

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675025	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER White Acres Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 7304 Good Samaritan Court El Paso, TX 79912	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents were provided services with reasonable accommodation of needs and preferences for 3 of 12 residents (Residents #24, #25, and #68) reviewed for call lights. The facility failed to ensure resident call lights were within reach for Residents #24, #25, and #68 on 01/27/2026. This failure placed residents at risk of having their needs unmet when they were unable to contact staff. Findings included Resident #24 Record review of Resident #24's face-sheet dated 01/29/2026, revealed an [AGE] year-old female with initial admission date of 08/21/2025, and re-admission date of 12/27/2025. Record review of Resident #24's Health and Physical dated 08/27/2025, revealed a medical history of hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side (weakness and paralysis following a stroke affecting the left non dominant side). Record review of Resident #24's admission MDS dated [DATE] revealed a BIMS score of 11 indicating moderate cognitive impairment. Section GG-Functional Abilities noted Resident #24 needed partial/ moderate assistance, meaning the helper does more than half the effort to complete activities, for personal hygiene including shaving. Resident #24 was dependent meaning the helper does all the effort. Resident does none of the effort to complete the activity for toileting hygiene Record review of Resident #24's Care plan revised 01/12/2026, revealed Resident was at risk for falls related to a cerebral vascular accident (blockage of blood flow to a part of the brain). Interventions included ensuring the residents' call light was within reach and encouraging residents to use it for assistance. An observation on 01/27/2026 at 10:15 a.m., of Resident #24's call light on the floor under her bed. Resident was asleep in bed. Resident #25 Record review of Resident #25's admission Record dated 01/29/2026 revealed a [AGE] year-old male initially admitted on [DATE] and readmitted on [DATE]. Record review of Resident #25's Quarterly MDS dated [DATE] revealed Resident #25 under Section GG indicated the resident was dependent meaning the helper does all the effort for tasks of: toileting hygiene, lower body dressing, putting on/taking off footwear, sit to lying, lying to sitting, sit to stand, chair transfer, toilet and shower transfer. Under Section H, Resident #25 was coded for being frequently incontinent for urinary and bowel continence. Under Section C, Resident #25 had a BIMS of 15 indicating cognitively intact. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #25's care plan dated 12/01/2025 revealed Resident #25 had a focus of at risk for falls related to chairbound with assist and had an intervention of, Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Record review of Resident #25's physical and health dated 11/28/2025 revealed that Resident #25 was diagnosed with epilepsy (a seizure condition), chronic respiratory failure with hypoxia (a condition where the lungs cannot transfer oxygen into the blood), cognitive communication deficit, heart failure, myotonic dystrophy type 2 (a disorder causing muscle pain, stiffness, and weakness), pure motor hemiplegia (a stroke syndrome characterized by weakness of the face, arm, and leg on one side off the body), and end stage renal disease (kidney failure). An observation and interview made on 01/27/2026 at 11:20 AM, revealed Resident #25 requested assistance from surveyor to use the restroom and stated the call light was out of reach for him. It was observed that the call light was laid across the nightstand on the resident's left side when he was right side dominant due to his medical condition. A follow-up interview on 01/27/2026 at 12:52 PM, Resident #25 stated he was waiting for 20 minutes before surveyor's arrival and denied being affected physically or emotionally by the delay. He stated staff usually take 5 to 20 minutes to respond to call lights. Resident #68 Record review of Resident #68's face-sheet dated 01/29/2026, revealed a [AGE] year-old male with initial admission date of 10/25/2024, and re-admission date of 12/03/2025. Record review of Resident #68's Health and Physical dated 11/11/2025, revealed a medical history of muscle wasting and atrophy (decrease in size, mass and strength of muscle tissue). Record review of Resident #68's significant change MDS dated [DATE] revealed a BIMS score of 13 indicating intact cognition. Section GG Functional Abilities notated Resident #68 was dependent meaning the helper does all the effort to complete activities, for personal hygiene. Resident #68 was dependent meaning helper did all of the effort. Resident did none of the effort to complete the activity for toileting hygiene. Record review of Resident #68's Care plan revised 07/15/2025, revealed Resident was at risk for falls related to weakness, history of falls interventions included ensuring call light within reach. An observation and interview on 01/27/2026 at 9:55 a.m., Resident #68's call string was detached from the switch, Resident #68 stated he did not know where his call light was. In an interview conducted on 01/29/2026 at 11:43 AM, LVN C stated, a call light was used for staff to be notified that a resident needed assistance. LVN C denied receiving concerns from residents or family members regarding the call system in place with a string connected to a light switch that illuminated the call light outside the residents' room. LVN C added that the call system in place would not be functional for residents with a limited range of motion who would require a touch pad. LVN C stated there was no residents within his halls that had such a range of motion that required a touch pad call system. LVN C stated a resident who had their call light out of reach could be left thirsty, soiled, in pain, or injured until rounds and would not be able to notify staff. LVN C stated Resident #25 had successfully used the call light in the past and recognized the limited range of (continued on next page)		

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review the facility failed to ensure the residents had the right to examine the results of the most recent survey of the facility and the facility failed to post in a place that is readily accessible area for the entire facility reviewed for required postings. The facility failed to ensure the annual survey results binder had a posted notice and was accessible for residents, family members, and staff on 01/29/2026 This failure placed residents, family members, and legal representatives of the residents at risk by limiting their right to examine the facility's survey results. Findings include: During the Resident Council interview conducted on 01/29/2026 at 10:33 AM with 10 alert and oriented residents, the group was unaware of their right to review the annual state inspection binder and was not aware where they could locate the binder. During an observation conducted on 01/29/2026 at 11:27 AM, a white unlabeled binder was in a basket mounted to the wall to the right of the facility entrance near a glass case and posterboard for employee rights. The binder was observed to be attached to the basket by a chain and was approximately 4 feet from the ground. The contents of the binder included the past annual survey results and previous investigations conducted. In an interview conducted on 01/29/2026 at 11:54 AM, LVN C stated the binder of annual survey results could be located with the receptionist in the front. He added that he was not aware of the exact location for the binder. He stated that while employed at the facility no resident had ever asked him for the results before. He stated that a resident or family member might not be able to make an informed decision if they did not have access to the binder or where to locate it. He stated the binder should be at eye level for residents who utilized wheelchairs to ensure accessibility. He was unable to recall whether he had ever received an in-service or training on locating the annual survey results binder. In an interview conducted on 01/29/2026 at 12:22 PM, CNA B who stated, the results for the annual survey could be located on the facility software called Kardex. She added that the supervisors of the nursing department would have the binder for the results of the annual survey. She declined to know what information was available in the annual survey results binder. She stated that it was important to know the location of the binder so that staff could provide the information to residents, family members and anyone asking for it. She stated it affected the residents because it was their right to have access to this information. She denied receiving in-services or training on locating the annual survey results binder. In an interview conducted on 01/29/2026 at 12:30 PM, the Receptionist stated she did not know what the annual survey results binder was. She stated she did not know who monitored, updated, or ensured its accessibility to residents. She stated that if a family member or resident was to ask her for the binder or information pertaining to the annual survey results, she would refer them to the DON or the Administrator to provide further information. She stated that it was important for the facility to have the annual survey results binder so residents and family members could feel at ease and know that the facility is up to date. She confirmed it was the residents' right to have access to the annual survey results. She stated she had never received training or in-service on locating the annual survey results binder or about the contents of the binder. In an interview conducted on 01/29/2026 at 3:05 PM, the Activities Staff stated she was not aware if residents had the right to review the annual survey results of the facility. She added no resident had ever asked her for the results of the annual survey. She stated she does not know where the binder for the annual survey results could be located or what the contents of the binder would include. She stated it was important for residents to have access to this information so that they were informed on how the facility was evaluated. She denied receiving any training on locating or providing the survey results binder to residents. She denied notifying residents during resident council about their right to the annual survey results. In an interview conducted on 01/29/2026 at 3:37 PM, the DON stated, no resident or family member had ever requested the annual survey results binder from her. She denied knowing the current location of (continued on next page)		

