

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: 675098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2025
NAME OF PROVIDER OR SUPPLIER Farwell Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Fifth St 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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review; it was determined the facility failed to ensure each resident was provided with the right to have personal privacy during medical treatments, for 4 (Residents #1, #4, #14, and Resident #38) of 15 residents reviewed for privacy. -RN D failed to knock or announce herself upon entering Resident #4's room or provide privacy before administering medication via peg-tub.-RN D failed to knock or announce herself upon entering Resident #38's room or provide privacy before administering an injectable medication. -RN D failed to knock or announce herself upon entering Resident #14's room or provide privacy before administering an injectable medication. -RN D failed to knock or announce herself upon entering Resident #1's room or provide privacy before administering and injectable medication. -RN A and CNA F failed to knock or announce themselves upon entering Resident #38's room or provide privacy during wound care. These failures could place residents at risk of feeling shame or embarrassment, lowered self-esteem, and a lack of a dignified existence. Findings Included:Resident #1Record review of Resident #1's clinical record revealed Resident #1 was a [AGE] year-old male, who was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus with diabetic neuropathy, unspecified (a condition where the body either doesn't make enough insulin or the body's cells don't respond properly to insulin, leading to elevated blood sugar levels (hyperglycemia), heart failure (a weakness of the heart that leads to a buildup of fluid in the lungs and surrounding body tissues), schizoaffective disorder, bipolar type (a serious mental illness combining symptoms of schizophrenia (hallucinations, delusions) with mood swings from bipolar disorder (mania/hypomania and depression)), bipolar disorder, current episode mixed, severe, without psychotic features (intense mood swings (manic/hypomanic and depressive) cause significant impairment in life, but without hallucinations or delusions), delusional disorders, (a mental health condition where a person has persistent, false beliefs (delusions) that aren't based in reality), major depressive disorder, single episode, unspecified (a serious mood illness causing persistent sadness, loss of interest (anhedonia), fatigue, and impaired daily functioning), intermittent explosive disorder (a mental health condition marked by sudden, impulsive, and disproportionate aggressive outbursts, including yelling, physical fights, or property damage, often preceded by tension and followed by regret). Record review of Resident #1's most recent MDS assessment, dated 10/03/2025, indicated Resident #1 had a BIMS of 06, indicated severe cognitive impairment and a functionality of maximal assistance required with showering/bathing, lower body dressing, and putting on/taking off footwear. Partial/moderate assistance was required with toileting, upper body dressing, and personal hygiene. Resident #1 required supervision with oral hygiene and setup or clean-up assistance with eating. Resident #4Record review of Resident #4's clinical record revealed Resident #4 was a [AGE] year-old female, who was admitted to the facility on [DATE] with diagnoses including epilepsy, unspecified, intractable, with status epilepticus (a severe, hard-to-treat epilepsy where seizures are prolonged or occur in clusters), major depressive disorder, recurrent severe without psychotic features (describes repeated episodes of significant depression where a person experiences core depressive symptoms (sad mood, loss of pleasure, fatigue, sleep/appetite changes, concentration issues, worthlessness) but does not experience delusions or hallucinations (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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observation on 12/14/2025 at 7:17 PM revealed RN D did not announce herself or knock on door of Resident #38's room when RN performed blood glucose check and insulin administration. RN did shut door or pull privacy curtain before the start of procedure for Resident #38 during either procedure. During an observation on 12/14/2025 at 7:32 PM revealed RN D did not announce herself or knock on door of Resident 14's room when RN performed blood glucose check and insulin administration. RN did not shut door or pull privacy curtain to provide privacy to Resident #14 during either procedure. During an observation on 12/14/2025 at 7:42 PM revealed RN D did not announce herself or knock on door of Resident #1's room when RN performed blood glucose check and insulin administration. RN did not shut door or pull privacy curtain to provide privacy to Resident #1 during either procedure. During an interview on 12/14/2025 at 7:48 PM RN D stated the negative outcome for not knocking or announcing oneself or providing privacy during a treatment would be lack of privacy for the residents. During an observation on 12/16/2025 at 10:43 AM revealed RN A and CNA F did not knock or announce themselves before entering Resident #38's room to perform wound care. Neither RN or CNA shut door or pull privacy curtain to provided privacy for Resident #38 before or during wound care treatment. During an interview on 12/16/2025 at 11:25 AM RN A stated the negative outcome for not knocking or announcing herself to the resident or providing privacy during treatment could embarrass the resident. During an interview on 12/16/2025 at 11:30 AM CNA F stated the negative outcome for not knocking or announcing himself to the resident was that it would be invading the resident privacy. During an interview on 12/16/2025 at 1:35 PM I-DON stated that a negative outcome of not knocking or announcing oneself is an invasion of the resident's privacy. During an interview on 2/16/2025 at 12:03 PM CN stated that by not knocking on the door to a resident's room before entering is a dignity and privacy issue, the resident could be changing clothes. The staff is not respecting the resident's dignity, and like I said if they were changing clothes, it could embarrass the residents. Record review of policy titled, Residents Rights, dated 09/01/2023, revealed the following: .Policy Explanation and Compliance Guidelines: .11. The facility will ensure that all direct care and indirect care staff members, including contractors and volunteers are educated in the rights of residents and the responsibility of the facility to properly care for its residents. Privacy and confidentiality. The resident has a right to persona privacy and confidentiality of his or her personal and medical records.a. Personal privacy includes accommodations, medical treatment, . Record review of policy titled, Provision of Quality Care, dated 09/01/2023, revealed the following: .Policy Explanation and Compliance Guidelines: 1. Each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being.4. Qualified persons will provide the care and treatment in accordance with professional standards of practice, .6. Policies and procedures will reflect current professional standards of practice. a. All employees are responsible for following established policies and procedures. Record review of policy titled, Training Requirements, dated 09/01/2023, revealed the following: .6. Training content includes, at a minimum: b. Resident rights and facility responsibilities for caring of resident. Record review of policy title, Medication Administration via Enteral Tube, dated 09/01/2023, revealed the following: .11. Procedure: .d. Provide privacy by pulling the privacy curtain or closing the door to a private room. Record review of policy titled, Medication Administration, dated 09/01/2023, revealed the following: .Policy Explanation and Compliance Guidelines: .5. Knock or announce presence.7. Provide Privacy .		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical well-being of each resident for 1 (RN D) of 5 staff reviewed for nursing services. -RN D failed to knock or announce herself upon entering Resident #4's room or provide privacy before administering medication via g-tub.-RN D failed to check placement of g-tube for Resident #4 before administering medication via g-tube. -RN D failed to perform hand hygiene before administering medication to Resident #4 via g-tube. -RN D failed to knock or announce herself upon entering Resident #38's room or provide privacy before performing glucose check and the administration of an injectable medication. -RN D failed to perform hand hygiene or glove change before or after preparation of glucometer, glucose check, preparation of the medication, and the administration of Insulin for Resident #38.-RN D failed to store medications in accordance with professional standards for Resident #38. RN D left insulin on top of medication cart unattended in the hallway. -RN D failed to perform hand hygiene before or after the preparation of the glucometer, glucose check, preparation of the medication, and the administration of Insulin for Resident #57. -RN D failed to ensure surface of bedside table was clean to place glucometer on in Resident #57's room. -RN D failed to perform hand hygiene after Resident #57's glucose check and removed her gloves in the hallway at her medication cart. -RN D failed to knock or announce herself upon entering Resident #14's room or provide privacy before performing glucose check and the administration of an injectable medication. -RN D failed to perform hand hygiene or glove change before or after preparation of glucometer, glucose check, preparation of the medication, and the administration of Insulin for Resident #14.-RN D failed to perform hand hygiene or glove change in between treatments of Resident #14 and Resident #1. -RN D failed to knock or announce herself upon entering Resident #1's room or provide privacy before performing glucose check and the administration of an injectable medication. -RN D failed to perform hand hygiene or glove change before or after preparation of glucometer, glucose check, preparation of the medication, and the administration of Insulin for Resident #1. These failures could place residents at risk of feeling shame or embarrassment, lowered self-esteem, and a lack of a dignified existence. These failures could also place residents are risk for lack of drug efficacy, and adverse reactions, as well as exposing them to care that could lead to the spread of viral infections, secondary infections, communicable diseases. Findings Included:Resident #1Record review of Resident #1's clinical record revealed Resident #1 was a [AGE] year-old male, who was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus with diabetic neuropathy, unspecified (a condition where the body either doesn't make enough insulin or the body's cells don't respond properly to insulin, leading to elevated blood sugar levels (hyperglycemia).Record review of Resident #1's most recent MDS assessment, dated 10/03/2025, indicated Resident #1 had a BIMS of 06, which indicated severe cognitive impairment.Resident #4Record review of Resident #4's clinical record revealed Resident #4 was a [AGE] year-old female, who was admitted to the facility on [DATE] with diagnoses including epilepsy, unspecified, intractable, with status epilepticus (a severe, hard-to-treat epilepsy where seizures are prolonged or occur in clusters), type 2 diabetes mellitus without complications (a condition where the body either doesn't make enough insulin or the body's cells don't respond properly to insulin, leading to elevated blood sugar levels (hyperglycemia), functional quadriplegia (a state of complete inability to move all four limbs, not from a spinal cord injury, but from severe underlying frailty or disability), unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety (refers to a clinical presentation where cognitive decline (memory, thinking) occurs without the common neuropsychiatric symptoms like agitation, depression, hallucinations, or worry), other symptoms and (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents.Privacy and confidentiality. The resident has a right to persona privacy and confidentiality of his or her personal and medical records.a. Personal privacy includes accommodations, medical treatment, . Record review of policy titled, Provision of Quality Care, dated 09/01/2023, revealed the following: .Policy Explanation and Compliance Guidelines: 1. Each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being.4. Qualified persons will provide the care and treatment in accordance with professional standards of practice,5. To ensure persons are qualified, .oversight to ensure ongoing employee competency and education regarding areas of employee weaknesses.6. Policies and procedures will reflect current professional standards of practice. a. All employees are responsible for following established policies and procedures. Record review of policy titled, Training Requirements, dated 09/01/2023, revealed the following: Policy Explanation and Compliance Guidelines: .3. Competencies and skill sets for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers must be consistent with there expected roles. 