

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675311	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Fairview Healthcare Residence		STREET ADDRESS, CITY, STATE, ZIP CODE 601 E Reunion St Fairfield, TX 75840	

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675311	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Fairview Healthcare Residence		STREET ADDRESS, CITY, STATE, ZIP CODE 601 E Reunion St Fairfield, TX 75840	
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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident's right to a safe, clean, comfortable, and homelike environment for 1 of 1 resident (Resident #10) reviewed for environment. 1. The facility failed to ensure Resident #10 room floors on halls 100 did not have a buildup of stains and physical dirt, scratches, peeling and chipping paint on the walls. 2. The facility failed to ensure the furniture wood was not chipping in room # 108A for Resident #10. These failures could place residents at risk of a diminished quality of life. [NAME], [NAME] (47243) - EnvironmentFindings included: Review of the undated face sheet for Resident #10 reflected an [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included Alzheimer's disease (Alzheimer's disease is the biological process that begins with the appearance of a buildup of proteins in the form of amyloid plaques and neurofibrillary tangles in the brain), hypothyroidism (Hypothyroidism happens when the thyroid gland doesn't make enough thyroid hormone), hyperlipidemia (is an excess of lipids or fats in your blood), depressive disorder (are characterized by persistent feelings of sadness and worthlessness and a lack of desire to engage in formerly pleasurable activities), anxiety (a feeling of worry, nervousness, or unease about something with an uncertain outcome), and hypertension (a common condition that affects the body's arteries. It's also called hypertension).Review on the quarterly MDS assessment for Resident #10 dated 08/23/24 reflected a BIMS score of 03, indicating severe cognitive impairment. It also reflected she required supervision/touching assistance in the activity of dressing. Observation and interview with Resident #10 on 08/05/2025 at 10:41 AM revealed the floor trim detached from the wall, hanging off wall, walls and dresser draws with scratches, chipping and peeling paint, had deep scratches on the walls and doors and doorways. Resident #10 stated the scratches in the paint were ugly. She stated she do not want to complain because she was just admitted to the facility, but she did not feel she should have to live like that. Observation of the hallways in the facility on 08/05-07/25 revealed there were no floor trim coming off wall hanging off wall detached from wall, walls with scratches and peeling paint deep gouges in doors. However, there was hallways with half painted walls. Interview on 08/07/25 at 10:10 AM, the MAINT revealed the CNAs were usually responsible for cleaning the residents' rooms. He stated he remodeled the rooms when there were not any residents in them. He stated the baseboards were cove based and needed to be repaired. He stated that wallpaper on the walls and it needed to be repaired. He stated the intent was to be done with painting in the halls, but it was the wrong color. He stated he checked the daily logs, and he was the only one doing repairs. He stated he was the only one doing repairs according to the urgency and everyone pitched in to help him paint the facility. Interview on 08/07/25 at 10:35 AM, the ADM revealed the expectation was for maintenance to fix whatever was broken. He stated housekeeping was expected to clean. He stated if the resident was out of the room, housekeeping could deep clean the room. He stated housekeeping picked two rooms and deep cleaned them daily. If there was an infection outbreak, the expectation was to deep clean those rooms daily to keep it from spreading. He stated if the rooms were not clean it could make the resident feel bad. He stated they were picking rooms systematically. During a slower workday, everyone would pitch in to assist with getting some of the rooms done. Interview and observation on 08/07/25 at 11:50 AM, the HSKE revealed she was the supervisor, and she made sure all her staff deep cleaned 2 rooms a week. She stated the staff used a disinfectant spray and wiped down everything. She stated when the residents were not in the room, they wipe down the beds and mattresses. She stated maintenance did all the broken items repairs. She stated there was a book at the nurses' station and they wrote all the repairs that needed to be done in the book, and he looked at it daily. She stated when they were going into the COVID positive rooms, they cleaned them last. She stated her staff gown up and sanitize. They disinfect and clean up everything. Record review of the facility's, undated, policy on Residents Rights reflected .You have a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Review of facility policy dated February 2021 and titled, Homelike Environment reflected the following: Residents are provided with a safe, clean, comfortable, and homelike environment, and encouraged to use their personal belongings to the extent possible.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675311	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Fairview Healthcare Residence		STREET ADDRESS, CITY, STATE, ZIP CODE 601 E Reunion St Fairfield, TX 75840	
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)		
<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to transmit and ensure an MDS was completed and electronically transmitted to the CMS System for within 14 days, after completion resident assessment within the required time frame, for 1 of 6 (Resident #19) residents reviewed for data transmission in that: The facility failed to complete and transmit Resident #19's quarterly MDS completed on 07/05/25. This failure could place residents at risk of not having their assessments transmitted timely and an incomplete record. Findings included:Record review of undated facility face sheet reflected Resident #19 was admitted to the facility on [DATE]. Medical diagnoses diagnosis included Hemiplegia and Hemiparesis following cerebral infarction (paralysis caused by a stroke), Covid 19, Malignant Neoplasm of the Prostate (prostate cancer), and Diabetes Mellitus type 2. Record review of Resident #19's quarterly MDS assessment dated [DATE] reflected the MDS had been completed but was not transmitted. In an interview on 08/07/2025 at 1:41PM, the MDSC stated she was not sure why Resident #19's quarterly MDS from 07/05/2025 was not transmitted. She stated the MDS was checked do not transmit. The MDSC stated that she was responsible for the transmission of the MDS but there was a system error. Record review of policy titled Electronic Transmission of the MDS dated 2021 and revised October 2023 reflected All MDS assessments (e.g., admission, annual, significant change, quarterly review, etc.) and discharge and reentry records are completed and electronically encoded into our facility's MDS information system and transmitted to CMS' Internet Quality Improvement and Evaluation System (iQIES) system in accordance with current OBRA regulations governing the transmission of MDS data. All staff members responsible for completion of the MDS receive training on the assessment, data entry, and transmission processes, in accordance with the Resident Assessment Instrument (RAI) User's Manual, before being permitted to use the MDS information system. A copy of the RAI User's Manual is maintained by the resident assessment coordinator.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675311	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Fairview Healthcare Residence		STREET ADDRESS, CITY, STATE, ZIP CODE 601 E Reunion St Fairfield, TX 75840	

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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675311	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Fairview Healthcare Residence		STREET ADDRESS, CITY, STATE, ZIP CODE 601 E Reunion St Fairfield, TX 75840	
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)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to ensure the resident assessment accurately reflected the resident's status for 1 of 5 residents (Resident #4) reviewed for accuracy of assessments. The facility failed on 6/8/2025 to accurately code Resident #4's hearing ability on his comprehensive MDS assessment. This failure could place residents at risk of incorrect care and services necessary for their physical, mental, and psychosocial well-being. Findings included: Record review of Resident #4's comprehensive MDS, dated [DATE], indicated Resident #4 was a [AGE] year-old male, who was admitted to the facility on [DATE]. His diagnoses included: stroke (when a blood vessel in the brain leaks or bursts and causes bleeding in the brain), aphasia (inability to speak well), dysphagia (difficulty swallowing), hemiplegia (total or nearly complete paralysis on one side of the body) and muscle wasting and atrophy. Resident #4 did not have a BIMS score as question 'C0100. Should Brief Interview for Mental Status be conducted? Was indicated as '0. No (resident is rarely/never understood)'. In 'Section B Hearing' question B0200 indicated that Resident #4 was Highly impaired - absence of useful hearing and question B0700 indicated that Resident #4 was rarely/never understood. Record review of Resident #4's comprehensive MDS, dated [DATE], reflected that Resident #4 did not have a BIMS score as question 'C0100. Should Brief Interview for Mental Status be conducted? Was indicated as '0. No (resident is rarely/never understood)'. In 'Section B Hearing' question B0200 indicated that Resident #4 had Adequate - no difficulty in normal conversation, social interaction, listening to TV' and question B0700 indicated that Resident #4 was 'Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time. Record review of Resident #4's care plan dated last revised 07/28/2025 reflected Resident #4 was very hard of hearing, could read lips, would communicate with head nods, and had a communication problem related to difficulty hearing and aphasia. Interventions included staff to look directly at him and talk slow so he could understand and give him time to process due to the stroke. Record review of a nursing note dated 09/01/2021 reflected, Resident admitted via EMS with personal belongings-hearing aide x1 placed inside table drawer. Unable to speak or help turn-total care x2. Does not appear to be in any pain. Resident is deaf but reads lips- does not appear to understand what is being asked of him and does not follow commands at all. Record review of Resident #4's weekly nursing summary dated 07/29/2025 reflected in section 'D. Communication' Question '1. Ability to express ideas and wants, consider both verbal and non-verbal expression' was answered with '3. Rarely/never understood.'. Question '1a. If impaired ability to make self-understood, choose the example that applies' was answered with '5) Unable to make needs known, all needs anticipated and met by staff. Question '2. Ability to hear (with hearing aid or hearing appliances if normally used)' was answered with '3. Highly impaired' Record review of Resident #4's progress note dated 07/29/2025 reflected, Resident's responsible party had inquired about hearing testing services. Resident to be referred to [hearing aid center] that services nursing home residents. Face sheet sent to [hearing aid center] for implementation of referral process. In an observation and attempted interview on 08/05/2025 at 10:31 AM Resident #4 was in his bed asleep and did not arouse when the surveyor was talking or nearing his bedside. After about 30 minutes of the state surveyor speaking with Resident #4's roommate, Resident #4 appeared to be awake. When asked by the surveyor about his stay at the facility, his care, and his daily activities, Resident #4 just blankly stared at the surveyor and did not respond with head gestures or words. In an additional attempted interview and observation on 08/06/2025 at 11:17 AM Resident #4 was lying in bed revealed when the state surveyor asked him how he was doing, he had a blank stare and shook his head in a 'no' motion about 45 seconds after being asked. When the state surveyor asked for permission to check his bedside table for hearing aids, he slowly moved his head to look in the direction of the surveyor's finger, but he did not respond with head movements or words. In an interview on 08/06/2025 at 11:29 AM with LVN A she stated she had worked at the facility almost 4 years. She stated that Resident #4 never pressed his call light. She stated that he worked with occupational therapy, received tube feedings, and that when the aides provided check and change of undergarments, he could hold the bed rail with his one good side. She stated that he was able to understand the staff, but he was not able to communicate his needs at all due to his diagnosis of stroke. She stated that he was not a big fan of being up out of bed. She stated that when Resident #4 first admitted, he had hearing aids, but she was unsure what happened with them, and she stated he was able to hear based on his ability to help during check and change. In an interview/observation</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675311	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Fairview Healthcare Residence		STREET ADDRESS, CITY, STATE, ZIP CODE 601 E Reunion St Fairfield, TX 75840	
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on 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 2 medication carts reviewed. The facility failed on 07/27/2025 to sufficiently record the accurate reconciliation of controlled substances. This failure could place residents at risk of misappropriation of resident medication. Findings included: Record review on 08/05/2025 at 2:07 PM of the [NAME] wing medication cart's narcotic sign on and sign off sheet revealed that LVN E failed to sign that the narcotics were counted with LVN D when LVN E assumed the medication cart on 7/27/2025, and when she handed off the medication cart at the end of her shift on 7/27/2025 to LVN D. In an interview on 08/05/2025 at 2:30 PM with LVN D she stated that she always signed off with someone when doing the narcotic count. She stated that 2 people always counted the cart, it was required that the person coming on shift and the person going off shift, were to count the cart together and sign that it was done. She stated she passed the cart off to LVN E on 7/27. She stated that immediately after counting they were supposed to sign off on the narcotic sign on and sign off log. She stated that once she finished counting, and signed the narcotic log, she did not stand there to watch the other person sign. She stated the purpose of counting the narcotics was to keep an accurate count of the narcotics and verifying that all medications were accounted for. She stated it helped if there was a medication discrepancy, they would know who worked. She stated a negative outcome was that if medications were not accounted for it was an issue of misappropriation. If she had a discrepancy in count, she had to immediately notify her DON. In an interview on 08/06/2025 at 1:10 PM with LVN E she stated that she had worked at the facility for about 5 years and recently went PRN. She stated that she did always count the cart at the beginning of her shift with the outgoing nurse and then she would count the cart at the end of her shifts with the oncoming nurse. She stated that she did not know why she did not sign the sign off sheet on 07/27/2025 but that it was hers and the facility's practice to not assume the medication cart until counting with the prior shift nurse. She stated that it was the responsibility of both the outgoing nurse and the oncoming nurse to sign the log as proof of the narcotics being counted together. She stated that a negative outcome would be that it could appear that the narcotics were not being counted amongst the shift changes. In an interview on 08/07/2025 at 9:17 AM with the DON she stated the purpose of the narcotic sign on and sign off log was to verify that the narcotic count on the cart was correct. When asked what would blanks on the narcotic log indicate to her, she stated that she would first question if a 2-person count occurred, but ultimately it would tell her if the cart was properly counted by the outgoing and ongoing nurse. She stated that signing the log was for quality control measures, and it could affect the residents' if their medications were not being counted and if doses were missing. She stated it was the responsibility of both nurses to sign the log when handing it off and when assuming it. She stated they (DON or ADON) should verify the logs weekly. She stated that when the sheet ran out of space, it would be turned into and verified by the ADON or DON. Review of the facility's policy titled 'Controlled Substances' dated July 2025 reflected: Controlled substances are counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals sign the designated controlled substance record. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675311	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Fairview Healthcare Residence		STREET ADDRESS, CITY, STATE, ZIP CODE 601 E Reunion St Fairfield, TX 75840	

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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675311	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2025
NAME OF PROVIDER OR SUPPLIER Fairview Healthcare Residence		STREET ADDRESS, CITY, STATE, ZIP CODE 601 E Reunion St Fairfield, TX 75840	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program designated to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 4 of 6 residents (Resident #3, Resident #19, Resident #32, and Resident #33) reviewed for infection control. The facility failed to supply staff with proper eye/face PPE for Resident #19 who was in droplet isolation during an observation of supplies on 08/05/2025. MA C failed to properly sanitize the blood pressure cuff after use on Resident #3 and Resident #33 during an observation of medication administration on 08/06/2025. MA C touched medications with her fingers prior to administration to Resident #38 during an observation of medication administration on 08/06/2025. This failure could place residents at risk for infection by the spreading of germs that could lead to illness and hospitalization. Findings included: Resident #19 Record review of undated facility face sheet reflected Resident #19 was admitted to the facility on [DATE]. Medical diagnosis included Hemiplegia and Hemiparesis following cerebral infarction (paralysis caused by a stroke), Covid 19, Malignant Neoplasm of the Prostate (prostate cancer), and Diabetes Mellitus type 2. Record review of Resident #19's Quarterly MDS dated [DATE] reflected a BIMS score of 12 indicating moderate cognitive impairment. Record review of Resident #19's care plan dated 07/27/2025 reflected he tested positive for covid 19 on 07/27/25 and interventions included Quarantine in their room. Notify family and encouraged to limit visitation and to wear masks while in the facility, full PPE when in a positive resident's room. Droplet and contact precautions. In an observation 08/05/2025 at 9:45am 4 (four) white plastic bins were located outside of rooms in the hallway. The bins contained PPE, blue gowns and surgical mask. Resident #19 had a sign on his room door indicating he was in isolation with droplet precautions. Staff were observed going in and out of Resident #19's room not wearing face shield or eye protection. There were no face shields or eye protection available/accessible for staff in the PPE bins. Resident #3 Record review of undated facility face sheet reflected Resident #3 was admitted on [DATE]. Diagnosis included Heart Failure, Hyperglycemia (elevated blood sugar), Hypertension (elevated blood pressure), and Lack of Coordination. Record review of Resident #3's care plan dated 06/09/2024 and updated 12/27/2024 reflected an alteration in cardiovascular status (a disease process affecting the heart). Interventions included to monitor Vital Signs (blood pressure, heart rate, respirations, and temperature) everyday as ordered. Notify physician of any abnormal readings. Record review of Resident #3's quarterly MDS dated [DATE] reflected a Bims score of 15 indicating he was cognitively intact. In an observation of medication administration on 08/06/2025 at 9:44 AM, MA C checked Resident #3's blood pressure using an electronic wrist cuff. MA C completed the check and cleansed the blood pressure cuff with alcohol-based hand sanitizer and nose tissue. Resident #33 Record review of undated facility face sheet reflected Resident #33 was admitted on [DATE]. Diagnosis included Major Depressive Disorder, Hyperglycemia (elevated blood sugar), Anxiety, and Hypertension (elevated blood pressure). Record review of Resident #33's care plan dated 05/05/2025 reflected an alteration in cardiovascular status. Interventions included to Obtain blood pressure readings as ordered. Take blood pressure readings under the same conditions each time. For example, resident is sitting, use right arm. Record review of Resident #33's quarterly MDS dated [DATE] reflected a Bims score of 14 indicating she was cognitively intact. In an observation of medication administration on 08/06/2025 at 9:56AM, MA C checked Resident #33's blood pressure using an electronic wrist cuff. MA C completed the check and cleansed the blood pressure cuff with alcohol-based hand sanitizer and nose tissue. Resident #32 Record review of undated facility face sheet reflected Resident #32 was admitted on [DATE] and readmitted on [DATE]. Diagnosis included Senile Degeneration of the Brain (a disorder of the brain resulting in confusion), chronic kidney disease (failure of the kidneys), Major Depressive Disorder (depression), and Lack of Coordination. Record review of Resident #32's quarterly MDS dated [DATE] reflected a Bims score of 14 indicating she was cognitively intact. Record review of Resident #32's care plan dated 06/09/2024 reflected an alteration in respiratory status. Goals included The resident will be free of signs of respiratory infections through review date. Interventions included Monitor/document/report to MD PRN any signs of respiratory infection Fever, Chills, increase in sputum (document the amount, color and consistency), chest pain, increased difficulty breathing (Dyspnea), increased coughing and wheezing. In an observation of medication administration on 08/06/2025 at 10:10AM MA C prepared Resident #32's medication for administration</p>		