STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455946	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sweetwater Healthcare Center	1600 Josephine St Sweetwater, TX 79556

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure all Pre-admission Screening and Resident Review (PASRR) Level I residents with mental illness were provided with an accurate PASRR Level I for 3 of 24 residents (Resident #9, Resident #17, and Resident #18) reviewed for PASRR screening, in that: Resident #9 did not have an accurate and updated PASRR Level 1 assessment, reflecting a diagnosis of mental illness. Resident #17 did not have an accurate and updated PASRR Level 1 assessment, reflecting a diagnosis of mental illness.Resident #18 did not have an accurate and updated PASRR Level 1 assessment, reflecting a diagnosis of mental illness. This failure could place residents, with an inaccurate PASRR Level 1 and no PASRR Level 2 Evaluation, at risk for not receiving care and services to meet their needs. The findings included: Resident #9: Record review of Resident #9's electronic face sheet dated 03/09/2026 revealed a [AGE] year-old female admitted to the facility on [DATE]. The face sheet included the following diagnoses: cerebral infarction due to thrombosis of an unspecified cerebral artery(primary) (type of ischemic stroke), Major Depressive Disorder, recurrent, severe with psychotic features (a mood disorder that causes a persistent feeling of sadness and loss of interest), unspecified Dementia, severe, with agitation (decline in mental abilities-including memory, language, problem-solving, and thinking), Post Traumatic Stress Disorder (severe, long-term mental health condition arising from, or persisting after, a traumatic event, characterized by symptoms lasting longer than three months (often over one year)), and other specified disorders of brain. Record review of Resident #9's Annual MDS dated [DATE], under section I (Active Diagnoses), indicated Resident #9 had a Psychotic/Mood Disorder of Post Traumatic Stress Disorder. Additionally, under Section C Cognitive Patterns, Resident #9's MDS revealed a BIMS of 3, indicating the resident was severely, cognitively impaired. Record review of Resident #9's care plan dated 02/25/2026, under Diagnoses indicated Resident #9 had a diagnosis of Major Depressive Disorder and Post Traumatic Stress Disorder. Record review of Resident #9's physician's Order Summary as of 03/09/2026 revealed under Diagnoses Major Depressive Disorder, recurrent, severe with psychotic features and Post Traumatic Stress Disorder. Resident #9 was prescribed Seroquel oral tablet 200 MG (Quetiapine Fumarate) (Give 1 tablet by mouth, three times a day) related to Major Depressive Disorder, Recurrent, severe with psychotic symptoms. Record review of Resident #9's PASRR Level 1 Screening dated 10/08/2024 revealed the following: under section C (PASRR Screening), C0090 Primary Diagnosis of Dementia: NO, under section C (PASRR Screening), C0100 Mental Illness: NO. Record review of Resident #9's Diagnosis Report, dated 03/10/2026, revealed the following under Diagnosis: Major Depressive Disorder recurrent, Severe with Psychotic Features with an onset date of 12/13/2024 and Post Traumatic Stress Disorder with an onset date of 12/13/2024. Resident #17: Record review of Resident #17's electronic face sheet dated 03/09/2026 revealed a [AGE] year-old female admitted to the facility on [DATE]. The face sheet included the following diagnoses: Type 2 Diabetes Mellitus with diabolic polyneuropathy (primary) (chronic metabolic disorder characterized by high blood sugar that causes widespread nerve damage throughout the body), Major Depressive Disorder, recurrent, severe without psychotic features (a mood disorder that (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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	causes a persistent feeling of sadness and loss of interest), and Vascular dementia, unspecified severity, with other behavioral disturbance (d Cognitive decline (memory, thinking, and reasoning problems) caused by impaired blood flow to the brain,). Record review of Resident #17's Annual MDS dated [DATE], under section I (Active Diagnoses), indicated Resident #17 had a Psychotic/Mood Disorder of Depression. Additionally, under Section C Cognitive Patterns, Resident #17's MDS revealed a BIMS of 12, indicating the resident was cognitively impaired. Record review of Resident #17's care plan dated 12/31/2025, under Diagnoses indicated Resident #17 had a diagnosis of Major Depressive Disorder. Record review of Resident #17's physician's Order Summary as of 03/09/2026 revealed under Diagnoses Major Depressive Disorder, recurrent, severe without psychotic features. Resident #17 was prescribed Zoloft oral tablet 100 MG (Sertraline HCl) (Give 1 tablet by mouth, three times a day) related to Major Depressive Disorder, Recurrent, severe without psychotic symptoms. Record review of Resident #17's PASRR Level 1 Screening dated 10/08/2024 revealed the following: under section C (PASRR Screening), C0100 Mental Illness: NO. Record review of Resident #17's Diagnosis Report, dated 03/10/2026, revealed