| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675098 | A. Building<br>B. Wing | 05/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Farwell Care and Rehabilitation Center | 305 Fifth St<br>Farwell, TX 79325 |

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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the residents' environment remained as free from accident hazards as was possible; and that each resident received adequate supervision to prevent accident hazards for one resident (Resident #1) of 5 residents observed for accident hazards. -Resident #1 had an oxygen bottle/cylinder left unsecured in his room. This failure could lead to injuries such as bruising, skin tears, fractures, and feelings of fear and isolation. Findings include: Record review of the clinical record for Resident #1 revealed an [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses to include Parkinson's (a disorder of the central nervous system that affects movements toinclude tremors), acute respiratory failure (occurs when the lungs cannot adequately pull oxygen into the blood or remove carbon dioxide from the body), obstructive sleep apnea (a sleep disorder that involves cessation or significant decrease in airflow in the presence of breathing effort), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and heart failure (a chronic condition in which the heart dose not pump blood as well as it should). Record review of Resident #1's clinical record revealed he had been in the facility for 4 days and an MDS assessment was not due to be completed. Record review of Resident #1's clinical record revealed a baseline care plan with admission date of 05/15/2026 listing him for the use of oxygen therapy. During an observation and attempted interview on 05/19/2026 at 07:58 AM Resident #1 was in his room in his bed. Observed was an oxygen bottle leaning against his dresser and the wall in the corner of his room that was unsecured with a nasal cannula attached to it. When asked about the oxygen bottle Resident #1 reported something about him being under his house. He was unable to give an intelligible answer. During an observation on 05/19/2026 at 09:00 AM Resident #1 was in his wheelchair outside his room. The oxygen bottle was unsecured leaning against his dresser and the wall in the corner of his room. During an observation on 05/19/2026 at 10:00 AM Resident #1 was in his wheelchair in the hallway by the physical therapy department. The oxygen bottle was unsecured leaning against his dresser and the wall in the corner of his room. During an observation on 05/19/2026 at 10:55 AM Resident #1 was in his wheelchair with a staff member taking him to the dining room. The oxygen bottle was unsecured leaning against his dresser and the wall in the corner of his room. During an interview on 05/19/2026 at 10:57 AM LVN A (the nurse responsible for Resident #1 this shift) reported staff should round every 2 hours or as needed, and all staff including the nurse and CNAs should do rounds. LVN A entered Resident #1's room, noted the oxygen bottle leaning against the dresser and wall in the corner of his room, and reported the oxygen bottle was not secured and could explode. LVN A was not sure who was responsible for completing the training for staff since she only started last Thursday. During an interview on 05/19/2026 at 11:02 AM CNA B (the CNA responsible for Resident #1 this shift) reported she constantly walks back and forth down the hallway and checks every room all the time. CNA B reported she will check every resident for their oxygen, but she is not allowed to touch the oxygen. When made aware of the unsecure oxygen bottle in the room CNA B stated, I don't know if that is a problem. I don't know if that bottle is his or not. When asked if she had been trained on oxygen safety and care CNA B stated, It's only my<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | second day and CNA C is my instructor. During an interview on 05/19/2026 at 11:09 AM the DON reported the CNA staff are to do rounds every two hours and the nursing staff are to do rounds at the opposite hours. The DON entered Resident #1's room and noticed the unsecure oxygen bottle and stated, that is a problem. That bottle is supposed to be secured on the back of a wheelchair or in a small cart. That is like a loaded bomb. I just gave an in-service on that. During an interview on 05/09/2026 at 12:00 PM CNA C (the trainer for CNA B) reported she was on light duty at this time and was being utilized as a trainer. CNA C reported CNA B had only been working for 2 days and she had not had much time to work with CNA B. CNA C reported staff are expected to do rounds every two hours. CNA C reported an oxygen bottle should be stored in a place that was secure and if that bottle was not stored correctly it could get dropped and break. CNA C reported the DON has completed training with all the staff on oxygen bottle safety. Record review of the facility provided policy titled Oxygen Safety undated, revealed the following:Policy: It is the policy of this facility to provide a safe environment for residents, staff, and the public. Policy Explanation and Compliance Guidelines:Safety of the responsibility of staff.4. Oxygen storage - c. Cylinders will be properly chained or supported in racks or other fastening (i.e. sturdy portable cars, approved stands) to secure all cylinders from falling, whether connected, unconnected, full, or empty. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents who need respiratory care were provided such care consistent with professional standards of practice for 1 (Resident #1) of 5 residents reviewed for respiratory care. The facility failed to store Resident #1's nasal cannula properly. This failure could place resident at risk for complications such as shortness of breath, confusion, respiratory failure, infection, and exacerbation of their condition.Findings include: Record review of the clinical record for Resident #1 revealed an [AGE] year-old male resident admitted to the facility on [DATE] with diagnoses to include Parkinson's (a disorder of the central nervous system that affects movements toinclude tremors), acute respiratory failure (occurs when the lungs cannot adequately pull oxygen into the blood or remove carbon dioxide from the body), obstructive sleep apnea (a sleep disorder that involves cessation or significant decrease in airflow in the presence of breathing effort), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and heart failure (a chronic condition in which the heart dose not pump blood as well as it should). Record review of Resident #1's clinical record revealed he had been in the facility for 4 days and an MDS was not due to be completed. Record review of Resident #1's clinical record revealed a baseline care plan with admission date of 05/15/2026 listing him for the use of oxygen therapy. During an observation and attempted interview on 05/19/2026 at 07:58 AM Resident #1 was in his room in his bed. Observed was his O2 concentrator that was on, but his nasal cannula was on the floor next to the head of his bed beside the O2 concentrator. When asked about the nasal cannula Resident #1 reported something about him being under his house. He was unable to give an intelligible answer. During an observation on 05/19/2026 at 09:00 AM Resident #1 was in his wheelchair outside his room. Resident #1's nasal cannula was on the floor in his room in the same position as noted on 05/19/2026 at 07:58 AM. During an observation on 05/19/2026 at 10:00 AM Resident #1 was in his wheelchair in the hallway by the physical therapy department. Resident #1's nasal cannula was on the floor in his room in the same position as noted on 05/19/2026 at 07:58 AM. During an observation on 05/19/2026 at 10:55 AM Resident #1 was in his wheelchair with a staff member taking him to the dining room. Resident #1's nasal cannula was on the floor in his room in the same position as noted on 05/19/2026 at 07:58 AM. During an interview on 05/19/2026 at 10:57 AM LVN A (the nurse responsible for Resident #1 this shift) LVN A reported staff should round every 2 hours or as needed, and all staff including the nurse's and CNAs should do rounds. LVN A entered Resident #1's room and reported his oxygen tubing should not be on the floor, this was an infection control issue, and the resident could get germs. LVN A was not sure who was responsible for completing the training for staff since she only started last Thursday. During an interview on 05/19/2026 at 11:02 AM CNA B (the CNA responsible for Resident #1 this shift) reported she constantly walks back and forth down the hallway and checks every room all the time. CNA B reported she will check every resident for their oxygen, but she is not allowed to touch the oxygen. She entered Resident #1's room and reported she would turn on the oxygen button and put the nasal cannula on the resident. When asked if she would use the current cannula (that was on the floor) CNA B stated yes and when asked if the cannula on the floor was an issue she stated, No it's not an issue if it's on the floor. When asked if she had been trained on oxygen safety and care CNA B stated, It's only my second day and CNA C is my instructor. During an interview on 05/19/2026 at 11:09 AM the DON reported the CNA staff are to do rounds every two hours and the nursing staff are to do rounds at the opposite hours. The DON noticed the nasal cannula on Resident #1's floor and reported it was an issue and should have been addressed to prevent infection control issues. During an interview on 05/09/2026 at 12:00 PM CNA C (the trainer for CNA B) reported she was on light duty at this time and was being utilized as a trainer. CNA C reported CNA B had been working for 2 days and she had not had much time to work with CNA B. CNA C reported staff are expected to do rounds every two hours<br>(continued on next page) |

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| | 675098 | A. Building<br>B. Wing | 05/19/2026 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and a resident's nasal cannula cannot be on the floor. That if the nasal cannula was found on the floor it should be changed for a new one. If a staff member were to use a nasal cannula that had been on the floor, then that was a violation of infection control. CNA C reported the DON has completed training with all the staff on oxygen bottle safety. During an interview on 05/19/2026 at 11:48 AM the Administrator reported the facility did not have a policy that was specific for storing the nasal cannula and tubing off the floor. That it was generally understood. Record review of the facility provided policy titled Oxygen Safety undated, revealed the following:Policy: It is the policy of this facility to provide a safe environment for residents, staff, and the public. Policy Explanation and Compliance Guidelines:Safety of the responsibility of staff.7. Accessories - a. Accessories, i.e. cannulas/tubing, are to be stored when not in use. Cannulas and tubing should be stored in clean zip lock bags that are accessible to the residents. |