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the annual survey results binder and where the facility could be located. She added that the information could be located online through government portals and residents/family members could ask for assistance from the receptionist, ADON, DON, and Administrator to locate this information apart from the binder located in the facility. She stated it was important that the annual survey results binder was available to everyone because it provided insight into the facility based on surveyor findings. She identified it was a resident's right for them to have access to the annual survey results binder. She denied providing or receiving training to her employees on locating and providing the annual survey results binder. She identified the Administrator as the individual responsible for updating and placing the annual survey results binder in an accessible area. She added that all direct care staff members and heads of department should be informed on the location and importance of the contents of the binder. In an interview conducted on 01/29/2026 at 4:45 PM, the Administrator stated, the annual survey results was located in a white binder near the entrance of the facility and online at care.gov. She stated that every staff member and head of department should be informed on where to locate the annual survey results binder. She stated that no residents or family members had asked for the annual survey results binder before. She added that the binder contained surveyors' findings during the annual recertification process from the year and from investigations completed. She stated that everybody who was in the facility should always have access to the binder. She stated that it affected residents and family members because they could be looking for the information and would not be able to find it or know who to ask for help. She stated that the resident should have access to the annual survey results binder. She denied providing training to the staff or department heads for the annual survey results binder. She declined to have a policy in place for mandatory postings or in reference to the annual survey results binder. Record review of the facility's monthly Resident Council Minutes dated 12/16/2025 under Resident Rights Issues Reviewed read in part: Resident rights. Record review of a previous meeting dated 11/17/2025 under Resident Rights Issues Reviewed read in part: Resident rights. Record review of a previous meeting dated 10/06/2025 under Resident Rights Issues Reviewed read in part: Resident rights. Record review of a previous meeting dated 09/08/2025 under Resident Rights Issues Reviewed read in part: -The right to receive visitors, -The right to participate in activities, -The right to file complaints and grievances without fear of retaliation. Record review of a previous meeting dated 08/04/2025 under Resident Rights Issues Reviewed read in part: Reviewed. Free of abuse. Right to complain.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, 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 good nutrition, grooming, and personal and oral hygiene for two of six residents (Resident# 24, and Resident #68) reviewed for ADL care. The facility failed to ensure Resident #24's face was clean and free of facial hair on 01/27/26. The facility failed to ensure Resident #68's fingernails was clean and free from debris on 01/27/26. This failure could place residents who required assistance with ADL's at risk for unmet care needs. Findings included: Resident # 24Record review of Resident #24's face-sheet dated 01/29/2026, revealed an [AGE] year-old female with initial admission date of 08/21/2025, and re-admission date of 12/27/2025. Record review of Resident #24's Health and Physical dated 08/27/2025, revealed a medical history of hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side (weakness and paralysis following a stroke affecting the left non dominant side). Record review of Resident #24's admission MDS dated [DATE] revealed a BIMS score of 11 indicating moderate cognitive impairment. Section GG-Functional Abilities notated Resident #24 needed partial/ moderate assistance, meaning the helper does more than half the effort to complete activities, for personal hygiene including shaving. Record review of Resident #24's Care plan revised 03/12/2024, revealed Resident had an ADL Self Care Performance deficit related to limited mobility. The interventions noted Resident #24 required partial moderate assistance with personal hygiene. An observation and interview on 01/27/2026 at 10:15 a.m., Resident #24 was observed to have long white hair on her chin. She declined to answer the question regarding grooming. Resident # 68Record review of Resident #68's face-sheet dated 01/29/2026, revealed a [AGE] year-old male with initial admission date of 10/25/2024, and re-admission date of 12/03/2025. Record review of Resident #68's Health and Physical dated 11/11/2025, revealed a medical history of muscle wasting and atrophy (decrease in size, mass and strength of muscle tissue). Record review of Resident #68's significant change MDS dated [DATE] revealed a BIMS score of 13 indicating intact cognition. Section GG Functional Abilities notated Resident #68 was dependent meaning the helper does all the effort to complete activities, for personal hygiene. Record review of Resident #68's Care plan revised 07/15/2025, revealed resident had an ADL Self Care Performance deficit related to limited weakness. The interventions noted Resident #68 was dependent with personal hygiene. An observation and interview on 01/27/2026 at 9:55 a.m., Resident #68 was observed to have long fingernails on right and left hands. He stated that his nails had not been cut, and that he would like them to be trimmed. In an interview on 01/29/2026 at 1:26 p.m., CNA F revealed that residents were checked for trimming when they were showered. If a resident voiced wanting their nails trimmed, they would trim them right away if the residents were not diabetic., for diabetic residents, the nurse would be responsible for trimming them. She stated that the nurse and CNAs were responsible for ensuring that the residents was well groomed, this included nail trimming and shaving. She stated that residents with long fingernails was at risk of injuring themselves by scratching themselves and causing an infection. She stated that facial grooming was also provided upon shower or per resident preference. She stated that if a female resident had long facial hair, she might feel self-conscious about it. She stated that the last Inservice over ADLs was given about a month ago. In an interview on 01/29/2026 at 2:04 p.m., LVN G revealed that CNAs would let the nurses know when the resident had long nails and needed to be trimmed. He stated that it was the responsibility of the nurses and CNAs to ensure to offer nail trimmings to the residents. He stated that long nails could lead to potential injury. He stated that CNAs would be able to trim nails if residents were not diabetic. He stated that facial grooming was offered to residents, and it was performed based on their preference. He stated that a potential risk for a female resident with long facial hair would be a negative view of themselves affecting their self-esteem. He stated that there was an ADL training upon hire and did not recall a (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	recent in-service. In an interview on 01/29/2026 at 3:37 p.m., the DON revealed nail trimming was offered at least once a week by CNAs or nurses. If the resident was diabetic, the nurses would trim the nails if not the CNAs were able to do it. Nails were trimmed as soon as they were noticed to be long, or the residents voiced wanting a nail trim. She stated that a common risk of injury would be a resident scratching themselves. She stated that it was the responsibility of the nurses, CNAs and department heads to ensure that the residents were well groomed. She stated that facial grooming was performed upon resident request or family could request to have the resident shaved as well. She stated that there was no risk to female resident having long facial hair because it could be resident preference. She stated there was an in-service regarding ADLs she could not recall the date. In an interview on 01/29/2026 at 4:26 p.m., the Administrator revealed that nails and facial hair was trimmed and shaved as soon as it was noticed and residents was okay with trimming and shaving. She stated that the risk of long nails was that residents could scratch themselves causing injury and females with long facial hair could feel embarrassed by it. She stated that nurses, CNAs and department heads was responsible for ensuring that residents was well groomed. She stated that she could not recall the date of the last in-service over ADLs but that it was done last year. Review of the facility policy titled Grooming Care of the Fingernails and Toe nails not dated read in part . Fingernails are trimmed by Certified Nursing Assistants except for the residents with the following condition, Diabetes or circulatory impairment of the hands, ingrown infected or painful nails, nails that are too hard, thick or difficult to cut easily note: a licensed nurse will trim those residents)		