4. All facility staff needs to be trained to be able to interact in a manner that enhances the resident's quality of life and quality of care and that they can demonstrate competency in the topic areas of the training program. 5. Training requirements should be met prior to staff and volunteers independently providing services to resident, annually, and as necessary based on the facility assessment. 6. Training content includes, at a minimum: .b. Resident rights and facility responsibilities for caring of resident. Record review of policy title, Medication Administration via Enteral Tube, dated 09/01/2023, revealed the following: .11. Procedure: .d. Provide privacy by pulling the privacy curtain or closing the door to a private room.g. Perform hand hygiene and apply gloves. h. enteral tube placement must be verified prior to administering any fluids or medication. Record review of policy titled, Medication Administration, dated 09/01/2023, revealed the following: . Policy Explanation and Compliance Guidelines: .4. Wash hands prior to administering medication per facility protocol and product.5. Knock or announce presence.7. Provide Privacy .19. Wash hands using facility protocol and product. Record review of policy title, Hand hygiene, dated 09/01/2023, revealed the following: Policy Explanation and Compliance Guidelines: 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table.Hand Hygiene Table: .Between resident contactsAfter handling contaminated objectsBefore performing invasive proceduresBefore applying and after removing personal protective equipment (PPE), including glovesBefore preparing or handling medications.Before performing resident care procedures.After handling items potentially contaminated with blood, body fluids, secretions, or excretions.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 6 of 15 (Resident #1, #4, #14, #27, #38, and Resident #57) Residents reviewed for infection control, in that:-RN D failed to perform hand hygiene or glove change before or after preparation of glucometer, glucose check, preparation of the medication, and the administration of Insulin for Resident #1.-RN D failed to perform hand hygiene before administering medication to Resident #4 via g-tube.-RN D failed to perform hand hygiene or glove change before or after preparation of glucometer, glucose check, preparation of the medication, and the administration of Insulin for Resident #14.-MA E failed to perform hand hygiene or don gloves to administer eye drop medication to Resident #27.-RN D failed to perform hand hygiene or glove change before or after preparation of glucometer, glucose check, preparation of the medication, and the administration of Insulin for Resident #38.-RN D failed to clean glucometer before or after glucose check for Resident #38.-RN D failed to ensure surface of bedside table was clean to place glucometer on in Resident #57's room.-RN D failed to perform hand hygiene or glove change in between treatments of Resident #14 and Resident #1These failures had the potential to affect residents in the facility by placing them at risk of contracting, spreading, and/or exposing them to bacterial or viral infections that could lead to the spread of communicable diseases.Findings Included:During an observation on 12/14/2025 at 7:07 PM RN D did not perform hand hygiene before the start of the medication administration via g-tube for Resident #4. During an observation on 12/14/2025 at 7:17 PM RN D did not perform hand hygiene before donning one glove. RN D stated that the gloves were too big, took off glove, and placed it (glove) back in the box with the other XL gloves. RN D did not clean glucometer machine before starting with the blood sugar check for Resident #38. RN D left Resident #38's room with same gloves that she performed glucose check with and started to prepare medication for Resident #38. No hand hygiene or glove change was performed. RN D then returned to Resident #38's room to administer insulin with the same gloves that she performed all previous tasks with. Once procedures were completed RN D removed gloves but did not perform hand hygiene. During an observation on 12/14/2025 at 7:23 PM RN D did not perform hand hygiene before the preparation of the glucometer, or the performance of the glucose check for Resident #57. RN D took glucometer, lancet, and alcohol wipe into the room and placed the equipment on Resident #57's bedside table, which was dirty from an unidentified spilled liquid. RN D then performed glucose check for Resident #57. RN D left Resident #57's room with no hand hygiene and removed her gloves in the hallway at her medication cart. No hand hygiene was performed before the preparation of Resident #57's insulin. RN D attempted to put gloves on and when the gloves that RN D pulled from the box would not go on her hands, RN D proceeded to wipe her hands on her scrubs and then place her hands in clean gloves. No hand hygiene was performed before or after the administration of the insulin to Resident #57. During an observation on 12/14/2025 at 7:32 PM RN D did not perform hand hygiene or glove changes before or after performing a glucose check, the preparation of Resident #14's insulin, or administration of Insulin to Resident #14. RN D did not remove gloves or perform hand hygiene and then proceeded to prepare the glucometer machine for Resident #1 with the same gloves that she just used for treatment of Resident #14. During an observation on 12/14/2025 at 7:42 PM RN D prepared glucometer, performed glucose check, and performed the administration of Resident #1's insulin with the same gloves that she used with Resident #14, and no hand hygiene or glove changes were performed. During an interview on 12/14/2025 at 7:48 PM RN D stated the negative outcome for not performing hand hygiene or glove changes could lead to infection control issues. During an observation on 12/14/2025 at 7:57 PM MA E performed medication administration of eye drops to Resident #27 and MA E did not perform hand hygiene or don gloves before administering eye drops to Resident #27. During an interview on (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/14/2025 at 7:59 PM MA E was asked why hand hygiene and gloves were not used when eye drops were administered to Resident #27. MA E stated, I don't know, you just make me nervous. MA E stated not performing hand hygiene or donning gloves could lead to increased risk for infection. During an interview on 12/16/2025 at 10:13 AM CN stated not performing hand hygiene or glove changes at the appropriate times could lead to infection for the residents. During an interview on 12/16/2025 at 1:35 PM I-DON stated by not performing hand hygiene it could lead to increased risk for infections. Record review of policy titled, Provision of Quality Care, dated 09/01/2023, revealed the following: .Policy Explanation and Compliance Guidelines: 1. Each resident will be provided care and services to attain or maintain his/her highest practicable physical, mental, and psychosocial well-being.4. Qualified persons will provide the care and treatment in accordance with professional standards of practice,5. To ensure persons are qualified, .oversight to ensure ongoing employee competency and education regarding areas of employee weaknesses.6. Policies and procedures will reflect current professional standards of practice. a. All employees are responsible for following established policies and procedures. Record review of policy title, Medication Administration via Enteral Tube, dated 09/01/2023, revealed the following: .g. Perform hand hygiene and apply gloves. Record review of policy titled, Medication Administration, dated 09/01/2023, revealed the following: . Policy Explanation and Compliance Guidelines: .4. Wash hands prior to administering medication per facility protocol and product.19. Wash hands using facility protocol and product. Record review of policy title, Hand hygiene, dated 09/01/2023, revealed the following: Policy Explanation and Compliance Guidelines: 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table.Hand Hygiene Table: .Between resident contactsAfter handling contaminated objectsBefore performing invasive proceduresBefore applying and after removing personal protective equipment (PPE), including glovesBefore preparing or handling medications.Before performing resident care procedures.After handling items potentially contaminated with blood, body fluids, secretions, or excretions		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents had the right to formulate an advance directive for 1 (Resident #1) of 15 residents reviewed for advance directives. The facility failed to ensure Resident #1's DNR was dated by the physician, thereby rendering it invalid. This failure could place residents at risk of not having their end-of-life wishes honored. Findings Included: Record review of Resident #1's admission record dated [DATE] revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, chronic kidney disease (longstanding disease of the kidneys leading to kidney failure), type 2 diabetes (insufficient production of insulin, causing high blood sugar), and heart failure (heart muscle fails to pump blood as it should). Resident #1's advance directive was listed as DNR. Record review of Resident #1's quarterly MDS completed on [DATE] revealed a BIMS score of 6 which indicated severely impaired cognition. Record review of Resident #1's care plan completed on [DATE] revealed the following: The resident's advance directives are: DNR . The resident's wishes will be honored throughout the review period. Honor the resident's wishes. Record review of Resident #1's OOH-DNR titled, Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Order Texas Department of State Health Services revealed Resident #1 and a notary signed the document on [DATE]. The physician signed the document, printed his name, and provided his license number but the line for the physician to date the document was blank. During an interview on [DATE] at 11:05 AM RN A stated everybody was responsible for ensuring residents' advance directives were honored. She stated that a DNR not dated by the physician was not valid. RN A stated an invalid DNR could result in a resident passing without no intervention or opportunity to survive. During an interview on [DATE] at 11:36 AM I-DON stated she and the nurses on the floor were responsible for ensuring a resident's advance directive was honored. She stated she did not know if a DNR undated by the physician was valid or not. I-DON stated an invalid DNR could result in the facility going against their (residents') wishes. During an interview on [DATE] at 11:53 AM CN stated a resident's advance directive started with the social worker and if the facility did not have a social worker, the responsibility to ensure a resident's advance directive was honored fell to the DON. He stated a DNR not dated by the physician was not valid. CN stated a possible negative outcome of a resident having an invalid DNR was, We could be letting someone pass when we should be doing a code on them. During an interview on [DATE] at 12:04 PM ADM stated facility staff were responsible as a team to ensure resident advance directives were honored. She stated during admission it was made clear to residents and their families that if they opted for a DNR it had to be signed by a doctor before it could go into effect. ADM stated a DNR not dated by the physician was not valid. She stated a possible negative outcome of an invalid DNR was that a resident could get CPR and not want it. Record review of facility policy titled Residents' Rights Regarding Treatment and Advance Directives and dated [DATE] revealed the following: .It is the policy of this facility to support and facilitate a resident's right to . formulate advance directives. Record review of a blank Out-of-Hospital Do-Not-Resuscitate (OOH-DNR) Texas Department of State Health Services Instructions for Issuing an OOH-DNR Order revealed the following: . The original or a copy of a fully and properly completed OOH-DNR Order or the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professionals.