

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675076	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER Llano Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 800 W Haynie St Llano, TX 78643	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews the facility failed to properly store, prepare, distribute food in accordance with professional standards for food service safety for 1 of 1 kitchen observed for food storage and sanitation. 1. The facility failed to properly store, label, and date all food items located in the walk-in refrigerator, freezer and in the dry food pantry area on 9/02/2025 and 9/03/2025. 2. The facility failed to discard expired food items located in the walk-in refrigerator and in the dry food pantry area on 9/02/2025 and 9/03/2025. 3. The facility failed to ensure the trash containers were covered with lids on 9/02/2025 and 9/03/2025. These failures could place residents who received meals from the kitchen at risk of foodborne illnesses. The findings included: Observation during the initial tour of the kitchen on 9/02/2025 beginning at 9:10 AM, revealed the following: Freezer:*1-gallon freezer bag labeled Philly meat, with an opened date of 6/14, no year or discard date.*1-gallon freezer bag labeled meat pies, with 7/9, no year, open date, no discard date.*1 quart freezer bag, labeled chicken enchiladas with 5/15, no year, use by or discard date*1 gallon freezer bag labeled chicken 7/1, item in a blue plastic inside freezer bag, no open or discard date.*1-gallon freezer bag labeled pork chop with date 8/22, no use by or discard date*1 gallon freezer bag labeled breaded Pork, dated 7/9, no use by or discard date. Walk-in refrigerator:*7 unlabeled bottles of liquid that appeared to look like tea*1 unlabeled and dated opened package of bread*1 unlabeled and dated opened package of buns*1 unlabeled and dated full package of buns*2 opened gallon containers of salad dressings*1 opened gallon container of tartar sauce with 12/4/24 written on outside (unsure if it's the received, open or discard date)*1 opened storage bag of sliced cheese dated only 9/1*1 opened bag of turkey breast dated 9/1 sitting on top of 2 packs of opened tortillas in a bowl with juices from the turkey dripped in the bottom.*1 container of sliced white cheese with a discard date of 8/27*1 open storage bag with parmesan cheese labeled open on 5/22/2025 with no discard date*1 open box containing 4 packages of tortillas with no labels*2 5-pound containers of potato salad with manufacturers use by date of 8/29/2025*1 large bag of opened breakfast links, no label or dates*4 loaves of bread, not labeled or dated Dry Food Pantry area:*2 large storage containers filled with different cereal dated 2/18, no discard dates*1 large storage open container marked macaroni dated 10/5/24*1 large storage container filled with spaghetti noodles dated 7/30*1 large storage container filled with egg noodles dated 7/30*1 large storage container filled with powder milk dated 5/7*1 powdered sugar dated 5/12 with open date of 8/12, no discard date*1 opened yellow cornbread mix opened 8/24, no discard date*1 opened container of sugar labeled 7/30, no discard date*1 opened package of muffin mix dated 4/12, no discard date*1 opened large container of corn meal with a use by date of 2/21/24*1 large container of flour dated 2/14, no discard date*5 boxes of scalloped potatoes with expiration date of 4/16/2025*1 Large bag of cornbread stuffing mix with expiration date of 8/20/25*1 bag of opened grits with open date of 1/14 and use by date of 1/6*4-32-ounce boxes of tomato juice with expiration date of 5/29/25*5 Boxes of Grits with expiration dates of 8/8/2025 *1- Trash can with trash observed with no lid in dishwashing area. Observation during follow up tour of kitchen on 9/03/2025 beginning at 2:03 PM, the following was observed: *1 (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	lids and be always closed. Surveyor showed her the trash can without lid by the dishwasher, DM stated she not aware the trash can in the dishwashing area required a lid. The DM stated she will get a lid for it today. The DM stated the potential harm of not having trash properly covered could lead to food borne illnesses. On 9/03/2025 at 5:15 PM, kitchen food labeling policies were requested from ADM. Interview conducted 09/04/2025 at 4:20 PM, The DC stated she has been working at the facility for 2 months and was trained by the dietary manager on kitchen and dining procedures. DC stated she attempted to label and date all foods before storing them. She stated food should be labeled with the name, date received, and date opened. Interview conducted 09/04/2025, at 6:21 PM, the ADM stated all food items should be labeled each time they are opened with a sticker showing the date opened, expiration date, and name of the product. He further stated all food should also be labeled with the date received (day, month, and year). He reported that trash cans should always have lids and liners. The Administrator stated all expired food should be discarded immediately. He stated if expired food was served, residents could potentially experience negative side effects such as stomach aches or illness. Record review of facility policy named Food Safety Requirements dated 7/23/2025 revealed: Policy: It is the policy of this facility to procure food from sources approved or considered satisfactory by federal, state, and local authorities. Food will be stored, prepared, distributed and served in accordance with professional standards for food service safety. Policy Explanation and Compliance Guidelines: 1. Safe thawing, cooking, cooling, holding, and reheating of food. 2. Refrigerated storage-store raw meat on shelves below fruits, vegetable or other ready-to-eat foods so that meat juices do not drip onto these foods. 