STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675019	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apex Secure Care Brownfield	1101 E Lake St Brownfield, TX 79316

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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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an effective Infection Control Program designed to provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of communicable diseases and infections for 2 of 11 residents (Resident #32 and Resident #36) reviewed for infection control. LVN A provided wound care to Resident #32 with contaminated supplies: scissors and dermal wound cleanser (often no-rinse spray solutions designed to remove dirt, debris, and exudate from acute and chronic wounds) after she had used the same supplies to provide wound care for Resident #36 who had a positive wound culture on 4/8/26 for STREPTOCOCCUS AGALACTIAE (GROUP-B) (an opportunistic bacteria that can cause skin and soft tissue infections, including cellulitis, abscesses, and occasionally, severe necrotizing infections) and STAPHYLOCOCCUS AUREUS (a bacteria that can cause infections ranging from minor skin abscesses to life-threatening bloodstream infections).LVN A failed to follow enhanced barrier precautions and hand hygiene practices when providing wound care for Resident #32 and Resident #36. The facility failed to implement EBP for Resident #36 after receiving a positive wound culture on 4/8/2026. An Immediate Jeopardy (IJ) was identified on 4/13/2026 at 4:50pm. The IJ template was provided to the facility Administrator on 4/13/2026 at 4:56pm. While the immediate jeopardy was lifted on 4/14/2026 at 5:01pm, the facility remained out of compliance at a severity level of no actual harm with potential for more than minimal harm and a scope of isolated, because all nursing staff had not been trained on 4/14/2026. These failures could place residents at risk for infection and cross contamination of pathogens and illness, which could lead to worsening of their condition, hospitalization, or death. Findings include: Resident #36Record review of Resident #36's face sheet revealed a [AGE] year-old male originally admitted to the facility on [DATE]. Resident #36 had a medical history of Alzheimer's disease (a progressive, irreversible brain disorder), chronic venous hypertension with ulcer of right lower extremity and left lower extremity (chronic, often painful, sores on the leg or ankle resulting from poor circulation), type 2 diabetes and chronic obstructive pulmonary disease (a progressive, incurable lung disease). Record review of Resident #36's quarterly MDS assessment dated [DATE] Section C- Cognitive Patterns revealed a BIMS score of 5 which indicated Resident #36's cognition was severely impaired. Record review of Resident #36's care plan revealed [Resident #36] have stasis ulcers to BLE r/t [related to] lymphedema (tissue swelling) .enhanced barrier precautions. Staff members will wear a clean gown and gloves while performing high contact resident care activities to include: .providing wound care last revised on 4/06/2026. Record review of Resident #36's physician orders reviewed on 4/13/2026 at 10:58am reveal no order for enhanced barrier precautions. Resident #36 had an order for wound care to the bilateral lower extremities, with a start date of 4/07/2026. Resident #36 had an order for clindamycin (antibiotic used to treat serious bacterial infections, including skim infections) 300mg Give 1 capsule by mouth four times a day for + [positive] culture to stasis ulcers to BLE for 7 Days. Record review of Resident #36's progress note from 4/05/2026 at 1907 [7:07pm] revealed sent info to [MD], DON, ADON on resident's wounds to, BLE shins. right wound 15cm x 15cm x 1.2cm raised wound. Left wound 18cm x 24cm x 1.2cm raised wound. slight drainage from both wounds with slight smell. warm (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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to touch. C/O (complained of) pain when wounds are cleaned and wounds are pressed down. LVN [E] can not feel pedal pulse. BLE generalized edema from knees down to feet. wound seem to be growing up the leg slightly. mostly growing around the thigh toward the back of the leg. can feel some small nodules around the back. [MD] contacted this LVN [E], that he would see resident tomorrow when making his round. signed by LVN E. Progress note from 4/08/2026 at 1749 [5:49pm] revealed stasis wounds are staph + [positive], ADON has notified [MD] waiting for new orders signed by LVN A. Record review of Resident #36's wound test results revealed STAPHYLOCOCCUS AUREUS-DETECTED and STREPTOCOCCUS AGALACTIAE (GROUP-B)- DETECTED with a date reported of 4/08/2026. Resident #32Record review of Resident #32's undated face sheet revealed a [AGE] year-old female originally admitted to the facility on [DATE]. Resident #32 had a medical history of dementia, pressure ulcer of left buttock stage 2 (a shallow, open wound), and muscle weakness. Record review of Resident #32's quarterly MDS dated [DATE] Section C- Cognitive patterns revealed a BIMs score of 99 which indicated Resident #32 was unable to complete the interview. Section C1000 Cognitive Skill for Daily Decision Making revealed Resident #32 was severely impaired and never/rarely made decisions. Record review of Resident #32's physician orders dated 4/04/2026 revealed Cleanse left lower buttocks with wound cleanser.daily and PRN. Physician order dated 4/13/2026 revealed an order for EBP for Resident #32. Record review of Resident #32's care plan dated 4/13/2026 revealed [Resident #32] have a pressure ulcer to left buttock.enhanced barrier precautions, staff members will wear a clean gown and gloves while performing high contact resident care activities to include. providing wound care. During a wound care observation for Resident #36 on 4/13/2026 at 9:42am, LVN A gathered dermal wound cleanser spray, gauze, 3 packets of kerlix (crinkle-weave gauze dressing), 1 large calcium alginate (a highly absorbent wound dressing), and approximately 8 packets of xeroform (a non-adherent, petrolatum-impregnated gauze dressing) from treatment cart A. Resident #36 did not have EBP sign or PPE available outside or inside of the room. LVN A placed the supplies on Resident #36's bedside table, that was not cleaned prior to use. LVN A put on a clean gloves and used the dermal wound cleanser spray directly on Resident #36 bilateral legs, spraying the wound sites multiple times to saturate the wounds (spraying wound cleanser directly onto a wound can potentially contaminate the bottle nozzle if the spray nozzle touches the skin or if splash-back from the wound hits the nozzle). LVN A cleaned the legs with gauze and removed her gloves. LVN A put on a new pair of gloves without using hand hygiene in between. LVN A utilized the scissors to open the xeroform packets for the right leg. LVN A placed the xeroform onto Resident #36's right leg, and touched the wound to ensure the dressing fully covered the wound. LVN A used the scissors multiple times to open the remaining packages of xeroform for the left leg and dressed the left leg. LVN A did not change her gloves or use hand hygiene before applying wound dressings to the right leg. LVN A completed wound care with Resident #36, and after removing her contaminated gloves and using hand hygiene, LVN A grabbed the contaminated scissors and dermal wound cleanser spray and placed them on treatment cart A. LVN A placed the dermal wound cleanser inside treatment cart A on the bottom drawer. LVN A did not use EBP during Resident #36's wound care. LVN A did not sanitize the scissors before or after use with Resident #36. During a wound care observation for Resident #32 on 4/13/2026 at 10:07am, LVN A gathered supplies from treatment cart A. LVN A gathered gauze, skin barrier cream, scissors and dermal wound cleaning spray. LVN A grabbed the same contaminated scissors and dermal wound cleaning spray that were utilized during wound care for Resident #36. LVN A entered Resident #32's room, along with the contaminated items, and placed them on the dresser beside Resident #32's