STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455986	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Henderson Health & Rehabilitation Center	1010 W Main St Henderson, TX 75652

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273 Based on interview, observation and record review, the facility failed to ensure the MDS assessment accurately reflected the resident's status for 1 of 4 residents (Resident #12) reviewed for accuracy of assessments. The facility failed to accurately code the 04/30/25 MDS for an in-dwelling catheter (tube inserted into the bladder to drain urine) used for Resident #12. This failure could put residents at risk for lack of proper care and decreased quality of life. Findings included: Record review of a facility face sheet dated 5/14/25 for Resident #12 indicated he was a [AGE] year-old male admitted to the facility on [DATE] and subsequently readmitted on [DATE] with diagnosis of cerebrovascular disease (heart disease). Record review of a Comprehensive MDS assessment dated [DATE] for Resident #12 indicated he had a BIMS score of 12, which indicated moderately impaired cognition. Question H0100 did not indicate he had an indwelling catheter. Record review of a comprehensive care plan dated 3/13/25 for Resident #13 indicated that he had a urinary catheter. Record review of a physician's order summary report dated 5/14/25 for Resident #13 indicated he had the following physician's order dated 4/24/25: .Urinary catheter 24 FR 20 CC bulb to gravity (BSD). Change the catheter if it becomes occluded, to obtain a urine specimen, or if the closed system has become compromised . During an observation on 5/12/25 at 12:13 pm Resident #12 was observed lying in bed. He was observed to have a Foley catheter. During an interview on 5/14/25 at 11:00 am MDS Nurse was not receptive to questioning. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/14/25 at 11:15 am DON said the MDS nurse was responsible for MDS accuracy. She said MDS assessments were responsible for the payments to the facility. She said she did the care plans and nothing on the care plan was missed due to the MDS being inaccurately coded. She said going forward she would have a system of checks to ensure MDS assessments are coded correctly. During an interview on 5/14/25 at 11:35 am Administrator said if MDS assessments are coded incorrectly it could possibly cause payment issues. She said going forward there would be multiple reviews and meetings to discuss the residents to hopefully prevent this from happening. Record review of a facility policy titled MDS Completion dated 2/10/21 read: .According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46436 Based on observation, interview, and record review the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain grooming, and personal and oral hygiene were provided for 1 of 12 residents (Resident #23) reviewed for ADL care. The facility failed to ensure Resident #23 had a shower and shave from 4/15/2025 to 5/08/2025. This failure could place residents at risk of not receiving care/services, decreased quality of life, and loss of dignity. Finding included: Record review of Resident # 23's facility face sheet revealed Resident #23 was a [AGE] year-old male and admitted on [DATE] with diagnosis of cerebral infarction (stroke). Record review of Resident 23's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 9 indicating moderately impaired cognition, relied on staff for assistance with bathing and personal hygiene and was incontinent of bowel and bladder at times. Record review of Resident #23's comprehensive care plan dated 5/12/2025 revealed Resident #23 had an ADL self-care performance deficit and was at risk for not having their needs met in a timely manner and to provide shower, shave, oral care, hair care, and nail care per schedule and when needed. During an observation and interview on 5/12/2025 at 10:43 AM Resident # 23 had long facial hair and faint urine odor. He said he had not had a shower in a while, and no one has offered to shave him. He said the staff had changed him and cleaned his private area but that was all. He said he was not able to shave himself and needed help. Record review of an untitled and undated form listed Resident #23 for a shower on Wednesday and Saturday. Record review of POC (point of care) response history dated 5/12/2025 for bathing revealed Resident # 23's nurse aide response for bathing was recorded as not applicable from 4/15/2025 to 5/08/2025. There was no entry for shaving. During an interview on 5/13/2025 at 11:20 AM Resident # 23 was sitting in his room and clothes were different then yesterday and said the staff helped him change his clothes but did not get a shower and shave. He said he thought about it from yesterday's conversation and could not remember the last shower and shave he had. He said he would like a shower and shave at least 1-2 times a week. He said he didn't feel upset about not getting a shower but would like to be clean and free of odors. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/13/2025 at 11:30 am CNA A said that each resident had a shower schedule and Resident #23 was scheduled on the night shift for a shower. CNA A said there was a shower book at the nurses station for the nurse aides and nurses and once the task was complete then the CNA entered the task into the computer. CNA A said if the task was checked as not applicable then the task was not done . CNA A said she could not speak on why Resident #23 had not been receiving a shower and he had not voiced any concerns to her, but she would ensure he was showered and shaved today. CNA A said residents that don't receive proper ADL care like a shower and shave could feel bad or have skin changes. During an interview on 5/13/2025 at 11:35 am LVN C said she worked at the facility as needed as a charge nurse. She said she was to oversee resident care by the CNA's and observed their ADL care on her rounds. LVN C said she had noticed resident #23 had an odor on 5/12/25 but today 5/13/25 had clean clothes on and thought he had been showered. LVN C said that residents that don't receive ADL care like showers could have changes in skin and feel bad about not being clean. During an interview on 5/14/2025 at 9:39 am the DON said that ADL care was now overseen by the treatment nurse and the facility had a new treatment nurse as of this week due to the previous treatment nurse not completing her job duties. DON said there was no alert for when care was not provided, and the nurses and aides should be aware of care that needed to be completed. She said she was not sure why Resident #23 did not have a shower recorded since before 04/15/25 and felt that was an error in documentation. She said she expected all residents to receive their ADL care and by not providing ADL care residents could have an adverse outcome. During an interview on 5/14/2025 at 11:31 am the Administrator said all staff were responsible for ensuring resident's received ADL care and CNA's should be accurately recording ADL care and completing their job task as assigned. She said all staff made rounds and if they see something they should say something. She said she did not know why Resident #23 did not have a shower recorded since before 4/15/25 and felt it was a documentation error because she had seen him the shower room. Administrator said if ADL care was not provided it could affect resident skin and infection control and expected all staff to follow the ADL assignments and follow the residents care plan. Record review of a facility policy titled Activities of daily Living Care Guidelines dated 01/23/2016 revealed, . residents will receive essential services for activities of daily living to maintain good nutrition, grooming, and personal and oral hygiene .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46273 Based on observations, interviews, and record review, the facility failed to ensure the residents' environment remained as free of accident hazards as possible for 1 of 4 residents (Resident #39) reviewed for accidents/hazards. The facility failed to remove worn and damaged mechanical lift slings from service on 5/12/25. This deficient practice place residents at risk of injuries. Findings included: Record review of a facility face sheet dated 5/12/25 for Resident #39 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including hypotension (low blood pressure) and muscle weakness. Record review of a Quarterly MDS assessment dated [DATE] for Resident #39 indicated that he had a BIMS score of 15 which indicated that he had intact cognitive status. Resident #39 was dependent for transfers. Record review of a Comprehensive Care Plan dated 3/7/24 for Resident #39 indicated that he had an ADL self-care performance deficit and required 2 staff for transfers. During an observation on 5/12/25 at 9:27 am Resident #39 was observed being transferred by CNA E and LVN D using a mechanical lift. Mechanical lift sling loops were observed to be faded in color and the labels appeared to have been cut off of sling. During an interview on 5/12/25 at 3:15 pm CNA E said she would check for broken hooks or loops. CNA E said that broken hooks or loops would indicate wear and tear on the sling. She said she did not know to look for faded colors on loops. During an interview on 5/12/25 at 3:20 pm LVN E said nurses and CNAs check the slings before use and they look for signs of dry rotting, faded coloring. She said they have so many different kinds of lift pads that it's hard to notice the fading sometimes, because they are all different colors. During an interview on 5/12/25 at 3:30 pm Laundry Aide said she did not use bleach on the lift pads, and she hangs them to air dry. She said she looks for rips/tears and colors fading. Laundry Aide said she would notify the ADON if she noticed anything out of the ordinary and let them make the decision on whether to remove them from service. During an interview on 5/14/25 at 11:15 am DON said direct care staff using the slings were responsible to check them before use. She said faded or fraying slings could tear with any weight and cause accidents. She said she would be holding an in-service with all staff to ensure they knew to ensure the tag was on the sling and readable and the colors were bright and not faded. DON said she would also in-service laundry staff to ensure they did not use bleach or place slings in dryer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/14/25 at 11:35 am Administrator said if lift sling loops are faded the sling would need to be replaced. She said direct care staff are responsible for checking before using on a resident, but it also goes up the chain as well, so ultimately administrative staff were also responsible. She said if staff cannot discern the loop colors, they may not use the correct hooks and it could lead to resident injury. Administrator said she would put a new system in place to check slings going forward. Record review of a facility policy titled Hydraulic Lift (Mechanical Lift) dated 9/13/24 indicated that policy did not address safety checks of lift slings. Record review of the manufacturer instruction for Medline full body slings undated indicated, .Full body slings are made of durable materials and are ideal for patient transferring and toileting activities. Always inspect slings prior to each use. Signs of color fading, bleached areas, indicate improper laundering which is unsafe and could result in injury. Any slings with signs of wear or improper laundering should be immediately removed from use .