the following under Diagnosis: Major Depressive Disorder recurrent, Severe without Psychotic Features with an onset date of 08/17/2024. Resident #18: Record review of Resident #18's electronic face sheet dated 03/09/2026 revealed an [AGE] year-old female admitted to the facility on [DATE]. The face sheet included the following diagnoses: Unspecified sequelae of unspecified cerebrovascular disease (primary) (long-term physical or cognitive impairments resulting from an undefined brain blood vessel disease or stroke), Major Depressive Disorder, recurrent, severe without psychotic features (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia, Dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (Cognitive decline (memory, thinking, and reasoning problems) caused by impaired blood flow to the brain,). Record review of Resident #18's Annual MDS dated [DATE], under section I (Active Diagnoses), indicated Resident #18 had a Psychotic/Mood Disorder of Anxiety and Depression. Additionally, under Section C Cognitive Patterns, Resident #18's MDS revealed a BIMS of 7, indicating the resident was moderately, cognitively impaired. Record review of Resident #18's care plan dated 03/05/2025, under Diagnoses indicated Resident #18 had a diagnosis of Major Depressive Disorder. Record review of Resident #18's physician's Order Summary as of 03/09/2026 revealed under Diagnoses Major Depressive Disorder, recurrent, severe without psychotic features. Resident #18 was prescribed Cymbalta oral Capsule Delayed Release Particles 60 MG (Duloxetine HCll) (2 capsules by mouth at bedtime related to) related to Major Depressive Disorder, recurrent, severe without psychotic symptoms. Record review of Resident #18's PASRR Level 1 Screening dated 07/02/2019 revealed the following: under section C (PASRR Screening), C0100 Mental Illness: NO. Record review of Resident #18's Diagnosis Report, dated 03/10/2026, revealed the following under Diagnosis: Major Depressive Disorder Recurrent, Severe without Psychotic Features with an onset date of 07/03/2019. During an interview conducted on 03/10/2026 at 10:00 AM with the DON and the SW, the DON stated the MDS nurse was usually responsible for PASRR screenings and ensuring they were completed and accurate. The DON stated the facility had a new MDS nurse that was currently in training. The DON stated she and the ADON were currently screening PASRR assessments when residents were admitted to the facility. The DON stated she was not aware a diagnosis of Major Depressive Disorder would classify as a mental illness and should be reflected on the PASRR Level 1. The DON stated she was not aware of Resident 9, Resident #17, and Resident #18's diagnoses of a mental illness that was not reflected on the PASRR screenings. The SW stated she assisted with screening PASRR Level 1 screenings, but she was not aware of the incorrect PASRR Level 1 screening for Resident #9, Resident! #17, or Resident #18. The DON stated, when a resident received a new diagnosis of a mental illness, it was her expectation that a new PASRR Level 1 screening was requested for the resident. The DON stated she believed the mental illness diagnoses for Resident #9, Resident #17, and Resident #18 were received after the PASRR Level 1 screenings (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were completed. The DON stated she did not know why this was not completed for Resident #9, Resident #17, or Resident #18. The DON stated staff received training on PASRR, and they would complete an updated PASRR training soon. The DON stated if a resident did not have an accurate PASRR Level 1, it could affect the resident receiving services from which they may benefit. The SW stated if a resident qualified for services, this could potentially be an additional visitor for residents who would benefit form more social interaction. During an interview conducted on 03/10/2026 at 11:30 AM the ADM stated the DON, ADON, SW, and MDS nurse were responsible for ensuring PASRR Level 1 screenings were accurate upon admission, and they were all responsible for requesting an updated PASRR Level 1 screening when a resident received a new mental illness diagnosis. The ADM stated the facility's MDS nurse was new and in training. The ADM stated he was not aware Resident #9, Resident #17, and Resident #18 did not have an accurate PASRR Level 1 screening, reflecting mental illness diagnoses. The ADM stated PASRR screenings were reviewed during the admission process and should have been updated if any changes arose. The ADM stated it was his expectation for all residents' PASRR Level 1 screenings to be accurate. The ADM stated he and facility staff have received training on PASRR. The ADM stated if a resident's PASRR Level 1 screening was not accurate, the resident may not have received the services for which they may qualify. Record review of the facility's policy titled, PASRR, dated 01/20/2026 revealed the following: Purpose:The aim of the PASRR program is to identify residents with Mental Illness (MI), Intellectual Disability (ID), or Developmental Disability (DD)/Related Conditions (RC) and to ensure they are properly placed, whether in