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs for 1 (Resident #7) of 5 residents reviewed for unnecessary drugs. The facility failed to ensure a gradual dose reduction of Resident #7's four psychotropic medications was attempted or contraindicated from May 2024 to December 2025. This failure could lead to residents being overmedicated. Findings Included: Record review of Resident #7's admission record dated 12/16/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), schizoaffective disorder bipolar type (mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder), anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life), major depressive disorder recurrent (a mental disorder characterized by persistent low mood, low self-esteem, and loss of interest or pleasure in normally enjoyable activities), and generalized anxiety disorder (inability to control constant worrying). Record review of Resident #7's quarterly MDS completed on 11/20/25 revealed a BIMS score of 5 which indicated severely impaired cognition. Section N - Medications revealed Resident #7 was coded for antipsychotic, antidepressant, and anti-anxiety medications. Question N0450A indicated Resident #7 had been receiving antipsychotic medications on a routine basis. Gradual dose reduction questions N0450B-N0450E were blank. Record review of Resident #7's care plan completed on 11/24/25 revealed she received antidepressant, anti-anxiety, and antipsychotic medications. One of the interventions listed was, Consult with pharmacy, MD to consider dosage reduction when clinically appropriate at least quarterly. Record review of Resident #7's physician's order summary report dated 12/16/25 revealed the following orders with corresponding start dates: 08/24/24 Abilify Oral Tablet 2 MG (Aripiprazole) Give 2 mg by mouth at bedtime for schizo-effective disorder related to SCHIZOAFFECTIVE DISORDER, BIPOLAR TYPE .05/27/23 busPIRone HCl Oral Tablet 7.5 MG (Buspirone HCl) Give 1 tablet by mouth at bedtime related to GENERALIZED ANXIETY DISORDER .08/23/24 Mirtazapine Oral Tablet 7.5 MG (Mirtazapine) Give 1 tablet by mouth at bedtime related to MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE .05/27/23 PARoxetine HCl Oral Tablet 40 MG (Paroxetine HCl) Give 1 tablet by mouth one time a day related to MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE .Record review of the facility's Drug Regimen Review book revealed no mention of gradual dose reductions for any of the medications listed for Resident #7. During an observation and interview on 12/14/25 at 12:19 PM Resident #7 was seated at a table in the dining room. She stated she had depression, but it was not bad. During an interview and record review on 12/16/25 at 03:58 PM CN provided documentation of gradual dose reduction recommendations on the four medications listed for Resident #7 from May of 2024. He stated but he had not found any others gradual dose reduction recommendations and did not know where else to look for more recent gradual dose reductions. During an interview on 12/16/25 at 04:08 PM RN A stated a resident could be negatively affected by not having a gradual dose reduction for psychotropic medications because the medication might become less effective against their symptoms, they could have withdrawal symptoms, or their symptoms might worsen. During an interview on 12/16/25 at 04:11 PM I-DON stated she was not sure how often a gradual dose reduction should be considered for psychotropic medications. She stated that was a good question for CN. I-DON stated a possible negative outcome for a resident not receiving a gradual dose reduction was if you can get them (residents) off of it (psychotropic medication), that is great. During an interview on 12/16/25 at 04:15 PM CN stated the facility was responsible for ensuring (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a gradual dose reduction was considered for every resident receiving psychotropic medications at least yearly. He stated a possible negative outcome of not addressing gradual dose reductions was, It could be that we are medicating a resident who doesn't need to be medicated. During an interview on 12/16/25 at 04:19 PM Pharm stated gradual dose reductions for psychotropic medications should be addressed at least quarterly. She stated in her personal opinion there was no negative outcome to a resident if that was not done because she believed psychotropic medications should very rarely be reduced in dose because it could result in unwanted withdraw symptoms and exacerbation of the original symptoms. Record review of facility policy titled Unnecessary Drugs and dated 11/2/2025 revealed the following: . It is the facility's policy that each resident's entire drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical and psychosocial well-being free from unnecessary drugs. The policy did not address gradual dose reduction for psychotropic medications.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to refer all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition to state designated authority for level II resident review upon a significant change in status assessment for 1 (Resident #6) of 15 residents reviewed for PASRR. The facility failed to refer Resident #6 to state designated authority for a PASRR Evaluation due to his diagnosis of PTSD. This failure could place residents at risk of not receiving necessary services or of being harmed by residents who have not been screened properly for placement in a nursing home setting. Findings Included: Record review of Resident #6's admission record dated 12/14/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified psychosis not due to a substance or know physiological condition (mental health disorder characterized by a loss of touch with reality where the exact cause cannot be identified), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life), and post-traumatic stress disorder chronic (mental health condition caused by a traumatic event that affects your ability to function normally). Record review of Resident #6's quarterly MDS completed on 11/05/25 revealed a BIMS score of 7 which indicated severely impaired cognition. Section I Active Diagnoses revealed Resident #6 was coded as having PTSD. Record review of Resident #6's care plan completed on 10/15/25 revealed he was care planned for experiencing excessive worry, nervousness or unease which may interfere with daily functioning and quality of life. Resident has history of trauma or post-traumatic stress disorder (PTSD), which may impact emotional well-being, daily functioning, and response to care. Resident has PTSD related to past traumatic experiences, evidenced by anxiety, hypervigilance, sleep disturbance, and verbalized intrusive memories. Record review of Resident #6's PASRR Level 1 Screening revealed it was completed by the MDS Coordinator of his previous facility on 08/20/25. Resident #6 was coded as having no mental illness. Record review of Resident #6's EHR under the miscellaneous tab revealed no other PASRRs. During an observation and attempted interview on 12/14/25 at 12:14 PM Resident #6 was seated at a table in the dining room. He did not have any food in front of him, and he was making chewing motions with his mouth. He did not respond to questions but did nod when asked if he was [name of Resident #6]. During an observation and interview on 12/15/25 at 11:52 AM Resident #6 was seated at a table in the dining room. He did not have any food on the table yet. He nodded when asked if staff were taking good of him and nodded again when asked if he was okay. When asked about triggers for his PTSD he looked into the middle distance and began to make chewing motions with his mouth. During an observation and interview on 12/15/25 at 03:59 PM Resident #6 was seated in his wheelchair in the common area. AD interpreted for the surveyor and asked him if he was willing to answer some questions. He looked past us into the middle distance and began making chewing motions with his mouth. AD stated, Oh wow! He is not going to talk. He usually talks a lot. I bet it is because he doesn't recognize you (surveyor). During an interview on 12/16/25 at 11:05 AM RN A stated she did not know what a PASRR was. During an interview on 12/16/25 at 11:36 AM I-DON stated she was unsure who was responsible for ensuring residents with a qualifying diagnosis were referred for a PASRR Evaluation. She stated, I usually just get them (the evaluations) sent to me. I-DON stated there was probably a negative outcome if a resident with a qualifying diagnosis was not referred for a PASRR evaluation, but she was unable to specify what the negative outcome might be. During an interview on 12/16/25 at 11:53 AM CN stated a resident who had a qualifying diagnosis and was not referred for a PASRR Evaluation would be in danger of not receiving necessary treatment. During an interview on 12/16/25 at 12:04 PM ADM stated she was responsible for ensuring (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents with qualifying diagnoses were referred for a PASRR Evaluation. She stated she was unaware Resident #6 had a diagnosis of PTSD. Record review of facility policy titled Resident Assessment - Coordination with PASARR Program and dated 11/2/2025 revealed the following: This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. 9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to perform a preadmission screening for individuals with a mental disorder and individuals with intellectual disability for 1 (Resident #29) of 15 residents reviewed for preadmission screening. The facility failed to perform a preadmission screening for Resident #29 prior to admission on [DATE]. This failure could place residents at risk of not receiving needed services. Findings Included: Record review of Resident #29's admission record dated 12/15/25 revealed an [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life), Parkinson's disease (chronic and progressive movement disorder that initially causes tremors in one hand and stiffness or slowing of movement), and psychotic disorder with hallucinations due to know physiological condition (mental health condition where the hallucinations are caused by a general medical disorder). Resident #29's admission record noted he arrived to the facility from his home. Record review of Resident #29's quarterly MDS completed 09/15/25 revealed a BIMS score of 3 which indicted severely impaired cognition. Section I - Active Diagnoses revealed he had diagnoses for anxiety disorder and psychotic disorder. Record review of Resident #29's care plan completed on 09/22/25 revealed he was care planned for using antipsychotic, antidepressant, and antianxiety medications. Record review of Resident #29's PASRR Level 1 Screening revealed it was completed on 03/08/25, four days after he was admitted to the facility. During an interview on 12/16/25 at 11:05 AM RN A stated she did not know what a PASRR was. During an interview on 12/16/25 at 11:36 AM I-DON stated she was unsure who was responsible for ensuring residents had a PASRR Level 1 Screening prior to admission. She stated, I usually just get them (PASRRs) sent to me. I-DON stated there was probably a negative outcome if a resident was admitted without a PASRR Level 1 Screening, but she was unable to specify what the negative outcome might be. During an interview on 12/16/25 at 11:53 AM CN stated MDS LVN was responsible for ensuring residents have a PASRR Level 1 Screening prior to admission. He stated if the resident was coming from the community and not from another facility or a hospital the facility would send a staff member to perform a PASRR Level 1 Screening prior to admission. He stated a resident who was admitted without a PASRR Level 1 Screening would be in danger of not receiving necessary treatment. During an interview on 12/16/25 at 12:04 PM ADM stated she was responsible for ensuring residents had a PASRR Level 1 Screening prior to admission. She stated if a resident was admitted without a PASRR Level 1 Screening it was against regulations and they might not get the right services. Record review of facility policy titled Resident Assessment - Coordination with PASARR Program and dated 11/2/2025 revealed the following: This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. a. PASARR Level I - initial pre-screening that is completed prior to admission .		