bed. Resident #32 had a sign for EBP and PPE was hanging on Resident #32's door, visible upon entering the room. LVN A put on gloves (LVN did not utilize a gown while providing wound care) and grabbed the wound supplies and contaminated scissors from the dresser and placed them directly on Resident #32's bed. LVN A removed dirty dressing from Resident #32s wound, and grabbed the dermal wound cleanser bottle, spraying directly onto Resident #32's wound. LVN A used her right hand and cleaned the wound with gauze. LVN A (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	grabbed gauze with her left hand and grabbed the dermal wound cleanser spray with her contaminated right hand and sprayed it onto the gauze. LVN A changed her gloves, but did not use hand hygiene between glove changes. LVN A completed wound care and removed her gloves, but did not use hand hygiene. LVN A grabbed the contaminated scissors and contaminated dermal wound cleansing spray and placed them on [NAME] of treatment cart A. LVN A placed the contaminated bottle of dermal wound cleansing spray back into the bottom drawer of treatment cart A. During an interview on 4/13/2026 at 12:02pm, LVN A stated she had been trained on infection control and the infection preventionist was the ADM. She stated she did not know when her last in-service on wound care or infection control was, but she felt they did them all the time. She stated about a week ago, the ADM had gone over EBP and what it was for and when to use it. She stated EBP was for staff to utilize gowns and gloves when providing any care that had contact with bodily fluids. She stated she was not sure if EBP was needed for wound care, but if it did not have bodily fluids then she would only wear gloves. She stated she believed Resident #36 and Resident #32 did have EBP signs on their doors, but because she didn't handle bodily fluids, she only wore gloves. She stated she obviously did not wear a gown for wound care for Resident #32 or Resident #36. She stated she had changed her gloves during wound care but did not use hand hygiene but her hands were not visibly soiled, so she didn't believe she needed to. LVN A stated Resident #36 currently had an active staph infection (bacterial skin infection) to his legs and that was why she was doing wound care on Resident #36's legs. She stated she had received the results of his wound cultures (a laboratory test that identifies bacteria) the week prior but was unsure what treatment he was on. She stated she was not sure if taking the dermal wound cleanser was right or wrong because no one had told her she couldn't do that. She stated she used the same spray for all the residents. She stated she did not think it came in contact with the resident's wounds so it wouldn't be contaminated. She stated she usually cleaned her supplies after use, but was not aware she had not cleaned her scissors when she took them into Resident #32's room. She stated she had not used the scissors during Resident #32's wound care, but she had grabbed them and brought them into Resident #32's room after she used them in Resident #36's room. She stated she thought she had cleaned the wound cleansing spray after use with Resident #36 but was not sure if she had or not. She stated she was not aware she contaminated the bottle when doing wound care with Resident #36 or Resident #32 by grabbing it after cleaning or touching the wounds. She stated the potential negative outcome of not following infection control practices could be spreading bacteria, especially if they have an infection. She stated by not using EBP she could spread bacteria between residents. She stated she was aware Resident #36 had the infection, and she could potentially spread the same infection to other residents. She stated she felt she could spread infection between residents by not cleaning the dermal wound cleanser or the scissors between residents use. She stated everything the dermal wound cleanser came into contact in treatment cart A could be contaminated. During an interview on 4/13/2026 at 2:51pm with the ADON, he stated they did not have a DON at that time. He stated staff had been trained on infection control and wound care. He stated the training typically covered contact precautions, PPE, EBP, and hand hygiene. He stated Resident #36 had stasis ulcers (a slow-healing, shallow wound usually occurring on the lower leg) to bilateral legs, and he was being treated for an infection to those wounds. He stated he expected staff to utilize EBP for any wound care. He stated if equipment was used between residents, it should be cleaned before and after use. He stated the dermal wound cleanser spray should not have been taken into the room. He stated staff should have prepped their wound supplies outside the room and placed the gauze inside a clean cup and saturated the gauze with dermal wound cleansing spray to use during wound care. He stated the dermal wound cleanser should not have been placed back into the treatment cart, as it was contaminated after use in Resident #36's room. He stated he should have ensured the EBP signs and PPE were placed, but staff should also know that any wound care required EBP. He stated the potential risk of using contaminated supplies or equipment between residents could be infection of another residents' open (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	wound or spreading the same bacteria to another resident. He stated staff should be utilizing hand hygiene between glove changes to prevent the spread of infection. He stated that infection control was monitored through resident assessments, infection trends, and physician rounding. During an interview on 4/13/2026 at 3:08pm with the ADM, he stated he was currently the infection preventionist. He stated the infection control training or in-service training was done as needed. He stated he did have an in-service on 1/09/2026 for standard precautions and infection control. He stated he had also reviewed EBP with the nursing staff approximately one week ago. He stated the facility used EBP to prevent the spread of infection and it was used on residents who had invasive devices, or who had wounds. He stated any equipment used inside residents' rooms, should be sanitized after use and before use on another resident. He stated dermal wound cleanser should not be used inside the rooms during wound care because it would be considered cross contamination. He stated staff should spray the gauze inside of a cup when they were prepping for the wound care. He stated EBP meant staff should use gowns and gloves before starting care, and removing it before exiting the room. He stated hand hygiene should be used between glove changes and before and after care. He stated Resident #36 was on EBP due to his bilateral stasis ulcers to his lower extremities (legs). He stated he believed he did have drainage coming from the wounds and staff should have used EBP. He stated staff should utilize EBP on any wound regardless of an infection or not. He stated the incident was a systemic failure and Resident #36 should have been on EBP. He stated LVN A had been trained on infection control and should have worn the EBP with Resident #36 and Resident #32. During an interview on 4/13/2026 at 3:50pm with the MD, he stated LVNA A shouldn't have taken those items into the resident's room without following EBP and infection control policies. He stated the policies were there to prevent infection, and although Resident #36's wounds were caused by a common bacteria, LVN A should have still utilized universal knowledge. Record review of the facility's policy titled Enhanced Barrier Precautions dated August 2022 revealed Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply.a. Gloves and gowns are applied prior to performing the high contact resident care activity (as opposed to before entering the room).b. Personal protective equipment (PPE) is changed before caring for another resident.c. Face protection may be used if there is also a risk of splash or spray.3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: .h. wound care (any skin opening requiring a dressing).5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization.10. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required.11. PPE is available outside of the resident rooms. Record review of the facility's policy titled Standard Precautions revised October 2018 revealed: Policy StatementStandard Precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard Precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. 2. Gloves.h. After gloves are removed, wash hands immediately to avoid transfer of microorganisms to other residents or environments.5. Resident-Care Equipmenta. Resident-care equipment soiled with blood, body fluids, secretions, and excretions are handled in a manner that prevents skin and mucous membrane exposure, contamination of clothing, and transfer of microorganisms to other residents and environments.b. Reusable equipment is not used for the care of more than one resident until it has been appropriately cleaned and reprocessed.c. Single use items are properly discarded. The ADM was notified an IJ situation was identified due to the above failures on 4/13/2026 at 4:56pm and the IJ template was provided, and plan of removal was requested. The following Plan of Removal was accepted on 4/13/2026 at 6:58pm: Document the facility's actions taken to remove the immediacy in an IJ or IT situation *- Must address the specific failure(s) that caused or led to the IJ /IT -Incident (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview, and record review, the facility failed to ensure each resident had a right to a safe, clean, comfortable, and homelike environment in the facility and failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior in 3 of 24 resident rooms (E2, E9, and F3) and 1 of 1 areas for visitation reviewed for environment. 1. The facility failed to ensure residents that used common areas and rooms were clean, safe, and did not need repair. 2. The facility failed to have a designated visitation area with adequate seating for visitors and residents. These failures could place residents at risk of living in an unsafe, unclean, uncomfortable, and unhomelike environment which could cause a decline in resident psychosocial well-being.The findings included: During an observation and interview on 4/12/26 at 10:32 AM, Resident #37 in room F3 said there was water leaking from the ceiling in his room and he worried about the ceiling falling down. Resident #37 stated he hated the leak in the ceiling and that it needed to be repaired because it was ugly. Observation revealed a thick layer of paint on the ceiling in front of the closet that was bubbled out with a couple of large holes in the paint. Water was observed dripping from the holes in the bubbled paint. During an observation on 4/12/26 at 10:54 AM in room E9 it was revealed to be occupied by two residents. A hole in the ceiling above the bed near the window that was approximately 1 to 2 inches long. Additionally, the restroom sink was filled with dark grey water. There was nothing observed in the sink to prevent the water from draining. During an observation on 4/12/26 at 11:20 AM in room E2 it was revealed to be occupied by one resident. A thick layer of paint on the ceiling in front of the window that was bubbled out with a large hole in the paint. Water was observed dripping from the hole in the bubbled paint and along the privacy curtain rails that were secured to the ceiling. Record review of a document titled, Maintenance Work Order Log, undated, revealed no repair requests for ceiling repairs in rooms E2, E9, and F3. Additionally, there was no repair request for a stopped-up sink in room E9. During a confidential interview on 4/13/26 at 12:01 PM a visitor stated they were concerned that the facility was dirty and needed to be cleaned, updated, and needed new paint. They stated the only place to sit for visitors was outside and that was not always an option. They stated that sitting outside got too hot at times and people smoked outside and they were allergic to the smoke. They stated it would be nice if the facility had chairs available for visitors to sit in inside the facility. During an interview on 4/14/26 at 2:52 PM, the MS stated he assessed the building for daily repairs that included the floors, rooms, ceilings, and all other basic repairs needed. He stated all staff were trained to write repairs needed in the maintenance logbook that was kept at the monitoring station. He stated all pending and completed repairs were logged in the maintenance logbook. He stated the timeframe of a repair being made was prioritized based on the nature of the request. The MS stated the ADM also reviewed the maintenance log monthly. He stated he was responsible for ensuring repairs were completed. He stated he was not sure if there was a policy regarding repairs. The MS stated he was aware about a month ago of a leak in the ceiling of a resident room on E-hall. He stated he was not aware of leaks in any other resident rooms. The MS stated he called a roofing company to get quotes about a month ago and they had not gotten back to him. He stated he called them again today and was told they would come sometime today to look at the roof. The MS stated he was not aware of the stopped-up sink in room E9. He stated he had repaired the hole in the ceiling in room E9, but the rain damaged the repair he made, and it began to leak again. He stated he believed the roof needed to be repaired to stop the leaks. The MS stated he would fix the sheetrock in the ceilings after the roof was repaired because it would damage repairs made to the ceilings as long as the roof continued to leak. He stated staff had in-services once a month, and he also reminded his staff weekly that he expected them to log all repairs needed in the logbook even if they verbally told him about the issue. He stated his direct staff were the Monitoring Technicians and housekeeping staff. The MS stated he had a meeting about his (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expectations of logging and reporting repairs with staff last Wednesday (04/08/26). He stated he was not aware of the complaints about not having a place with chairs for residents to sit with visitors. He stated visitors usually visited residents in their rooms or the dining room, and there was also a gazebo outside they could visit at. He stated he was not aware of complaints about the facility not being clean. The MS stated the housekeeping staff cleaned rooms daily. He stated he inspected rooms after staff cleaned them to ensure they had been cleaned after he received complaints. He stated there were residents that put food and stuffed paper down the sinks which caused them to get stopped up, however that was the nature of what happened at the facility. He stated a potential negative outcome was that water leaks could cause a fall. The MS stated stopped up sinks caused bad odors, and sitting water could grow bacteria which could cause infection on skin that had an open cut. The MS stated it was important for there to be a clean environment and inviting visitation area because this was the residents' home and it was important that the facility felt comfortable for them. The MS stated visitors were important because they help residents to not feel abandoned, so it was important for them to have a clean space with chairs to visit that had some privacy. He stated the chairs were important as they encouraged visitors to visit the residents. During an interview on 4/14/26 at 3:42 PM, the ADM stated assessing the building for repairs was done daily by all staff. The ADM stated he expected staff to write all repairs needed in the maintenance logbook as that was their system to monitor all needed and completed repairs. He stated any urgent matters needed to be reported to himself or the MS. He stated the MS was responsible for ensuring all repairs were completed timely and the timeliness of repairs being completed was based on the nature of how extensive the repair was. He stated for example, a leak in the wall was about 3 days minimum, however a leak in a resident's rooms needed to be repaired immediately but the leaks in the ceiling would continue to be an issue because the roof was old and needed