community or in a Nursing Facility (NF) and to ensure they receive the services they require for their MI, or ID/DD.6. The facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Procedure:The PASRR Level 1 Screen (PL1)The facility Admissions Coordinator or designee will ensure the referring entity provides a copy of the PL1 upon admission.In the event the facility is considering an admission from the community (home, homeless shelter, jail, group home, off the street etc.) and if the facility Interdisciplinary Team (IDT) suspects any MI, ID, or DD the community Admissions Coordinator prior to admission will contact the LIDDA and follow the preadmission process.1. The referring entity {the family, group home, homeless shelter, jail, off the street, etc.) faxes PL1 to LIDDA (72 hour timer starts)If needed, the NF can assist the family, etc. to complete and fax the PL1 to the LIDDA.When it is determined that a PL1 was filled out incorrectly, the MOS Coordinator, Social Worker or designee will reach out to the hospital/responsible case worker and ask them to correct the form.If the referring case worker is unwilling/unable to correct the PL1 that contains a potential error, the social worker or designee will complete and submit a form 1012 {MI) or new PL1 {ID/DD). A subsequent positive PL1 will be entered according to 1012 findings {MI).When it is determined that an individual's diagnosis was changed and/or a state surveyor determines the PL1 was incorrect, the social worker or designee will complete and submit a form 1012 (MI) or new PL1 (ID/DD). A subsequent positive PL1 will be entered according to 1012 findings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services, in that:The facility failed to ensure frozen french fries were stored in a sealed, dated, and labelled freezer-safe bag in the freezer. The facility failed to ensure frozen tator tots were stored in a sealed, dated, and labelled freezer-safe bag in the freezer. The facility failed to ensure a container of parmesan cheese contained an expiration/use by date after opening and was discarded by that date. The facility failed to ensure a container of processed, sliced strawberries contained an expiration/use by date after opening and was discarded by that date. The facility failed to ensure a container of prepared sloppy joe mix was discarded by the use by date. The facility failed to ensure a dented can of peaches was discarded. These failures could place residents who received meals and/or snacks from the kitchen at risk of food contamination and food borne illness.Findings included:During the initial tour and observation of the kitchen on 03/08/2026 at 11:00 AM the following were revealed: One package of opened french fries was observed in the freezer, unsealed, unlabeled, and undated. One package of opened tator tots was observed in the freezer, unsealed, unlabeled, and undated. A plastic container of grated parmesan cheese was observed in the refrigerator with an opened date of 10/21/2025. The container did not have an expiration or use by date on the container. A plastic container of processed sliced strawberries was observed in the refrigerator with an opened date of 03/04/2026. There was no expiration or use by date on the container. A plastic container of prepared sloppy joe mix was observed in the refrigerator with a prepared date of 03/04/2026 and a use by date of 03/07/2026. A can of peaches was observed on the shelf with other cans. The first can of peaches contained a dent at the bottom of the can that continued into the side of the can. The dent was visible without rotating the can on the shelf. During an interview on 03/08/2026 at 11:15 AM [NAME] A stated prepared foods and containers of processed foods were good for 3 days in the refrigerator, and they were discarded after 3 days. [NAME] A stated the facility did not have a separate area to store dented cans of food items. [NAME] A stated she had never seen any dented cans of food items in the facility. [NAME] A stated they never used dented cans or expired foods as it could cause residents to get sick. [NAME] A stated all food items had to be labeled and dated once they were opened with an opened date and an expiration date. During an interview on 03/08/2026 at 11:20 AM [NAME] B stated the facility did not have a separate area to store dented cans of food items. [NAME] B stated she had never seen any dented cans of food items in the facility. [NAME] B stated they never used dented cans since it could cause residents to get sick. [NAME] B stated all food items had to be labeled and dated once they were opened with an opened date and an expiration date. [NAME] B stated prepared foods and containers of processed foods were good for 3 days in the refrigerator, and they were discarded after 3 days. [NAME] B stated they never used expired foods as it could cause residents to get sick. During an observation of the kitchen on 03/09/2026 at 11:30 AM revealed the following:A plastic container of processed sliced strawberries was observed in the refrigerator with an opened date of 03/04/2026. There was no expiration or use by date on the container. A can of peaches was