3. Label, date, refrigerated food, including, but not limited to leftovers, so it is used by its use-by date, or frozen/discard Record review of facility policy named Kitchen Sanitation and Cleaning Schedules revealed: 1. Stock will be rotated first-in, first out. (FIFO) Foods will be used or discarded prior to the expiration date. 2. All opened containers or leftover food is to be tightly wrapped or covered in clean containers. It should be labeled, dated with the opened or use by date. Review of the FDA Food Code revealed all food to be labeled and dated, and under 42 CFR S483.60 the facility ensures this standard is followed so that food is safe, sanitary, and never served past its use-by date.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that described the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and document a care plan conference following a quarterly or annual MDS (minimum data set) for 6 (Resident #22, Resident #5, Resident #2, Resident #6, Resident #8, Resident #30) of 10 residents reviewed for care plan conferences. The facility failed to complete a comprehensive care plan for Resident # 30 in the required timeframe after the completion of the comprehensive MDS dated [DATE]. The comprehensive care plan for Resident # 30 was due to be completed by 8/31/25. The facility failed to conduct a care conference for Resident #22, Resident #5, Resident #2, Resident #6, and Resident #8. This failure could place residents at risk of not having their physical, mental and psychosocial needs met. Record review of undated admission Face Sheet for Resident # 30 reflected a [AGE] year-old female admitted on [DATE] with a diagnosis of traumatic subarachnoid hemorrhage (brain bleed as a direct result of a head injury) without loss of consciousness, anxiety disorder, insomnia, hypertension (high blood pressure), morbid obesity, repeated falls, syncope (fainting) and collapse. Record review of Resident # 30 Comprehensive MDS dated [DATE] reflected a BIMS score of 6 indicating severe cognitive impairment. Further review of section GG Functional Abilities reflected Resident # 30 required set up clean up assist for eating. Supervision touching assist required for oral hygiene. Partial moderate assist for toileting, bathing, dressing, and personal hygiene. Substantial maximal assist for all transfers. Record review of Resident # 30 Baseline Care Plan dated 8/21/25 reflected Baseline care plan will identify my care needs, risks, strengths, and goals for the first 48 hours. Approaches of activities and functional level for daily care I will receive necessary setup, cueing, support, and assistance level for activities of daily living. Approach nutrition: initial height/weight, physician/NP diet orders, functional assistance level with eating, swallowing precautions as needed will be maintained until further nutritional evaluation is completed. Approach safety fall risk evaluation will be completed to identify and minimize initial risk factors. Record review of Resident # 30 Care Conference Report undated reflected the only care conference recorded was dated 8/27/25. Record review of Resident # 30's clinical records revealed no comprehensive care plan documented in the records. Resident #22 Record review of undated admission Face sheet for Resident #22 reflected an [AGE] year-old female with an admission date of 05/14/21 and a readmission date of 10/02/24. Her diagnoses included type 2 diabetes (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), whooping cough, generalized anxiety disorder, dysphagia (difficulty swallowing foods or liquids), cough, cognitive communication deficit, dysuria (difficult urination), depression, osteoarthritis of knee, muscle wasting and atrophy (shrinkage), unspecified dementia (a group of (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	thinking and social symptoms that interferes with daily functioning), hyperlipidemia (fat particles in the blood), and hypertension (high blood pressure). Record review of Resident #22's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 13, which indicated mild cognitive impairment. Further review of section GG Functional Abilities reflected Resident #22 required set-up or clean up assistance for eating and oral hygiene, and required partial/moderate assistance for personal hygiene, dressing, bathing, toileting, and transfers. Record review of Resident #22's Care Plan Conference Report undated reflected care conferences recorded were dated 05/01/25, 11/20/24, and 08/01/24. The facility did not have a care conference for Resident #22 between 11/20/24 and 05/01/25, and there had not been a care conference for Resident #22 between 05/01/25 and the date of survey, 09/04/25. Resident #5 Record review of undated admission Face sheet for Resident #5 reflected an [AGE] year-old female with an admission date of 11/19/21 and a readmission date of 07/15/25. Her diagnoses included cerebral palsy (a group of conditions that affect movement and posture. It's caused by damage that occurs to the developing brain, most often before birth), major depressive disorder (clinical depression), acute upper respiratory infection, iron deficiency anemia, osteoarthritis, hypokalemia (low potassium), dysphagia (difficulty swallowing foods or liquids), weakness, unsteadiness on feet, cognitive communication deficit (an inability to communicate effectively due to underlying problems with cognitive skills such as attention and memory), muscle wasting and atrophy (shrinkage), major depressive disorder (clinical depression), hypertension (high blood pressure) and insomnia. Record review of Resident #5's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 10, which indicated mild to moderate cognitive impairment. Further review of section GG Functional Abilities reflected Resident #5 independent with eating with set-up assistance, and required total assistance for personal hygiene, dressing, bathing, toileting, bed mobility and transfers. Record review of Resident #5's Annual MDS assessment dated [DATE] reflected no changes in the care area assessment