STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675134	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whispering Oaks Rehab & Nursing	105 Hospital Dr Cuero, TX 77954

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 - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure residents have a right to personal privacy for 1 of 6 resident (Residents #21) reviewed for privacy, in that: LVN B left her computer screen open showing Resident #'21's protected information while administering medications. This deficient practice could place residents at-risk of loss of dignity due to lack of privacy.The findings included:Record review of Resident #21's face sheet, dated 07/21/2025, revealed an admission date of 10/03/2019 and, a readmission date of 02/08/2022, with diagnoses which included: Hyperlipidemia (Elevated level of any or all lipids(fat) in the blood), Dementia (decline in cognitive abilities), Peripheral vascular disease (progressive disorder that affects blood flow to the limbs and other body parts), Osteoporosis (causes bones to become weak and brittle) and, Anxiety (A group of mental illnesses that cause constant fear and worry).Record review of Resident #21's Quarterly MDS assessment, dated 06/28/2025, revealed the resident had no BIMS score, had memory problem and was severely cognitively impaired. Resident #21 required total assistance with his ADLs. Observation on 07/17/2025 at 8:43 a.m., revealed while administering medications for Resident #21, LVN B left the screen of her tablet open which reflected the electronic medical record. The tablet reflected the medication administration record with the name of Resident #21. The tablet was on the medication cart, which was in the hall in view of residents and other staff members. During an interview with LVN B, on 07/17/2025 at 8:45 a.m., LVN B confirmed the screen was left open to be seen by other staff and residents and she should have locked it to hide the information. She confirmed receiving training for resident rights within the year. During an interview with the DON on 07/17/2024 at 3:48 p.m., the DON confirmed the medication administration record was protected information and the nurse should have locked her tablet to hide the information from other staff and residents. She confirmed the staff was receiving resident rights training at least annually and the training was provided by her or the ADON. Review of facility's policy, titled Maintenance of Electronic Clinical Records, dated 01/04/2022, revealed HIPPA standards should be used when sharing confidential medical information about residents with employees or other providers from the clinical record. The facility should not release resident-identifiable medical information to the public.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible for 1 of 6 resident (Resident #4) reviewed for incontinent care, in that: While providing incontinent care for Resident #4, CNA C used a back to front motion to clean Resident #4's buttocks. This deficient practice could place residents at-risk for infection and skin break down due to improper care practices. The findings were: Record review of Resident #4's face sheet, dated 07/17/2025, revealed an admission date of 04/20/2017, and, a readmission date of 01/03/2024, with diagnoses which included: History of traumatic brain injury (Brain injury caused by an outside force), Dysphagia (Difficulty swallowing), Hypertension (High blood pressure), Congenital hydrocephalus (condition in which too much fluid builds up in the brain). Record review of Resident #4's Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 09 indicating moderate cognitive impairment. Resident #4 required limited to extensive assistance and was frequently incontinent of bowel and bladder.Review of Resident #4's care plan, dated 12/26/2024, revealed a problem of Incontinence: [.] is frequently incontinent of bowel/bladder related to Confusion, poorcontrol. and an intervention of INCONTINENT: Check frequently for wetness and soiling and change as needed.Observation on 07/17/2025 at 11:40 a.m. revealed while providing incontinent care for Resident #4, CNA c wiped Resident #4's buttocks in a back to front motion. During an interview on 07/17/2025 at 11:48 a.m. with CNA C, she confirmed she had wiped Resident #4's buttocks in a back to front motion. She said she thought she was using the correct technique. She confirmed receiving training on incontinent care from the facility. During an interview with the DON on 07/17/2025 at 3:48 p.m., she confirmed the correct motion to clean the residents during perineal care was front to back to prevent fecal matter from contacting the urethra and possibly cause an infection. The DON revealed the staff received training on infection control and incontinent care at least annually. The staff skills were checked yearly. The DON and ADON spot checked the staff while they provided care for infection control and quality of care. Review of annual skills check for CNA C revealed CNA C passed competency for Perineal care/incontinent care on 03/14/2025. Review of facility policy, titled Incontinent care, dated 04/10/2017, revealed Cleanse peri-area and buttocks with cleansing agent wiping from front of perineum toward rectum [.].