observed on the shelf with other cans. The first can of peaches contained a dent at the bottom of the can that continued into the side of the can. The dent was visible without rotating the can on the shelf. There was no identifiable areas for dented cans to be stored away from non-dented cans. During an interview on 03/10/2026 at 9:40 AM the DM stated she had been the dietary manager for the facility for two years. The DM stated she was responsible for putting away food items in the freezer and refrigerator as well as canned items in the pantry area. The DM stated this was a task she did herself, but dietary staff did help her at times. The DM stated she became aware of the opened bags of french fries and tator tots after the initial tour on 03/08/2026. The DM stated she believed they (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were left from the previous night staff. The DM stated she completed in-service training with her staff frequently, with reminders daily about labeling and dating opened food items. The DM stated this was something she planned to complete again as soon as possible. The DM stated she became aware of the container of parmesan cheese in the refrigerator after the initial tour on 03/08/2026. The DM stated the hold time for the opened container of grated parmesan cheese should have been one month. The DM stated this item was overlooked and she had since discarded it. The DM stated the expired container of prepared sloppy joe mix was overlooked as well, but it had since been discarded. The DM stated the hold time for the opened container of strawberries was approximately seven days, and she did not know why it did not have a use by date. The DM stated she was unaware of the dented can of peaches. The DM stated she would discard it right away. The DM stated all dietary staff have received training on the importance of not using dented cans. The DM stated it was her expectation that all food items were labeled and dated with an opened date and a use by date, and that all items were discarded on those dates. The DM stated it was important that all food items be labeled and dated as consuming expired or outdated items may cause residents to get sick. During an interview on 03/10/2026 at 10:40 AM the ADM stated all food items were supposed to be dated when they came in and when the staff opened the food item. The ADM stated he expected that any expired food items be discarded properly. The ADM stated the DM and all dietary staff were responsible for ensuring food was stored properly. The ADM stated he also made frequent rounds in the kitchen to ensure food was stored properly. The ADM stated all dented cans should have been stored separately and not used. The ADM stated dietary staff received training upon hire and with regular in-services. The ADM stated it was important that dietary staff followed all policies and procedures to protect the residents' health, and not doing so could cause infections and illnesses. Record review of the facility's policy titled, Refrigerators and Freezers, dated November 2022, revealed the following: Policy Statement:This facility will ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines.Policy Interpretation and Implementation:7. All food is appropriately dated to ensure proper rotation by expiration dates. Received dates (dates of delivery) are marked on cases and on individual items removed from cases for storage. Use by dates are completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food are observed and use by dates are indicated once food is opened.8. Foods kept in the refrigerator/freezer are stored according to the Food Receiving and Storage policy.9. Supervisors are responsible for ensuring food items in pantry, refrigerators, and freezers are not past use by or expiration dates. Supervisors should contact vendors or manufacturers when expiration dates are in question or to decipher codes on packaging. Record review of the facility's policy titled, ,Food Receiving and Storage dated November 2022, revealed the following: Policy Statement:Foods shall be received and stored in a manner that complies with safe food handling practices.Policy Interpretation and Implementation:Refrigerated/Frozen Storage1. All foods stored in the refrigerator or freezer are covered, labeled and dated (use by date).3. Refrigerated foods are stored in such a way that promotes adequate air circulation around food storage containers.7. Refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their own established smoking policy for 5 of 6 residents reviewed for smoking. (Resident #11, #21, #29, #35, #38)The facility failed to follow smoking policy and complete smoking assessments quarterly for the following Residents #11, #21, #29, #35, #38. This failure could place residents at risk of injury or harm.Findings included:1. Record review of Resident #11's face sheet dated 03/10/2026 indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #11 had diagnoses which included cerebral infarction (blood flow to part of the brain was blocked), difficulty walking, diabetes (high blood sugar), nicotine dependence, and hypertension (high blood pressure). Record review of Resident #11's annual MDS assessment dated [DATE], indicated he had a BIMS score of 15, which indicated he had intact cognition. The MDS indicated Resident #11 was independent or needed set-up/clean-up assistance for most ADLs. Record review of Resident #11's Care Plan Report dated 09/02/25 indicated he was a smoker. Record review of Resident #11's Safe Smoking assessment dated [DATE] indicated Resident #11 had demonstrated ability to safely smoke. 