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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. 40124 Based on observations, interviews, and record review the facility failed to ensure all drugs were only accessible by authorized personnel, 1 of 4 medication carts (hall two cart) reviewed for storage of medications. The facility failed to ensure LVN C kept the hall two medication cart secured and was unable to be accessed by unauthorized personnel or residents on 05/12/25. This failure could put residents at risk of unauthorized use of medication and accidental ingestions/use of an unprescribed medication. Findings included: During an observation on 5/12/2025 at 12:10 pm, medication cart for hall two was located at the nurses station and observed unlocked. During an observation on 5/12/2025 at 12:15 pm, a visitor and two unlicensed staff members (CNA's) passed by the unlocked medication cart located on hall two. During an observation on 5/12/2025 at 12:20 pm, two housekeepers passed by the unlocked medication cart located on hall two. During an observation on 5/12/2025 at 12:25pm, a resident passed by the unlocked medication cart located on hall two. During an observation and interview at 12:30 pm, LVN C returned to the unlocked medication cart and proceeded to lock the medication cart. LVN C said she had worked at the facility for two weeks and had been a nurse for about two years. She said that not locking the cart could cause a drug diversion if a visitor, resident, or unlicensed staff member entered the unlocked cart. LVN C said a confused resident might access medications and cause harm to themselves if medications that were not ordered for them were consumed. During an interview on 5/12/2025 at 12:35 pm, the Administrator said it was the responsibility of the DON or her designee to train and in-service the nursing staff on medication storage. The Administrator said that the medication cart should be locked while not attended and the unopened cart could cause harm if the cart was accessed by a confused resident. During an interview on 5/12/2025 at 2:00 pm, the DON said the medication carts should be always locked when unattended. She said there was a risk of harm if a resident entered the cart, and consumed medications. She said there was a risk of a drug diversion if visitors or unlicensed staff had access to medications. Record Review of a facility Medication Storage policy dated1/20/2021 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy . It is the policy of this facility to ensure all medications housed on our premises will be stored, dated and labeled according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security .Policy Explanation and Compliance Guidelines 1. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. b. Only authorized personnel will have access to the keys to locked compartments c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46436 Based on observations, interviews, and record reviews, 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 1 of 8 residents (Resident #57) and 2 of 8 staff (CNA A and CNA B) reviewed for infection control. The facility failed to ensure CNA A and CNA B followed enhanced barrier precautions and performed hand hygiene when providing incontinent care to Resident #57 on 5/12/2025. These failures could place residents at risk for cross contamination and infection. Findings included: Record review of Resident # 57's facility face sheet revealed Resident #57 was a [AGE] year-old male and admitted on [DATE] with diagnosis of cerebral infarction (stroke). Record review of Resident 57's Annual MDS assessment dated [DATE] revealed a BIMS score of 14 indicating intact cognition, relied on staff for all ADL's, was incontinent of bowel and bladder, and required a feeding tube. Record review of Resident #57's comprehensive care plan dated 3/17/2025 revealed Resident #57 was incontinent of bowel and bladder and dependent on staff for care and required EBP due to feeding tube and staff to wear a gown and gloves during high-contact resident care activities. Record review of nurse assistant skills review checklist dated 5/07/2024 revealed CNA B had been trained on infection control measures for EBP and hand hygiene. Record review of nurse assistant skills review checklist dated 5/08/2024 revealed CNA A had been trained on infection control measures for EBP and hand hygiene. During an observation on 5/13/2025 at 9:11 AM CNA A and CNA B provided incontinent care to Resident #57. Resident #57 had an EBP sign on his door indicating he required gloves and gown for direct care. Neither CNA applied a gown when providing incontinent care and personal care to Resident #57. During incontinent care both CNA's washed their hands and applied gloves prior to starting care. CNA B began care by cleaning Resident #57's front periarea with wipes. After care she continued to wear the soiled gloves while turning the resident. CNA A then cleaned the back periarea of Resident #57 of stool using wipes and then removed her gloves and applied new gloves without hand hygiene. CNA A then applied a clean pad and brief and applied skin barrier cream to Resident #57's buttocks. Resident #57 was then turned back to his right side and CNA B using the same soiled gloves from the beginning , placed clean linens, pad and brief. CNA B and CNA A then repositioned the resident and adjusted his linens and head of the bed with soiled gloves. CNA B gathered the soiled linen and left the room with soiled gloves on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/13/2025 at 9:45 am CNA A said that she forgot Resident #57 required EBP and should have