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observations, interviews and record reviews the facility failed to ensure that CNAs were able to demonstrate competency in skills and techniques necessary to care for residents' needs for 1 of 6 residents (Resident #4) by 1 of 4 CNAs (CNA C) reviewed for competent staff, in that:The facility failed to ensure CNA C used the right technique to clean Resident #4 while providing incontinent care. This deficient practice could place residents at-risk for infection and skin break down due to improper care practices. The findings were: Record review of Resident #4's face sheet, dated 07/17/2025, revealed an admission date of 04/20/2017, and, a readmission date of 01/03/2024, with diagnoses which included: History of traumatic brain injury (Brain injury caused by an outside force), Dysphagia (Difficulty swallowing), Hypertension (High blood pressure), Congenital hydrocephalus (condition in which too much fluid builds up in the brain). Record review of Resident #4's Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 09 indicating moderate cognitive impairment. Resident #4 required limited to extensive assistance and was frequently incontinent of bowel and bladder.Review of Resident #4's care plan, dated 12/26/2024, revealed a problem of Incontinence: [.] is frequently incontinent of bowel/bladder related to Confusion, poorcontrol. and an intervention of INCONTINENT: Check frequently for wetness and soiling and change as needed.Observation on 07/17/2025 at 11:40 a.m. revealed while providing incontinent care for Resident #4, CNA c wiped Resident #4's buttocks in a back to front motion.During an interview on 07/17/2025 at 11:48 a.m. with CNA C, she confirmed she had wiped Resident #4's buttocks in a back to front motion. She said she thought she was using the correct technique. She confirmed receiving training on incontinent care from the facility.During an interview with the DON on 07/17/2025 at 3:48 p.m., she confirmed the correct motion to clean the residents during perineal care was front to back to prevent fecal matter from contacting the urethra and possibly cause an infection. The DON revealed the staff received training on infection control and incontinent care at least annually. The staff skills were checked yearly. The DON and ADON spot checked the staff while they provided care for infection control and quality of care.Review of annual skills check for CNA C revealed CNA C passed competency for Perineal care/incontinent care on 03/14/2025.Review of facility policy, titled Incontinent care, dated 04/10/2017, revealed Cleanse peri-area and buttocks with cleansing agent wiping from front of perineum toward rectum [.].Review of facility policy, titled Staff competency, dated 01/01/2025, revealed The purpose of this Staff Competency Policy is to ensure that all staff employed by the long term care facility demonstrate and maintain the knowledge, skills and, abilities required to deliver safe, effective, and person-centered care.

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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. Based on observation, interview, and record review, the facility failed to ensure all drugs and biological were stored in locked compartments for 1 of 3 medication carts (Treatment cart) reviewed for storage, in that: RN A left the treatment cart unlocked on 1 occasion. This deficient practice could place residents at risk of misappropriation of medications or harm due to accidental ingestion of unprescribed medications.The findings were: Observation on 07/17/2025 at 9:10 a.m. revealed RN A was providing wound care to residents. On one occasion the treatment cart was left unlocked and out of sight of RN A. The lock had not been pushed down to lock the cart. Inside the unlocked cart were wound care supply, ointments, cream, dressing and other supply for treatment including a pair of scissors. Observation on 07/17/2025 at 9:34 a.m., the ADON passed by the cart going down the hall and locked the cart. Interview on 07/17/2025 at 9:35 a.m. with the ADON revealed that the treatment cart should have been kept locked when the nurse was not around it. She stated residents could open the cart and take things from it that could harm them. She confirmed the staff was trained about medications diversion and keeping their cart locked when not used. During an interview with RN A on 07/17/2025 at 10 a.m., RN A confirmed the treatment cart should not have been left unlocked while she was providing care in the resident's room. RN A confirmed she knew she had to keep the cart locked and had forgotten. During an interview with the DON on 07/17/2025 at 4:38 p.m., the DON confirmed the treatment carts should have been kept locked. The DON confirmed the nursing staff received training about drug diversion including keeping their cart locked at all times when not in use to prevent drug diversion. The DON revealed one possible outcome of drug diversion was the residents missing doses of medications or treatments. Record review of the facility's policy titled, Medication Storage, dated 01/20/2021, revealed, All drugs and biologicals will be stored in locked compartments [.] only authorized personnel will have access to the keys to locked compartments.