repairs. He stated he was told a repairman would come today or tomorrow to try and fix roof. He stated the roof needed to be fixed first before ceiling could be fixed. He stated the MS would fix the ceilings once the roof was fixed. He was not aware resident's rooms had leaks, and he was not aware the sink was backed up in a resident's room. He stated the MS was responsible for fixing ceilings and clogged sinks. He stated he was not aware there were complaints about the lack of seating and not having a clean area for visitation. He stated he was only aware of one regular visitor as there were not many visitors at the facility. He stated visitors could visit outside in the front of the building or the gazebo area outside. He stated there was the front lobby or the residents' rooms where people could visit. He stated visitors could also meet with residents in the dining room. He stated there was no private area for them to visit. He stated there were a couple of recliners in the lobby for people to sit and staff could bring chairs from the dining room if visitors requested them. He stated it was important for there to be chairs for visits to sit in so they could visit with their loved ones and it was also important to have a sitting area so the visitation experience could be more homelike. The ADM stated a potential negative outcome of leaks in the ceiling was that the ceiling could fall and hurt someone or a resident. He stated stopped up sinks were a sanitation and hygiene issue. He stated not having a sitting area could prevent families from being able to spend quality time with their loved one. Record review of the facility policy, Housekeeping, undated, revealed the following in part: Purpose: Establish standards of cleanliness and consistency in the way in which resident rooms and common areas are cleaned and maintained. The facility will be cleaned on a regular basis according to a specified cleaning schedule and according to Federal/state guidelines. 2. Resident Rooms- Resident's room floors are to be clear of spills, stains, and debris.- Porcelain sinks are to be free of cracks, chips, or stains.- Sink drainpipes are to be free of dust and dirt.- If nursing personnel notice any of these sanitary violations occurring in the resident's room, housekeeping and/or maintenance should be notified promptly. Record review of the facility policy, Safe Environment, undated, revealed the following in part: Purpose: The resident has a right to a safe, clean, comfortable and homelike environment1 including but not limited to receiving treatment and supports for daily living safely.Procedure: This facility will (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provide -Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. 1. A safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.2. Housekeeping and maintenance services necessary to maintain a sanitary, including, but not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored, orderly (uncluttered physical environment that is neat and well-kept) and comfortable interior.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interviews and record review, the facility failed to use the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week in the facility for 6 (10/4/2025, 10/5/2025, 10/11/2025, 10/12/2025, 10/19/2025, and 11/9/2025) of 67 days reviewed for RN coverage. The facility failed to maintain RN coverage of eight hours a day for 6 days. This failure could place residents at risk of not having their nursing and medical needs met and receiving improper care.Findings included: Record review of the facility's employee survey roster dated 4/12/26 revealed there were three RNs employed at the facility. Record review of Punch Detail Reports, dated 10/4/2025, 10/5/2025, 10/11/2025, 10/12/2025, 10/19/2025, and 11/9/2025, revealed there were no hours logged for RN coverage. Record review of an email dated 4/13/2026 at 10:53 AM, revealed the ADM's response to the surveyor read, unfortunately, facility did not have RN coverage dates requested, when punch-in details for RN coverage were requested for 10/4/2025, 10/5/2025, 10/11/2025, 10/12/2025, 10/19/2025, and 11/9/2025. During an interview on 4/15/26 at 3:42 PM, the ADM stated he was aware there was no RN coverage for 6 days in October and November 2025 He stated the RN who was scheduled to work chose not to work on those days. He stated the RN was contracted to work at the facility through an agency they had a contract with. The ADM stated the facility policy required RN coverage 7 days a week for 8 hours per day. He stated there currently was no DON employed at the facility. He stated he had hired a new DON who would start soon. He stated the facility DON resigned without notice on 4/09/2026. He stated the DON usually monitored RN coverage and would contact an agency to ensure there was RN coverage. He stated staff had been trained in RN coverage requirements. He stated there was a DON employed at the facility during the time RN coverage was not met. He stated he expected there to be RN coverage daily or filled by the DON. He stated a potential negative outcome was that there would be lack of supervision from an RN to ensure quality of care and quality of life to every resident. He stated the punch details sheets he had would reflect no hours for RN Coverage on those dates. During an interview on 4/15/26 at 4:54 PM, the BOM stated the documents provided for RN coverage on the dates requested had the date at the top of the document and were blank to show there was no RN coverage on those dates. Record review of the policy provided by the facility titled, Registered Nurse, undated, revealed the following: Purpose: Ensure that a Registered Nurse is available for supervision in the facility. Procedure: Except when waived, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

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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 ensure food was stored, prepared, and served in a safe and sanitary manner to prevent cross contamination and the potential for foodborne illness for (64 of 64) residents reviewed for food and nutrition services. 1. The facility failed to ensure opened food items open in the refrigerator and dry storage areas were labeled with the open or use by date.2. Food transportation carts were dirty.3. Clean plates, serving utensils, and pans were stored facing upwards stored on a table.4. The facility failed to ensure staff followed hygienic practices for proper hand hygiene and use of hair restraints.5. The facility failed to ensure [NAME] D used gloved hands instead of utensils to handle prepared food, 6. Bleach, lime scale, and soak tank concentrate were stored on the floor in the food prep area. These failures could place residents at risk for food contamination and foodborne illness. Findings include: On 4/12/26 at 9:58 AM an initial kitchen observation tour began. The tour ended at 10:44 AM and revealed the following:Outside the kitchen door were two food tray carts. Cart A had brown /sticky substances on 1 slot and light brown substance on 4 slots. Cart B had red liquid substance on 3 slots, and sticky dried food on bars to push carts.In front of the refrigerator #1 a package of opened precooked sausage patties in an opened plastic bag without an open or use by date and not stored in the refrigerator or freezer. There was a 5-gallon bucket of kosher dill slices - keep refrigerated on the label on the bucket. The following items were inside refrigerator #1. The items had been opened and did not have an open or use by date:1 opened container of Silk Almond milk 1 opened bag of cheddar cheeses shredded, the top of the bag was turned down but not in a sealed container.1 opened container of Lyon's ready care thickened sweetened tea 1 opened bag of 5 cheese pizza blend with the top of the bag rolled over and not in a sealed container.1 opened and undated jar Dijon mustard 1 opened bag of lunch meat dated 4/7, that did not indicate if it was date opened or use by date. 3 opened blocks of sliced cheese. 2 of 3 were stored in a clear storage bag without an opened or used by date, and 1 of 3 blocks was opened, undated, and not in a sealed container. 