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. Based on observation, interview, and record review the facility failed to ensure the activities program was directed by a qualified professional who was a qualified therapeutic recreation specialist or an activities professional for 1 of 1 (activities staff) reviewed for staff qualifications. The facility failed to ensure the activities staff had completed State approved training to direct facility activities. This failure could place residents who participated in facility activities at risk of physiological, psychological, social, and spiritual harm by receiving services from unlicensed personnel. Findings include: It was observed during survey from 01/27/2026 to 01/29/2026 the Activities Staff facilitated multiple activities during the week to include organizing the resident council meeting for the surveyor. Observation on 01/29/2026 at 3:05 PM, the Activities Staff badge had the title Activities Director covered with a printed label that read Staff. During an interview conducted on 01/29/2026 at 3:30 PM, the Activities Staff stated she was the individual responsible for organizing and hosting activities for the residents. She added that she had worked on Saturday and Sunday before to provide activities because there was no one else to facilitate activities for the residents on weekends. She stated she was not the Activities Director because she had not completed her certification. She added that she was working on her certification to become the Activities Director since December 2025 and anticipated completion for March 2026. She stated that she was previously employed as a CNA for the past 5 years, and this was her first full-time job working in activities. She added her previous experience as a CNA required her to assist in activities when asked, but that was not her full-time responsibility. In an interview conducted on 01/29/2026 at 3:45 PM, the DON stated it was not okay for staff to be working without a professional license or certification when the position required it. She added it was important to possess licenses for staff because it signified that the employee had completed their competencies to perform their duties. She agreed it was a liability for employees who provided services they were not licensed to perform. She stated HR was responsible for performing license checks prior to hiring individuals for licensed positions. She added that it was not appropriate for employees to provide care/services without the supervision of a licensed individual in place. She stated that HR does annual checks for licenses. She stated it affected residents who received services from an unlicensed individual because the employee may not be able to perform the task. In an interview conducted on 01/29/2026 at 03:50 PM, the HR Manager stated the Activities Staff was hired on 10/29/2025. She identified that the Regional Director of Activities was the Director of Activities for the facility; she added the Regional Director of Activities was not in the building and was a traveling employee. She stated within the year she had worked at the facility, the Regional Director of Activities had never been in the facility to her knowledge. She stated that the Activities Staff did not have a license or certification in place and added that Activities Staff was actively working on her certification. She stated that the Activities Staff began her course in December 2025 and was expected to finish in March 2025. She denied being concerned with unlicensed personnel facilitating activities. She confirmed that the Activities Staff was hired to facilitate activities independently with oversight from the Administrator and the Regional Director of Activities. She added that the facility was using the license of the Regional Director of Activities for compliance. She stated the Activities Staff nametag said Director because the individual who created the badge (unknown) thought she was hired as the Director. She stated that it was not acceptable for unlicensed staff to provide services when their position required a license. She identified herself as the individual responsible for ensuring staff was licensed prior to hiring the position. She added if an individual did not have a license for the position they were applying for, she would not hire them. She clarified because the position was for Activities Staff, the license was not required. She added she was not involved in the supervising activities conducted by the Activities Staff; this was left between the Regional Director of Activities and the Administrator to oversee the operation of activities. She stated she did not know how it would affect residents if the person in charge of activities was (continued on next page)		

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unlicensed. In an interview conducted on 01/29/2026 at 4:50 PM, the Administrator stated the Activities Staff and the Regional Director of Activities oversaw the activities department; she added she had not met the Regional Director of Activities since she began in October 2025. She stated the Activities Staff and the Regional Director of Activities conducted virtual communication for oversight of the facilities activities; she was unaware of the frequency of the meetings between the two or the contents of discussion between the two. She recognized that the Activities Staff was unlicensed and independently facilitated the activities. She stated that the Activities Staff should have had their license upon hire for compliance. She identified herself and the HR Manager was responsible for hiring the Activities Staff to independently host activities as an unlicensed employee. She added that herself and the HR Manager was responsible for ensuring employees had active licenses before providing services. She agreed it was unethical for the facility to appoint an unlicensed individual to complete tasks that required a license. She stated it could affect residents if an employee was providing unlicensed services and added there could be issues of competency on the employee's behalf. Record review of the facility's Background Check Policy revised 02/2025, read in part: Policy (subtitle) .This policy sets for the Company's procedures for conducting pre-employment background checks or all staff positions .Background Check. Checking or verifying any or all parts of the candidate's employment, educational, criminal, or certification/license histories .Education History Check. Verifying that the candidate possesses the relevant educational credentials cited or listed in the candidate's application .Certification or Licensure History Check. Verifying, if required for the position, that the candidate possesses the certifications or licenses listed in the candidate's application, resume, or cover letter, including establishing the current status of the relevant licenses. This includes any professional certification or license required for the position .General Procedure (subtitle) . Candidate for all staff positions are subject to standard background checks of employment, education, criminal, or certification and licensing histories. Criteria for identifying a position as possibly requiring license, or other additional background checks include but are not limited to: Direct responsibility for the care, safety, and/or security of individuals .A requirement for a certificate, professional license, or accreditation . Authority, Interpretation and Amendment (subtitle) The Payroll and Human Resources Account Managers are responsible for enforcing this policy. The Department of Human Resources is responsible for the general administration and implementation of this policy. Record review of the facility's employee roster for company 40488 undated, revealed one employee under the Activities Department with the title of Activities Staff.		

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NAME OF PROVIDER OR SUPPLIER White Acres Wellness & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 7304 Good Samaritan Court El Paso, TX 79912	
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice for 3 (Resident #12, Resident # 46 and #62) of 12 residents observed for oxygen management. 1.The facility failed to ensure Resident #12's nasal cannula was maintained off the floor while oxygen was in use on 01/27/2026. 2. The facility failed to clean the oxygen concentrator air filter for Resident #46 while the oxygen was in use, concentrators was observed with air filters with dust, and lint collected on them on 1/27/2026.3. The facility failed to ensure Resident #62's suction tubing equipment was stored properly on 01/27/26. This failure could place residents on oxygen therapy at risk of receiving incorrect or inadequate oxygen support and decline in health. Findings included: 1.Record review of Resident #12's admission Record, dated 01/29/2026, revealed a [AGE] year-old female with an initial admission date of 11/03/2021, and re-admission date of 01/06/2026.Record review of Resident #12's history and physical document, dated 12/17/2025, revealed Resident #12 had a diagnosis of Chronic hypoxic respiratory failure (Long term condition where the lungs cannot get enough oxygen into the blood).Record review of Resident # 12's admission MDS, dated [DATE], revealed there was no BIMS score as the resident did not participate. Section O special treatments procedures and programs indicated use of oxygen therapy.Record review of Resident #12's care plan, revised 01/04/2026, revealed Resident #12 had altered respiratory status related to respiratory failure. The interventions included in the care plan were to provide oxygen as ordered. 