summary, and reflected it was signed on 08/19/25 for sections A, C, D, E GG, J, K M, N O, Q, and for section Z on 08/22/25, and there was no signature by the RN Assessment Coordinator. Record review of Resident #5's Care Plan Conference Report undated reflected the last care conference recorded was dated 06/26/24 (Quarterly). Care Plan Conference Report further reflected there had not been a care conference for Resident #5 from 06/26/24 to the date of annual MDS assessment dated [DATE]. Resident #2 Record review of undated admission Face sheet for Resident #2 reflected a [AGE] year-old female with an admission date of 10/20/24 and a readmission date of 11/01/24. Diagnoses of hemiplegia and hemiparesis (muscle weakness or partial paralysis) following cerebral infarction affecting left non-dominant side, unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning), major depressive disorder (clinical depression), anxiety disorder, stage 2 pressure ulcer, lack of coordination, muscle wasting and atrophy (shrinkage), whooping cough, rheumatoid arthritis, aphasia (a language disorder that affects a person's ability to communicate), (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gastroesophageal reflux disease (acid reflux), dysphagia (difficulty swallowing foods or liquids), anemia (lack of blood), hypothyroidism (underactive thyroid), type 2 diabetes (a long term condition in which the body has trouble controlling blood sugar and using it for energy), hyperlipidemia (fat particles in the blood), chronic pain syndrome, hypertension (high blood pressure), atherosclerotic heart disease (damage or disease in the heart's major blood vessels), cerebral infarction (stroke), chronic obstructive pulmonary disease (group of lung diseases that block airflow and make it difficult to breathe), edema (swelling caused from fluid buildup in tissue), convulsions, and metabolic encephalopathy (brain dysfunction caused by underlying medical condition chemical imbalance). Record review of Resident #2 Quarterly MDS dated [DATE] reflected a BIMS score of 10 indicating moderate cognitive impairment. Further review of section GG Functional Abilities reflected Resident #2 required substantial maximal assistance needed for eating and was dependent on staff for personal hygiene, dressing, bathing, toileting, and transfers. Record review of Resident #2 Care Plan Conference Report undated reflected the only care conference recorded was dated 7/17/25 and did not state if this was an annual or significant change conference. Resident #6 Record review of undated admission Face sheet for Resident #6's reflected a [AGE] year-old female admitted on [DATE] and readmitted on [DATE]. Diagnoses of Alzheimer's disease, schizoaffective disorder bipolar type, urinary tract infection, cellulitis of right lower limb, muscle wasting and atrophy, whooping cough, need for assistance with personal care, macular degeneration of both eyes, unspecified dementia, severe protein calorie malnutrition, abnormalities of gait and mobility, schizophrenia, hypokalemia, anxiety disorder, gastro-esophageal reflux disease, hyperlipidemia, hypertension, lack of coordination, dysphagia, and metabolic encephalopathy. Record review of Resident #6's Quarterly MDS dated [DATE] reflected a BIMS score not recorded. Further review of section GG Functional Abilities reflected Resident # 6 required substantial maximal assistance with eating, oral hygiene, and transfer. Resident # 6 was dependent on staff for toileting, bathing, dressing, and personal hygiene. Record review of Resident #6's Care Plan dated 4/24/25 indicated the next care conference due 7/21/25. Record review of Resident #6's undated care conference report reflected care conferences conducted on 11/16/22, 2/8/23, 5/3/23, 10/25/23, 12/13/23, 3/13/24, 6/12/24, 9/18/24, and 4/24/25. Resident #8 Record review of Resident #8's Face sheet, 09/03/2025, reflected she was an [AGE] year-old female, who was admitted to facility on 07/15/2022 with a diagnosis of Alzheimer's disease with early onset, hyperlipidemia, Muscle wasting and atrophy, other speech and language deficits following other cerebrovascular disease, and Major depressive disorder, recurrent severe without psychotic features. Record review of Resident #8's MDS, dated [DATE], indicated she had a Brief Interview for Mental Status (BIMS) of 03, indicating severe impairment. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident #8's comprehensive care plan revealed comprehensive care plan conference was due for quarterly review on 07/06/2025. Record Review of Resident#8's MDS revealed there was no MDS recorded close to 7/6/2025. Record Review of Resident #8's care conference report undated reflected, Care Conferences were held 4/9/2025, 11/20/2024,8/21/2024, and 5/15/2024. Interview on 09/04/25 at 02:25 PM with the SW said he had worked here and at a sister facility for almost 6 months. The SW said the facility was supposed to conduct a care plan conference for each resident quarterly or as needed by families The SW said the purpose of a care plan was to identify each residents' needs, discharge planning, psychoactive medications, things that fully encompass the reasons the residents are here in the facility. The SW said he primarily handled the discharge planning by identifying recommendations from therapy such as discharge home with home health or a conversion over to hospice care. The SW said the DON was responsible for completing resident care plans timely and accurately. The SW saidthe DON was supposed to conduct a baseline care plan within 48 hours of a resident admission, and the facility was supposed to conduct a care plan conference for each resident quarterly or as needed by families. He further said not completing care plans timely or accurately can affect the resident negatively because it does not encompass the reason the resident was in the facility. The SW said he had been trained on completing resident care plans