1 opened bag of American cheese shredded with the top of the bag rolled over and not in a sealed container. The following items were observed unsealed, without an open or use by date in the dry pantry:1 opened bag of tortilla round chips, not stored in a sealed container, undated, with the top of the bag rolled down. 1 opened jar of granulated garlic without an opened or use by date1 opened container of black pepper without an opened or use by date1 opened container of onion powder without an opened or used by date1 opened bottle of classic syrup cinnamon without an open or use by date2 opened containers of salt free seasoning without an opened or use by date. 1 of 2 was sticky to touch1 opened gallon of sweet red chili wing sauce without an open or use by date and label indicated best flavor refrigerates after opening2 opened, 1-gallon containers of liquid butter, without an opened or use by date1 opened gallon Worcestershire sauce without an opened or use by date1 opened gallon of golden Italian dressing without an opened or use by date2 opened 1/2 gallon bottles of sweet and sour sauce without an opened or use by date. Bottle labeled refrigerate after open 1 opened gallon canola oil without an opened or use by date1 opened container of dried parsley flakes without an opened or use by date1 opened 1.5 lb. container whey protein without an opened or use by date1 opened 7.9 lb. container of chicken bouillon without an opened or use by date2 unopened packages of dinner rolls, with an expiration date of 3/17/26 and without a date received and had an expiration date of 3/17/261 unopened case of individual containers of orange juice with received date 4/10/26 the label indicated keep frozen on a shelf thaw overnight in 38 F cooler The following items were opened in the freezer without an open date or use by date:1 opened bag of frozen burritos not in a sealed container and without an opened or use by date1 opened bag country fried breaded beef patty not in a sealed container without an open or use by date The following equipment was observed in the kitchen stored in unsanitary ways:1 4 slice toaster with brown residue spots2 sticky medium size plates1 stack of (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	large plates and 1 stack of divided plates sitting right side up2 clear containers containing serving utensils stored with serving surfaces up outside of the container. 1 stack of clear lids that was visibly wet, stored stacked and wet inside.1 reusable water bottle under the three-compartment sink Refrigerator #2 did not have a thermometer inside and the last date the temperature was checked was 4/9/26.Freezer #3 did not have a current temperature log last date the temperature was checked 4-9-26. Sitting on the floor near the sink by the dishwasher:1 gallon bleach 1 gallon Lime scale1 gallon of soak tank concentrate During an observation on 4/12/26 at 10:30 AM, the DM took the temperature of the kosher pickles in the 5 gallon bucket the temperature was 72 Fahrenheit. An observation on 4/12/26 at 12:01 PM of the lunch meal service revealed:12:01 PM [NAME] B put on new gloves without preforming any hand high before she started the puree cornbread. 12:03 PM [NAME] B with gloves on, touched the lid of trash can, then opened the oven door, picked up oven mitts and took the pan of chopped ham out of the oven. [NAME] B removed the oven mitts and started to remove the pan liner from the chopped ham and tempted the ham at 165 F. The pan liner fell on the floor and picked it up and placed it back in the box. 12:09 PM [NAME] B began to serve the lunch meal, placed new gloves on hands, but did not practice hand hygiene before she put the new gloves on. 12:11 PM Dietary Aide C entered the kitchen without a hair restraint on and did not wash his hands. He walked behind [NAME] B and went around the kitchen and entered the office. Dietary Aide C walked out of the office, put a hair restraint on and then walked around the kitchen to the hand-washing sink and washed his hands. 12:20 PM Dietary Aide C put gloves on, grabbed two bags of sliced bread and placed them on the prep table. He walked to the refrigerator, removed a container of lunch meat and sliced cheese. He returned to the prep table and placed the sliced bread on the pan liner. He opened the container of lunch meat and placed one slice on one slice of bread. He returned to the refrigerator and took out another bag of lunch meat. He walked back to the prep table, picked up a knife, opened the package of lunch meat with the knife, and continued to take slices of lunch meat out of the container and placed it on slices of bread. He opened the container and removed sliced cheese and placed cheese on the sliced bread. He picked up a coffee cup that had keys attached and exited the kitchen wearing gloves. He returned to the kitchen wearing the same gloves and had two additional bags of bread. He placed the bags of bread on the prep table and set the coffee cup with keys on it on another prep table. He went to the refrigerator and removed 2 plastic clear bins with lids on them and placed them on the prep table, removed his gloves and washed his hands. He replaced his gloves and returned to the prep table and cut the sandwiches and placed them in one of the clear containers. He picked up the two bags of bread, opened them and placed sliced bread out on a pan liner to make peanut butter and jelly sandwiches. He picked up the grape jelly that was sitting on the shelf behind the prep table and started to squeeze jelly on the bread. He walked to the dry pantry and grabbed another grape jelly returned to the prep table, opened the jelly and continued making sandwiches. He stepped away from the prep table and returned with a rubber spatula, smeared the jelly on the bread, then placed the rubber spatula in the peanut butter, and smeared peanut butter over the jelly. He continued this process until the sandwiches were done. Jelly residue was observed inside the container of peanut butter. Dietary Aide C then used the same knife, he cut the meat and cheese sandwiches, to cut the peanut butter and jelly sandwiches. During an observation on 4/13/26 at 5:15 PM, the evening meal was served. [NAME] D did not use utensils for the bun, fish patty, and chicken nuggets. [NAME] D touched plates, meal tickets and handles of other serving utensils then used her gloved hand to serve the bun, fish patty, and chicken nuggets. She did not change gloves after handling non-food items and handling ready-to-eat food items. During an interview on 4/12/26 at 10:24 AM, [NAME] B stated she threw the sausage patties in the trash. She stated that she forgot to place them back in the refrigerator and they had been sitting out for about one hour. [NAME] B stated she had been trained to put things up or residents could get sick. She stated the DM was unable to get a temperature for the sausage patties because staff threw them away. During an interview on 4/12/26 at 10:32 AM, the DM stated, with the 5-gallon bucket of kosher dill pickles, he bought the (continued on next page)

