STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675217	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhart Oaks Care Center	214 Jones Rd Elkhart, TX 75839

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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 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** 43994 Based on observation, interview, 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 of 6 (Resident #43) reviewed for pharmacy services. The facility failed to provide Resident #43's naproxen (anti-inflammatory medication) 250 mg tablet ordered to be given two times a day from 1/4/2025-4/8/2025 per physician's orders. This failure could place residents who received administered medications at risk of not receiving the intended therapeutic benefit of their medications. Findings included: Record review of a face sheet for Resident #43 dated 4/8/2025 indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of heart failure (heart is not able to pump enough blood to the body), ankylosing spondylitis in spine (anti-inflammatory disease that causes pain and stiffness in the spine), and spinal stenosis (narrowing of the spine). Record review of a Quarterly MDS assessment dated [DATE] for Resident #43 indicated she had moderate impairment in thinking with a BIMS of 12. She required substantial/maximal assistance with eating, oral hygiene and upper body dressing and was dependent with all other ADL's. She received scheduled pain medication regimen during the 5 day look back period and had pain frequently with pain intensity of a 5 (moderate pain) out of 10 on a 1-10 pain scale. Record review of a care plan for Resident #43 dated 3/24/2025 indicated she had pain in right shoulder. Interventions included to administer medications per MD order. Record review of a MAR for Resident # 43 dated 4/1/2025-4/8/2025 indicated an order for naproxen 250 mg twice a day to be given at 8 am and 8 pm with a start date of 1/4/2025 revealed from April 1-April 8, 2025, the medication was given as ordered with initials present. Record review of active physician orders for Resident #43 dated 4/8/2025 indicated an order for naproxen 250 mg twice a day to be given at 8 am and 8 pm with a start date of 1/4/2025. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 4/8/2025 at 8:58 AM, revealed MA C was in the process of administering medications to Resident #43. MA C pulled a bottle of OTC naproxen that was 220 mg from the medication cart and said all the facility had available was for 220 mg tablets and the MAR for Resident #43 had an order that started on 1/4/2025 for naproxen 250 mg to be given twice daily. He said he had been giving naproxen 220 mg since the order was given by the physician in January 2025. He said he did not notice the order being incorrect until being observed by the Surveyor that day (4/8/2025). He did not give the medication and said he would notify the charge nurse. He said he was instructed to look at the medication before administering to be sure it was for the right person, the right dosage, the right time, the right medication, the right site, and the right route. He said if they did not follow those things, it could cause sickness, or a possible reaction and they would have to let the family and physician know. He said a resident could have a reaction to the medicine. He said he should have paid more attention. He immediately called for the charge nurse who came to the medication cart and told her that the order in the chart for Resident #43's naproxen was 250 mg and all available in the facility was an over-the-counter supply of 220 mg tablets. LVN D said she would contact the physician. Record review of clinical competency: medication pass for MA C dated 11/1/2024 indicated he was satisfactory with observing the seven rights of administration that included the right dose/dosage form. During an interview on 4/8/2025 at 9:09 AM, LVN D said she was the charge nurse for that day. She said she was not aware of the order for naproxen 250 mg for Resident #43 before being notified by MA C and all that was available in the cart was naproxen 220 mg tablets. She said staff should verify the medication with the order for the milligrams before administering. She said if they did not then it was a medication error, and residents could have side effects of an overdose or not get enough of the medication that was needed. LVN D said she contacted the NP and received an order for naproxen 220 mg to be given twice daily. She said the order was a data entry error as the facility only had 220 mg of naproxen OTC available. Record review of a MAR for Resident #43 dated 4/1/2025-4/8/2025 indicated an order for Aleve (naproxen) OTC 220 mg twice a day with a start date of 4/8/2025. Record review of active physician orders for Resident #43 dated 4/8/2025 indicated an order for Aleve (naproxen) OTC 220 mg twice a day with a start date of 4/8/2025. During an interview on 4/9/2025 at 8:43 AM, the DON said she was not aware of Resident #43's order for naproxen not matching what was in the medication cart. She said staff should look at the order and compare to the bottle of medication and if not correct it should be reported. She said with each medication to be administered they should check the order against the MAR. She said if they did not check, there could be a medication error. She planned to in-service staff to make sure they checked to make sure orders were entered correctly. She said there was health risk to the residents if staff did not follow the physician orders for medications. Record review of an in-service dated 4/8/2025 conducted at the facility on Medication Administration and MA C was in attendance with his signature present. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/9/2025 at 9:40 AM, the Administrator said the DON was responsible for ensuring physician's orders were entered correctly. He said dosages could be mistaken and residents could receive the wrong medications if they were not accurate. He said he expected all medications to be entered correctly and accurately. Record review of a facility policy titled Administering Medications dated April 22, 2022, indicated, . Medications shall be administered in a safe and timely manner as prescribed. 8. The individual administering the medication must check the label three (3) times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication .

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40124 Based on observation, interview, and record review, the facility failed to ensure each resident received and the facility provided food prepared in a form designed to meet individual needs for 4 of 4 (Resident #6, Resident #28, Resident #40, and Resident #41) residents reviewed for puree diets. The facility failed to prepare the pureed diet to the consistency required for Residents #6, Resident #28, Resident #40, and Resident #41. This failure could place residents who received pureed meat and vegetables at risk of not having nutritional needs met by consuming foods that could cause choking and decreased meal intakes. Findings included: Record review of face sheet dated 04/08/25 for Resident #6 indicated she admitted to the facility on [DATE] and was a [AGE] year-old female with diagnoses of diabetes (high glucose levels in the blood) and muscle weakness. Record review of a physician's order summary dated 04/08/25for Resident #6 indicated an order for regular pureed diet and thin liquids dated 11/23/20. Record Review of face sheet dated 04/08/25 for Resident #28 indicated she admitted to the facility on [DATE] and was [AGE] year-old female with diagnoses of dysphagia (difficulty swallowing) and dementia unspecified (decline in cognitive abilities) Record review of a physician's order summary dated 04/08/25 for Resident #28 dated 04/08/25 indicated an order for enhanced regular diet, pureed texture dated 12/02/2024. Record review of face sheet dated 04/08/25 for Resident #40 indicated he admitted to the facility on [DATE] and was [AGE] year-old male with diagnoses of dysphagia (difficulty swallowing) and muscle wasting. Record review of a physician's order summary dated 04/08/25 for Resident #40 dated 04/08/25 indicated an order for pureed double portion enhanced with nectar thick liquids dated 01/02/2025. Record review of face sheet dated 04/08/25 for Resident #41 indicated she admitted to the facility on [DATE] and was [AGE] year-old female with diagnoses of dysphagia (difficulty swallowing) and muscle weakness. Record review of a physician's order summary dated 04/08/25 for Resident #41 indicated an order for enhanced regular pureed diet with thin liquids dated 02/04/2025. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 04 /08/25 at 12:00 PM the [NAME] pureed the meat loaf, green beans, roasted potatoes and roll without a recipe. She added milk to all items and then added thickener to obtain a pudding consistency. The [NAME] did not taste test the items for consistency. The [NAME] said she did not routinely check to see if the foods fully blended . All foods were plated for lunch service to resident#6, Resident #28, Resident #40, and Resident #41. During an observation on 04 /08/25 at 12:20 PM revealed a sample test tray from the pureed meal for lunch of meat loaf, green beans, roasted potatoes, and roll. The meatloaf and roasted potatoes contained chunks and was not at pudding consistency as required. The DM tested the puree tray along with surveyors and agreed the meal contained chunks, not pudding consistency. The DM said the Robot Coupe had stopped working over a year ago and they had been blending the puree foods with a blender. She said certain foods were hard to process with the blender the facility was using. The DM said the risk to the residents was possible choking and a decreased dining experience. During an interview on 04/08/25 at 2:30 PM the RD said that she had started working for the facility as a consultant the end of February 2025 and she watched puree processes while she was at the facility but did not sample the pureed foods to determine if the texture was smooth. The RD said pureed foods should be nutritional and palatable and a smooth consistency. She said the risk to the residents was choking if the puree diet was not at the required consistency. During an interview on 04/09/25 09:37 AM the Administrator said he had obtained a bid for a new Robot Coupe and would be replacing the blender. The Administrator said pureed foods should be nutritional and palatable and a smooth consistency. He said if the foods were not blended to pudding consistency there could be a risk of choking. He said if the pureed foods were not prepared correctly the resident would not get the full nutritional value of the food. Record review of an undated Lifestyle Diet Manual . Page 9 .Based on the foods served on the Regular Diet plan blended to a consistency of mashed potatoes or pudding. The Pureed Diet may be used for residents with oral, esophageal, or stomach disorders that are unable to tolerate solid food. Conditions such as dysphasia (difficulty swallowing), stroke, cancer of the head or neck, or lack of chewing ability may warrant this diet prescription.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40124 Based on observation, interview, and record review the facility failed to store and distribute food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for kitchen sanitation. 