put on a gown and gloves before providing care. CNA A said she should have performed hand hygiene between glove changes and should not use soiled gloves to touch clean objects. CNA A said she had been trained on EBP and proper hand hygiene but was nervous. CNA A said by not following infection control measures infections could spread. During an interview on 5/13/2025 at 9:47 am CNA B said that she did not see the sign for EBP on the door and failed to put on proper PPE for Resident #57. CNA B said she should have removed her gloves and performed hand hygiene between dirty and clean task and before exiting the residents room. CNA B said by not following infection control measures infections could spread. During an interview on 5/14/2025 at 9:39 am the DON said that she was the now the infection prevention nurse and that all staff were responsible for following the facilities infection control policies. DON said the staff were trained on hire, annual and throughout the year on infection control measures like hand washing and EBP. DON said if staff were not following the infection control program, then infections could spread. During an interview on 5/14/2025 at 11:31 am the Administrator said the infection control program was the responsibility of the DON who was the infection prevention nurse. Administrator said all staff were trained on hire and throughout the year on infection control measures including EBP and hand hygiene. Administrator said if the infection control program measures were not followed by staff, infections could spread and expected all staff to follow the facilities infection control program. Record review of a facility policy titled Hand Hygiene dated 02/11/2022 indicated, .all staff will perform proper hand hygiene procedures to prevent the spread of infections;6a. the use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves . Record review of a facility policy titled Infection Prevention and Control Program dated 11/6/24 indicated .6. Enhanced Barrier Precautions: EBP are used in conjunction with standard precautions and expand the use of gown and gloves during high contact resident care activities .

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40124 Based on interview and record reviews, the facility failed to implement their policy to ensure the residents, or their responsible party, received education of the benefits and risks, or potential side effects of Covid -19(a severe acute respiratory syndrome) immunizations, receipt of Covid-19 immunizations, or the residents did not receive the Covid-19 immunizations, due to medical contraindication, or refusal, for 74 of 74 residents living in the facility and 5 of 5 residents who were reviewed for immunizations (Resident #11, Resident #35, Resident #52, Resident #56 and Resident #57) The facility failed to document, in Resident #11, Resident #35, Resident #52, Resident #56 and Resident #57 medical records, having had received education, whether by self or with their responsible party, of the benefits and risk, and potential side effects, of the Covid-19 immunization, receipt of the of the Covid-19 immunization, or having had not received the Covid-19 immunization due to medical contraindication or refusal. This failure could place residents at risk of not being informed of complications and potential adverse health outcomes. Findings included: Record review of a facility face sheet dated 5/14/25 for Resident #11 indicated that she was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: pain in right hip, altered mental status and repeated falls. Record review of a physician order summary report dated 5/14/25 for Resident #11 indicated that she had no orders for Covid vaccination. Review of a document titled, immunization audit report dated 5/13/2025, revealed Resident # 11 and/or her representative was not offered the Covid-19 vaccine since 01/19/21 The document indicated no education given. Record review of a facility face sheet dated 5/14/25 for Resident #35 indicated that she was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: chronic pain, atrial fibrillation (rapid heart rate) and anorexia (no desire to eat). Record review of a physician order summary report dated 5/14/25 for Resident #35 indicated that she had no orders for Covid-19 vaccination. Review of a document titled, immunization audit report dated 5/13/2025, revealed Resident #35 and/or her representative was not offered the Covid vaccine on admission and the document indicated there was no education given to Resident #35. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of a facility face sheet dated 5/14/25 for Resident #52 indicated that she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including: anemia (low blood volume), atrial fibrillation (rapid heart rate) and anorexia (no desire to eat). Record review of a physician order summary report dated 5/14/25 for Resident #52 indicated that she had no orders for Covid-19 vaccination. Review of a document titled, immunization audit report dated 5/13/2025, revealed Resident #52 and/or her representative was not offered the Covid-19 vaccine since 01/03/21. The document indicated there was no education given to Resident #52 or a representative. Record review of a facility face sheet dated 5/14/25 for Resident #56 indicated that she was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: atrial fibrillation (rapid heart rate), weakness and chronic cough. Record review of a physician order summary report dated 5/14/25 for Resident #56 indicated that she had no orders for Covid-19 vaccination. Review of a document titled, immunization audit report dated 5/13/2025, revealed