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During an interview on 4/12/26 at 12:35 PM, the DM stated there were a few residents that asked for peanut butter and jelly sandwiches in the morning. He stated he thought maybe staff left the jelly out that they had forgotten to put it in the refrigerator. The DM temped the grape jelly and it was 76.3 F. During an interview on 4/13/26 at 8:49 AM, the DM stated, per policy, everything in the kitchen should have a received date, opened date and they kept most items 7 days after they were opened. He stated they use a first in first out rotation. He stated as far as the food items are not labeled or dated, they used a different tag and maybe they fell off. He stated he was not sure why dietary staff did not label and date opened food items. He stated they could serve expired food and residents could get sick. He stated the ADM was going to order something for them to hang the serving utensils on so staff would not touch the serving ends. He stated for now staff would place the serving utensils in the dishwasher before they used them. He stated it was everyone's responsibility to make sure food was labeled and dated correctly. During an interview on 4/14/26 at 1:51 PM, the DM stated staff should practice hand hygiene when they entered the kitchen, go from clean to dirty or the task changed. Staff would need to remove gloves and wash their hands before putting gloves back on. DM stated staff have been trained to practice hand hygiene. DM stated he thought maybe staff were nervous and frantic and they forgot. He stated staff should have done everyday practices, and follow the rules set for the kitchen. He stated staff were trained and in-serviced in storing food appropriately. He stated staff told him the reason they had not labeled the opened food items with dates was they didn't have pens or didn't know where labels were located. He stated staff told him the reason they did not refrigerate some of the food, that was labeled refrigerate after opened, was there was not enough room in the refrigerator. He stated food borne illness could happen if food was served at the incorrect temperature. He stated if staff did not perform proper hand hygiene it could cause cross contamination. He stated chemicals stored in the kitchen, should be stored away from food and off the floor a little bit, that way the chemicals could not leak into any food. He stated he planned to move the chemicals off the floor. He stated there was not enough room on that storge shelf to store all the chemicals. He stated the chemicals were not stored appropriately at that time. He stated staff cleaned the floors every day after every meal. He stated the staff in the kitchen probably didn't see that reusable water bottle was on the floor under the 3-compartment sink. He stated staff should have noticed the reusable water bottle when they cleaned. He stated when staff did not use utensils when they served buns, fish patties, and chicken nuggets, [NAME] D forgot. He stated he discussed, with the staff, that utensils had to be used to prevent cross-contamination. He stated it was his responsibility to monitor staff, and make sure they followed sanitation practices in the kitchen. He stated he monitored that; he watched staff do their work but would monitor them even more. During an interview on 4/14/26 at 3:25 PM, ADM stated staff should label food with the appropriate dates. He stated staff should store food appropriately, and refrigerate after it is opened, if required. He stated unlabeled and undated food could cause food borne illness, and cross contamination. He stated staff should have practiced hand hygiene when they worked in the kitchen and handled food. He stated staff failure to do so could cause cross-contamination. He stated staff should use utensils when they serve ready-to-eat food and not use their hands with a glove. He stated staff did not follow the facility's policy for sanitation of kitchen, handling food, or storing food properly. During a (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	telephone interview on 4/14/26 at 4:16 PM with Dietary Aide C, he stated he worked in the kitchen for 2 years. Dietary Aide C stated he received training on washing his hands and he washed them when he entered the kitchen, and if he touched something with his gloves, he should have taken them off and washed his hands. He stated there was no excuses for him not practicing hand hygiene on 4/12/26. He stated, residents could get sick or get something bad. He stated he was in-serviced and trained to label and date food when opened. He stated he was not sure why food was not dated, because they had labels and were supposed to use them. He stated he did read labels to see if items needed to be refrigerated once opened. During a telephone interview on 4/14/26 at 4:32 PM, [NAME] B stated she was in-serviced on dating and labeling opened food in the kitchen, and didn't know why food was opened and not dated. She stated, some staff do it and some don't. She stated she knew about hand hygiene and knew when to wash her hands before she handled any food items when she changed to a different job, or when dirty, and that her hands were so dry from washing them. She stated she was nervous on 4/12/26, during meal service, and she just forgot to wash her hands when she was changing gloves. She stated that not washing her hands could cause residents to get sick with nausea and vomiting. She stated she was not sure why chemicals were on the floor in the kitchen chemicals should have been stored on the racks, not on the floor She stated that staff cleaned the kitchen after each meal. Record review of the labels for the chemicals stored on the floor revealed the following:Lime scale, multipurpose lime scale remover, to avoid food contamination during application and storage. Do not store in food processing areas.Clorox Germicidal Bleach-Danger, keeps out of reach of children. Deluge soak tank concentrate - Medical emergency, warning causes eye irritation. Keep out of reach of children. Record review of the facility's policy Food and Nutrition Services dated 2001 Revised October 2017 reflected:Policy Statement Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.Policy Interpretation and Implementation .b. Foods that are left without a source of heat (for hot foods) or refrigeration (for cold foods) longer than 2 hours will be discarded. Record review of the facility's policy Food Preparation and Service dated 2001 Revised April 2019Policy Statement Food and nutrition services employees prepare and serve food in a manner that complies with safe food handling practices. Policy Interpretation and ImplementationFood Preparation Area .5. Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness.Thawing Frozen Food .1. Foods will not be thawed at room temperature. Thawing procedures include:Thawing in the refrigerator in a drip-proof container.Completely submerging the item in cold running water (70 F or below) that is running fast enough to agitate and remove loose ice particles;Thawing in a microwave oven and then cooking and serving immediately; orThawing as part of a continuous cooking process. Food Preparation, Cooking and Holding Time/Temperatures .1. The danger zone for food temperatures is between 41 F and 135 F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illnesses.3. The longer foods remain in the danger zone the greater the risk for growth of harmful pathogens. Therefore, PHF must be maintained below 41 F or above 135 F. Food Service/Distribution Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks. Disposable gloves are single-use items and are discarded after each use.3.Food and nutrition services staff, including nursing services personnel, wash their hands before serving food to residents. Employees also wash their hands after collecting soiled plates and food waste prior to handling food trays.6. Food and nutrition services staff wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food. Record review of the facility's policy Sanitization dated 2001 revised October 2008Policy StatementThe food service area shall be maintained in a clean and sanitary manner.1. All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects.1. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their (continued on next page)

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	675019	A. Building B. Wing	04/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apex Secure Care Brownfield	1101 E Lake St Brownfield, TX 79316

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	use or proper cleaning. Seals, hinges and fasteners will be kept in good repair.16. Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime.17. The Food Services Manager will be responsible for scheduling staff for regular cleaning of kitchen and dining areas. Food service staff will be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment.Texas Food Establishment Rules The container of ready-to-eat food shall be marked to indicate the date by which food shall be consumed on the premises, sold or discarded, The ready -to-eat food if held at 41 degrees Fahrenheit can only be held for a maximum of 7 days, with day of preparation being day 1.