1. The facility failed to store and label foods in accordance with professional standards. 2. The facility failed to ensure there were no gaps under the air conditioning unit beside the handwashing sink. 3. The facility failed to maintain clean air vents on the air conditioner located near the clean dish station. These failures could place residents who ate the food from the kitchen at risk for food-borne illness and/or transmission-based infections. Findings include: During an observation on 04/07/25 at 09:20 AM revealed the dry storage area had clear plastic bins of bulk granulated sugar, breadcrumbs, bulk powdered sugar, flour, and corn meal with no best by date or expiration dates on the bins. A box of dry pinto beans was open to air, not sealed. During an observation interview on 04/07/2025 at 09:30 AM revealed a gap approximately 1 inch x 18 inches at the bottom of a window unit , located beside the employee handwashing station, with the outside visible. The window AC unit located above the clean dish station was noted to have dirty lint and black buildup on the vents. The DM said the prior maintenance man was aware of the gap but she had not reported the gap to the new maintenance man that started working at the facility two weeks ago. During an observation and interview on 04/07/2025 at 09:35 AM revealed containers of spiked/opened juice concentrate connected to the juice dispenser (apple, pink lemonade, fruit punch, orange, cranberry) on the bottom shelf with no open dates. The DM said the juice was delivered every other week and had a shelf life of 7 days after being opened. During an interview on 04/07/24 at 9:45 AM the DM stated she was responsible for training all dietary staff and dietary staff were trained on kitchen sanitation to include cleaning vents on the air conditioners, reporting the gap underneath the air conditioner, dating items when they were opened and use by dates, when to discard those items per the guidelines of that item. She stated she would begin retraining all staff because of the sanitary risks and expected all staff to follow all kitchen sanitation rules. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 04/08/25 08:16 AM the Registered Dietician said the bulk granulated sugar, bulk powdered sugar, flour, and corn meal stored in bins in the dry storage should be dated with the use by date as well as the open date. She said she was not sure when the 5 boxes of concentrated juices expire but all items should be labeled when opened. She said that if cleaning, sanitation, and proper storage measures were not followed in the kitchen, it could cause resident illness and contamination. During an interview on 04/08/24 at 11:30 AM the Administrator said the DM was responsible for oversight of kitchen sanitation, cleanliness, labeling and storage, as well as the training for the dietary staff. He said that if cleaning, sanitation, and proper storage measures were not followed in the kitchen, it could cause resident illness and contamination. He stated he expected all dietary staff to follow the regulations for cleaning the kitchen, maintaining sanitation and proper storage of all foods. Record review of a facility policy dated 4/18/2022 titled Food Safety in Receiving and Storage indicated, . Food will be received and stored by methods to minimize contamination and bacterial growth; 7. check expiration dates and use by dates to assure the dates are within acceptable parameters . Record review of a facility policy dated 10/01/2018 titled General Kitchen Sanitation indicated, .The facility recognizes that food borne illness has the potential to harm the elderly and frail residents. All nutrition and service employees will maintain clean, sanitary kitchen . Record review of https://www.fda.gov/media/164194/download, accessed 04/08/2025 indicated .Labeling 3-602.11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers. (B) Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement; (2) If made from two or more ingredients, a list of ingredients and sub ingredients in descending order of predominance by weight, including a declaration of artificial colors, artificial flavors and chemical preservatives, if contained in the FOOD; (3) An accurate declaration of the net quantity of contents; (4) The name and place of business of the manufacturer, [NAME], or distributor; and (5) The name of the FOOD source for each MAJOR FOOD ALLERGEN contained in the FOOD unless the FOOD source is already part of the common or usual name of the respective ingredient.