timely and accurately, and it was a team effort between the DON and the entire IDT. The SW said he monitored resident psych behaviors and initiated psych services and assist with making psych referrals, along with cognitive testing and consent from family. Interview on 09/04/25 at 05:45 PM with the DON said she had been working here since 06/24/25. The DON said IDT meets once per week, and on the phone with social worker and dietary manager. She said they discussed what was not working at that time and strived to make it a more inclusive and working documents. Care plan is a road map and tells us everything we need to know and how ER can best meet their needs. First one within a couple of months, and then every 90 days/once per quarter. Generally, the care plan is completed by the MDS nurse and the DON, especially the initial care plan. This is a team process. Once baseline care plan is completed, the comprehensive cp is completed within 21 days of the baseline which is within 48 hours. The resident can be affected if the care plan is not completed timely and accurately, an example is a new resident has teeth, and then he might have a decline in dental health, nutrition. Also addresses the residents' loss of control, activities they like, and what is going on in their life. Said she has someone in corporate that helps her out, but no official training in this position. IDT meets once per week, and on the phone with social worker, dietary manager, and what is not working at that time, we strive to make it a more inclusive and working documents. Discussion during morning meetings. Said the maintenance man could be included also. DON said the facility had a PIP in place regarding resident care plans since they had not been being completed timely and accurately. DON said she had been working to get all the resident care plans accurate and up to date. Interview on 09/04/25 at 06:15 PM with the Administrator said he had been here for two months, 06/30/25. The Administrator said the care plan conference should be conducted within 90 days. The ADM said the purpose of a care plan was to make sure we address all residents' concerns. The ADM said the MDS nurse, and the DON were responsible for getting the initial care plan completed. He said the care plan conference should be conducted within 90 days, and the initial care plan should be completed in 72 hours. The ADM said after the baseline care plan, the comprehensive care plan should be completed in one week. He said a negative effect of care plans not being completed timely and (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	accurately could affect the resident by staff missing the right care for the resident, and other problems or concerns of residents' care. The ADM said he had not officially received training on the importance of completing care plans timely and accurately. Review of the facility's PIP (Performance Improvement Plan) dated 08/18/25 reflected one of the reasons for the Performance Improvement Plan was not completing care plans in a timely manner. The PIP's improvement goals were to keep residents safe, follow up on all resident care, and have staff trained and qualified to take care of our residents. The PIP further reflected tools and training to be provided were in-services and trainings and follow up on all agency staff to ensure the complete orientation before getting on the floor. The PIP's completion date was 09/30/25. Review of the facility's Policy & Procedure Comprehensive Care Plans dated 07/2025 reflected, Policy: Policy Explanation and Compliance Guidelines: 1. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. All services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality, and incorporate culturally competent and trauma-informed care as indicated. 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. b. Any services that would otherwise be furnished but are not provided due to the resident's exercise of his or her right to refuse treatment. c. Any specialized services or specialized rehabilitation services the nursing facility will provide as a result of PASARR recommendations. d. The resident's goals for admission, desired outcomes, and preferences for future discharge. e. Discharge plans, as appropriate. f. Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity, as indicated. If the resident is non-English speaking, the facility will identify how communication will occur with the resident. The care plan will identify the language spoken and tools used to communicate. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Llano Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 800 W Haynie St Llano, TX 78643	
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g. Individualized interventions for trauma survivors that recognizes the interrelation between trauma and symptoms of trauma, as indicated. Trigger-specific interventions will be used to identify ways to decrease the resident's exposure to triggers which re-traumatize the resident as well as identify ways to mitigate or decrease the effect of the trigger on the resident. 4. The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to: a. The attending physician or non-physician practitioner designee involved in the resident's care, if the physician is unable to participate in the development of the care plan. b. A registered nurse with responsibility for the resident. c. A nurse aide with responsibility for the resident. d. A member of the food and nutrition services staff. e. The resident and the resident's representative, to the extent practicable. f. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. Examples include, but are not limited to: The RAI Coordinator Activities Director/Staff Social Services Director/Social Worker Licensed therapists Family members, surrogate, or others desired by the resident. Administration Discharge Coordinator Mental health professional Chaplain		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, the facility failed to accommodate each resident's allergies, intolerances, and preferences for 4 of 7 residents (CR #1, CR # 2, CR # 3, CR # 4) reviewed for food and nutritional services. The facility failed to ensure CR # 1, CR # 2, CR # 3, and CR # 4 meal preferences were met- By not offering breakfast meal alternate.