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide a therapeutic diet, in the appropriate form as prescribed by a physician for 1 of 8 residents (Resident #19) observed for therapeutic diets. The facility failed to provide Resident #19 a CCHO (Controlled Carbohydrate) NAS (No Added Salt) diet, as ordered by the physician. This failure could affect residents with physician orders for therapeutic diets and could result in consumption of inappropriate food items which could cause elevated blood sugars and a decline in health. The findings were: Record review of Resident #19's face sheet, dated 07/17/2025, revealed he was admitted to the facility on [DATE] (original admission on [DATE]) with diagnoses which included: type 2 diabetes mellitus without complications, hypo-osmolality (a condition where the concentration of dissolved particles (solutes) in a fluid, like blood, is lower than normal) and hyponatremia (a condition where there is too much sodium in the blood, indicating a deficit of water relative to sodium in the body), essential (primary) hypertension (high blood pressure), and localized edema (swelling caused by excess fluid trapped in your body's tissues). Record review of Resident #19's Quarterly MDS assessment, dated 07/09/2025, revealed the resident's BIMS score was 15, which indicated intact cognition. The Quarterly MDS assessment further revealed Resident #19 received a therapeutic diet (e.g., low salt, diabetic, low cholesterol) while a resident. Record review of Resident#19's physician's order summary dated 07/17/2025 revealed the following order CCHO NAS diet Regular texture. with a start date of 07/11/2025. Record review of Resident #19's care plan date initiated 05/24/2025 revealed Focus: [Resident #19] is on a CCHO NAS diet, Regular texture. Intervention: Provide and serve diet as ordered- CCHO NAS diet, Regular texture, THIN LIQUIDS consistency with a revision date of 07/11/2025. Observation and interview on 07/17/2025 at 12:11 p.m. revealed the survey test tray that was sent the halls was not present on the tray rack. An interview with CNA C revealed she had given the meal tray with no ticket on it to Resident #19. CNA C further stated she had given it to Resident #19 due to the day before his tray had come out without a ticket and so she thought it had happened again. Observation and interview on 07/17/2025 at 12:18 p.m. revealed Resident #19 in his room sitting on the edge of his bed with his over bed table in front of him eating his lunch. There was not a diet ticket on the tray. Resident #19 stated the tray did have condiments on the tray including salt and a packet of sugar. He then stated he had thrown them in the trash can when he was finished with them. Resident #19's trash can revealed a salt packet and sugar packet torn open. Resident #19 stated he was not to have salt, but he sure did use it. Resident #19 further stated he was pleased with today's meal and said he could really see the turkey chunks today in the sauce. During an interview on 07/17/2025 at 12:25 p.m. CNA C stated she usually would check the trays when they came on the hallway and made sure everyone had a slip, but because yesterday Resident #19 did not have a slip she thought he did not have one then. CNA C further stated she just passed out the trays. CNA C stated the nurse was responsible for checking the diets on the trays. CNA C stated Resident #19 was a regular diet, so she thought it was his tray. CNA C further stated she did not know anything about their diets, only knew when saw the diet card. CNA C stated the meal trays were checked. CNA C further stated she realized Resident #19's meal tray was on the cart after she had given him the one that did not have a meal ticket. During an interview on 07/17/2025 at 12:39 p.m. the Dietary Manager stated a CCHO diet was a controlled carbs diet. and NAS was no added salt. The Dietary Manger further stated a tray with that diet would be sent with no salt and a pink or yellow sweetener (sugar substitute). The Dietary Manager stated the facility diets were liberalized, and the resident would have been served what was on the menu and on their diet ticket. During an interview on 07/17/2025 at 3:58 p.m. the DON stated if the CNA saw the tray without a ticket, she should have gone back for a ticket to make sure it was the resident's tray. The DON further stated the final check was done in the kitchen and the nurses did look at the trays, but the final check was done in the kitchen. The DON stated if the diet had not been the same texture there could have been a risk for choking, however the DON stated Resident #19 was a regular diet texture. The DON further stated she though the only risk there might have been for Resident #19 was his blood sugars could have risen or changed. The DON stated by Resident #19 having received the sodium, it could have been more heart related but nothing immediate for him. During an interview on 07/18/2025 at 3:39 p.m. the Administrator stated the staff should not have passed out a tray without a meal ticket. The Administrator further stated the risk could vary from #1. they did not know who it belonged to and #2. the tray without a diet could be given to a person that was on a different