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and time frames to meet residents' mental and psychosocial needs for 2 of 15 (Residents #6 and Resident #36) Residents reviewed for care plans.1. Resident #6 had a diagnosis of PTSD, and his care plan was not specific or person-centered regarding his history of trauma and his triggers.2. Resident #36 did not have TED hose care planned had an order for TED hose daily. There was no documentation in the care plan of measurable objectives, interventions, or timeframes for how staff would meet this need.These failures could affect all residents that reside in the facility by not having their needs met and putting them at risk of being inappropriately cared for and/or re-traumatized. Findings included:1. Record review of Resident #6's admission record dated 12/14/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified psychosis not due to a substance or know physiological condition (mental health disorder characterized by a loss of touch with reality where the exact cause cannot be identified), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life), and post-traumatic stress disorder chronic (mental health condition caused by a traumatic event that affects your ability to function normally).Record review of Resident #6's quarterly MDS completed on 11/05/25 revealed a BIMS score of 7 which indicated severely impaired cognition. Section I Active Diagnoses revealed Resident #6 was coded as having PTSD.Record review of Resident #6's care plan completed on 10/15/25 revealed he was care planned for experiencing excessive worry, nervousness or unease which may interfere with daily functioning and quality of life. Resident has history of trauma or post-traumatic stress disorder (PTSD), which may impact emotional well-being, daily functioning, and response to care. Resident has PTSD related to past traumatic experiences, evidenced by anxiety, hypervigilance, sleep disturbance, and verbalized intrusive memories. Interventions listed were initiated on 08/25/25 and included, but were not limited to, the following:Assess resident's trauma history and triggers (as they are willing to disclose), emotional responses, and coping strategiesDevelop an individualized care approach that avoids known triggers and incorporates resident-preferred coping mechanisms (e.g., calming music, quiet time, grounding techniques).Ensure all staff are educated on trauma-informed care principles and specific resident considerations to promote a safe, respectful care environment.Monitor for signs of re-traumatization (e.g., agitation, nightmares, avoidance behaviors) and report patterns to the interdisciplinary team for care plan adjustment.Assess resident for PTSD symptoms daily (anxiety, flashbacks, nightmares, triggers).Document resident's identified triggers and preferred calming strategies in care plan.During an observation and attempted interview on 12/14/25 at 12:14 PM Resident #6 was seated at a table in the dining room. He did not have any food in front of him, and he was making chewing motions with his mouth. He did not respond to questions but did nod when asked if he was [name of Resident #6].During an observation and interview on 12/15/25 at 11:52 AM Resident #6 was seated at a table in the dining room. He did not have any food on the table yet. He nodded when asked if staff were taking good of him and nodded again when asked if he was okay. When asked about triggers for his PTSD he looked into the middle distance and began to make chewing motions with his mouth.During an interview on 12/15/25 at 02:30 PM RN A stated she had worked for the facility for 3.5 months and had not received training on providing trauma-informed care for Resident #6 in regard to his PTSD diagnosis. She stated she did not know what any of Resident #6's triggers were.During an interview on 12/15/25 at 02:33 PM CNA I stated she had been working in the facility for a month and had not (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	received training on providing trauma-informed care for Resident #6 regarding his PTSD diagnosis. During an interview on 12/15/25 at 02:41 PM CNA G stated she had worked for the facility for 31 years and was trained all the time on how to care for Resident #6 in regard to his PTSD diagnosis. She could not provide details of the training except to mention that Resident #6 could get upset and/or angry easily. During an interview on 12/15/25 at 02:51 PM, the I-DON stated regarding Resident #6, We just monitor him, if he gets anxious, we remove him from the situation he is in. We let him decide and guide us on what we need to do. Sometimes he just needs quiet. She stated she had seen him be triggered by Westerns 9genre) on TV. She stated she did not know if it was the gunfire or what it was that triggered Resident #6. The I-DON stated once he was triggered, he might need to be put to bed for 15 or 20 minutes to calm him down. The I-DON stated Resident #6's voice would raise an [NAME] to two if he was triggered. She stated she did not know any details of Resident #6's trauma. During an observation and interview on 12/15/25 at 03:59 PM Resident #6 was seated in his wheelchair in the common area. AD interpreted for the surveyor and asked him if he was willing to answer some questions. He looked past us into the middle distance and began making chewing motions with his mouth. AD stated, Oh wow! He is not going to talk. He usually talks a lot. I bet it is because he doesn't recognize you (surveyor). During an interview on 12/16/25 at 11:29 AM CNA B stated she had not received training on providing trauma-informed care for Resident #6 in light of his PTSD diagnosis. She stated, I didn't know about that. I thought it (his behavior) was because he is always hurting. She stated she had noticed moving too quick triggered Resident #6. During an interview on 12/16/25 at 11:36 AM, the I-DON stated she had not received training on providing trauma-informed care for Resident #6 and she had not trained staff on providing trauma-informed care for him. She stated, We pretty much let him lead us which way he wants to go. During an interview on 12/16/25 at 11:41 AM, MA K stated she had not received training on providing trauma-informed care for Resident #6. She stated she did not know what any of Resident #6's triggers were. During an interview on 12/16/25 at 11:53 AM, CN stated it was the responsibility of the IDT to ensure a resident with a history of trauma received trauma-informed care. He stated he had not trained staff on providing trauma-informed care for Resident #6 because he was not aware Resident #6 had a diagnosis of PTSD. During an interview on 12/16/25 at 12:04 PM, the ADM, when asked if staff had been trained to provide trauma-informed care for Resident #6, stated, As far as I know we have trained them on his aggressive behaviors but I don't know about PTSD specifically because I was not even aware he has PTSD so I didn't check up on them (trainings). 2. Resident #36 Record review of an admission record dated 12/14/25 revealed Resident #36 was an 84-y o female admitted to the facility on [DATE] with diagnoses of heart failure, heart disease, muscle weakness, dementia and chronic kidney disease. Record review of a care plan dated 9/29/25 documents resident was sometimes incontinent, was at risk for fluid overload, and needed some assistance with ADLs. The Care Plan did not reflect any interventions, objectives or goals for TED hose. Record review of a quarterly MDS dated [DATE] documented a BIMS score of 14 out of 15 which indicates cognition was intact. Record review of Resident #36's physician's orders revealed an order for TED hose with a start day of 11/13/25. In an observation and interview on 12/14/25 at 3:30 pm, Resident #36 stated she had not had any TED hose on and revealed her legs. She stated she had not been aware she was supposed to wear TED hose. She stated she was not able to bend over to put the hose on. Resident #36 stated the aides would have to help her put the TED hose on. She stated if she had some TED hose she would wear them. In an observation and interview on 12/15/25 at 11:05 am, Resident #36 had been observed in her room with no TED hose on. Resident #36 stated she had no TED hose on. In an interview on 12/15/25 at 11:10 am, CNA B stated she had cared for Resident #36 for the past week and stated Resident #36 did everything for herself. When asked if Resident #36 had any orders for TED Hose, CNA B stated Resident #36 did not have any orders for TED hose. She stated she had never put TED hose on Resident #36. She stated she did not know what the care plan said and had not looked at it. In an interview on 12/16/25 at 11:05 am, RN A stated she thought the ADON, DON, and charge nurse (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were responsible for the care plans. She stated a whole team came up with the plan. She stated the care plan should be specific to each person because what worked for some might not work for others. In an interview on 12/16/25 at 11:36 AM the I-DON stated she had been responsible for care plans. She stated she had put them in the EHR and the MDS Coordinator reviewed them. When asked what the consequences of an inaccurate or not person-centered care plans would be she stated As you get to know them you can better get a feel for what they want or need. In an interview on 12/16/25 at 11:53 AM, the CN stated staff responsible for care plans were the interdisciplinary team. He stated that usually the MDS Coordinator would cover everything that came from the MDS. He stated acute care plans for nursing had been done by the ADON and DON, Activities, Dietary, and SW. He stated the consequences of having inaccurate or not person-centered care plans would depend on what had not been care planned. He stated for example, If it was an allergy, we might give them something they are allergic to. If PTSD had not been care planned, we may not be taking care of him as we should be. In an interview on 12/16/25 at 12:04 PM, the ADM stated care plans were in the computer and whoever was doing an admission had been responsible for the care plan. The ADM stated, The DON should check to make sure it was accurate. The care plan meetings were done by the MDS coordinator. The ADM stated the ADON had the task of contacting the families. The ADM stated the MDS coordinator had attended the care plan meetings by teams or phone. The ADM stated the consequences of inaccurate or not person-centered care plans would be residents not getting the care they need. Record Review of the facility policy dated 11/2/25, titled Comprehensive Care Plans revealed: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished are to maintain the residents' highest practicable physical, mental, and psychosocial well-being. 6. The comprehensive care plan will include measurable objectives and timeframes to meet the residents' needs as identified in the residents' comprehensive assessment. Record review of facility policy titled Trauma Informed Care and dated 11/2/2025 revealed the following: . It is the policy of this facility to provide care and services which in addition to meeting professional standards, are delivered using approaches which are culturally-competent, account for experiences and preference, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization. d. Collaboration - an emphasis on partnering between residents and/or his or her representative, an all staff and disciplines involved in the resident's care in developing the plan of care. The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals . to develop and implement individualized care plan interventions. The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will 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 and will be added to the resident's care plan . Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. These interventions will also recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery. In situations where a trauma survivor is reluctant to share their history, the facility will still try to identify triggers which may re-traumatize the resident and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents received treatment and care in accordance with professional standards of practice for 1 of 16 residents (Resident #36) reviewed for physician orders for treatments. A. The facility failed to follow physician's orders and apply TED hose as ordered for Resident # 36. (Thrombo-Embolitic Deterrent hose which are medical stockings designed to prevent blood clots to the legs). The failure could affect residents currently residing in the facility resulting in not receiving needed care to maintain optimum health and placing them at risk for injury and/or deterioration in their condition. Findings included: Record review of admission record dated 12/14/25 revealed Resident #36 was an 84-y o female admitted to the facility on [DATE] with diagnoses of heart failure, heart disease, muscle weakness, dementia and chronic kidney disease. Record review of Resident #36's care plan dated 9/29/25 documents resident is sometimes incontinent, was at risk for fluid overload, and needed some assistance with ADLs. Record review of Resident #36's Quarterly MDS dated [DATE] documented a BIMS score of 14 out of 15 which indicates cognition was intact. Record review of Resident #36's active physician's orders dated 12/15/25 revealed an order for TED hose to be used daily with an order start date of 11/13/25. In an observation and interview on 12/14/25 at 3:30 pm, Resident # 36 stated she had not had any TED hose on and revealed her legs. She stated she had not been aware she was supposed to wear TED hose. She stated she had not had any TED hose and stated she was not able to bend over to put the hose on. Resident #36 stated the aides would have to help her put the TED hose on. She stated if she had some TED hose she would wear them. In an observation and interview on 12/15/25 at 11:05 am, Resident #36 had been observed in her room with no TED hose on. Resident #36 stated she had no TED hose on. In an interview on 12/15/25 at 11:10 am, CNA B stated she had cared for Resident #36 for the past week and stated Resident #36 did everything for herself. When asked if Resident #36 had any orders for TED Hose, CNA B stated Resident #36 did not have any orders for TED hose. She stated she had never put the TED hose on Resident #36. She stated she did not know what the care plan said and had not looked at it. In an interview on 12/15/25 at 11:20 am Resident #36's family member stated she had taken Resident #36 to the cardiologist last month and the cardiologist wrote the order for the TED hose. She stated the cardiologist stated it would be good for Resident #36 to wear them. The family member stated she brought the order back and gave it to the facility staff in the front office. The family member stated she had made visits to the facility several times a week and she had not seen Resident #36 wearing any TED hose. The family member stated she cleaned and straightened Resident #36 drawers every week and she had not seen any TED hose in her drawer. In an interview and record review on 12/15/25 at 2:55 pm, the I-DON reviewed the TAR and stated the initials on the November and December TAR for Resident # 36 were hers. When asked if she had passed meds or done any ADL care for Resident # 36 in the past month, she stated she had not. When asked if she had been aware there was an order for Resident # 36 to wear TED hose daily, she stated she had not known of the order for TED hose. Review of the TAR with I-DON revealed the TED hose boxes had been checked as completed by her. I-DON replied, Oh shit. The I-DON then stated she must have clicked the wrong box by mistake. The I-DON stated Resident #36 did not have any TED hose in the facility. She stated the facility had to order the TED hose and the facility had not ordered the hose yet. The I-DON stated Resident #36 had edema all the time and she was encouraged to put her legs up in her recliner. The I-DON stated the nurse providing care was responsible for filling out the MAR and TAR. The I-DON stated she reviewed the TAR for the residents at the end of the day and had gone through the TAR and clicked the boxes to complete tasks as she went. She stated she had not let the agency staff document on the MAR or TAR. She stated the consequences for checking boxes on the TAR without providing service would be inaccurate records and poor care for the residents. In an interview on (continued on next page)		

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/15/25 at 3:00 pm RN A stated she had not done any med pass for Resident #36 and had not assisted her with any ADLs or dressing. She stated she had not been aware of Resident #36 having an order to wear TED hose. She stated she had not seen her wearing TED hose. She stated she did not know if she had any TED hose or not. When asked if she had completed the TAR documenting Resident #36 had worn TED hose, she stated she had just clicked the boxes. She stated with the agency staffing she had just clicked the boxes herself instead of relying on agency staff to do it. She stated the consequences for not following physician orders for this resident would be the resident being vulnerable to having deep vein thrombosis. She stated other consequences would be inaccurate records. In an interview on 12/16/25 at 11:00 am the CN stated the policy for the TAR would be the same as policies for the MAR. In an interview on 12/16/25 at 11:53 am the CN stated the nurse doing the treatment was responsible for checking the boxes on the TAR. He stated he had not been aware of the I-DON and the charge nurses checking boxes but not providing services. He stated it should have been done by the person providing service. He stated it was never correct to check the boxes without providing services. Record Review of the facility policy dated 11/2/25, titled Medication Administration revealed Medications are administered by licensed nurses or other staff . as ordered by the physician and in accordance with professional standards of practice. 17. Administer medication as ordered.20. Sign MAR after administered.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 1 (Resident #6) of 15 residents reviewed for trauma-informed care. The facility did not ensure Resident #6 had a trauma screening that identified possible triggers when Resident #6 had a history of trauma. This failure could put residents at an increased risk for severe psychological distress due to re-traumatization. Findings Included: Record review of Resident #6's admission record dated 12/14/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified psychosis not due to a substance or known physiological condition (mental health disorder characterized by a loss of touch with reality where the exact cause cannot be identified), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life), and post-traumatic stress disorder chronic (mental health condition caused by a traumatic event that affects your ability to function normally). Record review of Resident #6's quarterly MDS completed on 11/05/25 revealed a BIMS score of 7 which indicated severely impaired cognition. Section I Active Diagnoses revealed Resident #6 was coded as having PTSD. Record review of Resident #6's care plan completed on 10/15/25 revealed he was care planned for experiencing excessive worry, nervousness or unease which may interfere with daily functioning and quality of life. Resident has history of trauma or post-traumatic stress disorder (PTSD), which may impact emotional well-being, daily functioning, and response to care. Resident has PTSD related to past traumatic experiences, evidenced by anxiety, hypervigilance, sleep disturbance, and verbalized intrusive memories. Interventions listed were initiated on 08/25/25 and included, but were not limited to, the following: Assess resident's trauma history and triggers (as they are willing to disclose), emotional responses, and coping strategies. Develop an individualized care approach that avoids known triggers and incorporates resident-preferred coping mechanisms (e.g., calming music, quiet time, grounding techniques). Ensure all staff are educated on trauma-informed care principles and specific resident considerations to promote a safe, respectful care environment. Monitor for signs of re-traumatization (e.g., agitation, nightmares, avoidance behaviors) and report patterns to the interdisciplinary team for care plan adjustment. Assess resident for PTSD symptoms daily (anxiety, flashbacks, nightmares, triggers). Document resident's identified triggers and preferred calming strategies in care plan. Record review of Resident #6's EHR assessments tab revealed a Brief Trauma Questionnaire completed on 08/21/25 by the previous DON. Record review of Resident #6's Brief Trauma Questionnaire revealed it was completed on 08/21/25 by his resident representative and the following questions were answered yes for Resident #6: Event 1: Have you ever served in a war zone, or have you ever served in a noncombat job that exposed you to war-related casualties? If the event happened, did you think your life was in danger or you might be seriously injured? If the event happened, were you seriously injured? Event 4: Have you ever had a life-threatening illness such as cancer, heart attack, leukemia, AIDS, multiple sclerosis, etc? If the event happened did you think your life was in danger? Event 8: Have you ever been in any other situation in which you were seriously injured, or have you ever been in any other situation in which you feared you might be seriously injured or killed? If the event happened, were you seriously injured? Event 9: Has a close family member or friend died violently, for example, in a serious car crash, mugging, or attack? Event 10: Have you ever witnessed a situation in which someone was seriously injured or killed, or have you ever witnessed a situation in which you feared someone would be seriously injured or killed? Note: Do not answer yes for any event if you (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have already reported it in questions 1-9. The bottom of the Brief Trauma Questionnaire form had the following information: K1. Are any of the above answered - YES1. Yes K2. If the answer to any of the above is yes - insert the date and time for the IDT meeting regarding interventions and plan of care 09/10/2025 10:00 (AM) During an observation and attempted interview on 12/14/25 at 12:14 PM Resident #6 was seated at a table in the dining room. He did not have any food in front of him, and he was making chewing motions with his mouth. He did not respond to questions but did nod when asked if he was [name of Resident #6]. During an observation and interview on 12/15/25 at 11:52 AM Resident #6 was seated at a table in the dining room. He did not have any food on the table yet. He nodded when asked if staff were taking good of him and nodded again when asked if he was okay. When asked about triggers for his PTSD he looked into the middle distance and began to make chewing motions with his mouth. During an interview on 12/15/25 at 02:00 PM I-DON stated Resident #6 was his own emergency contact. When asked who the resident representative was who filled out his trauma screening, she stated it was probably her (I-DON). She stated, I don't speak Cuban. but we were translating back and forth. During an interview on 12/15/25 at 02:30 PM RN A stated she had worked for the facility for 3.5 months and had not received training on providing trauma-informed care for Resident #6 in regard to his PTSD diagnosis. She stated, I keep my eye on him and if he is crying, I get someone to interpret for me. I make sure he is comfortable. She stated that Resident #6 said his legs hurt when she asked him why he was crying. She stated she did not know what any of Resident #6's triggers were. During an interview on 12/15/25 at 02:33 PM CNA I stated she had been working in the facility for a month and had not received training on providing trauma-informed care for Resident #6 regarding his PTSD diagnosis. During an interview on 12/15/25 at 02:41 PM CNA G stated she had worked for the facility for 31 years and was trained all the time on how to care for Resident #6 in regard to his PTSD diagnosis. She could not provide details of the training except to mention that Resident #6 could get upset and/or angry easily. During an interview on 12/15/25 at 02:51 PM I-DON stated regarding Resident #6, We just monitor him, if he gets anxious, we remove him from the situation he is in. We let him decide and guide us on what we need to do. Sometimes he just needs quiet. She stated she had seen him be triggered by Westerns on TV. She stated she did not know if it was the gunfire or what it was that triggered Resident #6. I-DON stated once he was triggered, he might need to be put to bed for 15 or 20 minutes to calm him down. I-DON stated Resident #6's voice would raise an [NAME] to two if he was triggered. She stated she did not know any details of Resident #6's trauma. During an interview on 12/15/25 at 03:41 PM ADM stated she had no evidence of the IDT meeting mentioned on the bottom of Resident #6's Brief Trauma Questionnaire