-By not offering a daily meal alternate for the lunch and dinner meals.-By not honoring food preferences on resident meal cards. These failures could place residents at risk of not having their food preference needs met. Findings included: Observation on 09/02/25 at 9:45 AM of menu posting revealed no alternate menu posted. Observation on 09/02/25 at 11:00 AM of menu posting revealed no alternate menu posted. Observation on 09/02/25 at 5:15 PM of menu posting revealed no alternate menu posted. During a confidential Resident Council meeting on 9/4/25 revealed CR # 1 stated they serve the same breakfast every day, so they do not eat it. CR #1 had sked for different breakfast choices, but nothing ever changed. CR #1 stated they receive the same old scrambled eggs and link sausage every single day. CR #1 would like fried egg, omelets, fruit sometimes. CR #1 stated they were supposed to have a meeting with kitchen person, and it never happened. CR #1 stated due to right side heart failure they were not to have salt in their diet and no precooked food. CR #1 stated food was brought in from the outside, by a family member every of day. CR # 1 stated their wounds cannot heal due to the salt. Stated the DM was very rude, DM will shut the door in your face, she is so d*** rude. CR # 2 stated they tried speaking to the DM and she was very disrespectful when ask for different food choice. Stated a couple of months ago, DM sent a choice for two days and afterwards she stopped. CR # 3 stated not liking the pimento cheese and the bologna and those are the only choices for sandwiches. All CR's stated they have asked for meal of the month, only got it once and it was lasagna which was something they already had severed. CR # 4 stated they continue to serve pork, spaghetti and fish, and they knew CR #4 do not like those foods. CR #4 stated if they wanted a bowl of soup as night, they should be able to get it if needed. In an interview on 09/03/25 at 3:53 PM revealed the DM had worked at the facility for 7 months. The DM stated the DM from a sister facility had come and provided 1 day of training. The DM stated Corporate and sister facility contacts provided for further training via email and phone. The DM stated she does not feel that they received enough hands-on training in the beginning but has since received more training and self-taught on some things. The DM stated the facility conducts training thru In-services and CBT. The DM stated alternate meal options are available to residents. and there was a posting of alternate meal option next to the menus. The DM stated the facility kept pimento cheese and chopped BBQ on hand. The DM stated the residents know they can come to the kitchen door to make request or tell their nurse. The DM stated it could negatively affect a resident if they did not receive meal options as it could emotionally affect them and make them feel as if their choices do not matter. The DM stated the DM are responsible for ensuring residents have meal options. The DM stated meal preferences are obtained from new admits and states several of the residents were already at facility prior to her starting and their preferences are updated at care plan meetings. The DM stated it could negatively affect a resident if their meal preferences are not obtained emotionally by making them feel that their preferences do not matter. In an interview on 09/03/25 at 5:46 PM the DON revealed they had worked at the facility for 4 months. The DON stated meal options are available to residents, and they do have residents ask for different items such as leftovers or sandwiches. The DON stated she was unsure if there was a printed alternate menu. The DON stated the resident has the option and availability to ask the nurse or CNA, what the alternative meal option was for the day. DON stated the alternate meal option of the day was now posted outside the kitchen next to the daily menu. DON stated it could negatively affect a resident if they did not have meal options by it could affect the resident eating and in turn their weight and nutrition. The DON stated Dietary or DM was responsible for ensuring the resident have meal (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	options. The DON stated it was the responsibility of the RD or DM to obtain the resident meal preferences. The DON stated she was unsure how often resident meal preferences are obtained. In an interview on 09/04/25 at 6:15 PM revealed the ADM had worked at the facility for 2 months. The ADM stated the facility always has meal options available in the kitchen, but they do not have a set list of food items as it changes with their inventory. The ADM stated the CNAs are supposed to tell the residents the daily meal and the alternate. The ADM stated the daily meal, and the alternate are posted outside of the kitchen. The ADM stated it could negatively affect a resident by not having meal options by weight loss. The ADM stated the DM was responsible for ensuring there are meal options for the residents. The ADM stated the DM, or designee was responsible for obtaining resident meal options and preferences. The ADM stated resident meal preferences are obtained upon admission and at care plans. Record review of facility alternate meal policy undated reflected the alternate is to include starch, protein (2 oz at dinner, 3 oz at lunch), and vegetable serving are determined prior to the meal based on what is on the menu. For example, if chicken was on the menu, then the alternate would be a protein that was not also chicken. Or if potatoes were on the menu, then a noodle or rice would be the starch alternate.		