2 liters per minute via nasal cannula. May titrate up to 4 Liters per minute as needed.2. Record review of Resident #62's admission record, dated 01/29/26, revealed a [AGE] year-old male with initial admission date of 09/11/23, and re-admission date of 08/04/25.Record review of Resident #62's PPS MDS, dated [DATE], revealed the BIMS was not conducted because Resident #62 was not able to participate. Resident #62 was never/rarely understood. The MDS noted under Section K- Swallowing/Nutritional Status, Resident #62 had a feeding tube on admission and while a resident in the facility.Record review of Resident #62's health and physical, dated 12/24/25, revealed a medical history of: Amyotrophic lateral sclerosis (a nervous system disease that affects the nerve cells causing loss of muscle control), and Acute Respiratory Failure with hypoxia (occurs suddenly when the lungs fail to adequately oxygenate the blood or remove carbon dioxide).Record review of Resident #62's care plan, with last revision made on 12/29/2025, noted the resident was to be on oxygen therapy and provide respiratory care as directed.3. Record review of Resident #46's admission sheet dated 01/29/2026 revealed a [AGE] year-old male with admission date 10/10/2025.Record review of Resident #46's Quarterly MDS dated [DATE] revealed a BIMS score of 14, indicating resident was cognitively intact. Section I-Active Diagnoses included Respiratory Failure. Section O noted Resident #46 was on Oxygen Therapy while a resident in the facility.Record review of Resident #46's diagnosis list dated 01/27/25 revealed a medical history of: hypertension (high blood pressure), Cerebrovascular Accident (CVA, or stroke, when blood flow to the brain is disrupted potentially leading to brain damage), seizure disorder (a burst of electrical activity in the brain that can cause changes in movement, behavior, and level of consciousness, which can last from a few seconds to minutes), anxiety disorder (excessive and persistent worrying or fear which can affect everyday life tasks), and acute respiratory failure with hypoxia (the lungs cannot adequately exchange gases, leading to low oxygen levels).Record review of Resident #46's care plan last revised 01/14/2026, revealed resident was on oxygen therapy via Nasal Cannula (a medical device that provides supplemental oxygen through 2 prongs that are placed in the nostrils). In an observation on 01/27/2026 at 9:31 AM revealed Resident #12's nasal cannula on the floor while the resident slept and the oxygen concentrator was in use. In an observation on 01/27/2026 at 9:45 AM, revealed Resident #62 was in his room, sitting in a specialized recliner chair with his feet elevated. A [NAME] (a firm plastic suction tip with a large opening with a bulbous head (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and is designed to suction secretions out of the resident's mouth) was observed at bedside on the nightstand, open to air. Resident #62 was not able to answer questions. In an observation on 01/27/2026 at 09:57 AM, Resident #46's oxygen concentrator filter was observed dirty with dust, and lint, while in use. Resident #46 was unable to recall when the filter was last cleaned. In an interview on 01/29/2026 at 1:20 PM, CNA F stated CNA staff was to notify the nurse of observed dirty oxygen concentrator filters, and she stated nurses was responsible for maintaining and ensuring they were clean. She stated the possible risk of the concentrator filter being dirty included for the resident potentially becoming ill from the dirty filter. CNA F stated there was an in-service regarding the concentrator maintenance but was unable to recall when. CNA F revealed when a resident's nasal cannula was on the floor, the nursing staff were to throw it away and they were to replace it with a new nasal cannula, because the one on the floor was considered contaminated and the resident could get an infection. She stated CNAs conducted rounds every 2 hours, during those rounds they checked to see if nasal cannulas were stored properly when not in use along with ensuring nasal cannulas were off of the floor. She stated it was the responsibility of the CNAs and nurses to ensure nasal cannulas were stored properly when not in use or on the resident while the oxygen concentrator was in use. In an interview on 01/29/2026 at 1:50 PM, LVN G stated the oxygen concentrator filters was to be clean. He stated CNA's was responsible for monitoring and cleaning the residents' oxygen concentrator filters. He said the filter was to be monitored after nurses provide resident care or provided assistance during their rounds. He stated potential risks for residents using an oxygen concentrator with a dirty filter, was possible infection and illness. LVN G revealed nasal cannulas were supposed to be stored in a bag when not in use and kept off from the floor. He stated if the nasal cannula was found on the floor, it would have to be changed out due to contamination and risk of infection to residents. He stated the charge nurses were responsible to ensure the nasal cannulas were stored properly while not in use or that it was placed in the residents' nostrils while in use. He stated the facility conducted Inservice about oxygen/ tubing storage upon hire and had not been with the company long enough to have participated in another Inservice. LVN G stated suction equipment should not be left open to air and exposed. He stated the assigned nurse who provided suctioning was responsible for storing the equipment properly after being used. He stated it should not be exposed, should be stored, and it was an infection control issue. The assigned nurse would be responsible, after every use, staff stored it or threw it away and got new tubing. In an interview on 01/29/2026 at 03:15 PM, the ADON, who is also Infection Preventionist for the facility, she stated all staff was able to clean resident oxygen concentrator filters and all staff was responsible for ensuring it was clean. She stated the potential risk to residents not having a clean oxygen concentrator filter included an infection control issue as it could potentially affect the residents' respiratory system since they breathe in the oxygen from the concentrator. The ADON, she stated residents who required more frequent suctioning were left suctioning equipment stored at residents' bedside. She stated the nurse who performed the suctioning was responsible for storing it back into its original packing or container. She stated the purpose of having the [NAME] suction stored in its' container was for infection control. She stated she was responsible for monitoring and identifying potential infection control hazards and re-educate staff as needed. She stated she rounded on the residents daily. She stated the last in-service for infection control was October or November 2025. In an interview on 01/29/2026 at 3:37 PM with DON revealed when staff found a resident nasal cannula on the floor, they were supposed to dispose of the nasal cannula due to infection control, obtain a new tubing, label it and place back onto the resident. She stated there would be no risk for the residents if their nasal cannula were found on the floor. She stated it was everyone's responsibility to ensure nasal cannulas were placed in residents' nostrils during use and not on the floor. She could not recall the last Inservice done over oxygen tubing/ storage. The DON stated nursing staff were responsible for ensuring [NAME] suctioning equipment were stored properly and covered for infection control. She stated the nurse assigned to the resident was responsible for ensuring all equipment per policy. The DON was (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shown the picture of Resident #62's suctioning equipment on 01/27/2026, and she stated the equipment was considered dirty and needed to be replaced. She stated there was no real risk to Resident #62, because the resident did not need to be suctioned frequently. The DON stated nursing staff was responsible for cleaning or changing oxygen concentrator equipment such as cannulas or filter. She stated nursing staff completed this task every 7 days, on Wednesdays. She stated for residents under hospice, the hospice agency will assist with cleaning the oxygen concentrator filter. She stated there was no potential risks for residents to use oxygen concentrators with dirty filters. In an interview on 01/29/2026 at 4:23 PM, the Administrator stated all direct care staff was responsible for ensuring oxygen concentrators was clean. She stated nursing monitored the residents and was unsure how often staff check the oxygen concentrator filters. She stated the potential risk of not having a clean oxygen concentrator filter was that the resident becoming ill since a dirty filter would not be able to filter properly. She stated department supervisors check in on residents daily through Ambassador rounds, and included ensuring the oxygen concentrator filter was clean. The Administrator revealed if the nasal cannula was found on the floor by the CNA, they would report it to the nurse so the nurse could change it. A nasal cannula that was on the floor needed to be disposed of because it had been exposed to contaminants and it was an infection control issue that could potentially cause residents to become ill. She stated it was the responsibility of all staff to check that nasal cannulas were not on the floor. She stated ambassador rounds were conducted daily every morning by department heads, and each department head was responsible for doing rounds and part of those rounds included ensuring nasal cannulas were not on the floor when in use or stored properly when not in use. She stated that she could not recall the date of the Inservice regarding oxygen tubing storage and disposal, but she stated the facility had conducted one. Record review of the facility's In-service Training Report dated 08/07/25, noted nursing staff participated with continuing education for Oxygen Administration. The document did not specify who was responsible for cleaning the oxygen concentrator filters. Record review of the facility's policy titled Oxygen Administration, Nursing Manual-Nursing Care, with revision date 06/2020, read in part: Purpose: To prevent or reverse hypoxemia and provide oxygen to the tissues. Under Policy, bullet III. Infection Control, read in part: All oxygen tubing. Humidifiers, masks, and cannulas used to deliver oxygen: i. Are for single use only. ii. Will be changed weekly and when visibly soiled, or as indicated by state regulation. Record review of the facility's policy titled Infection Prevention and Control Program- Infection Control Manual, with revision date 10/24/2022, read in part: Purpose: to ensure the Facility establishes and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with Federal and State requirements. Under Policy, it noted The facility must establish an Infection Prevention and Control Program under which it- A. identifies, investigates, and prevents infections in the facility. Under Program and Procedures, and C. Duties and Responsibilities, included vi. Help monitor and assess the facility-wide environmental infection control practices.