Resident # 56 and/or her representative was not offered the Covid-19 vaccine since 07/22/22. The document indicated there was no education given to Resident #56 or a representative. Record review of a facility face sheet dated 5/14/25 for Resident #57 indicated that he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including: pain, weakness, and lack of coordination. Record review of a physician order summary report dated 5/14/25 for Resident #57 indicated that he had no orders for Covid-19 vaccination. Review of a document titled, immunization audit report dated 5/13/2025, revealed Resident #57 and/or her representative was not offered the Covid-19 vaccine. The document indicated there was no education given to Resident #57 or a representative. During an interview on 5/14/2025 at 8:45 am, the DON said she was the Infection Preventionist for the facility. The DON could not provide documentation of any resident (74 residents in the facility) education for Covid immunization refusals. DON said the facility had no form for declination to be used when the resident or representative refused and there was no refusal scanned into the electronic system for residents that indicated they had been education on benefits or risks of the covid vaccine. She said there was no documentation of education provide after refusal of Covid vaccination for any resident in the facility. The DON said she would be responsible going forward to ensure that residents were educated on immunizations and providing documentation. She said residents could be at risk of not knowing what they were refusing if they were not provided education. The DON said residents could be at risk of contracting infections, severe respiratory problems and even death if they were not properly educated and did not receive vaccinations. DON said they would be providing education and have consent/declination forms signed going forward. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455986	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Henderson Health & Rehabilitation Center	1010 W Main St Henderson, TX 75652

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/14/2025 at 9:00 am, the Administrator said there was no documentation of education provide after refusal of Covid vaccination for any of the 74 residents in the facility. She said the facility had not provided covid vaccinations or education on Covid vaccinations in the last two years due to no interest and refusal of the residents or families. The Administrator said the DON was responsible for immunizations and going forward residents will be provided education regarding benefits and risks. Administrator said that residents and families could possibly not have the knowledge to make informed decisions concerning covid vaccinations if risks and benefits were not provided. Record Review of a facility policy titled Infection Control Program dated 10-24-2022 indicated . COVID-19 Immunization : a. Residents and staff will have the opportunity to receive the COVID-19 vaccination, and change their decision based on current guidance. b. Residents and staff will be screened prior to offering the vaccination for prior immunization, medical precautions, and contraindications to determine candidacy for the vaccination. c. Education about the vaccine, risks, benefits, and potential side effects will be given to residents or resident representatives and staff prior to offering the vaccine. d. Documentation will reflect the education provided and details regarding whether or not the resident or staff received the vaccine.

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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have policies on smoking. 46273 Based on observations, interviews, and record reviews, the facility failed to ensure it formulated, adopted, and enforced policies regarding smoking, smoking areas, and smoking safety that also consider non-smoking residents for 1 of 1 smoking area reviewed for smoking safety. The facility failed to ensure cigarette butts were not discarded into a regular trash can that also contained paper trash on 5/12/25 causing a fire hazard. The facility failed to ensure regular trash was not discarded into the red metal ashtray container on 5/12/25 causing a fire hazard. This failure could place residents at risk of injury, burns, and an unsafe smoking environment. Findings included: During an observation on 5/12/25 at 10:50 am a red metal ashtray container was observed with paper trash in it. A metal trash can was also observed in the smoking area with a clear plastic liner in it. Observation revealed that can was full of cigarette butts along with cigarette boxes and regular trash. During an interview on 5/13/25 at 1:50 pm DON said there was not one specific person responsible for emptying the ashtrays in the smoking area, but whoever took the residents out to smoke should be emptying the ashtrays into the ashtray container. DON said she would get with the maintenance man to correct this issue. During an interview on 5/13/25 at 2:00 pm Maintenance man said staff that take residents out to smoke should be emptying the ashtrays into the red metal can. He said there was no one specific person responsible for this. He said ashtrays should not be emptied into the regular trash can, due to it being a fire hazard. Maintenance man said it was also a fire hazard for regular trash to be emptied into the red metal can. Record review of a facility policy titled Smoking Policy dated 4/12/23 read: .It is the policy of this facility to provide a safe and healthy environment for residents, visitors, and employees as related to smoking .