #65 was always incontinent of bowel and bladder. During an observation and interview on 06/15/2026 at 11:07 AM, Resident #65 was seen lying in bed with the head of the bed slightly propped. Resident #65 stated her bed was broken. Resident #65 stated when she pushed the button on the remote for the bottom foot area of the bed to lower it would creak and drop all at once. Resident #65 stated she lowered it at 2:00 AM and it startled her but did not harm her. Resident #65 stated a few weeks prior she notified LVN H who notified maintenance of the broken bed. Resident #65 stated the Maintenance Assistant informed her the Maintenance Supervisor was ordering her a new bed. During an interview on 06/16/2026 at 8:45 AM, the Maintenance Supervisor stated he was unaware of anything wrong with Resident #65's bed. The maintenance supervisor provided the current work orders and stated there was no current Maintenance Request for Resident #65's bed. A record review on 06/16/2026 at 8:46 AM of the current maintenance requests dated 06/12/2026 through 06/15/2026 did not reveal any current maintenance requests for Resident #65's bed. During an interview and observation on 06/16/2026 at 8:47 AM, the Maintenance Assistant went to Resident #65's room to look at her bed and stated he did not know it was broken. The Maintenance Assistant was able to operate the buttons on the remote by pushing them with force. The Maintenance Assistant lowered the foot of the bed and a loud creaking sound was heard with a sudden drop occurring as the foot of the bed was lowered. During an interview on 06/16/2026 at 8:49 AM, Resident #65 stated she told LVN H about her issues with the bed weeks prior and CNA G who stated she also notified LVN H. Resident #65 stated LVN H operated the bed and it was working at that time but stated she would place a work order. During an interview on 06/16/2026 at 8:53 AM, LVN H stated Resident #65's bed has always worked fine for her and she was unaware of any issues Resident #65 or staff were having with the bed. During an interview on 06/16/2026 at 8:57 AM, CNA G stated she believed the Maintenance Assistant looked at Resident #65's bed a week or two ago. CNA G stated she noticed issues with the bed and Resident #65 told her. CNA G stated she personally notified the Maintenance Assistant the top buttons of the bed remote were hard to push, but she did not know about any issues with the foot of the bed. During an interview on 06/16/2026 at 9:05 AM, the Maintenance Assistant stated after observing the bed, he thought the metal on the base was grinding against each other. The Maintenance Assistant stated he did not believe the bed was unsafe (continued on next page)

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as the legs are secured, which ensured nothing would fall through or off the bed. The Maintenance Assistant stated he knew Resident #65 wanted the head of the bed to go higher and about the foot of the bed dropping and was notified in the last month, but did not know about the remote being difficult to use or broken. The Maintenance Assistant stated he had never witnessed himself the foot of the bed dropping. The Maintenance Assistant stated he did not complete a maintenance request for this concern. The Maintenance Assistant stated he was unable to order Resident #65 a new bed as that was something the Maintenance Supervisor would have to do. The Maintenance Assistant stated he was sure he had notified the Maintenance Supervisor who stated they could obtain a bed from a different hall. During an interview on 06/16/2026 at 9:14 AM, the Maintenance Supervisor stated he expected staff to complete a maintenance request for any maintenance related concerns. The Maintenance Supervisor stated he did not expect the Maintenance Assistant to complete a maintenance request as they communicate verbally. The Maintenance Supervisor stated nursing staff were his eyes and if they saw any issues they needed to write a maintenance request. The Maintenance Supervisor stated that when a maintenance request was completed he did not have concerns related to it being resolved as he must resolve it before closing it out. The Maintenance Supervisor stated that every staff member was notified of the maintenance request board. A record review of the last month's maintenance request log on 06/16/2026 at 9:33 AM dated 05/07/2026 through 06/01/2026 indicated an undated maintenance request located between two other requests dated 05/21/2026. The undated maintenance request indicated the person making the request was the maintenance assistant, the location of repair was Resident #65's bed, and the type of repair made was maintenance. During an interview on 06/16/2026 at 9:35 AM, Resident #65 stated she was able to operate the buttons on the remote when she beat the remote, jammed the buttons down, and held her mouth right and even then it only occasionally worked. Resident #65 stated she was unsure if CNA G knew about the foot of the bed dropping abruptly. During an interview on 06/16/2026 at 9:44 AM, CNA G stated she personally told the maintenance assistant about Resident #65's bed not lowering completely as Resident #65 was upset about the bed not working. CNA G stated she did not complete a maintenance request. CNA G stated she was not in the room when the maintenance assistant spoke to the resident, but she thought she heard him say that he would get Resident #65's bed changed. During an interview on 06/17/2026 at 9:59 AM, Resident #65 stated she had multiple issues with the remote to the bed in the past day. Resident #65 stated at one time she was unable to push the button on the remote and required a CNA's assistance. Resident #65 stated that at another time she pushed the button to lower the head of the bed and it raised it. During an interview on 06/17/2026 at 11:32 AM, the DON stated if there were issues with a resident's bed or the bed was broken she expected staff to notify maintenance by completing a maintenance request. The DON stated staff could tell maintenance as they see them, but they typically were to write it on the maintenance request board. The DON stated a broken bed would need to be addressed. The DON stated the Maintenance Supervisor and the Maintenance Assistant were responsible for making sure resident beds were in working condition. The DON stated if the resident thought they needed a different bed and was agreeable to changing the bed, it should be changed. The DON stated the Maintenance Assistant told her two days prior that he looked at Resident #65's bed and the bottom was messing up but that he fixed the issue. The DON stated there was a gap in communication in addressing Resident #65's concerns with her bed. The DON stated the risk to residents for a gap in communication depended on what was wrong with the bed. The DON stated staff should have completed a maintenance request to address the issue with Resident #65's bed. A record review of facility policy titled Maintenance Service revised December 2009 indicated the following: Policy StatementMaintenance service shall be provided to all areas of the building, grounds, and equipment. Policy Interpretation and ImplementationThe Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.