having taken place. During an observation and interview on 12/15/25 at 03:59 PM Resident #6 was seated in his wheelchair in the common area. AD interpreted for the surveyor and asked him if he was willing to answer some questions. He looked past us into the middle distance and began making chewing motions with his mouth. AD stated, Oh wow. He is not going to talk. He usually talks a lot. I bet it is because he doesn't recognize you (surveyor). During an interview on 12/16/25 at 11:02 AM CNA J stated she had received training on how to approach Resident #6 if he was cranky. She stated he has mood swings. CNA J stated, If you speak Spanish to him, he is a little better towards you. She stated speaking Spanish to Resident #6 helped calm him if he was upset. CNA J stated she did not know what any of Resident #6's triggers were. She stated, Sometime he will just start crying. Sometimes he says it is because he is hurting. CNA J stated a possible negative outcome of not having trauma-informed care was staff would not know how to take care of and approach Resident #6. During an interview on 12/16/25 at 11:05 AM RN A stated she did not know what any of Resident #6's triggers were. She stated, I think it just randomly happens. When he gets upset there is usually a reason for it like another resident is making him mad. I think that if you get too close to his personal space that causes him to trigger. She stated a possible negative outcome of not providing trauma-informed care for Resident #6 was, He might lash out. He seems like he is hyperaware of everything that is going on. He is always looking around. During an interview on 12/16/25 at 11:29 AM (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA B stated she had not received training on providing trauma-informed care for Resident #6 in light of his PTSD diagnosis. She stated, I didn't know about that. I thought it (his behavior) was because he is always hurting. She stated she had noticed moving too quick triggered Resident #6. During an interview on 12/16/25 at 11:36 AM I-DON stated she had not received training on providing trauma-informed care for Resident #6 and she had not trained staff on providing trauma-informed care for him. She stated, We pretty much let him lead us which way he wants to go. During an interview on 12/16/25 at 11:41 AM MA K stated she had not received training on providing trauma-informed care for Resident #6. She stated she did not know what any of Resident #6's triggers were. During an interview on 12/16/25 at 11:53 AM CN stated it was the responsibility of the IDT to ensure a resident with a history of trauma received trauma-informed care. He stated if a facility did not have a social worker (as was the case for this facility at the time of survey) the responsibility fell on I-DON and ADM. CN stated he had not trained staff on providing trauma-informed care for Resident #6. He stated he did not know what any of Resident #6's triggers were. CN stated, To be honest, I did not realize he had PTSD. He stated a resident with a history of trauma could be negatively affected if the facility did not provide trauma-informed care. CN stated, That that trigger them we may inadvertently do and not know. We could put him too close to another resident who yells a lot and that might trigger him. We have to look out for his triggers and try to protect him from those. During an interview on 12/16/25 at 12:04 PM ADM, when asked if staff had been trained to provide trauma-informed care for Resident #6, stated, As far as I know we have trained them on his aggressive behaviors but I don't know about PTSD specifically because I was not even aware he has PTSD so I didn't check up on them (trainings). She stated she did not know what any of Resident #6's triggers were. She stated a resident with a history of trauma could probably be negatively impacted if staff did not provide trauma-informed care. ADM stated, It might cause them to have even more trauma. Record review of facility policy titled Trauma Informed Care and dated 11/2/2025 revealed the following: . It is the policy of this facility to provide care and services which in addition to meeting professional standards, are delivered using approaches which are culturally-competent, account for experiences and preference, and address the needs of trauma survivors by minimizing triggers and/or re-traumatization. ?Trauma' results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental physical, social, emotional, or spiritual well-being. Common sources of trauma may include, but are not limited to: . f. War . i. Traumatic life events (death of a loved one, personal illness, etc.) ?Trauma-Informed Care' is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization. The facility will work to facilitate the principles of trauma informed care which include: a. Safety - Ensuring residents have a sense of emotional and physical safety. b. Trustworthiness and transparency - Efforts to establish a relationship based on trust, and clear and open communication between staff and the resident. c. Peer support and mutual self-help - If practicable, assist the resident in locating and arranging to attend support groups. d. Collaboration - an emphasis on partnering between residents and/or his or her representative, an all staff and disciplines involved in the resident's care in developing the plan of care. The facility will use a multi-pronged approach in identifying a resident's history of trauma, as well as his or her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event as well as screening and assessment tools . The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals . to develop and implement individualized care plan interventions. The facility will identify triggers which may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 and will be added to the resident's care plan. While most triggers are highly individualized, some common triggers may include, but are not limited to: a. Experiencing a lack of privacy or confinement in a crowded or small space. b. Exposure to loud noises, or bright/flashing lights. d. Sounds, smells, and physical touch. Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety. These interventions will also recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery. In situations where a trauma survivor is reluctant to share their history, the facility will still try to identify triggers which may re-traumatize the resident, and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 (Unidentified Resident) of 13 who was observed for medication administration. -MA C prepared medication for 3 separate unidentified residents and was carrying 3 medication cups around dining room administering medications. -Facility failed to ensure Resident #41's medication bubble pack for her Carbidopa-Levodopa 25mg-100mg's instructions for dosing matched Resident #41's current medication orders. These failures could place residents at risk for receiving medications that do not belong to them; which could result in adverse reactions to medication, deterioration in their health, exacerbation of their disease process, and/or hospitalization. Resident #41Record review of Resident #41's clinical record revealed Resident #41 was a [AGE] year-old female, who was admitted to the facility on [DATE] with diagnoses including parkinsonism, unspecified (a broad medical term for a group of neurological conditions causing similar movement problems, primarily bradykinesia (slowness of movement), muscle rigidity (stiffness), and tremor (shaking), along with balance issues).Record review of Resident #41's most recent MDS assessment, dated 10/03/2025, indicated Resident #41 had a BIMS of 15, indicated no cognitive impairment and a functionality of total dependency was required for toileting, shower/bathing, lower body dressing, personal hygiene, and putting on/taking off footwear. Partial/moderate assistance was required for upper body dressing, and supervision or touching assistance was required for oral hygiene and eating.Record review of Resident #41's physicians orders, dated 12/15/2025 revealed the following: Carbidopa-Levodopa Oral Tablet 25-100 MG(Carbidopa-Levodopa) Give 1 tablet by mouth threetimes a day related to PARKINSONISM,UNSPECIFIED (G20.C) give 12:00pm, 5:00pm, and 9:00pm daily Record review of Resident #41's medication administration record, dated 12/15/2025 revealed that Resident #41 was getting Carbidopa-Levodopa Oral Tablet 25-100 MG three times a day as ordered. During an observation on 12/14/2025 at 11:48 AM MA C carried 3 medication cups into the dining room. MA C walked over to unidentified Resident and gave one of the cups of medication to Unidentified Resident in the dining room. Unidentified resident consumed the medication that was in what appeared to be pudding in the medication cup. MA C left the dining room with the remaining 2 medication cups. During an interview on 12/14/2025 at 11:58 AM MA C was asked if there were medications in the medication cups and if they were for 3 different residents. MA C stated that they were. MA C was asked how she knew who the medications belonged to, and MA C stated that she had written the names of the residents on the medication cups. During an observation of medication pass on 12/14/2025 at 8:18 PM the bubble pack for Resident #41 revealed instructions Take one tablet by mouth four times daily Carbidopa-Levodopa Oral Tablet 25-100 MG During an interview on 12/14/2025 at 8:18 PM MA E was asked why there was a discrepancy between the bubble pack and the order on the MAR. MA E stated it (the bubble pack) had always been like that and that she (MA E) had let the supervisor know, but nothing was changed. MA E stated that the negative outcome for this discrepancy was that it could have a negative outcome for the resident. During an observation of medication pass on 12/15/2025 at 11:05 AM the bubble pack for Resident #41 revealed instructions Take one tablet by mouth four times daily Carbidopa-Levodopa Oral Tablet 25-100 MG During an interview on 12/15/2025 at 11:05 AM MA H stated that they (MA's) question the label all the time. MA H stated that this discrepancy was it could possibly be harmful to the resident. During an interview on 12/15/2025 at 2:17 PM I-DON stated not locking up medications could lead to another resident taking medications that do not belong to them. I-DON stated that it was her (I-DON) and the charge nurses' responsibility to ensure that orders are updated in the system when a new/change in order is received. I-DON stated she was unaware that medication packets and MARS were not matching. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I-DON was asked what a negative outcome was for the instructions on the medications and orders for medication not matching, I-DON stated, I just never thought about it. During an interview on 12/16/2025 at 10:03 AM I-DON stated it is not standard practice to pre-prep medications before medication that is due. I-DON stated preparing medications and then carrying more than one resident medication at a time could lead to the wrong resident getting the wrong medication. During an interview on 12/16/2025 at 10:13 AM CN stated preparing multiple residents' medications and then distributing them all at the same time, could lead to the wrong medication being given to the wrong resident. CN stated that it was the nurse that takes the new/changed orders responsibility to place it (new/changed orders) into the MAR. CN stated it is the responsibility of the nurse who took the order to go into the medication cart and place a change of order sticker on the bubble pack for the medication. CN stated that a negative outcome for not following the correct order and following a bubble pack that had not been updated or had the sticker to indicate a change of order, was the resident could get the wrong dosage of medication. During an interview on 12/16/2025 at 2:51 PM MA C stated that she had prepared and dispensed medications as was observed on 12/14/2025 in the past. MA C stated preparing and administering medications for more than 1 resident at a time, could lead to the wrong medication being given to the wrong resident. Record review of facility provided policy titled, Medication Administration, dated 09/01/2023, revealed the following: .Policy Explanation and Compliance Guidelines: .10. Ensure that the six rights of medication administration are followed:a. Right residentb. Right drugc. Right dosaged. Right routee. Right timef. Right documentation11. Review MAR to identify medication to be administered.12. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time.		