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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 observations, interviews, and record reviews, the facility failed to treat each resident with respect and dignity in a manner and environment that promoted the maintenance or enhancement of quality of life for 1 (Resident #10) of 10 residents reviewed for dignity. 1. The facility failed to ensure Resident #10 was appropriately groomed without a brief showing during mealtime. This failure could place residents at risk of diminished dignity and affect their quality of life. Findings included: Resident #10 Record review of Resident #10 Face sheet dated 09/03/2025, reflected she was a [AGE] year-old female, who was admitted to facility on 01/21/2025 with a diagnosis of Spastic quadriplegic cerebral palsy(arms, legs, trunk, and face affected by muscle stiffness), Muscle wasting and atrophy(muscles shrink and weaken), Cognitive communication deficit, Major depressive disorder, Generalized anxiety disorder, and Moderate intellectual disabilities. Record review of Resident # 10's MDS, dated [DATE], section C0100, indicated a Brief Interview for Mental Status (BIMS) should not be conducted, a Staff Assessment for Mental Status indicated (3) severely impaired (never/rarely made decisions). Record review of Resident # 10's care plan, dated 04/08/2025 revealed she was total assist for dressing and grooming. Observation of the facility's dining room on 9/3/2025 at 5:26 PM, revealed Resident #10 in dining area with her brief completely showing on one side. Observation also revealed another resident at the same table advising Resident #10 her brief was showing. That same resident pulled up Resident #10's blanket and covered the brief. Interview conducted 9/3/2025, at 6:36 PM, CNA A stated she has been a certified nursing assistant for over a year, she stated she was an agency CNA. She said she had worked at this specific facility often and was assigned to Resident #10 for the day. CNA A stated she did not bring Resident #10 to the dining area as she recalled. CNA A verified with LVN on who assisted Resident #10 to dining, LVN replied she escorted Resident #10 to dining room. CNA A stated Resident #10 was wearing a dress, but it had not been pulled down over her brief. CNA A stated the situation could be a rights issue and have a potential negative effect, as it could cause the resident to not feel well when her brief was exposed in the dining room. Interview attempted on 9/4/2025, at 3:30 PM, with LVN A, she was out. A telephone call was placed to LVN, and a voicemail was left. Interview conducted 09/04/2025 at 5:55 PM, The DON stated the facility always try to promote dignity. The DON stated residents should not be brought out in a gown or with unwashed/unclean clothing. The DON stated it was the responsibility of the CNAs and the nurses to check the residents before coming to dining. The DON stated yes she considered it a rights and dignity concern if a resident was seated in the dining room with a brief exposed. She stated, it would affect anyone to sit in public with their underwear showing. The DON stated respecting every resident's dignity is important. Interview conducted 09/04/2025 at 6:21 PM, the ADM stated he and the DON are responsible for training staff on resident rights and dignity policies. The ADM stated they make sure all residents are properly clothed before coming to dining. He further stated all staff are responsible if they see a resident, not dressed appropriately to go correct the issue. The ADM stated it was the responsibility of the CNA ?s and the nurses to check residence appearance before bringing them to dining. The ADM stated he could see a dignity concern of a resident sitting in the dining room with their brief exposed. The ADM stated it could have a negative impact on the resident as it not only affects their dignity but also violate their privacy. Record review conducted 09/04/2025; Facility Policy on Resident Rights, revision dated February 2, 2022, stated, you have the right:2) to safe, decent, and clean conditions4) to be treated with courtesy, consideration, and respect.6) to privacy, including privacy during visits and telephone calls Record review conducted 09/04/2025; Facility Policy on Promoting and Maintaining Dignity, dated July 2025 read:It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	life by recognizing each resident's individuality.Compliance Guidelines:1. All staff members are involved in providing care to residents to promote and maintain dignity and respect resident rights. 5. When interacting with a resident, pay attention to the resident as an individual.9. Groom and dress residents according to resident preference.12. Maintain residents' privacy.		