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain clinical records in accordance with accepted professional standards and practices that are complete and accurately documented for 1 of 8 residents (Resident #12) reviewed for accuracy of medical records. The facility failed to ensure Residents #12 had transcribed orders for suction from the hospice orders to the resident's EMR (Electronic Medical Record). This deficient practice could affect residents whose records are maintained by the facility and could place them at risk for errors in care and treatment. The findings included: Record review of Resident #12's face sheet, dated 07/15/2025, revealed Resident #12 was admitted on [DATE] with diagnoses which included: cerebral infarction (a condition where a portion of the brain tissue dies due to a lack of blood supply) unspecified, cerebrovascular disease (a group of conditions that affect blood vessels and blood supply to the brain), adult failure to thrive, and disturbances of salivary secretion. Record review of Resident #12's admission MDS assessment, dated 06/30/2025, revealed Resident #12 unable to complete BIMS with resident appearing to exhibit short-term and long-term memory loss. Record review of Resident #12's care plan with an initiated date of 07/14/2025 and a targeted date 10/12/2025, revealed Resident #12 had a Focus: [resident's name] has impaired respiratory status and is at risk for shortness of breath, respiratory distress, increased anxiety and hypoxia. This related to diagnosis of: acute respiratory failure with hypoxia. Record review of Resident #12's Hospice IDG Comprehensive Assessment and Plan of Care Update Report from Resident #12's hospice binder at nursing station, dated, 07/03/2025, revealed, client orders for Resident #12, order date 06/24/2025 reflected, Hospice Nurse/Facility Nurse/Patient/Caregiver to perform oral suctioning PRN increased or excessive secretions. Record review of Resident #12's physician order summary report, dated, 07/15/2025, revealed no orders for Resident #12 to receive oral suctioning PRNObservation on 07/15/2025 at 3:52 p.m. revealed Resident #12 lying in her bed with a suction machine on her nightstand with the canister full of secretions. Observation on 07/17/2025 at 2:39 p.m. revealed Resident #12 sleeping wearing oxygen and a suction machine on the nightstand with the canister having the contents in it to the 150-cc line. Resident #12 while sleeping with head of bed elevated was observed to make periodic gurgling sounds and at times as if she was clearing her throat. During an interview and observation on 07/17/2025 at 3:21 p.m. LVN B stated Resident #12 was suctioned as needed. LVN B further stated she had just gone and suctioned her. LVN B stated it was the first time she had to suction Resident #12 herself and it being the second day she had worked with Resident #12. LVN B stated Resident #12 was also medicated with her Atropine drops (drops given for excessive secretions). LVN B stated there was not a schedule for suctioning for Resident #12, but it was to be done as needed. LVN B stated she was not sure if there was a set protocol regarding when Resident #12 was supposed to be suctioned. LVN B further stated there should have been an order for a resident to be suctioned. LVN B was observed reviewing Resident #12's EMR orders and stated Resident #12 did not have an order to be suctioned. LVN B stated by suctioning without orders could be ineffective or causes damage of some sort. During an interview on 07/17/2025 at 3:42 p.m. LVN B returned with forms from Resident #12's hospice binder. LVN B stated the hospice binder was kept at the nursing station and further stated the order should have been transcribed in the MAR. During an interview on 07/17/2025 at 3:47 p.m. the DON stated the orders for suctioning were not written on a physician's order for the nurses to transcribe to the EMR physician's orders, but there were orders from hospice. The DON further stated the hospice charts were available at the nurse's station for the nurses to review. The DON stated the orders in the hospice binder were signed by the doctor, so they had an order. During an interview on 07/18/2025 at 3:51 p.m. the Administrator stated hospice should have given the nurses a written order so it could have been in the system. The Administrator stated the nurses knew to do suction because it was in the hospice binder at the nurse's station. The Administrator stated by not transcribing an order it could possibly not be initiated or completed. The Administrator further stated by not transcribing an order the care provided would not be documented. The Administrator stated the nurses were responsible to put the orders in the PCC (Point Click Care facility EMR) when hospice or the physician writes an order. The Administrator further stated when hospice brought the suction machine the hospice should have written the order.Record review of the facility's policy titled Transcribing or Noting and Discontinuing, review date, 02/10/2021, revealed Purpose: To provide a guideline for the process of physician order management for transcribing or noting and discontinuing orders. Fundamental Information: Guideline: When