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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, in accordance with State and Federal laws, to store all drugs and biologicals in locked compartments and labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions for 2 (Resident #38 and Resident #41) of 15 residents, 1 (treatment cart) of 1 treatment cart reviewed for medication storage. -RN D failed to place Resident #38's Insulin back into treatment cart before going into Resident #38's room to perform a glucose test. This failure could place residents at risk of taking medications that do not belong to them or receiving the wrong dosage of medication, which could lead to adverse reactions, increased exacerbation of disease processes, and hospitalization. Findings Included: Resident #38 Record review of Resident #38's clinical record revealed Resident #38 was a [AGE] year-old female, who was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus with diabetic neuropathy, unspecified (a condition where the body either doesn't make enough insulin or the body's cells don't respond properly to insulin, leading to elevated blood sugar levels (hyperglycemia). Record review of Resident #38's most recent MDS assessment, dated 12/02/2025, indicated Resident #38 had a BIMS of 12, indicated moderate cognitive impairment and a functionality of maximal assistance being required for toileting, shower/bathing, lower body dressing, and putting on/taking off footwear. Supervision or touching assistance was required for oral hygiene, upper body dressing, and personal hygiene, and setup or clean-up assistance with eating. During an observation on 12/14/2025 at 7:17 PM RN D removed Insulin pen for Resident #38 from treatment cart and placed it on the top of the cart and left the medication unattended to go into Resident #38's room to perform her glucose check. During an interview on 12/14/2025 at 7:48 PM RN D stated a negative outcome for medication not being placed back in the medication/treatment cart was I guess someone could take it. During an interview on 12/15/2025 at 2:17 PM I-DON stated not locking up medications could lead to another resident taking medications that do not belong to them. I-DON stated that it was her (I-DON) and the charge nurses' responsibility to ensure that orders are updated in the system when a new/change in order is received. I-DON stated she was unaware that medication packets and MARS were not matching. I-DON was asked what a negative outcome was for the instructions on the medications and orders for medication not matching, I-DON stated, I just never thought about it. During an interview on 12/16/2025 at 10:13 AM CN stated that a negative outcome for not locking up medications was that residents could get a hold of a medication that was not theirs. CN stated that it was the nurse that takes the new/changed orders responsibility to place it (new/changed orders) into the MAR. CN stated it is the responsibility of the nurse who took the order to go into the medication cart and place a change of order sticker on the bubble pack for the medication. CN stated that a negative outcome for not following the correct order and following a bubble pack that had not been updated or had the sticker to indicate a change of order, was the resident could get the wrong dosage of medication. Record review of facility provided policy titled, Medication Administration, dated 09/01/2023, revealed the following: .Policy Explanation and Compliance Guidelines: .10. Ensure that the six rights of medication administration are followed: a. Right resident b. Right drug c. Right dosaged. Right routee. Right timef. Right documentation11. Review MAR to identify medication to be administered. 12. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to prepare food by methods that conserve nutritive value, flavor, and appearance for 3 (pureed bread, pureed vegetables, and pureed meat) of 5 pureed food items reviewed for meal service. A. The dietary staff did not follow recipes for preparing the pureed bread for the lunch meal on 12/14/25 and 12/15/25 which altered the flavor of the bread. B. Foods from the test tray were not prepared by methods that conserve flavor. These failures could place any resident who consumes food prepared and served by dietary services at risk for dissatisfaction with the food and possible resulting nutrition deficit. Findings Included: In an observation and interview on 12/14/25 at 10:20 am, [NAME] H stated she had already pureed the foods for lunch and pointed to the steam table. She stated she had pureed the foods at 10:00 am and had used leftover sweet potatoes from the day before in the bread. She stated she always used leftover foods to puree bread. She stated she regularly used leftover cake, fruit and sweet potatoes to puree bread. She stated there were 4 residents with pureed diets. In an observation and interview on 12/14/25 at 1:00 pm, test trays were sampled. The pureed test tray consisted of pureed beef roast, mashed potatoes, mixed vegetables, a dinner roll and pineapple cake. The pureed bread was thick in texture extremely sweet and did not taste like bread. The bread tasted like sweet potatoes. The beef roast was very bland and needed salt. The pureed vegetables were unidentifiable and tasted sweet. [NAME] H stated she pureed the bread with sweet potatoes as she thought the residents would eat it better. In an observation and interview on 12/15/25 at 10:30 am [NAME] H stated she had already pureed the bread with baked apples. [NAME] H stated the baked apples were being used for the noon dessert today. This writer tasted the pureed bread. The bread was thick in consistency like glue and stuck to the mouth and the spoon. The bread tasted like apple pie. [NAME] H tasted the bread and stated the bread tasted good like apple pie. In an interview on 12/15/25 at 2:46 pm, the RD stated foods should not be prepared with leftover foods like sweet potatoes or fruit and bread should have been pureed with a liquid like milk. She stated she was not aware the staff had done that. She stated all staff should be following the preprinted recipes for purees. She stated you should not put anything in a puree that was not listed as an approved liquid because it would change the texture and someone could be allergic to a food. She further stated the food would not taste right. She stated she had been in the facility at least monthly and had trained the kitchen staff in their kitchen duties. She stated having foods pureed with other foods like sweet potatoes could compromise foods in palatability, consistency and nutritive value. During an interview on 12/16/25 at 3:00 pm, the DM stated the RD had spoken to her about pureeing foods with sweet potatoes and apples. She stated the RD told her not to do that anymore. The DM stated she had no recipes for pureed bread and no policies for pureed foods. She stated the cooks use the handout titled Pureed Food Guidelines to prepare purees. The DM said milk was the normal liquid added to pureed bread. The DM stated many breads did not normally puree very well with milk. She said she found the residents on pureed diets had eaten better if the foods were sweet. The DM stated she trained the kitchen staff, and she had been trained by the dietician in meal preparation and following recipes. Record Review of the undated handout titled Pureed Foods Guidelines revealed: Add appropriate liquid (ex: broth, milk) if needed, to assist with pureeing. Pureed food should not be sticky. Pureed food should fall off the spoon in a single spoonful when tilted and continue to hold shape on a plate. Examples of liquids to use for bread- milk		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 the professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. 1. The facility failed to ensure walk in cooler items were properly stored, labeled, and dated. 2. The facility failed to ensure proper hot holding procedures were practiced. These failures could place residents who ate food served by the kitchen at risk of food-borne illness. Findings Included: Observation of the walk-in cooler on 12/14/25 at 10:17 am revealed 2 trays of cake pops on the top shelf of the cooler rack. One of the 2 trays was sitting directly under a pipe with a frozen water icicle hanging from the pipe. Both trays of cake pops had not been covered, labeled or dated. In an observation and interview on 12/4/25 at 10:20 am, [NAME] H stated she had already pureed the foods for lunch and pointed to the steam table. She stated she had pureed the foods at 10:00 am and had put the foods on the steam table then. She stated there were 4 residents with pureed diets. She stated the lunch service would start at 12 PM and room trays were plated first. She stated plating food for the dining room would start after room trays were plated. She stated the residents with pureed diets were served at the end of the meal service and they ate in the dining room. An observation of the foods on the steam table revealed all pureed foods were on the steam table. In an observation on 12/14/25 at 11:00 am the pureed foods were seen on the steam table. [NAME] H stated food service would start at 12: 00 pm. In an observation on 12/14/25 at 12:00 pm the pureed food items were on the steam table and had not been served. In an observation on 12/14/25 at 12:30 pm the pureed foods were on the steam table and had not been served yet. In an observation on 12/14/25 at 12:40 pm the pureed meals were served at the end of the service. In an observation on 12/14/25 at 3:33 pm, 2 trays of cake pops on the top shelf inside the cooler. One of the 2 trays of cake pops had been sitting directly under a pipe with a frozen water icicle hanging from the pipe. The 2 trays of cake pops had not been covered, labeled or dated. In an interview on 12/15/25 at 2:46 pm, the RD stated foods should not be prepared and put on the serving line until it was time to serve foods. She stated she was not aware the staff had placed pureed food on the steam table hours before meal service. She stated all staff should be covering, labeling and dating all foods. She stated she had been in the facility at least monthly and had trained the kitchen staff in their kitchen duties. She stated having food on the serving line for so long could compromise foods in palatability, consistency and nutritive value. She stated issues in the kitchen could cause food borne illness. In an interview on 12/16/25 at 3:00 pm, the DM stated the RD had told her not to put the foods on the serving line so early. She stated the foods are not usually put on the serving line that early. She stated the cake pops should have been covered, labeled and dated. She stated she had thrown out the cake pops. She stated the consequences of not covering labeling and dating the cake pops would be cross contamination for the residents. She stated she expected all staff to label and date all food items when used and stored. She stated if foods were not properly wrapped up or labeled and dated this could cause food contamination and sickness to residents. The DM stated she trained the kitchen staff, and she had been trained by the dietician in labeling and dating as well as meal service. Record Review of the facility policy and procedure, dated 12/1/11, titled Food Holding and Service documented: 3. Food is placed on steam table no more than 30 minutes prior to meal service Record Review of the facility policy and procedure, dated 12/1/11, titled Food Storage documented: Food is stored and protected from overhead pipes and other contamination. All refrigerated foods are dated, labeled and tightly sealed, including leftovers, using clean covered containers that are approved for food. Record Review of the 2012 facility policy and procedure, titled Post Production Checklist documented Food placed on steam table no sooner than 30 minutes prior to service.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to, in accordance with professional standards and practices, maintain medical records on each resident that are accurately documented for 3 (Resident #6, Resident #36, and Resident #41) of 15 residents reviewed for accuracy of medical records.1. The facility failed to ensure Resident #6's EHR did not contain NP progress notes for a female resident with his same last name.2. The facility failed to ensure the nurse checking boxes in Resident #36's TAR was providing the treatment being checked off.3. Facility failed to ensure Resident #41's medication bubble pack for her Carbidopa-Levodopa 25mg-100mg's instructions for dosing matched Resident #41's current medication orders. These failures could place residents at risk of not receiving necessary and accurate care/treatment due to inaccurate medical records. Findings Included:1. Record review of Resident #6's admission record dated 12/14/25 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified psychosis not due to a substance or known physiological condition (mental health disorder characterized by a loss of touch with reality where the exact cause cannot be identified), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a group of mental health conditions characterized by excessive and persistent worry, fear, and nervousness that can significantly interfere with daily life), and post-traumatic stress disorder chronic (mental health condition caused by a traumatic event that affects your ability to function normally). Record review of Resident #6's quarterly MDS completed on 11/05/25 revealed a BIMS score of 7 which indicated severely impaired cognition. Record review of Resident #6's care plan revealed it was completed on 10/15/25. Record review of Resident #6's NP progress notes in the miscellaneous tab of his EHR revealed a progress note dated 01/24/25 for a female resident with the same last name as Resident #6. During an interview on 12/16/25 at 11:05 AM RN A stated if a resident's medical record was not accurate, We might miss something that is potentially going wrong with them, for instance, if they get a new diagnosis. During an interview on 12/16/25 at 11:36 AM I-DON stated Resident #6's EHR should not contain any other resident's progress notes. She stated inaccurate medical records could negatively impact a resident's care. During an interview on 12/16/25 at 11:53 AM CN stated a possible negative outcome to residents of inaccurate medical records was, We could be treating the resident wrong if the records are inaccurate. Not treating them for what they really need to be treated for. During an interview on 12/16/25 at 12:04 PM ADM stated resident records needed to be accurate for the residents to receive accurate care.2. Record review of Resident #36's admission record dated 12/14/25 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, chronic systolic heart failure (a lifelong condition that affects the left ventricle. It occurs when the heart muscle is weak and the ventricle can't contract normally. Symptoms include shortness of breath, fatigue, leg swelling, and increased risk of arrhythmias and organ failure), diastolic heart failure (a condition in which the heart can no longer pump enough blood to the rest of the body), and chronic kidney disease (condition characterized by gradual loss of kidney function over time). Record review of Resident #36's care plan completed 09/29/25 revealed she was at risk for fluid overload and needed some assistance with ADLs. The care plan did not mention TED hose. Record review of Resident #36's quarterly MDS with ARD of 10/24/25 revealed a BIMS score of 14 which indicated intact cognition. Record review of Resident #36's physician's orders dated 12/15/25 revealed the following order with corresponding start date: 11/13/25 [NAME] Hose for compression, elevate legs for edema (swelling). one time a day Use ted hose daily. During an observation and interview on 12/14/25 at 3:30 PM Resident #36 stated she did not have any TED hose on and revealed her legs. She stated she had not been aware she was supposed to wear TED hose. She stated she did not have any TED hose and stated she was not able (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2025
NAME OF PROVIDER OR SUPPLIER Farwell Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 305 Fifth St 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.			
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to bend over to put the hose on. Resident #36 stated the aides would have to help her put the TED hose on. She stated if she had some TED hose she would wear them. During an observation and interview on 12/15/25 at 11:05 AM Resident #36 was observed in her room with no TED hose on. Resident #36 stated she had no TED hose on. During an interview on 12/15/25 at 11:10 AM CNA B stated she had cared for Resident #36 for the past week and stated Resident #36 did everything for herself. When asked if Resident #36 had any orders for TED Hose, CNA B stated Resident #36 did not have any orders for TED Hose. When asked if she was aware of an order for TED hose for Resident #36, she said she had not been aware of the order. She stated she had never put the TED hose on Resident #36. She stated she did not know what the care plan said and had not looked at it. During an interview on 12/15/25 at 11:20 AM Resident #36's family member stated she had taken Resident #36 to the cardiologist last month and the cardiologist wrote the order for the TED hose. She stated the Cardiologist stated it would be good for Resident #36 to wear. The family member stated she brought the order back and gave it to the facility staff in the front office. The family member stated she had made visits to the facility several times a week and she had not seen Resident #36 wearing any TED hose. The family member stated she cleaned and straightened Resident #36 drawers every week and she had not seen any TED hose in her drawer. During an interview and record review on 12/15/25 at 2:55 PM I-DON reviewed the TAR and stated the initials on the November and December TAR for Resident #36 were hers. When asked if she had passed meds or done any ADL care for Resident #36 in the past month, she stated she had not. When asked if she had been aware there was an order for Resident #36 to wear TED hose daily, she stated she had not known of the order for TED hose. Review of the TAR with I-DON revealed the TED hose boxes had been checked as completed by her. I-DON stated, Oh shit. I-DON then stated she must have clicked the wrong box by mistake. I-DON stated Resident #36 did not have any TED hose in the facility. She stated the facility had to order the TED hose and the facility had not ordered the hose yet. I-DON stated Resident #36 had edema all the time and she was encouraged to put her legs up in her recliner. I-DON stated the nurse providing care was responsible for filling out the MAR and TAR. I-DON stated she reviewed the TAR for the residents at the end of the day and had gone through the TAR and clicked the boxes to complete tasks as she went. She stated she had not let the agency staff document on the MAR or TAR. She stated the consequences for checking boxes on the TAR without providing the service would be inaccurate records and poor care for the residents. During an interview on 12/15/25 at 03:00 PM RN A stated she had not done any med pass for Resident # 36 and had not assisted her with any ADLs or dressing. She stated she had not been aware of Resident # 36 having an order to wear TED hose. She stated she had not seen her wearing TED hose. She stated she did not know if she had any TED hose or not. When asked if she had completed the TAR documenting Resident #36 had worn TED hose, she stated she had just clicked the boxes. She stated with the agency staffing she had just clicked the boxes herself instead of relying on agency staff to do it. She stated the consequences for not following physician orders for this resident would be the resident being vulnerable to having deep vein thrombosis. She stated other consequences would be inaccurate records. During an interview on 12/16/25 at 11:00 AM the CN stated the policy for the TAR would be the same as policies for the MAR. During an interview on 12/16/25 at 11:36 AM I-DON stated the nurse providing the care was the one who should check the box for the care on the TAR in the resident's EHR. She stated a possible negative outcome of her and the charge nurse checking the box for Resident #36's TED hose, but not applying the TED hose was Resident #36 might not get treatment. During an interview on 12/16/25 at 11:53 AM CN stated the nurse providing the care or treatment was the one who should be checking the box for that care or treatment on the TAR in the resident's EHR. He stated he was not aware the I-DON and charge nurse were checking boxes for Resident #36's TED hose on the TAR in the EHR but not applying the TED hose. He stated a possible negative outcome to residents of this practice was, They (nurses) could not really be doing the treatment they should be doing. During an interview on 12/16/25 at 12:04 PM ADM stated the nurse providing the care or treatment was the one who should (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be checking the box for that care or treatment on the TAR in the resident's EHR. She stated she was not aware the I-DON and charge nurse were checking boxes on the TAR in the EHR for Resident #36's TED hose but not applying the TED hose. She stated a possible negative outcome for residents of that practice was, They (residents) might not be getting the treatment at all.3. Record review of Resident #41's admission record dated 12/15/25 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Parkinsonism (conditions that affect the ability to move and live independently).Record review of Resident #41's admission MDS completed 10/03/25 revealed a BIMS of 15 which indicated intact cognition.Record review of Resident #41's care plan completed 10/15/25 revealed the following: Resident has Parkinson's [sic] disease, resulting in tremors (rhythmic movement of a body part that is out of your control), muscle rigidity (increased resistance to passive movement), bradykinesia (slow movement), and postural instability (inability to maintain equilibrium), placing them at risk for falls, aspiration (something other than air enters the airways), decreased mobility, medication side effects, and impaired ability to perform ADLs. Resident will maintain safe mobility and nutritional intake, demonstrate adherence to medication regimen, and remain free from falls or aspiration during the next 30 days. Administer Parkinson's [sic] medications on a strict schedule to optimize mobility and reduce symptoms fluctuations.Record review of Resident #41's physicians orders, dated 12/15/2025 revealed the following: Carbidopa-Levodopa Oral Tablet 25-100 MG (Carbidopa-Levodopa) Give 1 tablet by mouth three times a day related to PARKINSONISM, UNSPECIFIED (G20.C) give 12, 17, and 2100 dailyRecord review of Resident #41's medication administration record, dated 12/15/2025 revealed that Resident #41 was getting Carbidopa-Levodopa Oral Tablet 25-100 MG three times a day as ordered.During an observation on 12/14/2025 at 8:18 PM the bubble pack for Resident #41 revealed instructions Take one tablet by mouth four times daily Carbidopa-Levodopa Oral Tablet 25-100 MGDuring an interview on 12/14/2025 at 8:18 PM MA E was asked why there was a discrepancy between the bubble pack and the order on the MAR. MA E stated it (the bubble pack) had always been like that and that she (MA E) had let the supervisor know, but nothing was changed. MA E stated that the negative outcome for this discrepancy was that it could have a negative outcome for the resident.During an observation on 12/15/2025 at 11:05 AM the bubble pack for Resident #41 revealed instructions Take one tablet by mouth four times daily Carbidopa-Levodopa Oral Tablet 25-100 MGDuring an interview on 12/15/2025 at 11:05 AM MA H stated that they (MA's) question the label all the time. MA H stated that a negative outcome for this discrepancy was it could possibly be harmful to the resident.During an interview on 12/15/2025 at 2:17 PM I-DON stated it was her (I-DON) and the charge nurses' responsibility to ensure that orders are updated in the system when a new/change in order is received. I-DON stated she was unaware that medication packets and MARS were not matching. When asked what a negative outcome was for the instructions on the medications and orders for medication not matching, she stated, I just never thought about it.During an interview on 12/16/2025 at 10:13 AM CN stated that it was the responsibility of the nurse who took the new/changed orders to put said orders into the MAR. He stated it was the responsibility of the nurse who took the order to go into the medication cart and place a change of order sticker on the bubble pack for the medication. CN stated that a negative outcome for bubble pack that had not been updated was, the resident could get the wrong dosage of medication.During an interview on 12/16/25 at 11:02 AM CNA J stated a resident could be negatively impacted if their medical records were inaccurate because, We (staff) might not know what we need to know, like what they (residents) like and don't like.During an interview on 12/16/25 at 11:05 AM RN A stated she had been notified by MAs that some medications cards had instructions/signatures that did not match the physician's order. She stated residents could get the wrong dosage of their medication if MAs were not paying attention.During an interview on 12/16/25 at 11:36 AM I-DON stated she had noticed some medication cards with instructions that did not match physician orders. She stated when staff called her attention to that she placed a sticker over the instructions on the medication card that said, Refer to Orders and called the pharmacy for a correction. I-DON stated a (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	possible negative outcome of medication cards with inaccurate instructions was that the resident could be over or under medicated. During an interview on 12/16/25 at 11:41 AM MA K, when asked if she had noticed any instructions/signatures on medication cards not matching physician's orders, stated, We catch that a lot. She stated in that situation she followed the MAR and the physician's order, not the medication card. During an interview on 12/16/25 at 11:53 AM CN stated a resident could be negatively impacted by medication card instructions not matching physician's orders. He stated, We do have one example where originally it (administration of the medication) was 4 times a day and they (physician) changed the order, so [the resident] could get more (of the medication) than ordered. During an interview on 12/16/25 at 12:04 PM ADM stated she had no knowledge of medication card instructions not matching physician's orders. She stated a possible negative outcome to residents was, The wrong schedule or wrong dosage could be followed. Record Review of facility policy titled Medication Administration and dated 11/2/25 revealed the following: Medications are administered by licensed nurses or other staff . as ordered by the physician and in accordance with professional standards of practice. 10. Ensure that the six rights of medication administration are followed: a. Right resident b. Right drug c. Right dosage d. Right route e. Right time f. Right documentation 11. Review MAR to identify medication to be administered. 12. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, for, dose, route, and time. 17. Administer medication as ordered. 20. Sign MAR after administered. Record review of facility policy titled Documentation in Medical Record and dated 11/2/2025 revealed the following: . Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. Principles of documentation include, but are not limited to: a. Documentation shall be factual, objective, and resident centered. i. False information shall not be documented. ii. Record descriptive and objective information based on first-hand knowledge of the assessment, observation, or service provided. b. Documentation shall be accurate .		