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43994 Based on observation, interview, and record review, the facility failed to maintain and ensure safe and sanitary storage of residents' food items, per facility policy, for 1 of 3 resident's (Resident #2) personal refrigerators reviewed for food and nutrition services. The facility failed to ensure a plastic bag of sliced cheese and sandwich meat was labeled and dated in a personal refrigerator on [DATE] and [DATE] for Resident #2. These failures could place residents at risk for food borne illnesses. Findings include: Record review of a face sheet for Resident #2 dated [DATE] indicated she admitted to the facility on [DATE] and was [AGE] years old with diagnoses of PVD (narrowing or blockage in the blood vessels), disorganized schizophrenia (impairment in daily activities and communication), and acute ischemic heart disease (heart damage caused by narrowed heart arteries). Record review of an Annual MDS Assessment for Resident #2 dated [DATE] indicated she had moderate impairment in thinking with a BIMS score of 12. She required set up or clean up assistance with eating. Record review of a care plan dated [DATE] for Resident #2 indicated she was at risk for nutritional deficit related to her IDD. Interventions included to provide set up assistance with meals. During an observation on [DATE] at 9:36 AM, revealed Resident #2 was not in her room. A personal refrigerator was present that had a plastic bag of sliced cheese and sandwich meat that was not labeled or dated. During an observation on [DATE] at 10:00 AM, revealed Resident #2 was not in her room. The plastic bag of sliced cheese and sandwich was still in her personal refrigerator not dated or labeled. During an interview on [DATE] at 10:03 AM, the HSK Supervisor said all housekeeping staff were responsible for checking the temperatures of the personal refrigerators in the resident rooms. She said the nursing staff were to check them daily for expired foods. During an observation and interview on [DATE] at 10:05 AM, revealed the HSK Supervisor observed the refrigerator in the room of Resident #2 and said the plastic bags of sliced cheese and sandwich meat should have dates on them. She said the Administrator would purchase Resident #2 meat and cheese from the local market sometimes but was not sure when he bought them. She said she would remove them. During an interview on [DATE] at 10:07 AM, the Administrator said he did purchase meat and cheese for Resident #2 one day last week but did not put the dates that they were purchased on them. He said he would start putting dates on the items if he purchased them for the resident. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 8:42 AM, CNA E said the nurse aides were not responsible for checking the personal refrigerators. She said the housekeeping staff were. During an interview on [DATE] at 8:43 AM, the DON said housekeeping staff were responsible for checking the personal refrigerators for unlabeled and expired foods. She said staff were in-serviced on [DATE] and instructed them if food was brought in by family or visitors to make sure the foods were labeled and dated. She said residents could get sick if they ate foods that were not labeled or dated because they would not be aware of how long they had been in the refrigerator. During an interview on [DATE] at 9:42 AM, the Administrator said the facility currently had the housekeeping staff check to make sure temperatures were correct in the personal refrigerators. He said they also had other staff that included guardian angels (staff assigned to resident rooms) and himself to check. He said he was not sure when the foods were put in the refrigerator of Resident #2, and they should be labeled and dated. He said the refrigerators should be checked daily and residents could get sick if they ate old food. Record review of a facility policy titled Resident Refrigerators dated ,d+[DATE] indicated, .For safe and sanitary storage, handling, and consumption of food items purchased by residents from an outside vendor or other food items brought to residents by non-facility employees. 3. Food stored in a residents' room refrigerator will be labeled with a date. 4. A facility employee will inspect resident refrigerators on a weekly basis to ensure there are no expired foods and cleanliness is maintained. Housekeeping may discard food, drink, and perishables .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. 