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to provide special eating equipment for residents who needed them and appropriate assistance to ensure that the resident could use the assistive devices when consuming meals for 1 of 3 residents (Resident #4) reviewed for special eating equipment and assistance when consuming meals. The facility failed to ensure Resident #4 was provided with a Sippy Cup with built in straw to meet Resident #4's need for assistance while eating. This failure could place residents at risk for harm from weight loss, diminished independence, and self-esteem. The findings included: Record review of Resident #4 Face sheet, 09/02/2025, reflected she was a [AGE] year-old female, who was admitted to facility on 08/26/2023 with a diagnosis of unspecified dementia (loss of memory), dysphagia (difficulty swallowing food or liquids) and severe protein-calorie malnutrition (does not get enough protein and calories).Record review of Resident # 4 MDS assessment dated , 07/03/2025, indicated she had a Brief Interview for Mental Status (BIMS) of 01, indicating severe impairment. Eating ADL indicated limited assistance.Record review of Resident #4 Comprehensive Person-Centered Care Plan, 9/02/25 reflected that Resident #4 used a cup with built in straw and a scoop plate due to risk for alteration in nutrition. ^ Record review of Resident #4's Diet Profile dated 7/22/25 reflected the resident was to have a ^ Sippy Cup and Scoop Plate each meal. Observation of the facility's dining room on 09/03/2025 at 5:35 PM revealed Resident #4 was not provided her sippy cup for the dinner meal. Resident #4 received a regular cup with an unattached straw. The DON was observed to assist Resident #4 with adding sugar to her tea in the regular cup. An attempted interview was conducted on (date) at 5:58 PM, with Resident #4 ,she did not respond, shaking her head instead. Interview conducted 09/04/2025 at 3:18 PM, The DOR stated he has worked at the facility for almost 8 years. The DOR stated that all staff involved in meals share responsibility for ensuring residents have their prescribed adaptive equipment, with nurses checking trays and dietary staff as the first point of contact. He noted that failure to provide adaptive equipment could lead to aspiration, inadequate hydration, and loss of independence, affecting residents' quality of life. The DOR stated the systems in place include nurses checking trays at mealtimes and therapists observing when they are present to ensure compliance with physician or therapy orders. Interview conducted 09/04/2025 at 3:53 PM, The DM stated she has been working at the facility for 7 months. The DM stated she was trained on resident's adaptive feeding equipment by a dietary manager of a sister facility. The DM stated that the cook was responsible for ensuring residents have their adaptive equipment at all mealtimes. The DM stated she placed the adaptive cup on the tray for Resident #4 but noted that Resident #4 sometimes refused to use it. The DM was unsure if refusals are documented. She stated when the resident refuses, she is given a regular cup with a straw. The DM stated the resident could spill drink on herself or choke when given a regular cup with a straw. She stated that the system in place includes the adaptive equipment being printed on the meal card, with the nurse checking trays and other staff reviewing the cards when served. Interview conducted 09/04/2025 at 4:20 PM, The DC stated she has been working at the facility for 2 months and was trained by the dietary manager on dining procedures. The DC stated the kitchen staff was responsible for providing the adaptive equipment on the meal trays and then the nurses will check the trays afterwards. The DC stated that failure to provide adaptive equipment could potentially lead to choking or spills. Interview conducted 09/04/2025 at 5:55 PM, The DON stated she has not been trained on adaptive equipment at this facility, though she has received training in other facilities. The DON stated responsibility to train nursing staff on adaptive equipment, she assumed should come from therapy. She reported that she has never ordered adaptive equipment during her time at the facility. The DON stated the Dietary Manager is responsible for adaptive equipment at mealtimes, as the equipment should be on the tray card. She added that nurses are expected to check trays and (continued on next page)		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	make sure the correct equipment was provided. The DON stated in a morning meeting staff had discussed Resident #4 no longer needed a sippy cup, but the care plan had not yet been reassessed or updated. The DON stated potential risks if adaptive equipment, such as a prescribed sippy cup, was not provided a resident may not receive adequate fluids, spill fluids, choke, or aspirate. Record review conducted 9/04/2025, Facility Policy on Use of Assistive Devices dated July 2025 read:1. Assistive devices are tools, products, types of equipment, or technology that help individuals perform tasks and activities. They may help the individual move around, see, communicate, eat, or get dressed. Assistive devices include:g. Eating utensils 2. The use of assistive devices will be based on the resident's comprehensive assessment, in accordance with the resident's plan of care.6. A nurse with responsibility for the resident will monitor for the consistent use of the device and safety in the use of the device. Refusals of use, or problems with the device, will be documented in the medical record. Modifications to the plan of care will be made as needed.		