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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. Based on observation, interview and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public, in 1 of 1 dining rooms, 1 of 2 dry pantries (Dry Pantry A), around 1 of 1 nursing stations and 1 of 7 Hallways (Hall C), in that: The facility failed to ensure the dining room floors were in good condition.The facility failed to ensure the dining room ceiling was in good condition and not leaking.The facility failed to ensure Dry Pantry A's ceiling was in good condition and not leaking.The facility failed to ensure the floors around the nursing station were in good condition.The facility failed to ensure Hall C did not have water damage on the ceiling tiles outside Room C9. These failures could lead to resident injuries, falls, spread of infections and cause the facility to have an unsightly appearance. The findings include: Observations on 04/12/26 beginning at 9:58 AM, revealed the dining room was noted to have an area on the ceiling near the kitchen that was leaking water with 3 buckets on the floor with water noted in each bucket, 2 blankets were noted on the floor around the buckets and Caution Wet signs were noted around the water on the floor. The dining room floors were noted to have large white/black scratches/marks in several different areas on the brown flooring. The dry pantry area in the kitchen next to the dining room was noted to have an area on the ceiling that was slowly leaking water with 2 buckets noted on the floor with water in the buckets. Observation on 04/12/26 at 11:25 AM, revealed the floors around the nursing station were noted to have several areas of white/black marks on the brown flooring. Interview on 04/12/26 at 1:06 PM, the Maintenance Supervisor stated the ceiling had started leaking this weekend (04/11/26) with the rain. The Maintenance Supervisor stated the area was blocked off from the residents. The Maintenance Supervisor stated he had been working with a roofing company in town and was waiting for them to give a quote to fix the roof damage. Observation on 04/13/26 at 11:26 AM in C Hall, revealed brown water spots noted on 5 ceiling tiles outside Room C9. During a confidential family interview on an undisclosed dated at an undisclosed time revealed the facility was in bad shape and dirty. Interview on 04/14/26 at 1:35 PM, the Maintenance Supervisor stated the floors in the dining room and around the nursing station, he was working on pieces to get them replaced. The Maintenance Supervisor stated some areas on the floors were walked on a lot by residents and family members and their wheelchairs. The Maintenance Supervisor stated the roof and ceilings were a problem and a company had gone out about a month or two ago and he was still waiting for them to contact him with the quote. The Maintenance Supervisor stated the leaking areas were blocked off to the residents, so no one slipped. Interview on 04/14/26 at 2:44 PM the ADM stated the facility had spoken with two companies regarding the roof damage and it had been a while since they had gone back and forth, asking the Maintenance Supervisor about it needing the estimates. The ADM stated last week there was still no reply and he did not know what the hold-up was. The ADM stated the Maintenance Supervisor was trained on repairs, but he would start fixing one thing and then another area would need immediate attention. The ADM stated the building was old and had chronic issues. The ADM stated a potential negative outcome to the residents was a bad appearance or not homelike. Record review of the facility document titled, Maintenance Work Order Log from 3/16/26 to present revealed: 4/12 - Roof in dining room leaking Record review of the facility's policy titled, Maintenance Service, with a revised date of 12/09 reflected the following: Policy Statement: Maintenance service shall be provided to all areas of the building, grounds, and equipment.Policy Interpretation and Implementation:1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.2. Functions of maintenance personnel include, but are not limited to:a. maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines.b. maintaining the building in good repair and free from hazards .3. The maintenance director is responsible for developing and maintaining a schedule of maintenance services to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents have a right to personal privacy for 1 of 21 residents (Resident #32) reviewed for respect and dignity.LVN A failed to provide privacy for Resident #32 when LVN A failed to close the window blinds, the door, or the privacy curtain during wound care. This failure could place residents at risk of emotional distress, embarrassment, and lower self-esteem.Findings include: Record review of Resident #32s undated face sheet revealed a [AGE] year-old female originally admitted to the facility on [DATE]. Resident #32 had a medical history of dementia, pressure ulcer of left buttock stage 2 (a shallow, open wound), and muscle weakness. Record review of Resident #32's quarterly MDS dated [DATE] Section C-Cognitive patterns revealed a BIMs score of 99 which indicated Resident #32 was unable to complete the interview. Section C1000 Cognitive Skill for Daily Decision Making revealed Resident #32 was severely impaired and never/rarely made decisions. During a wound care observation on 4/13/2026 at 10:07am, revealed LVN A entered Resident #32's room and performed wound care to Resident #32's left buttock. LVN A did not close the door to Resident #32's room which allowed any staff, visitor or wandering resident to enter the room. Resident #32 was visible from the hallway. LVN A did not close the privacy curtain between Resident #32 and Resident #23, the roommate, who was sleeping in the room, facing away from Resident #32. LVN A did not close the window blinds, that had direct view to the street and to the facility exterior premises. During an interview on 4/13/2025 at 6:27pm with LVN A, she stated she had been trained to provide privacy but was unsure of her last training. She stated she did not close the door, but she had pulled the curtain enough so Resident #32 was not visible from the hallway. LVN A stated she did not close the curtain between Resident #32 and Resident #23 because Resident #23 was sleeping and was rolled the other direction. LVN A stated, I never close the windows or the blinds because it is a locked facility anyways. LVN A stated the purpose of providing privacy to residents during care was to for dignity and because no one wants to be exposed. LVN A stated a potential negative outcome of not providing privacy to residents could be residents feeling embarrassed or exposed. On 4/13/2026 at 6:44pm an interview was attempted with Resident #32. Resident #32 was not cognitively intact and was not interviewable.During an interview on 4/14/2026 at 3:13pm with the ADM, he stated he expected the staff to provide full privacy when providing care. He stated privacy meant having the door closed, the blinds closed and the privacy curtain pulled. He stated he was unsure if LVN A had been trained on privacy and dignity. He stated LVN A's actions were careless. He stated the potential negative outcome would be dignity issues for the residents. He stated they did not have a policy for privacy/dignity, but they had a quality-of-life policy that had information related to privacy and dignity. Record review of facility policy titled Quality of life- Dignity last revised February 2020, revealed; Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. 10. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. 11. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents. 12. Staff are expected to treat cognitively impaired residents with dignity and sensitivity.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure each resident received and the facility provided food that was palatable, attractive and at a safe, and appetizing temperature for 3 of 3 food forms (Regular, Mechanical Soft, and Pureed) for 1 of 1 (Dinner) meal reviewed for food and nutrition services. The facility failed to provide food that was palatable for the dinner meal on 04/13/26. This failure could place residents at risk of decreased food intake, hunger, and unwanted weight loss. The findings included: During confidential individual interviews 2 of 10 residents voiced concerns related to food palatability. One resident stated the food was cold. One resident stated the food was not good. Observation on 04/13/26 at 6:03 PM the test trays arrived at the family dining room and were sampled by three surveyors at 6:05 PM with the following results: Regular Meal - Regular TextureFish Sandwich - mushy texture, freezer tasteTator tots - cold/lukewarmSalad - okay Regular Meal - Mechanical Soft TextureFish - lukewarm beans - cold Regular Meal - PureeFish - okay, smoothTator tots - lukewarmBeans - okay, smooth During an interview on 04/14/26 at 2:33 PM, the DM stated he tasted the food before and after it was served about two to three times a month. The DM stated he also asked the residents about the food and had not heard a lot of negative feedback. The DM stated he was always in contact with the Dietician regarding the food and he was trained to follow the recipe. The DM stated a potential negative outcome to the residents was it could cause food borne illness if the food was cold or malnutrition if they did not want to eat all of it. During an interview on 04/14/26 at 2:44 PM, the ADM stated he expected the food to be tasteful, at an appetizing temperature and presentable. The ADM stated he tasted the food every once in a while. The ADM stated the DM had been trained on food palatability periodically. The ADM stated the Dietician had been out to the facility recently and he was still awaiting her report on the kitchen services. The ADM stated a potential negative outcome to the residents was they could get sick. Record review of the facility's policy titled, Food and Nutrition Services, with a revised date of 10/17 reflected the following: Policy Statement: Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.Policy Interpretation and Implementation:.7. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature.