40124 Based on observation, interview, and record review the facility failed to maintain all essential equipment in safe operating condition, for 1 of 1 stove in the kitchen reviewed for food service in that: The facility did not ensure the gas stove was in working order. Two of six gas stove burners (rear middle and font middle) did not light automatically, when the knob was turned, the pilot light on the burners would not light and both burners had black hard carbon buildup from spilled foods. This failure could place residents who eat out of the kitchen at risk for injury and under cooked food. Findings include: During an observation and interview on 04/07/25 at 9:15 am the Dietary Manager demonstrated both middle burners on the gas stove did not light and were noted to have black hard carbon build up from spilled foods from spill foods on them The Dietary Manager stated the kitchen staff were responsible for cleaning the stove burners and the burners had not worked in a long time. The Dietary Manager said the previous maintenance director and the Administrator were aware of the middle burners not staying lit. She said the burners not working correctly could be a fire hazard. She said she had not notified the current Maintenance Director to look at the stove. During an interview on 04/07/24 at 1:01 PM the Maintenance Director said he had been employed at the facility for two weeks. He said the kitchen staff were responsible for cleaning the stove burners and he performed maintenance to the gas stove if needed. He stated he was not aware of the burners not lighting, there was no request in the maintenance request book but would clean the burners and ensure the stove would light properly. During an interview on 04/08/24 at 10:45 AM the Administrator stated the dietary staff were responsible for everyday cleaning of the stove and the maintenance director was responsible for maintaining the equipment from carbon buildup and ensuring the equipment was working fully. He stated if equipment was not maintained it could cause an adverse event or be a fire hazard. He stated he expected all essential equipment to be maintained in proper working order. Record review of the maintenance request binder revealed no entry's found for the burners not lighting on the gas stove from the dietary department staff for the last 3 months. Record review of a facility policy dated 10/01/2018 titled Range and Grill indicated, .the facility will maintain the range in a clean manner to minimize the risk of food hazard; 2. scrape off burned particles and grease .

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46436 Based on observation, interview, and record review the facility failed to be adequately equipped to allow residents to call for staff through a communication system which relayed the call directly to a staff member or to a centralized staff work area from toilet and bathing facilities for 2 of 9 residents (Residents #4 and #6) reviewed for call lights. The facility failed to ensure Residents #4 and #6's bathrooms had a call light pull cord on 04/07/2025. This failure could place residents at risk of injury, pain, hospitalization , and a diminished quality of life. Findings included: 1. Record review of a facility face sheet revealed Resident #4 was a [AGE] year-old male that admitted to the facility on [DATE] with diagnosis of traumatic brain injury. Record review of a Quarterly MDS assessment dated [DATE] revealed Resident #4 had a BIMS of 6 indicating moderately impaired cognition and was dependent on staff for toileting and supervision of staff for toilet transfers. Record review of a comprehensive care plan dated 11/4/2024 revealed Resident #4 was at risk for injuries related to falls and to provide toileting assistance, resident to call for assist and keep call light in reach. During an observation and interview on 04/07/25 at 9:33 am revealed Resident #4's bathroom call light box was not attached to the wall. The light would activate with the touch of the button, but the pull cord did not work. Resident #4's best friend said he used his bathroom and would pull on the cord breaking the box. She said the Maintenance Director fixed the box last week, but it broke again sometime after she left on Friday 04/04/25. Resident # 4 said he would yell if he needed help. 2. Record review of a facility face sheet revealed Resident #6 was a [AGE] year-old female that admitted to the facility on [DATE] with diagnosis of heart failure. Record review of a Quarterly MDS assessment dated [DATE] revealed Resident #6's BIMS was not completed. Further review revealed a SAMS was completed and indicated severely impaired cognitive skills for daily decision-making. Record review of a comprehensive care plan dated 10/24/2023 revealed Resident #6 was at risk for injuries related to falls and would remain free from injuries. During an observation on 04/07/25 at 9:45 am revealed Resident #6's bathroom call light box was not attached to the wall. The light would activate with the touch of the button, but the pull cord did not work. Resident #6 was not able to be interviewed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675217	A. Building B. Wing	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkhart Oaks Care Center	214 Jones Rd Elkhart, TX 75839