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations, interviews, and record review the facility failed to ensure results of the most recent surveys such as (surveys, certifications, and complaint/incident investigations) of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to survey were readily available to examine for 1 of 1 facility in that: 1. The required state survey documents were not posted in a location readily accessible and visible to all residents, their legal representatives, or family members as required.2. The facility failed to maintain the survey binder; the binder failed to include 3 previous years of required state visit results from 6/28/23, 1/17/25, and 4/9/25. This failure could place all residents of the facility at risk of limited' rights to access information regarding the facility's compliance with state and federal requirements.Findings included: An observation conducted throughout the facility on September 2, 2025, at 2:15 PM, revealed the facility's survey results book was not displayed in the entry foyer nor in any other location within the facility. An observation conducted throughout the facility on September 3, 2025, at 8:30 AM, revealed the facility's survey results book was not displayed in the entry foyer nor in any other location within the facility. An observation conducted throughout the facility on September 4, 2025, at 8:42 AM, revealed the facility's survey results book was not displayed in the entry foyer nor in any other location within the facility. During a confidential group interview conducted on undisclosed date and time, 7 residents interviewed stated they had not known where or how to access the survey results in the facility. Several of the residents stated they would have liked access to this information. They had not understood or been aware that the survey book existed or that they were able to review the results.Interview and observation conducted September 4, 2025, at 10:19 AM, the ADM escorted the surveyor to his office and stated he had removed the survey binder due to painting in the building. The ADM reported that painting had been ongoing for approximately two weeks. The ADM proceeded to retrieve the survey results book from a cabinet in his office. The book was labeled with facility name and 2024 Annual Survey Results and contained only the August 8, 2024, annual survey results; no other survey results were included. Observation revealed the wall identified as the normal posting location had not yet been painted.Interview conducted on September 4, 2025, at 10:30 AM, with the ADM, facility policy requested for survey book.Interview conducted September 4, 2025, at 3:40 PM, the BOM/AD stated she did not know at this time where the survey binder was located. The BOM/AD reported she had not received training regarding the survey binder or its contents. She further stated she has not spoken with any residents about the survey results at Resident Council meeting because she was not aware of the binder. The BOM/AD stated she was scheduled to receive training on regulations through the activities department. Interview conducted September 4, 2025, at 6:21 PM, the ADM stated that he was responsible for maintaining the survey results binder and for training staff on the binder and its contents. He reported the binder was required to include the three most recent surveys and the corresponding plans of correction. The ADM was informed that only the 2024 annual survey was present in the binder. The ADM stated that residents and their family representatives have the right to review the survey results, and that the binder should be posted in a location visible and accessible to residents and families. The ADM stated keeping the binder in a closed cabinet in his office was not considered a prominent and readily available location, the ADM stated it should be posted. He stated he accepted responsibility for removing the survey binder and stated the negative impact of not having the survey results binder available as residents and family members deserve to know the results.Record review conducted September 4, 2025; Facility Policy on Availability of Survey Results dated July 2025 read: 1. A readable copy of our company's most recent federal and/or state survey report and plan of correction for any identified deficiencies is maintained in a 3-ring loose-leaf binder titled Results of Most Recent Survey. 3. The survey binder is located (in the main lobby) and is available for review by interested persons who wish to review information relative to our (continued on next page)		

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	company's compliance with federal or state rules, regulations, and guidelines governing our company's operation.3. A representative of management is assigned the responsibility of making weekly inspections of the survey binder to ensure that the binder contains current information, is located in its designated area(s), and is readily accessible without one having to ask staff members for the information.4. The facility will maintain reports of any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility. This information will be available for any individual to review upon request.5. The facility shall not alter the survey results unless authorized by the state agency.6. Signs identifying the availability and location of our survey binder and availability of previous survey results are posted throughout the building and public bulletin boards. Record review conducted September 4, 2025; Facility Policy on Resident Rights, revision dated February 2, 2022, stated:16. The resident has a right to examine the results of the most recent survey of the Center conducted by Federal or State surveyors and any plan of correction in effect with respect to the Center.		