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, 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 disease and infection for 1 of 6 residents (Resident #4) reviewed for infection control, in that: While providing incontinent care for Resident #4, CNA C failed to use proper infection control. These deficient practices could place residents at-risk for infection due to improper care practices. The findings were: Record review of Resident #4's face sheet, dated 07/17/2025, revealed an admission date of 04/20/2017, and, a readmission date of 01/03/2024, with diagnoses which included: History of traumatic brain injury (Brain injury caused by an outside force), Dysphagia (Difficulty swallowing), Hypertension (High blood pressure), Congenital hydrocephalus (condition in which too much fluid builds up in the brain).Record review of Resident #4's Quarterly MDS, dated [DATE], revealed the resident had a BIMS score of 09 indicating moderate cognitive impairment. Resident #4 required limited to extensive assistance and was frequently incontinent of bowel and bladder.Review of Resident #4's care plan, dated 12/26/2024, revealed a problem of Incontinence: [.] is frequently incontinent of bowel/bladder related to Confusion, poorcontrol. and an intervention of INCONTINENT: Check frequently for wetness and soiling and change as needed.Observation on 07/17/2025 at 11:40 a.m. revealed while providing incontinent care for Resident #4, CNA C, after washing her hands, touched the privacy curtain to close it and did not sanitize her hands prior to putting her gloves on and started care. During an interview with CNA C, on 07/17/2025 at 11:48 a.m., she stated she did not sanitize her hands after touching the privacy curtain and before putting her gloves on. She said she thought the privacy curtain was clean. She confirmed receiving training on incontinent care from the facility. During an interview with the DON on 07/17/2025 at 3:48 p.m., she confirmed the privacy curtain was considered dirty and the staff should have sanitized her hands after touching it and prior to putting her gloves on. Not sanitizing her hands before starting care could cause a risk of cross contamination and infection for the resident. The DON revealed the staff received training on infection control and incontinent care at least annually. The staff skills were checked yearly. The DON and ADON spot checked the staff while they provided care for infection control and quality of care. Review of annual skills check for CNA C revealed CNA C passed competency for Perineal care/incontinent care and infection control on 03/14/2025. Review of facility policy, titled Hand Hygiene, dated 11/12/2017, revealed Hand hygiene is indicated and will be performed under the conditions [.] After handling contaminated object [.] Before applying and after removing personal protective equipment, including gloves.

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews, the facility failed to ensure that 44 out of 44 resident rooms provided a minimum of 80 square feet of floor space per resident. Forty-Four of the two-bed resident rooms measured 155, 156 or 157 square feet per room leaving 77.5, 78 or 78.5 square feet per bed. This deficient practice could affect residents living in these rooms by restricting the amount of resident care equipment and resident's personal effects that could be accommodated in these rooms. The findings were: Review of the facility Bed Classification Form 3740 dated 06/14/2024 as completed by facility Administrator revealed, resident rooms 100 through 108, 201 through 207, 300 through 305, 401 through 404, 500 through 509, and 600 through 608 were listed as two resident bedrooms. Observation on 06/12/2024 beginning at 1:00 p.m. of the measurements of resident bedrooms using a laser measuring tool by the Life Safety Code surveyor, revealed the following measurements: Hall A - room [ROOM NUMBER] -measured 155 square feet providing 77.5 square feet per bed. Hall A - Rooms 100, 102, 103, 104, 105, 106, 107, and 108 - measured 156 square feet, providing 78 square feet per bed. Hall B - Rooms 201, 202, 204, 205 206, and 207 - measured 155 square feet, providing 77.5 square feet per bed. Hall B - room [ROOM NUMBER] - measured 156 square feet, providing 78 square feet per bed. Hall C - Rooms 300, 301, 302, 303, 304, and 305 - measured 156 square feet, providing 78 square feet per bed. Hall D - room [ROOM NUMBER] - measured 157 square feet, providing 78.5 square feet per bed. Hall D - Rooms 401, 402, 403, and 404 - measured 156 square feet, providing 78 square feet per bed. Hall E - rooms [ROOM NUMBERS] - measured 155 square feet, providing 77.5 square feet per bed. Hall E - Rooms 502, 503, 504, 505, 506, 507 508, and 509 - measured 156 square feet, providing 78 square feet per bed. Hall E - room [ROOM NUMBER] - measured 157 square feet, providing 78.5 square feet per bed. Hall F- Rooms 600, 601, 602, 603, 605 and 608 - measured 156 square feet, providing 78 sq. ft per bed. Hall F - room [ROOM NUMBER] - measured 155 square feet, providing 77.5 square feet per bed. During an interview on 07/18/2025 at 4:50 p.m., the Administrator confirmed the identified residents' rooms were 2-person rooms and did not provide a minimum of 80 square feet of floor space per resident. The Administrator requested a room size waiver for those resident rooms and completed Form 3762 Room Size Waiver for Facilities that reflected that all justification criteria for the wavier had been met which would not adversely affect the residents living in the rooms.