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure each resident received and the facility provided food and drink that was palatable, attractive, and at a safe and appetizing temperature for 2 of 2 residents (Resident #3 and Resident #7) reviewed for food and nutrition services.1. The facility failed to ensure Resident #3 and Resident #7 received food, in their rooms, at an appetizing temperature.2. The facility failed to adhere to their policy for acceptable serving temperatures. These failures could place residents at risk of food-borne illnesses, decreased appetite, and overall meal dissatisfaction. Findings include:Findings include: 1. Record review of Resident #3's face-sheet, dated 01/29/2026, revealed an [AGE] year-old female with an initial admission date 09/08/2023 and re-admission date 09/23/2025. Record review of Resident #3's Quarterly MDS, dated [DATE], revealed a BIMS score of 13, which indicated moderate cognitive impairment. Record review of Resident #3's care plan, last revised 01/21/2026, noted the resident was at risk for malnutrition and nutritional problems as she required a mechanical and therapeutic modified diet and included for staff to educate residents and families of not following the recommended diet. Record review of Resident #3's health and physical, dated 01/06/2026, revealed a medical history of: dementia and type II Diabetes. 2. Record review of Resident #7's face sheet, dated 01/29/2026, revealed a [AGE] year-old female resident who was admitted to the facility on [DATE].Record review of Resident #7's annual MDS dated [DATE], revealed under Section K, Resident #7 didn't have dietary restrictions or limitations due to swallowing . Section C documented Resident #7's BIMS score was a 10, which indicated for mild cognitive impairment. Record review of Resident #7 care plan, dated 01/19/2026, revealed the resident had a focus of potential for nutritional problems/malnutrition related to cognitive impairment and poor appetite. Resident #7's intervention to address the goal was to monitor for significant weight loss (3 lbs. in 1 week), provide, serve diet as ordered, monitor and record intake, and the registered dietician to evaluate and make diet change recommendations as needed. Record review of Resident #7's physical and history, dated 05/11/2025, revealed the resident had a urinary tract infection (a bacterial infection in the kidneys, bladder, and urethra) and was experiencing deliriums (acute disturbance in cognition and attention). In addition, Resident #7 had a history of experiencing paranoia (unjustified suspicion), delusions (fixed false beliefs despite clear contrary evidence), and hallucinations (false sensory perceptions that feel real). In an observation of the steam table conducted on 01/28/2026 at 11:45 AM, revealed [NAME] A collected the temperatures for 7 hot meals being served that day: pozole (Mexican soup with pork and hominy) at 172 F, rice 170 F, chicken noodle soup 180 F, cream of mushroom [ROOM NUMBER] F, puree pinto beans 167 F, puree flour tortillas 155 F, puree pozole 141 F. During observation of meal delivery to resident rooms on 01/28/2026 at 12:50 PM, the sample trays were initially not on the cart due to storage limitations; the sample trays arrived at the cart at 12:58 PM after space was made available. The sample trays arrived at the conference room at 1:08 PM and temperatures were recaptured by the Dietary Manager: pozole 139.4 F, rice 132.6 F, tres leches cake (Mexican desert made from various milks; cold served) 45.4 F, puree pozole 113.7 F, puree rice 123.6 F, puree pinto beans with tortilla 121.2 F, puree tres leches cake 60.6 F. The test trays were sampled by the survey team and revealed the food was cold but still maintained an appetizing flavors. In an interview on 01/27/2026 at 10:08 AM with Resident #3, she stated she was on a pureed diet and did not like how the food tasted and the food temperature was occasionally cold. She stated she would purchase her own meals from out of the facility, or have family bring her meals she enjoyed. In an interview conducted on 01/27/2026 at 1:21 PM with Resident #7, who stated she preferred to eat in her room for all meals. She stated her meals would arrive in her room cold, especially the eggs and sausage. She added if she did not like it or if it was too cold, she would request a substitute meal and staff would honor her request. Interview with the Dietician on 01/28/2026 at 10:28 AM, the State Surveyor (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	requested sample trays for puree and regular diet. In an interview on 01/29/2026 at 9:10 AM, with [NAME] A who stated the temperature of the food on the steam table needed to be 140 F or higher because it prevented contamination; and for foods served cold the temperature had to be 40 F or less to prevent contamination. She stated all residents received food at 140 F no matter if they ate in their room or in the dining room. She added this was done to prevent contamination and food borne illnesses associated with food served below 140 F. She identified monitoring the food temperatures was dietary staff's responsibility and specifically the Dietary Manager was responsible for ensuring dietary staff completed this task. She stated the last in-service training she received was 5 months prior. In an interview on 01/29/2026 at 9:37 AM with the Dietary Manager who stated, hot foods held on the steam table should be at 165 F and cold folds should be 35 F or less. He added food needed to be held at these temperatures to ensure the meal was cooked and edible. He clarified food could turn bad if not held at the proper temperature, which would result in the residents becoming ill. He stated food should be served to residents at 140 F for all residents who ate in their room or in the dining room. He stated residents who received cold food could be affected and experience disappointment, decreased appetite, or ultimately influence their nutritional status. In reference to the food tray samples, he stated the temperatures measured were not acceptable in accordance with the facility policy. He stated the last in-service provided to staff regarding food temperatures was in December 2025; documentation provided reflected the in-service for food temperatures was in April 2025. In an interview on 01/29/2026 at 10:06 AM with the Dietician who stated, hot foods on the steam table needed to be held at 145 F or more and cold foods needed to be held at 40 F. She added food needed to be in their temperature ranges to prevent the growth of bacteria in food from the danger zone (range between 40 F-140 F). She stated if contaminated food was consumed by residents, they could be exposed to food hazards. She stated a resident could experience negative effects on the body; she was unable to further elaborate due to limitations on clinical knowledge. She identified the cooks were responsible for monitoring food temperatures, and the dietary manager was responsible for ensuring cooks were completing proper food temperature monitoring. She stated meals should be served to all residents at 140 F or higher. She stated residents could be affected by food temperatures resulting in them declining cold food; she declined to elaborate on physiological and psychological effects due to her limited knowledge of these areas. In an interview on 01/29/2026 at 4:35 PM with the Administrator who stated, residents should receive hot foods at 140 F or higher and cold foods at 40 F or lower to prevent the food from spoiling. She added residents could get sick from their stomachs if they consumed food that was in the danger zone (range between 40 F-140 F) for too long. She identified the Cooks and Dietary Manager were responsible for ensuring the residents received food at acceptable temperatures per facility policy. She stated food delivered at unacceptable temperature ranges could result in the food losing its taste and residents could decline their food. She stated the last in service provided for food temperature was in December 2025. She identified the Dietary Manager was responsible for overseeing food delivery operations and ensuring staff monitored the temperatures. Record review of the facility's policy, dated 1/1/2026, titled Food Temperatures read in part: Measuring Food Temperature (subtitle) . At starting of meal services Hot Food should be above 140 F and Cold food should be served below 40 F . Acceptable Serving Temperature (subtitle) . Meats, entrees greater than 140 F . potatoes, pasta greater than 140 F . pureed foods greater than 140 F . dessert less than 40 F . milk less than 40 F		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen in the facility. 1. The facility failed to ensure expired foods were properly disposed. 2. The facility failed to ensure foods in the freezer and in the dry storage area were properly sealed and stored. 3. The facility failed to ensure the plastic strip doors to the walk-in fridge was not draped on the metal shelf with multiple hotdog packages. 4. The facility failed to ensure the freezer was free of trash. 5. The facility failed to ensure 2 dented cans (tapioca and tomato sauce) were .not stored on the floor in the dry storage room. 6. The facility failed to ensure a gallon of soy sauce located in the dry storage room was free of dry drippings. 7. The facility failed to ensure staff were trained to capture temperatures of waters for the 3-sink-compartment 8. The facility failed to ensure cookware was properly rinsed and sanitized in adherence to professional standards for food service safety. These failures could place residents at risk of food-borne illnesses.Findings include: During observations on 01/27/2026 beginning at 8:48 AM in the facility kitchen, revealed expired tortillas, dated 1/26/2026, in the fridge. At 8:49 AM, a carton of liquid eggs was in the second fridge with the top of the carton opened. At 8:49 AM, a cardboard box of frozen sugar cookie dough located in the freezer was left opened by the insulated bag and the cardboard flaps. At 8:54 AM, expired cheese, dated 01/24/2026, was in the walk-in fridge on the floor behind a metal shelf. At 8:54 AM, the plastic strip doors to the walk-in fridge were draped on a metal shelf that was held 3 sealed packages of hot dogs. At 8:56 AM, an empty cardboard box was left in the freezer on a metal shelf. At 8:56 AM, a package of frozen biscuits had a large opening through the film, and the remaining biscuits were left exposed to the air in the walk-in freezer. At 8:57 AM, an expired package of sopapillas, dated 01/01/2026, was discovered between the wall and cardboard boxes in the walk-in freezer. At 8:59 AM, 1 dented can of tomato sauce and 1 dented can of tapioca were located on the floor behind a rolling table in the dry storage room. At 9:00 AM, a 5-gallon container of cooking oil without the cap was on the metal shelving in the dry storage room. At 9:00 AM, a gallon of soy sauce with dry drippings from the spout, down the body of the container, was on a metal shelf. Observation on 01/28/2026 at 9:14 AM with Dietary Aide E, revealed sink the water temperatures for the 3-sink compartment were not captured and the wash, rinse, and sanitize cycle was completed in 11.58 seconds; not allowing the cookware to sit in the rinse and sanitization solution for a minimum of 1 minute as per facility policy. Dietary Aide E tested the sanitization solution with chemical testing strips that revealed 150-400 parts per million levels of quaternary ammonium within the water; acceptable levels per facility policy. In an interview on 01/27/2026 at 3:47 PM, with the Dietician who stated she visited the facility once a week and completed monthly audits on the kitchen to include dining, sanitization, serving, test trays, steam table, labeling and storage of foods in the fridge, freezer and dry storage. She stated the last audit she completed was on 01/07/2026 which resulted in a score of 95%. She stated her expectations of the kitchen were for everything to be labelled with dates, no items on the floor, and for food to be covered and properly sealed. She clarified food not properly sealed could lead to cross contamination and result in food borne illness. She was provided photos of the open carton of eggs, biscuits, and sugar cookies, expired corn tortillas, cheese, and sopapillas, and dry storage room findings and stated the conditions and storage of these photos were not acceptable. She stated this could affect the residents by exposing them to cross-contaminated food which could result in a potential food borne illness. She added a resident could experience negative effects and could potentially require hospitalization from complications with food-borne illness. She stated the last in-service she provided to the kitchen was on 12/26/2025 and provided supporting documentation for record review. She stated everybody in the kitchen was responsible for upholding cleanliness, sanitization, and proper storage. She identified the Dietary Manager was responsible for ensuring the expectations of the (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	kitchen were being met by dietary aides and cooks. In a follow-up interview with the Dietician on 01/29/2026 at 10:06 AM regarding the 3-sink compartment observation, she stated the purpose of the 3 sink was to clean and disinfect large cookware and serving utensils. She denied knowing what the temperature of the waters needed to be for the 3-sink compartment. She stated cookware needed to be left in the sanitizer (quaternary ammonium) for a minute or more to ensure all bacteria was killed. She clarified if this was not done the cookware could still contain contaminants. In an interview on 01/28/2026 at 9:20 AM with Dietary Aide E, who stated the last time he received training for washing dishes was approximately 2 years prior. He stated the water for the sinks needed to be changed when you started cleaning dishes from the next meal, when the water was noticeably dirty, or whenever you finished cleaning dishes. He denied knowing what the temperature of the water was supposed to be for the 3-sinks and recognized he forgot to capture the temperature before beginning the task. He stated it was important to know what the temperature of the water was supposed to be to ensure the dishes were cleaned properly. He stated he had to rinse the cookware with regular water because it would disrupt the concentration of the sanitizer if he didn't. He stated if cookware was not properly sanitized and used to hold/serve food, residents could become sick. He stated cookware did not need to be left soaking in the sanitizer solution it could be dunked and removed to dry immediately. He added that was how he was trained to complete the cookware washing task. In an interview on 01/28/2026 at 3:20 PM, with Dietary Aide D who stated the water temperature for the 3-sink compartment needed to be higher than 100 F. She stated the left sink contained soap and water, the middle sink was water, and the right sink was water with sanitizer. She stated cookware needed to be left in the sanitizer solution for 1 to 5 minutes to kill bacteria and prevent cross contamination. She added if cookware was not properly sanitized it could be contaminated and potentially affect the residents by exposing them to food-borne illness. She stated a resident could experience stomach sickness and vomit if they consumed cross-contaminated food. She stated she assisted with cleaning all fridges and freezers as this was a daily task. She stated expired food needed to be discarded because it could be mistakenly used and served to residents. She identified all dietary staff were responsible for discarding expired food and properly sealing food. She identified the Dietary Manager was responsible for ensuring staff were completing these tasks accordingly. She stated she received training for dishwashing in January 2025 and for proper food storage in November 2025. In an interview on 01/29/2026 at 9:10 AM, with [NAME] A who stated her responsibilities as a [NAME] were to clean the fridges, freezers, walk-ins and dry storage areas daily. She stated she discarded all ingredients that had expired because they had no use. She stated she also reviewed the food to ensure everything was properly sealed and covered. She stated this was a task all dietary staff completed throughout the day. She stated discarding expired food and properly sealing food needed to be done to prevent cross contamination and food-borne illness. She stated the plastic strip door was used to keep the cold from escaping the fridge. She added they needed to always be in front of the fridge door to prevent temperature from escaping. She stated the plastic strip door on the metal shelf was cross contamination because food encountered an object that was touched by employee's clothes and shoes. In reference to the 3-sink compartment, she stated the water temperature needed to be between 160 F to 200 F so cookware was properly washed, rinsed, and sanitized. She added cookware needed to be left in the sanitizing solution for more than a minute to thoroughly clean cookware. She stated the last in-service she received for food storage and 3-sink compartment was in August 2025. In an interview on 01/29/2026 at 9:37 AM, with the Dietary Manager who stated the observations made during the initial walk-through of the kitchen (expired food, unsealed food, plastic strip door, dry storage room findings) were not acceptable conditions. He added the conditions observed were potential for cross contamination because bacteria could have encountered food. He identified all dietary staff were responsible for properly sealing food, keeping the plastic strip doors down, and discarding expired food during their shift. He identified himself as the individual who was responsible for overseeing dietary staff was adhering to responsibilities and being completed per (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility policy. He stated these conditions affected residents by potentially exposing them to cross contaminated food. In reference to the 3-sink compartment, he stated the left sink was for soap and water, the middle sink was for water, and the right sink was for sanitizer and water. He added the sanitizer, and water was used to kill any bacteria that might be leftover on the cookware. He stated the temperature for the left and middle sink needed to be 120 F or higher and the right sink needed to be cold due to the chemical solution for sanitizing. He stated staff should check water temperatures before beginning the dishwashing process. He added cookware needed to be soaked in the sanitizer solution for one minute to kill the remaining bacteria. He recognized this was not conducted during 3-sink compartment observations on 01/28/2026. He stated if cookware was not properly sanitized, it could lead to cross contamination and food-borne illnesses. He was unable to recall when the last in-service training was regarding 3-sink compartment and food storage. In an interview on 01/29/2026 at 4:35 PM, with the Administrator who stated the kitchen should be clean, organized, nothing on the floor, food should be sealed and dated, dented cans should be in a designated area, expired food should be discarded, and the plastic strip door should be in front of the door at all times. She identified dietary staff was responsible for completing all tasks necessary to maintain a sanitary kitchen. She identified the Dietary Manager was responsible for ensuring dietary staff completed responsibilities in adherence to facility policy and standards. She stated residents could be affected by improper food storage and sanitization practices by exposing residents to cross-contaminated food. She stated a resident who consumed cross-contaminated food could become sick. Record review of the facility's policy, revised 01/21/2025, titled Food Storage read in part: Frozen Meat/ Poultry and Food Guidelines (subtitle) . Foods to be frozen should be stored in airtight in the original packing containers or plastic Ziploc bags or wrapped in heavy duty aluminum foil or special laminated papers . Canned Fruit/Vegetable Storage Guidelines (subtitle) . Dented or bulging cans should be placed in separate storage areas and returned for credit or discarded . Dry Storage Guidelines (subtitle) . Foods should be stored off the floor. Any open products should be placed in storage containers with tight-fitting lids or plastic Ziploc storage bags . Record review of the facility's policy, revised 01/25/2025, titled Sanitizing Agents - Acceptable Levels and Testing Methods read in part: Acceptable Sanitizer Levels (subtitle). All items will be sanitized by one of the following methods .Immersion for a period of at least one minute in a chemical sanitizing solution containing: . At least 150-400 parts per million quaternary ammonium at a temperature of no less than 75 F		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview and record review the facility failed to dispose of garbage and refuse properly for 1 of 3 dumpsters (Dumpster #2) reviewed for food and nutrition services. The facility failed to ensure the dumpster was closed for 1 of 3 dumpsters, and the surrounding area was free of debris on 01/27/2026. This failure could place residents at risk to an infestation of rodents and insects. Findings include: During observation of the dumpsters on 