2. Record review of Resident #21's face sheet dated 03/10/2026 indicated she was [AGE] years old and admitted to the facility on [DATE]. Resident #21 had diagnoses which included cerebral infarction (blood flow to part of the brain was blocked), limitation of activities due to disability, muscle weakness, diabetes (high blood sugar), nicotine dependence, and hypertension (high blood pressure). Record review of Resident #21's annual MDS assessment dated [DATE], indicated she had a BIMS score of 10, which indicated she had moderate cognitive impairment. The MDS indicated Resident #21 was dependent or substantial/maximal assistance for most ADLs. Record review of Resident #21's Care Plan Report dated 09/02/25 indicated she was a smoker. Record review of Resident #21's Safe Smoking assessment dated [DATE] indicated Resident #21 had demonstrated ability to safely smoke. 3. Record review of Resident #29's face sheet dated 03/10/2026 indicated she was [AGE] years old and admitted to the facility on [DATE] and readmitted on [DATE]. Resident #29 had diagnoses which included hyperlipidemia (high lipids), hypothyroidism (underactive thyroid), nicotine dependence, anxiety (feeling of fear and worry), difficulty walking, muscle weakness, chronic obstructive pulmonary disease (long term lung disease that makes it hard to breathe) and hypertension (high blood pressure). Record review of Resident #29's annual MDS assessment dated [DATE], indicated she had a BIMS score of 13, which indicated she had intact cognition. The MDS indicated Resident #29 was supervised or set up assistance for most ADLs. Record review of Resident #29's dated 09/22/25 Care Plan Report indicated she was a smoker. Record review of Resident #29's Safe Smoking assessment dated [DATE] indicated Resident #29 had demonstrated ability to safely smoke. 4. Record review of Resident #35's face sheet dated 03/10/2026 indicated he was [AGE] years old and admitted to the facility on [DATE] and readmitted on [DATE]. Resident #35 had diagnoses which included chronic kidney disease, major depressive disorder (mental health condition that causes a persistently low or depressed mood and loss of interest) Schizophrenia (mental condition that causes hallucination and delusions), diabetes (high blood sugar), muscle weakness and hypertension (high blood pressure). Record review of Resident #35's annual MDS assessment dated [DATE], indicated he had a BIMS score of 14, which indicated he had intact cognition. The MDS indicated Resident #35 was independent or needed set-up/clean-up assistance for most ADLs. Record review of Resident #35's Care Plan Report dated 10/03/2025 indicated he was a smoker. Record review of Resident #35's Safe Smoking assessment dated [DATE] indicated Resident #35 had demonstrated ability to safely smoke. 5. Record review of Resident #38's face sheet dated 03/10/2026 indicated he was [AGE] years old and admitted to the facility on [DATE]. Resident #38 had diagnoses which included major depressive disorder (mental health condition that causes a persistently low or depressed mood and loss of interest), Schizophrenia (mental condition that causes hallucination and delusions), (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	anxiety (feeling of fear or worry), and hypertension (high blood pressure). Record review of Resident #38's annual MDS assessment dated [DATE], indicated he had a BIMS score of 06, which indicated he had severe cognitive impairment. The MDS indicated Resident #38 was supervised or needed set-up/clean-up assistance for most ADLs. Record review of Resident #38's Care Plan Report dated 01/21/2026 indicated care plan for smoking. Record review of Resident #38's Safe Smoking assessment dated [DATE] (completed after surveyor intervention) indicated Resident #38 had demonstrated ability to safely smoke with direct visual supervision.During an interview on 03/10/2026 at 09:54 a.m. SW stated she was responsible for smoking assessments. She stated she was not aware Resident #38 was a smoker. She stated she found out he was smoking last week on Friday (03/06/2026). She stated she had not completed his safe smoking assessment until today (03/10/2026). She stated the process for completing smoking assessments was the smoking assessments should be completed on day of admission and quarterly. She stated she does not know why the smoking assessment was not completed. She stated she had been trained on the facility smoking policy. She stated the potential negative outcome could lead to a burn injury. During an interview on 03/10/2026 at 11:09 a.m. DON stated she was not aware the smoking assessments were not being completed on admission and quarterly. She stated the SW was responsible for completing the smoking assessment on admission and quarterly. She stated the facility recently switched to new electronic medical record software and smoking assessments were not scheduled. She stated all smoking residents should have quarterly smoking assessments. She stated the potential negative outcome could be not knowing if the resident can safely smoke or need a smoking apron. During an interview on 03/10/2026 at 11:25 a.m. ADM stated he was not aware smoking assessments were not being completed on admission and quarterly. He stated the SW was responsible for smoking assessments. He stated smoking assessments should be completed quarterly and with any change of condition. He stated all staff had been trained on the facility smoking policy. He stated the potential negative outcome could be a hazard to the residents even with staff present, if the resident required a smoking apron and it was not used. Record review of the facility policy titled Smoking Policy - Resident dated October 2022 reflected the following: Policy Statement - This facility shall establish and maintain safe resident smoking practices.Policy Interpretation and Implementation.7. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoke or smokeless tobacco uses, the evaluation will include: .d) ability to smoke safely with or without supervision (per a completed Smoking Assessment) .9. A resident's ability to smoke or chew tobacco safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by staff .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident's right to a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for 1 of 24 resident bathrooms (Resident #3) in that: The bathroom sink in Resident #3's room was broken and detached from the wall. This failure could lead to residents experiencing a diminished quality of life and could place residents at risk for injuries. The findings included:Record review of Resident #3's electronic face sheet dated 03/09/2026 revealed a [AGE] year-old female, admitted to the facility on [DATE]. The face sheet indicated, under Diagnosis Information, diagnoses that included Cerebral infarction due to thrombosis of unspecified cerebral artery (stroke caused by a blood clot (thrombus) that blocks a blood vessel supplying blood to the brain). Record review of Resident #3s MDS (Minimum Data Set) assessment dated [DATE], revealed underSection C Cognitive Patterns, a BIMS score of 3 indicating the resident was severely, cognitively impaired. During an observation and interview on 03/08/2026 at 11:38 AM the bathroom sink in Resident #3's room was observed to be broken and detached from the wall. During an attempted interview with Resident #3, the resident was determined to be unable to be interviewed due to the resident's severe cognitive impairment. During an interview on 03/08/2026 at 11:45 AM the DON stated she was aware of the broken sink, and it was her understanding the MD had already repaired the sink. The DON stated she would contact the MD immediately, and she would ensure the sink was repaired as soon as possible. During an observation on 03/08/2026 at 4:30 PM the bathroom sink in Resident #3's room was observed to be replaced with a new sink and was functioning normally. During an interview on 03/10/2026 at 10:10 AM the DON stated the MD was responsible for completing repairs within the facility. The DON stated needed repairs were reported through an online system. The DON stated all staff were capable of reporting repairs needed, either directly to the MD or through the online system. The DON stated a broken sink could have resulted in an injury to a resident. The DON stated it was her expectation for repairs to be completed as soon as possible. During an interview on 03/10/2026 at 10:30 AM the ADM stated the MD was responsible for completing repairs within the facility. The ADM stated the facility used an online system to report maintenance requests. The ADM stated the MD received notifications of all maintenance requests through a phone application, and the maintenance requests were prioritized based on necessity. The ADM stated it was his expectation that all high priority and necessary repairs, especially repairs that could pose a safety concern, were completed as soon as possible. The ADM stated he was notified of the broken sink in Resident #3's room, and it was his understanding the sink was fixed as soon as it was reported. The ADM stated he was not aware the sink had not been fixed immediately. The ADM stated a broken sink was a high priority maintenance order, as it could have resulted in a resident injury. The ADM stated an in-service was completed with the MD on the necessity of completing repairs or finding other solutions for residents when the repair could pose a safety concern or if everything in a resident's room was not functioning properly. During an interview on 03/10/2026 at 11:05 AM the MD stated he was responsible for completing repairs within the facility. The MD stated the facility used an online system to report and track repairs. The MD stated he checked the system daily and had an application on his phone to allow him to receive notifications of all new repair requests. The MD stated all repairs were organized by priority based on necessity as well as safety. The MD stated he also did weekly checks of the facility to observe repairs that may be needed. The MD stated he was aware of the broken and nonfunctioning sink in Resident #3's room. He stated this was a high priority level repair. The MD stated he attempted to repair the sink on the day it was reported to him, 03/06/2026, but the valves were unable to be turned off, so it required turning the water off to the facility temporarily while he replaced the sink and the valves. The MD stated he then became sick the same day, and he was unable to complete the repair. The MD stated he should (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455946	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sweetwater Healthcare Center	1600 Josephine St Sweetwater, TX 79556

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have advised the ADM so arrangements could have been made to move the resident, but he didn't consider this at the time. The MD stated the sink was now repaired and functioning normally. The MD stated it was important for high priority repairs to be completed as soon as possible to prevent accidents from occurring. The MD stated he received an in-service training on 03/08/2026 regarding high priority repairs. Record review of the facility's policy titled, Work Orders, Maintenance dated April 2019, reflected the following: Policy Statement:Maintenance work orders shall be completed in order to establish a priority of maintenance service.Policy Interpretation and Implementation:5. Emergency requests will be given priority in making necessary repairs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles and failed to store in a separate locked, permanently affixed compartment for storage of controlled drugs for 1 of 1 discontinued medication storage closet (ADON Office) reviewed for storage of discontinued drugs.The Facility failed to store discontinued narcotic medications under double lock. This deficient practice could place residents at risk of medication misuse and diversion.The findings were:Observation on 03/10/2026 at 10:50 a.m. revealed a locked closet in the ADON office with discontinued medication being stored in a black box on the floor of the closet that was not secure to the floor. The following discontinued narcotics stored in a plastic basket on top shelf of the closet that was not secure:Acetamin/Codeine 300/30 mg tablets - 62 tablets Ativan 1 mg tablets - 88 tabletsPregabalin 75 mg tablets - 55 tabletsHydrocodone-APAP 7.5-325 mg tablets - 109 tabletsTramadol 50 mg tablets - 197 tabletsDuring an interview on 03/10/2026 at 11:00 a.m. ADON stated the process for storing discontinued narcotic medications was she would remove them from the medication cart and store them in the backet in her closet. She stated the black box was storage for non-narcotic medications. She stated the black storage box did not have a lock and it was not secured. She stated she logged the narcotics on a drug destruction form and placed them in the white basket on the top shelf of closet. She stated the closet door was secured with a lock. She stated that when her office door was closed and locked it would be a double lock. She stated she did not always close her door when she left her office. She stated if she left her office door open it would not be a double lock. She stated she has been trained on how to store discontinued narcotic medications. She stated the potential negative outcome could be drug diversion. During an interview on 03/10/2026 at 11:09 a.m. DON stated discontinued narcotic medications were stored in the closet in the ADON office. She stated she was not aware the narcotics were not being stored with double locks. She stated the setup in her closet should be a black box secured to shelf with a lock. She stated the ADON was responsible for storage of discontinued medications. She stated all nurses have been trained on how to properly store medications. She stated the potential negative outcome could be a resident or staff getting the medication.During an interview on 03/10/2026 at 11:25 a.m. the ADM stated he was not aware discontinued narcotics were not being properly stored. He stated narcotics must be stored with double locks. He stated the nurses and DON were responsible for properly storing narcotics. He stated all nurses have been trained to properly store medications. He stated the potential negative outcome could be medications stolen and could be hazardous to staff and residents if taken. Record review policy tiled Controlled Substances, revised date November 2022 revealed the following: Policy Statement - The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications.Storing Controlled Substances1. Controlled substances are separately locked in permanently affixed compartments, except when using single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.13. Controlled substances remaining in the facility after the order has been discontinued or the resident has been discharged are securely locked in an area with restricted access until destroyed.