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/07/25 at 9:47 am CNA A said she worked on Saturday 4/05/25. She said Resident #4's and Resident #6's lights were not broken but noticed them being broken this morning. She said Resident #4 sometimes used his bathroom and Resident #6 used her bathroom daily. She said there was a maintenance log to notify the supervisor of broken things, but she had not put it in the log yet today. She said if the call light was broken, residents could not call for help, and they could get hurt. During an observation on 04/07/25 at 10:00 am revealed Resident #6 was in the bathroom toileting. During an interview on 04/07/25 at 10:18 am the Maintenance Director said he was responsible for broken call lights. He said he was not aware of Resident #6's call light box being off the wall and the pull cord not working. He said he fixed Resident #4's bathroom call light on 04/04/25 and it must have broken again over the weekend. He said there was a log, but the staff usually verbally reported to him, and he would fix the problem. He said a broken call light cord could result in a resident not getting help if they need it. During an observation on 04/07/2025 at 11:25 am revealed large bells were in Resident #4's and Resident #6's bathrooms. During an interview on 04/07/2025 at 11:30 am the Maintenance Director said he could not fix the pull cords on the bathroom lights for Resident #4 and Resident #6 until the parts were delivered. He said each resident was provided a bell to use for emergencies. During an interview on 04/09/25 at 9:44 am the Administrator said the call lights should be checked by all staff each shift and by maintenance as needed to ensure they are in full working order. He said the staff should be reported immediately any broken call lights to the maintenance director or himself. He said there was a maintenance log, and they could report verbally. He said if a call light was not in full working order and the cord did not work the resident could have a delayed response in care. Record review of a facility policy dated September 21, 2022 titled Answering the Call Light revealed, .6. report all defective call lights to the nurse supervisor promptly .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675217	A. Building B. Wing	04/09/2025

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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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. 46436 Based on observations, interviews, and record review, the facility failed to follow established policy regarding smoking areas, and smoking safety for the 1 of 2 (secured unit smoking area) smoking areas reviewed. The facility failed to ensure the paper trash and cigarette butts were disposed of separately in the ashtrays and red fire can on 04/07/25. This failure could place residents who smoke at risk of physical harm and lead to an unsafe smoking environment. Findings include: During an observation on 04/07/25 at 9:57 AM revealed the smoking area located outside the secured unit had one ashtray with cigarette butts and empty cigarette boxes and the red fire can had paper trash and cigarette butts. The paper trash was observed as burned ash. During an interview on 04/07/25 at 10:03 AM CNA A said that there should not be any paper in the ashtrays or cans because of fire. She said housekeeping was responsible for cleaning out the ashtrays and red fire can daily. She said that residents were supervised when smoking and staff supervising should also make sure paper trash was not disposed of in the ashtrays and red can to prevent fires. During an interview on 04/07/25 at 10:15 am Housekeeper B said she was not aware the smoking area outside the secured unit was her responsibility to clean. She said she started a month ago and was only cleaning inside the facility. She said she would see that the smoking area trash was removed from the cans, so a fire did not happen. During an interview on 04/07/25 at 10:30 AM the Housekeeping Supervisor said the housekeeping department was responsible for the smoking area and should be checking the area daily. She said there should not be any paper trash in the ashtrays or red fire can because of fires. She said she had a turnover of staff and will retrain staff maintaining the smoking area to prevent fires. During an interview on 04/07/25 at 9:55 am the Administrator said the smoking areas were to be maintained by housekeeping and maintenance. He said the areas should be checked daily and the supervising staff with each smoke break should ensure the area was clean, maintained, and no paper trash was mixed with cigarette butts. He said that not properly disposing of cigarette butts and trash could result in a fire. Record review of an undated facility document titled Smoking Area Monitoring Schedule revealed .daily schedule of responsible department to include maintenance and housekeeping schedule to ensure all ash trays are emptied, ensure trash and cigarette butts are being kept in separate containers and red cans are emptied daily . Record review of an undated facility policy titled Smoking Policy - Residents revealed, .this facility shall establish and maintain safe smoking practices .