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F 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ staff that are licensed, certified, or registered in accordance with state laws. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to maintain sufficient nursing staff with appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 1 of 5 (LVN C) nursing staff reviewed in that: The facility failed to ensure LVN C maintained an active nursing license while working as a nurse. The failure could place residents at risk of receiving care from an unlicensed professional. The findings include: Record review of the facility employee records on [DATE] at 4:20 PM, revealed LVN C had an LVN/LPN license with an expiration date of [DATE]. Record review of the facility's punch-detail report from [DATE] to [DATE] revealed the following:LVN C worked:[DATE] - 11.1 hours[DATE] - 11.08 hours[DATE] - 11.93 hours[DATE] - 11.17 hours[DATE] - 12.07 hours[DATE] - 9.07 hours[DATE] - 5.0 hours[DATE] - 10.92 hours[DATE] - 3.03 hours[DATE] - 12.82 hours Interview on [DATE] at 4:33 PM, the BOM stated that she had checked LVN C's license and the expiration date was correct. The BOM stated LVN C was sent home yesterday ([DATE]) when the facility checked her license and showed that it was expired. The BOM stated it was her responsibility to check the nursing staff's licenses and certificates. The BOM stated she checked the license for the nursing staff upon hire and that was how she was trained. The BOM stated it could be a problem for the residents if their nurse did not have a current license. Interview on [DATE] at 4:38 PM, the ADM stated the BOM was responsible for checking the license/certificate for the nursing staff. The ADM stated he expected all licensed individuals to be up to date when required. The ADM stated the BOM had been trained to check the employees' licenses regularly. The ADM stated a potential negative outcome to the residents was that they could be dealing with someone who did not have a license. Record review of the facility's policy titled, Licensure, Certification, and Registration of Personnel, with a revised date of 04/07 reflected the following: Policy Statement: Employees who require a license, certification, or registration to perform their duties must present such verification with their application for employment.Policy Interpretation and Implementation1. Personnel who require a license, certification, or registration to perform their duties must present verification of such license/certification/registration to the human resources director/designee prior to or upon employment.2. A copy of the current license, certification, or registration number must be filed in the employee's personnel record.3. A copy of recertifications (e.g. annual, bi-annual, etc., as applicable) must be presented to the human resources director/designee upon receipt of such recertifications and prior to the expiration of current licensure, certification, and/or registration. A copy of the recertification must be filed in the employee's personnel record.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition in 1 of 1 kitchen, in that: The facility failed to ensure the kitchen oven door remained closed and secure. This failure could place residents at risk for receiving unevenly cooked meals and at risk for fire emergencies.The findings included: During the initial kitchen observation on 04/12/26 beginning around 10:09 AM, the left oven door was opened, and a cardboard square came out from between the bottom of the stove and the top of the oven door and fell on the floor. The oven door did not close and had about two to three inches gap between the door and the stove.During an interview on 04/12/26 at 10:25 AM, [NAME] B stated the spring went out on the oven door about two to three weeks ago. [NAME] B stated she thought it had been reported. [NAME] B stated they had been using the cardboard square to help keep the oven door closed all of the way. During an interview on 04/14/26 at 1:35 PM, the Maintenance Supervisor stated he was aware of the broken oven door and he would get it fixed that day. The Maintenance Supervisor stated he asked the staff to write all repairs in the maintenance log, so he did not forget them. The Maintenance Supervisor stated that the oven door needed a spring, but he would find another way to keep the oven door closed without using the cardboard square. During an interview on 04/14/26 at 2:33 PM, the DM stated the left oven door had a broken spring. The DM stated the left oven door has been broken for about a month. The DM stated he was using towels to help keep the oven door closed, but the kitchen staff was using a cardboard square. The DM stated the maintenance supervisor did know about the broken oven door. The DM stated the facility had ordered a spring to fix the broken door, but he was not able to find an invoice related to it. The DM stated a potential negative outcome to the residents was that their food could not be cooked thoroughly or some of it could be burned. During an interview on 04/14/26 at 2:44 PM the ADM stated he expected the kitchen equipment to be operational and functional. The ADM stated the left oven door had been an issue and the DM had told him it needed a new spring. The ADM stated he would need more information on the oven to order a spring for the door due to how old the oven was. The ADM stated a potential negative outcome to the residents was bad food, food that was not fully cooked or was burned. Record review of the facility's policy titled, Maintenance Service, with a revised date of 10/09 reflected the following: Policy Statement: Maintenance service shall be provided to all areas of the building, grounds, and equipment.Policy Interpretation and Implementation:1. 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 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Put firmly secured handrails on each side of hallways. Based on observations, interviews, and record reviews, the facility failed to ensure the hallways were equipped with firmly secured handrails on each side for 1 of 6 (Hall C) hallways reviewed in that: The facility failed to ensure the handrail in Hall C between Rooms C3 and C4 was firmly attached to the wall. This failure could lead to resident injuries or falls. The findings include: Observation on 04/13/26 at 10:12 AM, the handrail in C Hall between Rooms C3 and C4 was noted to be loose/wobbly and not firmly attached to the wall. Interview on 04/14/26 at 1:35 PM, the Maintenance Supervisor stated he did not know about the handrail in C Hall or the water damage on the ceiling tiles. The Maintenance Supervisor stated if it was not written in the Maintenance logbook, then he did not know about it. The Maintenance Supervisor stated a resident could fall with a loose handrail. Interview on 04/14/26 at 2:44 PM, the ADM stated the Maintenance Supervisor was trained on repairs, but he will start fixing one thing and then another area will need immediate attention. The ADM stated the building was old and had chronic issues. The ADM stated a potential negative outcome to the residents was a bad appearance or not homelike. Record review of the facility document titled, Maintenance Work Order Log from 3/16/26 to present revealed no work orders related to the handrail between Rooms C3 and C4. Record review of the facility's policy titled, Maintenance Service, with a revised date of 12/09 reflected the following: Policy Statement: Maintenance service shall be provided to all areas of the building, grounds, and equipment.Policy Interpretation and Implementation:1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.2. Functions of maintenance personnel include, but are not limited to:a. maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines.b. maintaining the building in good repair and free from hazards .3. The maintenance director is responsible for developing and maintaining a schedule of maintenance services to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner.