

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675439	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Mullican Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 105 North Main Street Savoy, TX 75479	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review the facility failed to ensure the emergency crash cart was equipped with a readily available oxygen supply when an empty oxygen cylinder was identified on the crash cart for 1 of 1 crash carts reviewed. The facility failed to ensure the facility's crash cart had an oxygen cylinder that was not empty and ready for use on 07/22/2026. This failure placed resident at risk of delay if administration of oxygen during a resident emergency placing resident at risk of delayed emergency treatment. Finding included: Observation on 07/22/2026 at 1:30 p.m., of the emergency crash cart revealed the oxygen cylinder attached to the crash cart registered at 0 psi, indicating the oxygen tank was empty. Interview on 07/23/2026 10:19 a.m., CNA C stated that staff would obtain oxygen from the crash cart during a resident emergency and that the nurse would turn the oxygen on. The CNA C stated it was their understanding that crash cart oxygen was checked by the night nurse and that oxygen should be readily available for emergency situations. Interview on 07/23/2026 at 10:32 a.m., CNA B stated Oxygen should be readily available for emergency situations. The CNA B stated staff should be able to turn the knob on the oxygen cylinder and have a full tank available not an empty tank because residents could require oxygen during an emergency. Interview on 07/23/2026 at 10:46 a.m., LVN A stated the Oxygen cylinder on the crash cart should be full and not empty for emergency use the LVN A stated the nurse was responsible for checking the crash cart and all nursing would use the crash cart in an emergency situation. The LVN A stated the resident was at risk of delayed care in an emergency situation. Interview on 07/23/2026 at 10:54 a.m., The ADON stated the crash cart was expected to be checked every night and that the oxygen cylinder should be full and readily available for emergency situations. The ADON stated Residents were at risk of not having oxygen available during an emergency. The ADON stated she expected all nursing to be able to check the oxygen cylinder and ensure it was full. Interview on 07/23/2026 at 11:39 a.m., The DON stated the oxygen tank on the crash cart should not be empty and should be available for resident emergencies. The DON stated the crash cart was checked daily and that the night shift nurse was responsible for verifying the oxygen supply. The DON stated that she was unaware that oxygen tank was empty. The DON stated residents were at risk of not having oxygen during an emergency. Interview on 07/23/2026 at 12:32 p.m., the Administrator stated she expected nursing staff to ensure the crash cart had a full oxygen cylinder on the cart. The Administrator stated the residents were at risk of low oxygen level and delayed care. The Administrator stated that she expected the oxygen cylinder level to be checked daily. The Administrator was unaware of the empty oxygen cylinder on the crash cart. Record review of oxygen policy dated 02/2007 revealed the goal was for resident will maintain safe and effective prescribed oxygen delivery. Record review on 07/23/2026 revealed facility did not have a crash cart policy.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services. The facility failed to ensure: a pan with ground sausage was labeled and dated a container of turkey pot roast was discarded by the use by date of 07/16/2026. These failures could place residents at risk for food contamination and foodborne illness. Findings included: During an observation with the Dietary Manager on 07/20/2026 starting at 10:38 AM, there was a pan with ground sausage with no label or date and a container with turkey pot roast with a use by date of 07/16/2026 in the refrigerator in the kitchen. During an interview on 07/22/2026 at 2:42 PM, the Dietary Manager said all food in the refrigerator should be labeled and dated. He said expired food items were discarded on Mondays and Fridays. He said he was responsible for discarding expired food items and ensuring food was labeled and dated. He said he was not in the facility on Friday, so he did not discard expired food items. The Dietary Manager said he placed the pan of ground sausage in the refrigerator while preparing breakfast on 07/20/2026 and had not placed a label or date on the pan because he was in a hurry. The Dietary Manager said food should be labeled and dated and expired food items discarded because the residents could get sick. During an interview on 07/23/2026 at 10:37 AM, the Administrator said her expectations were all food items in the refrigerator were labeled, dated when opened, and dated with an expiration date. She expected expired food to be disposed of. The Administrator said the entire kitchen staff were responsible for ensuring food was properly labeled and disposed. The Administrator said she conducted random checks in the kitchen and if she noticed items needed to be labeled or discarded, she threw them away. The Administrator said not properly labeling/dating and not discarding expired food items could result in food borne illness. Record review of the facility's undated policy titled, Food Safety, indicated, Opened food shall be labeled, dated and stored properly. Record review of the facility's undated policy titled, Left-Over Foods, indicated, Food that is spoiled, contaminated, or suspect shall not be served and shall be discarded immediately.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for 1 of 1 Women's Secure Unit reviewed for a comfortable environment. The facility failed to ensure a comfortable environment was provided in the Women's Secure Unit dining room when the temperature was between 87-90.7 F on 07/21/2026. This failure could place residents at risk for heat-related illness, hospitalizations, and a decreased quality of life. Findings included: During an interview on 07/21/2026 at 8:21 AM, Resident # 5 said it had been hot in the Women's Secure Unit dining room lately. She was unable to provide a timeframe. During an observation and interview on 07/21/2026 at 3:21 PM, Resident #12 said it was hot in the Women's Secure Unit dining room. She appeared flushed but was not sweating. Resident #9 was flushed but not sweating, and she was unable to express how she felt due to her cognitive status. There were fans in the dining room, residents sitting in the dining area had water within reach, and the other residents in the dining room did not appear to be flushed or sweating. CNA G said it might have been about 2 weeks ago that the window unit in the Women's Secure Unit broke and it had been hot in the dining area. She said fans were placed in the dining room, but they were not helping. CNA G said the Maintenance Director was aware that the window unit was broken. She said none of the residents had complained to her about being too hot, and no residents had experienced any adverse effects related to the heat. During an interview on 07/21/2026 at 3:29 PM, a family member said it had been extremely hot in the dining room area for about 2 months, and she had reported it to administration and the ADON. The family member said the ADON told her it was being fixed and they had ordered parts for the window unit. During an observation of the dining room in the Women's Secure Unit with the Maintenance Director on 07/21/2026 at 3:45 PM, the temperature was 87-90.7 F. During an interview on 07/21/2026 at 3:54 PM, the Maintenance Director said one of the air conditioning units on the women's secure unit had not been working for about a month. He said he replaced the plug in it, but it still did not work, and he tried fixing it but it needed an electrician. He said he had been in contact with the electrician and was waiting for the electrician to go to the facility to fix the unit. He said he placed fans in the dining area to keep it cool, since the rest of the unit and resident rooms were cool. The Maintenance Director said he had been checking the temperature in the dining area of the Women's Secure Unit every other day, and it had been between 81-90 F at the peak of the day. The Maintenance Director said if the temperature in the Women's Secure Unit was too high the residents could get sick. During an observation and interview on 07/22/2026 at 2:49 PM, the Maintenance Director said the electrician had been to the facility, and the window unit on the women's secure unit was now functioning properly. An observation was made of the women's secure unit and the dining area was cool, and the window unit was functioning. During an interview on 07/23/2026 at 10:13 AM, LVN A said she was not aware of the dining room in the women's secure unit being hot. LVN A said she had not noticed any temperature issues, and none had been reported to her. LVN A said if there were any issues with the air conditioning units or with the temperature of the environment it should be reported to the Maintenance Director for him to address. LVN A said if the temperature was too high the residents could start feeling ill, their temperatures would go up, and they could dehydrate. LVN A said none of the residents in the women's secure unit had experienced any adverse events related to heat exposure. During an interview on 07/23/2026 at 10:16 AM, the ADON said one of the CNAs reported to her last week that it was hot in the dining room in the women's secure unit. The ADON said she went to the women's unit, and it was warm but not (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	excessively hot. She said at the time it was 79. She said she notified the Maintenance Director, and he said he ordered a part for the air conditioning unit, and he placed fans in the area to cool it off. The ADON said she had not received any complaints from family members or residents about the dining room in the women's secure unit being hot. The ADON said the temperature being high was not good for the residents' health and they could get overheated. During the interview on 07/23/2026 at 10:21 AM, the DON said she was not aware it had been hot on the women's secure unit or that the air conditioning unit was not functioning. She said if it was hot or the air conditioning unit needed to be repaired, it would be reported to the Maintenance Director for him to address. The DON said if there were complaints regarding the temperature it should be checked. The DON said the temperature being too high could be uncomfortable for the residents, and it would not be good for them and the residents would need to be moved to a different area. During an interview on 07/23/2026 at 10:30 AM, the Administrator said she was not aware of any temperature issues on the women's secure unit. She said anything above 81 degrees would require evacuation of the residents to a different area of the facility. The Administrator said the Maintenance Director was responsible for ensuring safe temperatures were maintained. She said temperatures above 81 were dangerous and could cause heat strokes, heat exhaustion, and heat related illnesses. Record review of the facility's discharges for the past 6 months did not indicate any residents had been hospitalized related to heat exposure. During an interview on 07/23/2026 at 1:23 PM, the Administrator said they did not have a policy on temperature for the environment.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for 1 out of 2 residents (Resident #25) reviewed for pressure ulcers. LVN A failed to provide wound care to Resident #25 according to physician orders for a stage III pressure ulcer. This failure could place residents at risk of complications which include worsening of existing wounds, development of new wounds, and infection. Findings included: Record review of face sheet dated 07/22/2026 revealed Resident #25 was a [AGE] year-old male admitted to the facility on [DATE] with a primary diagnosis of Parkinson disease without dyskinesia (standard stiffness, shaking, and slowness, but no extra, uncontrolled writhing movements). Record review of care plan with the revision date 07/02/2026 revealed Resident #25 had a care plan for a pressure ulcer or potential for pressure ulcer development to the buttocks and right hip. Resident #25 care plan included intervention of to keep Resident #25 positioned off coccyx, report loose or missing dressings to the nurse, notify nurse of new skin breakdown, and provide wound care according to physician orders. Record review of quarterly MDS dated [DATE] revealed Resident #25 at risk of developing pressure ulcers. MDS revealed 0 unhealed pressure ulcers identified on MDS quarterly assessment. MDS assessment revealed Resident #25 had a BIMS of 07 indicating severe impairment. MDS assessment revealed Resident #25 was occasionally incontinent of bladder and frequently incontinent of bowel. Record review of order summary reported dated 07/22/2026 revealed Resident #25 had an order for wound care with the start date of 07/22/2026. Order stated clean right hip with normal saline, pat dry, apply anasep and collagen, then cover with dry dressing one time a day every Monday, Wednesday, Friday for wound healing. Order started on 07/22/2026 stated order to clean the wound to the coccyx with wound cleaner, apply methylene blue foam, and cover with dry dressing everyday and PRN if saturated, soiled, or dislodged. The order for the coccyx was ordered for one time a day for wound healing. Record review of weekly skin report dated 07/02/2026 revealed Resident #25 had 2 identified wounds which were located on his coccyx and right hip. Record review of weekly report dated 07/20/2026 revealed Resident #25 had a new identified stage I pressure wound located to the left hip. Record review of Wound Care Report date 07/22/2026 revealed Resident #25 had been seen by the wound care doctor and measurements for coccyx were 8.5cm X 3.5cm X 1.5cm for the. Observation 07/22/2026 at 1:35 p.m., revealed during the survey a previously unidentified pressure injury noted to be reddened area unblanchable measuring 0.5cm X 0.7cm X 0.35cm was observed on Resident #25 left hip. Observation of wound care provided to Resident #25 LVN A did not follow physician orders when the LVN A sprayed the wound to the coccyx with wound cleaner and skipped the step of cleaning the wound and patting it dry. Interview on 07/23/2026 at 10:09 a.m., CNA C stated she was responsible for checking Resident #25 brief, changing Resident #25 brief during incontinent care, and rolling Resident #25 to perform care to Resident #25. CNA C stated Resident #25 was supposed to be offloading off his coccyx and right hip due to wounds. CNA C stated the DON incited yesterday turning every 2 hours and floating and using barrier cream. CNA C stated Resident #25 was at risk of pressure because he had been in more pain and staying in bed. CNA C stated that to her knowledge the nurses do wound care. CNA C stated the resident was at risk of wound worsening if he was not turned, changed, to prevent skin breakdown. CNA C stated elderly skin is thinner and breaks down faster. Interview on 07/23/2026 at 10:27 a.m., CNA B stated she knew Resident #25 had a pressure on his butt and right hip. CNA B stated she was (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible for floating his body with pillow. CNA B stated she was aware of the red spot to the left hip and it had been red for a couple of days. CNA B stated she reported it to her nurse. CNA B stated a new order for the CNAs to turn every 2 hours, and barrier cream was started yesterday 7/22/2026. CNA B stated Resident #25 was at risk for pressure ulcer CNA B stated that nursing was responsible for ensuring wound care was completed and prevented wounds from forming. Interview on 07/23/2026 at 10:40 a.m., LVN A stated she was supposed to follow physician orders when providing wound care. LVN A stated she was aware of the wound located on his right hip and coccyx, but the left hip wound was new and she was not notified. LVN A stated CNAs typically turned him on to the left hip to change his brief and off load his bottom. LVN A stated that she was not aware of Resident #25 needed to be on a turn schedule to reduce pressure to the left hip. LVN A stated Resident #25 was at risk of further skin breakdown with moisture from leaving the wound cleanser when she performed wound care to Resident #25. LVN A stated she expected the CNA to check and change every 2 hours. LVN A stated that she was nervous during observation of wound care and messed up. Interview on 07/23/2026 at 10:53 a.m., the ADON stated she expected wound care orders to be followed. ADON stated she was not aware until yesterday when the surveyor and DON identified the new pressure area located on the left hip. The ADON stated she was responsible for overseeing that the CNAs checked, changed, and repositioned Resident #25. The ADON stated Resident #25 should have been on a turn schedule, but it was not started until yesterday. The ADON stated he was high risk for skin breakdown due to his boney area located on his hips. The ADON stated she expected the nurse to be notified of new skin conditions. Interview on 07/23/2026 at 11:39 a.m., the DON stated that she observed the wound care. The DON stated she expected wound care orders to be followed. The DON stated she expected offloading with pillows to reduce pressure to the coccyx and right hip. The DON stated Resident #25 frequently layed on his right side which created a greater risk of skin breakdown. The DON stated she was unaware of the left hip pressure until surveyor identified it during observation of wound care to the coccyx and right hip. The DON stated she expected the CNA to notify the nurse of any skin changes. The DON stated Resident #25 was at risk of worsening wounds. Interview on 07/23/2026 at 12:14 p.m., the Administrator stated she expected wound care to be done according to physician order the nursing staff. The Administrator stated that his wound could have been prevented with interventions of turning every two hours. The Administrator stated that she was aware of the resident having the wound located on his coccyx and right hip. The Administrator stated she expected nursing to care for, treat, and prevent worsening of pressure ulcers. Record review of pressure injury: prevention, assessment and treatment policy revision dated 5/5/2025 revealed Nursing Prevention: The nurse can assist in the prevention of pressure injuries by performing the following nursing interventions: NOTE: Add any interventions to care plan.1. Determine resident's skin tolerance to pressure and develop a turning schedule; residents should be turned every two (2) hours or more often if necessary and notify the Treatment Nurse/designee of any potential problems. Assessment: 1. All residents should have a skin assessment on a weekly basis completed in PCC. 2. If the resident has any type of ulcer (pressure injury, arterial, venous, diabetic) an ulcer assessment should be completed at least weekly. Nursing Care Plan: 1. Identify the problem of pressure injuries on the Nursing Care Plan. 2. Under Nursing Intervention physician ordered treatments.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible in 1 of 6 shower rooms (located on the men's memory care unit) and in 1 of 8 Resident's room (Resident #40 in room [ROOM NUMBER]a) observed for safety hazards. 1.The facility failed to ensure the hygiene supply storage cupboard located on the men's memory care unit in the community shower room with supply items to include bottles of shampoo, body wash, shaving cream, and razors were secure and hygiene items were not accessible to cognitively impaired residents on 07/20/2026 at 12:27 p.m 2. The facility failed to ensure five disposable razors were secured and not left in room [ROOM NUMBER]a on Resident #40's over the bed table on 07/20/2026 at 11:57 a.m. These deficient practices could place residents at risk for harm or injury from sharp objects and liquids that are harmful if swallowed. The findings included: Observation of the men's memory care unit common shower room on 07/20/2026 at 12:27 p.m. revealed the bath hygiene storage cupboard was unsecured and contained a gallon of shampoo (opened with no lid) approximately 1/2 full, 5 cans of shaving cream, 4 disposable razors, 1 hairbrush and 6 bottles of body wash with varying levels of fullness. During an interview on 07/20/2026 at 11:12 a.m., CNA D stated that she was aware that the shower room supply cupboard was not secured and that she had not seen any residents taking items from the cupboard. CNA D stated that the residents could get sick if they drank from the shampoo or soap containers or they could cut themselves on the sharp razors. During an interview on 07/21/26 at 8:36 a.m., CNA E stated that the shower room is always unlocked and the residents on the memory care unit will often enter the restroom without assistance. CNA E stated that she would talk to the DON about getting a lock on the cupboard. During an interview on 07/22/2026 at 3:45 p.m. the ADON stated that it was important to keep hygiene supply items out of resident's reach, especially on the memory care unit and that she would notify the maintenance director to provide a lock for the storage cupboard. The ADON stated that Resident #40 should not have had disposable razors in his room and she would provide in-service for the staff on the memory care unit to ensure this does not happen again. Observation of room [ROOM NUMBER]a on 07/20/2026 at 11:57 a.m. revealed five disposable razors on the bedside table next to Resident #40's bed. Record review of Resident #40's face sheet dated 07/20/2026 revealed an [AGE] year-old male admitted [DATE] and readmitted [DATE]. Resident #40 resided on the men's secure memory care unit with diagnoses which included Alzheimer's dementia (loss of brain function that worsens over time), Major Depressive Disorder (persistent sadness or worry), Hypertension (high blood pressure), left eye blindness, and long-term use of anticoagulant (blood thinner). Record review of Resident #40's Quarterly MDS dated [DATE] revealed highly impaired hearing, resident was usually understood and was usually able to understand what was said to him with moderately impaired hearing and a BIMS score of 8 which indicated moderate cognitive impairment. Resident #40 required the use of a walker for mobility, was independent in eating, required supervision with bathing, dressing, transfers, and bed mobility. Record review of Resident #40's Care Plan with target date 09/27/2026 revealed impaired cognitive function or impaired thought processes, impaired visual function, and activities of daily living self-care performance deficit with intervention to assist with personal hygiene as required to include hair, shaving and oral care as needed. During an interview on 07/20/2026 at 11:12 a.m., CNA D stated that she had not given Resident #40 razors, had not noticed the razors in his room and was not sure if someone had given him the razors or if he took them from (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the restroom. CNA D stated she would remove the razors from his room for safety. During an interview on 07/21/2026 at 8:36 a.m., CNA E stated that she does not think it is safe for the residents to have disposable razors in their room because they could cut themselves. CNA E stated that the razors should have been in a locked area so Resident #40 could not get them on his own. During an interview on 07/23/2026 at 11:37 a.m., the DON stated that she expects the hygiene supply items and sharps like razors be kept out of reach of all residents, especially the residents who reside on the memory care wing. The DON stated that the risk was that residents could ingest dangerous liquids or cut themselves on the razor blades. During an interview on 07/23/2026 at 12:00 p.m., the Administrator stated that she was not aware the hygiene supply cupboard was not secured and items were accessible to the residents and put them at risk of becoming sick or injured. The Administrator stated that she expects the nursing staff to monitor the supplies and keep them out of reach from the residents. The Regional Nurse stated the facility did not have a policy regarding securing hygiene supply items and sharp items. Risks and Environmental hazards as identified in Appendix-PP of the State Operations Manual, Revised 08/08/2024, revealed in order to be considered hazardous, an element of the resident environment must be accessible to a vulnerable resident. Resident vulnerability is based on risk factors including the individual resident's functional status, medical condition, cognitive abilities, mood, and health treatments. Certain sharp items may be hazardous for others with cognitive impairments. Examples of such hazards might include improper storage and access to toxic chemicals.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were offered sufficient fluid intake to maintain proper hydration and health for 1 of 3 residents (Resident #4) reviewed for hydration. The facility failed to ensure Resident #4 had water available in her room to drink on 7/20/26 and 07/21/26 . This failure could place residents at risk for dehydration (occurs when your body loses more fluid than you take in), electrolyte imbalance (occurs when certain mineral levels in your blood get too high or too low), and infections. Findings included: Record review of Resident #4's face sheet, dated 07/22/26, reflected Resident #4 was an [AGE] year-old female, re-admitted to the facility on [DATE]with diagnoses which included dementia (a decline in mental ability that interferes with daily life), muscle weakness, anxiety (a feeling of unease, worry, or fear, often experienced as a normal reaction to stress), and depression (a common mental health condition characterized by persistent sadness and a loss of interest in activities, significantly impacting daily life).Record review of Resident #4's quarterly MDS assessment, dated 05/16/26, reflected Resident #4 rarely made herself understood, and was sometimes understood by others. Resident #4 had severe impairment in cognitive skills for daily decision making. The MDS indicated Resident #4 was dependent on ADLs such as eating and personal hygiene. Record review of Resident #4's comprehensive care plan revised 05/16/25 indicated Resident #4 had a history of fall. The intervention was for staff to keep needed items, water, etc., in reach. During an observation on 07/20/23 at 1:43 p.m. Resident #4 did not have a water pitcher in the room.During an observation and attempted interview on 07/21/23 at 9:26 a.m. Resident #4's did not have a water pitcher in her room. Resident #4 did not answer when asked about her water pitcher due to her impaired cognition.During an interview on 07/21/26 at 9:30 a.m., CNA C came in the room and verified Resident #4 did not have a pitcher in her room. She said she was Resident #4's aide on yesterday (07/20/26) and today (07/21/26). She said she did not notice that Resident #4 did not have a water pitcher in her room. She said she was supposed to offer fluid any time she provided care but could not recall if she did. She said everyone should have a water pitcher in their room for hydration. She said she would get her a cup.During an observation on 07/21/26 at 2:30 p.m., Resident #4 was sitting up in her chair with water at her bedside.During an interview on 07/23/26 at 11:00 a.m., LVN A said she expected all residents to have some type of cup in their room to receive fluids. She said she was not aware Resident #4 did not have a water pitcher in her room. She said it was everyone's responsibility to ensure residents had some way of receiving fluids to prevent dehydration.During an interview on 07/23/26 at 11:26 a.m., the DON said she expected all residents to have water at their bedside and within reach. She said everyone should ensure staff had water at bedside. She said it was important to have water at bedside to maintain hydration and prevent dehydration. During an interview on 07/23/26 at 11:43 a.m., the Administrator said she expected all residents to have water at their bedside. She said she expected staff to change out water in the morning and in the evening. She said all staff were responsible for ensuring all residents had some way of receiving fluid to maintain proper hydration.Record review of the facility's policy titled, Hydration, dated 03/2024, indicated, Goals: #1. The residents will maintain adequate hydration. Procedure: #3. Fresh water will be maintained at bedside.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that the medication error rate was not 5 percent or greater. The facility had a medication error rate of 8%, based on 2 errors out of 25 opportunities, which involved 2 of 5 residents (Resident #42 and Resident #10) reviewed for medication administration. 1. The facility failed to ensure Resident #10's was free from medication error when LVN A did not prime insulin pen Novolin R (medication used to treat high blood sugar) on 07/22/2025. 2. The facility failed to ensure Resident #42's was free from medication error when LVN A did not prime insulin pen Novolog (medication used to treat high blood sugar) on 07/22/2025. These failures could place residents at risk of not receiving the therapeutic effects of their medications, possible adverse reactions, and medication errors. Findings included: Record review of face sheet dated 07/22/2026 revealed Resident #10 was an [AGE] year-old male admitted to the facility on [DATE] with the diagnosis of dementia (severe memory loss) and type 2 diabetes (condition that effects blood sugar control). Record review of care plan dated 10/02/2025 revealed Resident #10 had a care plan for Diabetes Mellitus (condition that effects blood sugar control) with the intervention of diabetes medication as ordered by physician. Record review of Quarterly MDS dated [DATE] revealed Resident #10 had a BIMS of 14 indicating no cognitive impairment. The MDS assessment revealed an active diagnosis of Diabetes Mellitus. Record review of order summary report dated 07/22/2026 revealed Resident #10 had an order for NovoLog Flex Pen subcutaneous Pen-Injector 100UN/ML to inject per sliding scale: if 180 - 200 = 2U; 201 - 230 = 3U; 231 - 260 = 4U; 261 - 290 = 5U; 291 - 320 = 6U; 321 - 350 = 7U; 351 - 400 = 8U and Greater than 400, give 10 units and notify the doctor. Record review of Nursing MAR dated 07/22/2026 revealed Resident #10 had a blood sugar of 336 and 7 units were administered according to documentation. Record review of face sheet dated 07/22/2026 revealed Resident #42 was a [AGE] year-old male admitted to the facility on [DATE] with the diagnosis of type 2 diabetes mellitus (condition that effects blood sugar control). Record review of care plan dated revision date 01/10/2024 revealed Resident #42 had a care plan for Diabetes Mellitus with the intervention to receive diabetes medication as ordered by physician. Record review of Annual MDS assessment dated [DATE] revealed Resident #42 had a BIMS of 11 indicating moderate cognitive impairment. MDS assessment indicated resident had an active diagnosis of Diabetes Mellitus. Record review of order summary report dated 07/22/2026 revealed Resident #42 had an order for Novolin R solution 100 units/ML to inject per sliding scare: if blood sugar is 70 - 130 = 0U; 131 - 180 = 2U; 181 - 240 = 4U; 241 - 300 = 6U; 301 - 350 = 8U; 351 - 400 = 10U If greater than 400, 12 units and call doctor. Record review of Nursing MAR dated 07/22/2026 revealed Resident #42 had a blood sugar of 154 and 2 units were administered according to documentation. Observation on 07/22/2026 at 11:23 a.m., revealed LVN A failed to prime (remove air from the needle) Resident #10's insulin pen prior to administering 7 units of Novolog to Resident #10. Observation on 07/22/2026 at 11:30 a.m., revealed LVN A failed to prime (remove air from the needle) Resident #42's insulin pen prior to administering 2 units of Novolin R to Resident #42. Interview on 07/22/2026 at 11:32 a.m., LVN A stated that the DON showed her how to prime the insulin pen when she checked off her skills. LVN A stated at the time of check off she returned demonstrated. LVN A was unable to recall exact date of skills check off. Interview on 07/23/2026 at 10:47 a.m., LVN A stated she was unaware she did not prime the insulin pens for Resident #42 and Resident #10 when she administer insulin to both residents. LVN A stated she notified the DON of incorrectly performing priming of the insulin pen and she now knows how to properly turn and prime. LVN A stated she was supposed to prime the insulin (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and administer according to manufacture instructions. LVN A stated Resident #42 and Resident #10 was at risk of receiving less or more needed insulin than ordered when she did not properly prime the insulin pen to remove the air in the needle. LVN A stated Resident #42 and Resident #10 was at risk of adverse effects of insulin. Interview on 07/23/2026 at 10:54 a.m., the ADON stated she expected medications to be administered without error. ADON stated nursing staff who pass medications were checked off when hired. The ADON stated she expected insulin to be primed per manufacturer guidelines. The ADON stated Resident #42 and Resident #10 had the right to be free from medication error and received the physician ordered dose to treat the condition effectively. The ADON stated Resident #42 and #10 was at risk of high or low blood sugar. Interview on 07/23/2026 at 11:39 a.m., the DON stated she expected LVN A to prime the insulin pen according to the manufacturer guidelines when administering Resident #42 and Resident #10 insulin. The DON stated that Resident #42 and Resident #10 were at risk of high or low blood sugar. The DON stated Resident #42 and Resident #10 were at risk of adverse reactions of insulin. Interview on 07/23/2026 at 12:21 p.m., the Administrator stated she expected all medications including insulin pens to be administered according to manufacturer guidelines and physician orders. The Administrator stated Resident #42 and Resident #10 were at risk of adverse events due to inaccurate dosing. The Administrator stated insulin was for blood sugar control and it could have caused too high or too low blood sugar. Record review of Medication Administration and General Guidelines policy undated, revealed medications are administered in accordance with written orders of the attending physician. Record review of Insulin Pen Use policy revision date 04/01/2015 revealed always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by ensuring that pen and needle work properly and removing air bubbles. Policy revealed insulin pen should be primed by: A. Select a dose of 2 units by turning the dosage selector. B. Hold the pen with the needle pointing upwards. C. Tap the insulin reservoir so that any air bubbles rise up towards the needle. D. Press the injection button all the way in. Check if insulin comes out of the needle tip.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that residents were free of significant medication errors for 2 of 5 residents (Resident #10 and Resident #42) reviewed for pharmacy services. 1. The facility failed to ensure LVN A primed Resident #10's insulin pen Novolin R (medication used to treat high blood sugar) on 07/22/2025 according to manufacture instructions. 2. The facility failed to ensure LVN A primed Resident #42's insulin pen Novolog (medication used to treat high blood sugar) on 07/22/2025 according to manufacture instructions. This failure could place residents at risk of medical complications and not receiving necessary medications. Findings included: 1. Record review of face sheet dated 07/22/2026 revealed Resident #10 was an [AGE] year-old male admitted to the facility on [DATE] with the diagnosis of dementia (severe memory loss) and type 2 diabetes (condition that effects blood sugar control). Record review of care plan dated 10/02/2025 revealed Resident #10 had a care plan for Diabetes Mellitus (condition that effects blood sugar control) with the intervention of diabetes medication as ordered by physician. Record review of Quarterly MDS dated [DATE] revealed Resident #10 had a BIMS of 14 indicating no cognitive impairment. MDS assessment revealed an active diagnosis of Diabetes Mellitus. Record review of order summary report dated 07/22/2026 revealed Resident #10 had an order for Novolog Flex Pen subcutaneous Pen-Injector 100UN/ML to inject per sliding scale: if 180 - 200 = 2U; 201 - 230 = 3U; 231 - 260 = 4U; 261 - 290 = 5U; 291 - 320 = 6U; 321 - 350 = 7U; 351 - 400 = 8U and Greater than 400, give 10 units and notify the doctor. Record review of Nursing MAR dated 07/22/2026 revealed Resident #10 had a blood sugar of 336 and 7 units were administered according to documentation. 2. Record review of face sheet dated 07/22/2026 revealed Resident #42 was a [AGE] year-old male admitted to the facility on [DATE] with the diagnosis of type 2 diabetes mellitus (condition that effects blood sugar control). Record review of care plan dated revision date 01/10/2024 revealed Resident #42 had a care plan for Diabetes Mellitus with the intervention to receive diabetes medication as ordered by physician. Record review of Annual MDS assessment dated [DATE] revealed Resident #42 had a BIMS of 11 indicating moderate cognitive impairment. MDS assessment indicated resident had an active diagnosis of Diabetes Mellitus. Record review of order summary report dated 07/22/2026 revealed Resident #42 had an order for Novolin R solution 100 units/ML to inject per sliding scare: if blood sugar is 70 - 130 = 0U; 131 - 180 = 2U; 181 - 240 = 4U; 241 - 300 = 6U; 301 - 350 = 8U; 351 - 400 = 10U If greater than 400, 12 units and call doctor. Record review of Nursing MAR dated 07/22/2026 revealed Resident #42 had a blood sugar of 154 and 2 units were administered according to documentation. Observation on 07/22/2026 at 11:23 a.m., revealed LVN A failed to prime Resident #10 insulin pen when administering 7 units of Novolog. Observation on 07/22/2026 at 11:30 a.m., revealed LVN A failed to prime Resident #42 insulin pen when administering 2 units of Novolin R. Interview on 07/22/2026 at 11:32 a.m., LVN A stated she was unaware she did not prime the insulin pens for Resident #42 and Resident #10 when she administer insulin to both residents. LVN A stated she notified the DON of incorrectly performing priming of the insulin pen and she now knows how to properly turn and prime. LVN A stated she was supposed to prime the insulin and administer according to manufacture instructions. LVN A stated she was aware Resident #42 and Resident #10 were receiving insulin, which was a high-risk medication and was at risk of receiving less or more needed insulin than ordered when she did not properly prime the insulin pen to remove the air in the needle. LVN A stated Resident #42 and Resident #10 were at risk of adverse effects of insulin. Interview on 07/23/2026 at 10:54 a.m., the ADON stated she expected medications to be administered (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	without error. ADON stated nursing staff who pass medications were checked off when hired. ADON stated she expected insulin to be primed per manufacturer guidelines. ADON stated Resident #42 and Resident #10 had the right to be free from medication error and received the physician ordered dose to treat the condition effectively. ADON stated Resident #42 and #10 was at risk of high or low blood sugar because it was a high-risk medication. Interview on 07/23/2026 at 11:39 a.m., the DON stated she expected LVN A to prime the insulin pen according to the manufacturer guidelines when administering Resident #42 and Resident #10 insulin which was a high-risk medication. DON stated that Resident #42 and Resident #10 were at risk of high or low blood sugar. DON stated Resident #42 and Resident #10 were at risk of adverse reactions of insulin. Interview on 07/23/2026 at 12:21 p.m., the Administrator stated she expected all medications including insulin pens to be administered according to manufacturer guidelines and physician orders. The Administrator stated Resident #42 and Resident #10 were at risk of adverse events due to inaccurate dosing. The Administrator stated insulin was a high-risk medication. Administrator stated insulin is for blood sugar control and could have caused too high or too low blood sugar. Record review of Medication Administration and General Guidelines policy undated revealed medications are administered in accordance with written orders of the attending physician. Record review of Insulin Pen Use policy revision date 04/01/2015 revealed always perform the safety test before each injection. Performing the safety test ensures that you get an accurate dose by: ensuring that pen and needle work properly and removing air bubbles. Policy revealed insulin pen should be primed by: A. Select a dose of 2 units by turning the dosage selector. B. Hold the pen with the needle pointing upwards. C. Tap the insulin reservoir so that any air bubbles rise up towards the needle. D. Press the injection button all the way in. Check if insulin comes out of the needle tip.		

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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 that all drugs and biologicals used in the facility were labeled and stored in accordance with professional standards for 1 of 3 medication carts (Secure Unit Medication Cart) reviewed for drugs and biologicals. The facility failed to ensure MA F secured the Secure Unit Medication Cart, when it was not in use on 07/21/2026. This failure could place residents at risk of not receiving drugs and biologicals as needed, medication errors, medication misuse, and drug diversion. Findings included: During an observation on 07/21/2026 starting at 10:27 AM, there was an unlocked, unattended medication cart stationed in the hallway prior to entering the secured units. Multiple staff, visitors, and residents passed by the unlocked, unattended medication cart. At 11:50 AM, the State Surveyor notified the Administrator there was an unlocked, unattended medication cart. The Administrator said it should not be unlocked and locked it and said she would find the staff member responsible for the medication cart. During an interview on 07/21/2026 at 12:02 PM, MA F said she was responsible for the Secure Unit Medication Cart. She said she could have sworn that she had not left the medication cart unlocked. MA F said the medication cart should be locked at all times when not in use and out of sight. MA F said residents could open an unlocked, unattended medication cart and take the medications. During an interview on 07/23/2026 at 10:20 AM, the ADON said the person with the keys to the medication cart was responsible for making sure the medication cart was locked. The ADON said the medication carts should be locked anytime the staff walked away from the medication cart. The ADON said if the medication cart was unlocked the residents could get the medications. During an interview on 07/23/2026 at 10:21 AM, the DON said whoever was responsible for the medication cart at the time was responsible for ensuring it was locked. The DON said when she walked down the hall, she always checked the medication carts to ensure they were locked. The DON said she had not noticed any problems with the medication carts not being locked. The DON said if a medication cart was unlocked, a resident could have access to the medications. During an interview on 07/23/2026 at 10:28 AM, the Administrator said she expected the medication carts to be locked at all times unless the staff was in front of it administering medications. The Administrator said all the clinical staff and interdisciplinary team were responsible for ensuring the medication carts were locked. The Administrator said if a medication cart was unlocked, she feared a resident with a low BIMS score would have access to the medications or any other resident could get into the medication cart, and it was also a safety hazard. Record review of the facility's policy titled, Medication Storage in the Facility, dated 03/2025, indicated, Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to license nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Medication rooms, carts, and medication supplies are locked or attended to by persons with authorized access.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews and observations, the facility failed to maintain medical records in accordance with the accepted professional standards and practices that are complete and accurately documented for 1 of 6 (Resident #46) residents reviewed for documentation. Resident #46's electronic medical record did not contain complete and accurate documentation that reflected that a quarterly care plan conference was completed. This failure could result in the residents' records not accurately documenting completion of plan of care conference. The findings included: Record review of Resident #46's face sheet dated 07/23/2026 revealed an [AGE] year-old male admitted [DATE] with diagnoses which included [AGE] year-old female admitted [DATE] with diagnoses which included [NAME] Obstructive Pulmonary Disease (a progressive, irreversible lung disease that restricts airflow and makes breathing difficult), Diabetes mellitus Type II (a condition where the body does not make enough insulin or cannot use properly causing sugar to build up in the blood), Dementia (a group of symptoms that cause a loss of memory, thinking skills, and the ability to do daily tasks), and gout (a painful type of arthritis caused by high uric acid levels that form sharp crystals in the joint). Record review of Resident #46's Comprehensive MDS dated [DATE] revealed moderately impaired hearing, resident usually understood what was said to him and had a BIMS score of 9 which indicated moderate cognitive impairment. Resident #46 required the use of a walker for mobility, was independent in eating, required supervision in toileting bathing, dressing, bed mobility and transfers. Record review of Resident #46's Care Plan revealed the Care Plan was initiated 05/28/2026, and the next review date is 09/01/2026. Record review of the Care Plan Conference assessment for Resident #46 revealed only one assessment dated [DATE]. Record review of the EMR for Resident #46, revealed no evidence of an initial Care Plan Conference completed within 21 days of admission date of 05/28/2026. During an interview on 07/22/2026 at 2:28 p.m., the ADON stated that she does attend some care plan meetings and that the SW or the MDS Nurse will complete the Care Plan Conference for each meeting. The MDS Nurse stated that they used to sign in on a Care Plan Conference summary form, but they do not use that form any longer. During an interview on 07/22/2026 at 3:00 p.m., the SW stated that she had only been working at the facility for a few weeks, and that she would send an invitation to the responsible party. The SW stated that she believed she was responsible for completing the Care Plan Conference assessment but that anyone in the IDT meeting could complete the form. During an interview on 07/22/2026 at 3:39 p.m., the MDS Nurse stated she does attend some care plan meetings and did recall attending the initial plan of care meeting for Resident #46 with his daughter and son. The MDS Nurse was unable to locate any documentation which indicated the meeting took place, attendance at the meeting or content of the meeting. The MDS Nurse stated the SW was usually responsible for completing the Care Plan Conference for each meeting. During an interview on 07/22/2026 at 4:02 p.m., Resident #46's Responsible Party stated she had attended a care plan meeting with the facility staff, and other family members at the beginning of June 2026 but could not recall the date. The Responsible Party stated that she did not recall signing any document which indicated attendance at the review meeting. During an interview on 07/23/2026 at 11:37 a.m., the DON stated that she expects the meetings to be held quarterly and that someone from the IDT meeting should complete the Care Plan Conference assessment to reflect areas discussed during the meeting and attendance. The DON stated that the risks of not completing the required assessments is that there would be no proof that the required meeting took place. During an interview on 07/23/2026 (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 12:00 p.m., the Administrator stated that she expects a member of the IDT meeting to complete the Care Plan Conference assessment and indicate all members in attendance to include the resident or the responsible party. The Administrator stated that she expected the assessment to reflect what was discussed at each initial, quarterly and as needed meeting and the results to be documented on the designated assessment form. The Administrator stated the risks of not completing the assessment would be that there would be no way to prove that the meeting was done. A request for facility policy on accuracy of documentation was requested on 07/23/2026 at 1:45 p.m. The DON stated they did not have a policy for documentation.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure the quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 2 of 4 residents (Resident #4 and Resident #3) reviewed for hospice services.1.The facility failed to maintain Resident #4's hospice binder containing information related to hospice services provided for the resident such as an updated care plan or the last IDG also known as Interdisciplinary Group meetings (a regular, collaborative team review of a patient's care meetings).2. The facility failed to obtain Resident #3's most up to date hospice medication list.These deficient practices could place residents who receive hospice services at risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care, and communication of resident needs. Findings included: 1. Record review of Resident #4's face sheet, dated 07/22/26, reflected Resident #4 was an [AGE] year-old female, re-admitted to the facility on [DATE]with diagnoses which included dementia (a decline in mental ability that interferes with daily life), muscle weakness, anxiety (a feeling of unease, worry, or fear, often experienced as a normal reaction to stress), and depression (a common mental health condition characterized by persistent sadness and a loss of interest in activities, significantly impacting daily life). Record review of Resident #4's quarterly MDS assessment, dated 05/16/26, reflected Resident #4 rarely made herself understood, and was sometimes understood by others. Resident #4 had severe impairment in cognitive skills for daily decision making. The MDS indicated Resident #4 was on hospice services. Record review of Resident #4's comprehensive care plan revised 02/22/25 indicated Resident #4 had a terminal prognosis and was on hospice services. The intervention was to work with nursing staff to provide maximum comfort for the resident. Adjust provision of ADLs to compensate for resident's changing abilities and encourage participation to the extent the resident wishes. Record review of Resident #4's physician orders dated 09/29/25 indicated an order for {name} hospice with the diagnosis of dementia. Record review of Resident #4's hospice binder on 07/22/26 at 11:09 a.m., revealed it did not have last two IDG (Interdisciplinary Group) meetings or updated care plan. During an interview on 07/22/26 at 11:27 a.m., the hospice RN H said the binders at the facility should contain any supporting notes or documentation needed for Resident #4. She said the binder should at least have the face sheet, election form, code status, certification of terminal illness, plan of care, and medications. She said they meet every two weeks on Thursday for the IDG meetings and said the documentation should be updated at least the following week after the IDG meetings. She looked at Resident #4's hospice binder which contained the last IDG meeting which was held on 06/18/26 and last care plan was 02/22/26. She said she was at the facility and brought the meeting that was held on 07/16/26. She said she did not know why an updated care plan or IDG meeting which was held on 07/02/26 was not in the binder. She said she had just started working with Resident #4. She said it was important to have the binders at the facility to help the facility know the care and services they were providing. 2. Record review of Resident #3's face sheet dated 07/21/26 indicated she re-admitted to the facility on [DATE] with diagnosis which included stroke, anxiety (a feeling of unease, worry, or fear, often experienced as a normal reaction to stress), and depression (a common mental health condition characterized by persistent sadness and a loss of interest in activities, significantly impacting daily life). Record review of Resident #3's quarterly MDS (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Mullican Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 105 North Main Street Savoy, TX 75479	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated [DATE] revealed she was rarely understood and sometimes understood others. The cognitive skills for daily decision making revealed she was severely impaired. The MDS indicated she was receiving hospice services. Record review of Resident #3's care plan initiated on 05/18/26 indicated resident was receiving hospice services from (unnamed) Hospice related to a stroke. The intervention was for staff to work cooperatively with hospice team to ensure the residents' spiritual, emotional, intellectual, physical, and social needs were met. Record review of Resident #3's physicians order dated 09/16/26 indicated: Admit to (unnamed) hospice services for diagnosis of stroke. Record review of Resident #3's physician order dated 06/06/24 indicated: Sertraline HCl Oral Tablet 50 MG (Sertraline HCl) Give 3 tablet via gastrostomy tube one time a day related to major depressive disorder. Record review of hospice medication list printed on 06/29/26 indicated, give Sertraline 50mg, daily for depression. During an interview on 07/23/26 at 10:30 a.m., the hospice nurse said the hospice binder should have the care plan, recertification, IDG meetings, doctors' orders, medication profile, face sheet, and out of hospital DNR. She said IDG meetings were held every 2 weeks, every other Wednesday and updated information was provided to the facility the next day. She said it was her responsibility to bring updated hospice documents to the facility. She said it was important for the hospice binder to be updated so everybody could be involved in the changes that were made in the plan of care, medications, as well as other stuff. During an interview on 07/23/26 at 11:06 a.m., LVN A said orders, the medication administration record, who to call, and the names of the aids should be in the binder. She said the hospice nurse was responsible for delivering updated documents. She said the hospice binder served as a reference. She said the expectation was for the information to be updated and current. During an interview on 07/23/26 at 11:26 a.m., the DON said there are forms like 3074, 3071, plan of care, notes, and do not resuscitate (DNR) form in the hospice binder. She said the hospice nurse was responsible for bringing up updated information. She said it was important to have updated information for continuity of care. She said the expectation was for the information from the hospice binder to match the facilities. During an interview on 07/23/26 at 11:44 a.m., the administrator said the hospice binders are specific to the residents and had their plan of care. She said the binders should be updated regularly. She said the hospice company was responsible for bringing up updated information. She said it was important to have updated information because that was the right way to properly care for the residents. Record review of the facilities policy titled Hospices Services, undated, indicated Goals: 12. The nursing facility and hospice provider must ensure that a coordinated plan of care reflects the participation of the hospice, nursing facility, the recipient, and legal representative to the extent possible.		

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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, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 4 residents (Resident #20 and Resident#11) reviewed for infection control.1.The facility failed to ensure CNA B wore PPE which consisted of gown and gloves while in Resident #20's room on 07/21/26 who was on contact isolation for ESBL also known as extended-spectrum beta-lactamase, (infections are primarily transmitted through direct or indirect contact with the bacteria) and the facility failed to provide containers for the disposal of linen and trash.2. The facility failed to ensure LVN A wore PPE (gown) while performing wound care for Resident #11.These failures could place residents and staff at risk for cross-contamination and the spread of infection. Findings included:1.Record review of Resident #20's face sheet, dated 07/22/22, indicated she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included dementia (a decline in memory, thinking abilities, and behavior that interferes with daily life), stroke and muscle weakness.Record review of Resident #20's admission MDS assessment, dated 06/30/26, indicated Resident #20 usually understood and was usually understood by others. Resident #20's BIMS score was 03, indicating she was severely cognitively impaired. The MDS indicated Resident #20 required assistance with her ADLs and maximum assistance with toileting. The MDS indicated Resident #20 was always incontinent of bowel and bladder. The MDS did not indicate she was on isolation precautions.Record review of Resident #20's Physician order dated 07/20/26 indicated: Isolation precautions: Contact isolation for ESBL every shift. Record review of Resident #20's Physician order dated 07/20/26 indicated: Macrobid Oral Capsule 100 MG (Nitrofurantoin Monohyd Macro) Give 1 capsule by mouth two times a day for UTI (urinary tract infection) for 10 Days.Record review of Resident #20's comprehensive care plan, last reviewed 07/20/26, indicated she was on contact isolation for ESBL. The intervention was for staff after providing resident care to remove gown and gloves in the resident's room and place in the container for soiled PPE.During an observation and interview on 07/21/26 at 9:03 a.m., Resident #20 was in her bed. Resident #20 had a sign by her doorway that said isolation, along with how to [NAME] (put on) and [NAME] (take off) PPE. The isolation cart was outside her door with gowns and gloves. There were no containers to dispose of her linen or trash. Resident #20 said she was not sure why she was in isolation.During an interview on 07/21/26 at 9:19 a.m., LVN A said Resident #20 was on contact isolation because she had ESBL. She said anyone who entered her room should wash their hands, apply a gown and gloves, and rewash before leaving the room to prevent the spread of infection. She said she was not sure about how to dispose of the gown and glove except in the regular trash.During an observation and interview on 07/21/26 at 9:30 a.m., CNA B walked out of Resident #20's room with linen in a normal trash bag and placed the bag in the linen barrel in the hallway. CNA B then walked back into Resident #20's room without applying a gown or gloves. CNA B said she was aware Resident #20 was on isolation for her urine but was told by the DON that she did not have to wear PPE just to go into the room. She said she was told by the DON that she did not have to dispose of the linen or trash in any special container.During an interview on 7/21/26 at 10:15 a.m., Laundry Aide K said she was aware Resident #20 was on isolation. She said she knew if Resident #20's clothes came to the laundry, she was supposed to wash them separately but if staff used towels or other linen for her, she would not know to wash them separately because there was no identifying markings for her to wash them separately.During an observation on 07/22/26 (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 10:30 a.m., Resident #20 was in her bed. She had a box in her room with a red bag inside of it. During an interview on 07/22/26 at 11:00 a.m., CNA B said when she came to work this morning (07/22/26) the box with the red bag was in Resident #20's room. She said she asked the DON why the box was in her room and was told she needed to place her trash in the box related to Resident #20 being on contact and she was incontinent of urine. She said she could continue to put her linen in the regular barrel if it was in a regular trash bag. The surveyor asked how laundry staff would know if a resident was on contact isolation if she placed Resident #20's laundry in the regular linen barrel and she said she did not know. She said she could see how that might place other residents at risk for the spread of infection. 2. Record review of Resident #11's face sheet dated 07/17/2026 indicated he was a [AGE] year-old male who admitted to the facility on [DATE]. His diagnoses included stroke, diabetes (high blood sugar), and Peripheral vascular disease also known as PVD, (is a blood vessel disorder that includes peripheral artery disease (PAD) and venous problems). Record review of Resident #11's admission MDS assessment dated [DATE] indicated he sometimes made himself understood and usually understood others. The MDS also indicated he had a BIMS score of 08 which meant he was moderately cognitively impaired. The MDS indicated he required maximal assistance with toileting, transfers, dressing, bed mobility, and with eating. The MDS did not indicate a wound. Record review of Resident #11's comprehensive care plan last revised 06/02/26 indicated he had a wound. The intervention was to keep foot offloaded and treatment as ordered. Record review of Resident #11's physician's order dated 07/09/26, indicated, paint right lateral ankle with betadine and leave open to air daily. The order did not indicate EBP. During an observation and attempted interview on 07/20/26 at 2:20 p.m., Resident #11 was in bed and had an EBP sign on his door and a cart inside his room. Resident #11 did not answer when asked about EBP. During an observation on 7/22/26 at 2:05 p.m., LVN A went into Resident #11's room to do wound care for his right outer ankle. She explained what she was going to do and applied gloves (she did not apply a gown). She performed wound care as ordered removed her gloves and performed hand hygiene. During an interview on 07/22/26 at 2:20 p.m., LVN A said Resident #11 was on EBP precautions. She said she was supposed to wear gown and gloves while performing wound care. She said she forgot to wear a gown while doing his wound care. She said it was important to wear a gown and gloves to protect the resident and herself. During an interview on 07/23/26 at 11:26 a.m., the DON said she expected all staff to follow the guidelines on the sign posted on the door. She said the staff were aware of Resident #20 being on contact precautions by the sign on the door and the setup outside the door. She said staff had to wear PPE (gown or gloves) when they entered Resident #20's room. She said she expected staff to put their trash in the red box in the room and hand deliver their linen which should be doubled bagged to the laundry. She said it was important for staff to wear PPE (gown and gloves), wash their hands before entering and exiting Resident #20's room to prevent infection control issues. She said residents who were on EBP and staff provided care, she expected staff to wear gowns and gloves and dispose of PPE in regular trash and wash their hands when they exit the room to protect the residents from any kind of germs. The DON said she was the overseer to monitor for infection control issues. During an interview on 07/23/26 at 11:43 a.m., the Administrator said staff should wear PPE (gown and gloves) when entering contact isolation rooms and when providing care for residents who were on EBP. She said for residents on contact isolation she expected for the linen to be placed in a water-soluble bag and then placed in a yellow bag and taken to the laundry and for trash to be placed in a red bag in the room and taken to the biohazard room as needed. She said the DON was the oversee of infection control. She said for isolated and EBP residents, staff should practice hand hygiene before and after leaving the room to prevent infection. She said they wanted to contain the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infection to one area as much as possible. Record review of the facility's policy titled, Infection Control, dated 03/2024, indicated, The facility will establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection. When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility will isolate the resident. The facility will require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. The facility will require staff to Donn and Doff PPE before and after contact with residents who needs isolation to prevent the spread of infection to others in the facility. #7 Linens: 1. All soiled linen will be double bagged at the site that it was generated. All personnel will utilize appropriate personal protective equipment. 2. Soiled linen will be transported to the laundry site by cart. 3. The soiled linen will be processed as per linen protocol. Record review of the facility's policy titled, Enhanced Barrier Precautions, undated, indicated, Multidrug-resistant organism (MDRO) transmission is common in long term care (LTC) facilities. Many residents in nursing homes are at increased risk of becoming colonized and developing infections with MDROs. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.		