01/27/2026 at 9:08 AM, revealed 1 of the 3 dumpsters was left opened by the overhead plastic lid. The surrounding area for the dumpster corral had approximately 15 wooden pallets, 1 plastic rolling trash bin, 1 fish tank, and various types of waste on the ground (food, gloves, plastic, over-the-counter medicine bottle, briefs, bed liners, cans, and leaves). In an interview conducted on 01/28/2026 at 3:32 PM, with Dietary Aide D who explained the process of disposing of waste in the dumpsters. She stated she would apply gloves, collect all the trash in the kitchen in the rolling plastic bins, close the lid during transport to the dumpsters, tie the bag, discard, and ensure the dumpster was closed after use. She stated it was not acceptable for debris to be left on the floor because it was cross contamination and would attract cockroaches, flies, mice and cats. She added there was potential for insects and animals to enter the facility if there was an infestation at the dumpster. She identified every staff member was responsible for closing the dumpster after use. She stated the trash should be free of debris at all time. She declined knowing whose responsibility it was to maintain and remove debris. In an interview on 01/29/2026 at 9:29 AM, with [NAME] A who stated she would usually discard the kitchen trash near the end of her shift. She noted the dumpster was dirty two days prior but it now was much cleaner and free of debris. She stated the previous condition of the trash was not acceptable because it attracted organisms, animals and insects. She added there was potential for cross contamination and could potentially affect the facility. She was unable to further elaborate on how it could affect the facility beyond cross contamination. She stated the dumpster needed to be closed at all times to prevent odors from escaping and from attracting animals and insects. She identified a woman and man who were responsible for maintaining the dumpsters but was unable to recall names or department. She stated whoever used the dumpster last was responsible for closing the dumpster after use. She stated the last in-service training she received for the dumpster was 5 months prior. In an interview on 01/29/2026 at 9:59 AM, with the Dietary Manager who stated the condition of dumpster on 01/27/2026 was not acceptable because it was left opened and there were debris on the ground around the dumpsters. He stated the importance of closing the dumpster was to prevent infestation of insects and animals. He stated an infestation could potentially migrate and cross contaminate the facility. He identified all employees were responsible for ensuring the dumpster was closed. He stated if anyone had a concern for the condition of the dumpsters, they could notify the Administrator. He provided documentation for an in-service attendance record titled, Trash and Dumpster Comp that was completed on 07/18/2025. In an interview on 01/29/2026 at 11:45 AM, with LVN C who stated nursing used the dumpsters outside the facility to dispose of facility waste. He stated staff was supposed to close the dumpsters after every use. He added this needed to be done because trash could potentially fall out or could attract insects and animals. He stated the area around the dumpster needed to be free of debris, as well as, this could result in an infestation. He added there was potential for cross contamination and infection control if the facility's dumpster was not clean. He could not recall receiving in-service or training on how to properly dispose of waste or refusal. In an interview on 01/29/2026 at 12:02 PM, with Housekeeping who explained she collected trash from the residents' rooms and transported the waste to the dumpster by utilizing a plastic receptacle with wheels. She stated the contents of the trash could be food, waste, incontinent supplies, paper, and more. She stated after proper disposal she closed the lid to the dumpster, otherwise ants, insects, and animals could gain access to the waste. She stated the area around the dumpster needed to be cleaned to prevent bugs from developing in the area. She stated there was (continued on next page)		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	potential for insects to come into the building, because the dumpster was not located far from the facility. She denied receiving in-service or training on how to properly dispose of waste or refusal. In an interview on 01/29/2026 at 1:48 PM, with the Maintenance Supervisor who stated the dumpsters were shared with the apartments next to the facility. He stated he conducted exterior checks around the facility every morning. He stated debris were not supposed to be around the dumpsters because it made it difficult for the trash collector to maneuver the truck. He stated it was also for cleanliness and prevention of animals and insects getting into the trash. He stated the condition of the dumpster was a shared responsibility amongst all staff and departments. He stated the dumpster needed to be closed when not in use for the same reasons. He clarified any employee who was concerned with the dumpster could report it to their immediate supervisor. He stated a dumpster left open or with debris around would not affect residents and was not a potential for cross contamination. He denied providing in-services or training to staff or departments on proper disposal practices. In an interview on 01/29/2026 at 4:30 PM, with the Administrator who stated the dumpster had to be closed and free of debris to prevent bugs and insects from getting into the trash can. She stated everybody in the facility used the dumpster. She stated every employee was responsible for closing the dumpster after use. She stated employees were expected to report debris around the trash can to maintenance for removal. She clarified the dumpster needed to be closed to prevent offensive smells and bugs from accessing the contents of the dumpster. She stated infestation could affect residents because there was potential for insects and animals to migrate to the facility. Record review of the facility's policy, dated 04/01/2025, titled Garbage Cans, Dumpsters and Grease Trap Use and Cleaning read in part: Outside Trash Dumpsters (subtitle) . outside trash dumpsters, doors and/or lids will be kept closed when not in use. Outside trash dumpsters surrounding areas will be free of litter and debris		

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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, and interviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public for four halls (100-hall, 200-hall, 300-hall, and day-living area) reviewed for environment. The facility failed to maintain intact ceiling tiles in the 100-, 200-, and 300-, halls, and the day-living area, located next to the resident halls, on 01/27/2026. The facility failed to maintain stain-free ceiling tiles in the hall leading to the main dining area on 01/27/2026. These failures could place residents at risk of an unsafe, unsanitary, and uncomfortable environment. Observation on 01/28/2026 at 10:30 AM of the facility's ceiling tiles revealed they had cracks, and were bent, in the 100-, 200-, and 300- halls, and the day-living area located next to the resident halls. An observation on 01/28/2026 at 10:50 AM, of the hall leading to the main resident dining area was observed with stained ceiling tiles. In an interview on 01/29/2026 at 12:24 PM with the Maintenance Supervisor, he stated there was no policy regarding the environment of the facility, including the ceiling tiles. This state surveyor showed the Maintenance Supervisor pictures of the ceiling tiles in the living area and halls; he stated those ceiling tiles needed to be replaced, because they were cracked or damaged. He stated he was responsible for making those corrections in the facility building. He stated he monitored the facility environment daily. He stated he was not aware of the damaged/stained ceiling tiles until today and would replace them. He stated staff were trained to report any environmental concerns to him so he could address them. He stated with the pictures provided; he did not think there would be a risk to residents, staff, or visitors, unless someone moved the ceiling tiles. In an interview on 01/29/2026 at 1:17 PM with CNA F, she stated staff were trained to notify the nurse and maintenance of any environmental concerns right away. She stated the Maintenance supervisor was observed rounding through the facility daily, which included addressing environmental concerns. She stated the possible risks of the cracked, bent, ceiling tiles could be the possibility of it breaking and falling, which could cause someone to be injured if standing under or near the affected ceiling tiles. In an interview on 01/29/2026 at 2:02 PM with LVN G, he stated staff were trained to report their concerns to nursing staff or maintenance. He stated all staff were expected to report concerns right away. He stated maintenance was responsible for addressing facility environment concerns. The State Surveyor showed LVN G pictures of the mentioned ceiling tiles, and he stated he would report them as a concern so it could be replaced and fixed. He stated the possible risks for residents, staff, or visitors, being under or near cracked, bent, stained, ceiling tiles, could pose a risk for injury if it broke and fell. In an interview on 01/29/2026 at 4:06 PM with the DON, she stated staff were responsible for notifying maintenance of environmental concerns. She stated the Maintenance Supervisor was responsible for monitoring and fixing any facility maintenance concerns. She stated all supervisors would also assess the environment for potential concerns during their Ambassador rounds, daily. She stated there were no risks to residents, staff, and visitors. Interview with the Administrator on 01/28/2026 at 8:50 AM, the Administrator stated there was no policy regarding the environment or the facility's ceiling tiles. Record review of the facility's resident Grievances for the last 6 months did not have any concerns regarding the ceiling tiles. On 01/28/2025 at 4:00 PM, this State Surveyor requested documentation for maintenance work orders relating to the ceiling tiles from the facility, and it was not provided by time of exit.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement quality of life for one resident (Resident #62) of eight residents who was reviewed for dignity. The facility failed to cover Resident #62's foley catheter with a privacy bag, while resident was out of bed on 01/27/26. This failure could place the residents at risk of poor self-esteem and decrease of self-worth. Findings include: Record review of Resident #62's admission record, dated 01/29/26, revealed a [AGE] year-old male with initial admission date of 09/11/23, and re-admission date of 08/04/25. Record review of Resident #62's PPS MDS dated [DATE] revealed that the BIMS was not conducted because Resident #62 was not able to participate as he is never/rarely understood. The MDS noted under Section H- Bladder and Bowel, that the resident was marked with an indwelling catheter (including suprapubic catheter which is a flexible tube inserted through the abdominal wall to drain urine from the bladder, often used when traditional urethral catheters are not suitable). Record review of Resident #62's health and physical dated 12/24/25, revealed a medical history of: ALS (Amyotrophic lateral sclerosis, a nervous system disease that affects the nerve cells causing loss of muscle control), dysphagia (difficulty swallowing) post status PEG tube (a soft, flexible tube that provides a means of delivering nutrition directly into the stomach), suprapubic catheter, anxiety (a constant and/or intense feeling of worry or nervousness that could affect the person's ability to do daily activities), and depression (persistent feelings of sadness or hopelessness that can cause loss of interest in activities a person enjoyed). An observation on 01/27/2026 at 09:45 AM, Resident #62 was in his room, sitting in a specialized recliner located next to his bed, with his feet elevated. There was a foley catheter hanging on the side of the resident's chair, with yellow urine exposed. Resident #62 was unable to answer this surveyor's questions. In an interview on 01/29/2026 at 1:21 PM, CNA F stated all staff was responsible for ensuring the privacy bags was on residents foley catheters. She stated that the purpose of providing privacy was for residents' right to privacy. She stated direct care staff, including nursing staff, was responsible for ensuring the privacy bag was on after any care was provided to that resident. She stated the risk of a resident not having a privacy bag was a dignity issue. CNA F stated the facility provided an in-service training regarding foley catheter care, including providing privacy bags, but she was unable to recall the date. In an interview on 01/29/2026 at 1:54 PM, LVN G stated residents should always have the privacy bag on their foley catheter. He stated all nursing staff was responsible for monitoring residents including making sure a privacy bag was covering a resident's foley catheter, and the assigned nurse was responsible for overseeing the resident overall. LVN G stated the possible risk of foley catheters not being covered included for the resident having their self-esteem negatively affected, and it was a dignity issue. In an interview on 01/29/2026 at 4:00 PM, with the DON, she stated the resident was expected to have a privacy covering a resident's foley catheter when the resident was out of their room. She stated that the purpose of the privacy covering was to maintain the resident's privacy and dignity. The DON stated it was also for maintaining the resident's self-esteem. She stated CNA's was responsible for ensuring the privacy bag was on, as they were trained to apply a privacy covering, and all nursing staff was responsible for monitoring their residents. In an interview on 01/29/2026 at 4:21 PM, the Administrator stated the privacy bags was to provide the resident privacy by not exposing their urine to other residents or others in the nursing home. She stated the resident was expected to have their foley catheter covered when they leave their room. The Administrator stated nursing staff was responsible for ensuring the privacy bags was on residents' foley catheters. She stated there was Ambassador rounds, meaning different department supervisors, conducted daily check ins with the residents, and identification of concerns or issues in resident rooms, to be addressed. She stated (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that included privacy bags being on catheter bags. She stated the potential risk of residents not having a privacy bag covering the foley catheters included the resident feeling embarrassed. Record review of the facility's In-Service Training Report dated 08/07/2025 revealed staff received continuing education for Catheter Care. Record review of the facility's policy titled Catheter-Care of, Nursing Manual- Nursing Care, with no date read in part, under Procedure: IV. The resident's privacy and dignity will be protected by placing the cover over the drainage bag when the resident is out of bed.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals used in the facility was labeled in accordance with currently accepted professional principles, and included the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 10 residents (Resident #62) reviewed for enteral feedings. The facility failed to label Resident #62's enteral feeding on 01/27/26. This failure could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects. The findings include: Record review of Resident #62's admission record, dated 01/29/26, revealed a [AGE] year-old male with an initial admission date of 09/11/23, and re-admission date of 08/04/25. Record review of Resident #62's Prospective Payment System MDS, dated [DATE], revealed the BIMS was not conducted because Resident #62 was not able to participate and was never/rarely understood. Section K- Swallowing/Nutritional Status, noted Resident #62 had a feeding tube on admission and while a resident in the facility. Record review of Resident #62's health and physical, dated 12/24/25, revealed a medical history of: Amyotrophic lateral sclerosis (a nervous system disease that affects the nerve cells causing loss of muscle control), dysphagia (difficulty swallowing) post status PEG tube (a soft, flexible tube that provides a means of delivering nutrition directly into the stomach), anxiety (a constant and/or intense feeling of worry or nervousness that could affect the person's ability to do daily activities), and depression (persistent feelings of sadness or hopelessness that can cause loss of interest in activities a person enjoyed). Record review of Resident #62's care plan, with last revision made on 12/29/2025, noted the resident had dysphagia (difficulty swallowing) and required a G-tube (gastric tube, a flexible tube inserted through the abdominal wall directly into the stomach allowing for the delivery of liquid nutrition, fluids, and medications without the need for swallowing). Resident #62's goal included for the resident to maintain adequate nutritional and hydration status. An observation on 01/27/2026 at 09:45 AM revealed Resident #62 was in his room, sitting in a specialized recliner located next to his bed, with his feet elevated. An enteral feeding was observed to be hung at the resident's bedside and actively pumping. The bag was observed half full with pale brown fluid. There was no label on the enteral feeding observed, including no date, or name of feeding. In an interview on 01/29/2026 at 1:22 PM with CNA F, she stated nurses were responsible for ensuring residents' enteral feedings were dated and labeled. She stated the purpose of labeling the enteral feeding was for all staff and others were aware of the date the enteral feeding was being provided to the resident. She stated the possible risk of not labeling enteral feedings included spoilage of feeding, which could cause illness. In an interview on 01/29/2026 at 1:58 PM with LVN G, he stated nursing staff was responsible for ensuring enteral feedings that were being used were labeled. He stated that the assigned nurse completing the task was responsible for labeling the feeding they administered to the resident. He stated labeling included the name of the resident, room number, rate and goal of feeding, and the type of formula being administered. He stated the potential risk for not labeling residents' enteral feeding included the resident becoming sick. LVN G stated enteral feedings were to be replaced every 24 hours to prevent bacteria from growing. In an interview on 01/29/2026 at 3:19 PM with the ADON, who was also the Infection Control nurse for the facility, she stated enteral feedings were only to be used and administered for 24 hours. She stated the nurse administering the enteral feeding was responsible for labeling the feeding. She stated as the ADON; she was responsible for monitoring and confirming enteral feedings were labeled per protocol, which she did daily. She stated the risk to residents for not following protocol was an infection control issue. In an interview on 01/29/2026 at 4:04 PM with the DON, she stated nursing staff, specifically the assigned nurse administering the enteral feeding, was responsible for labeling the feeding and the (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	saline used to flush the feeding. She stated the purpose of labeling the enteral feeding was to ensure it was a fresh feeding and giving the resident a new feed. She stated there were Ambassador rounds, which included supervisors from different departments to check in with their assigned residents daily, which included checking the room for potential concerns. She stated there was no potential risk for staff not enteral feedings not being labeled. Record review of the facility's, 06/30/2025, enteral feeding program which included ensuring the Label on the feeding tube was complete and accurate, with nursing staff signing as acknowledgement to the continuing education. Record review of the facility's policy titled Tube Feeding, Operational Manual, Nutrition services did not include labeling of enteral feeding. Record review of the facility's policy titled Infection Prevention and Control Program-Infection Control Manual, with revision date 10/24/2022, read in part: Purpose: to ensure the Facility establishes and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with Federal and State requirements. Under Program and Procedures, and C. Duties and Responsibilities, included vi. Help monitor and assess the facility-wide environmental infection control practices.		