STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675443	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prairie Acres	201 E 15th Friona, TX 79035

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observations, interviews, and record review, the facility failed to ensure residents were treated in a respectful manner that maintained or enhanced each resident's dignity for 1 (Resident #21) of 16 residents reviewed for dignity. The facility failed to ensure CNA C did not incite a verbal altercation with facility staff in the presence of Resident #21. This failure could place residents who require assistance from nursing staff at risk of feeling disrespected. Findings included: Record review of Resident 21's face sheet dated 07/29/2025 revealed a [AGE] year-old female with an initial admission date of 08/26/2025 with diagnoses that included: Alzheimer's Disease, unspecified (having trouble remembering, thinking, or making decisions that affect everyday activities), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), generalized anxiety disorder (mental health condition that causes fear, a constant feeling of being overwhelmed and excessive worry about everyday things), and delusional disorders (false beliefs based on an incorrect interpretation of reality). Record review of Resident 21's Annual Comprehensive MDS assessment, dated 10/02/2024, revealed a BIMS score of 99, indicating severe cognitive impairment. The MDS Assessment, under Section D Mood, indicated Resident #21 did not respond to the mood assessment. Resident #21's MDS assessment, under Section GG Functional Abilities, indicated the resident was dependent on staff for eating, oral hygiene, toileting, shower/bathing, upper and lower body dressing, and personal hygiene. The MDS assessment, under Section GG Functional Abilities, also indicated the resident was dependent on staff for all transfers. Record review of Resident #21's care plan undated, included a focus area that began on 08/29/2017 which stated, I have impaired cognitive function and impaired thought processes r/t Alzheimer's., with a goal that stated, I will be able to communicate basic needs on a daily basis., with the Interventions that included the following: I need assistance with all decision making. The care plan also has a focus are that began on 07/09/2018 that stated, I have an ADL Self Care Performance Deficit r/t Dementia. with a goal that stated, I will maintain my current level of function in Bed Mobility, and interventions that states, MOBILITY: I use a Geri chair-for positioning and safety. Staff must take me where I need to go.; TRANSFER: I require assistance x 2 with transfers w/Hoyer lift'; BATHING: I am totally dependent on staff to bath me. Hospice comes to facility to bathe me.; Personal care: I require one person assistance to complete my grooming care. I have my own teeth. R/T dementia, I am unable to complete my ADLs. During an observation on 07/29/2025 at 11:07 AM CNA C was observed coming out of a resident's room. CNA A was observed several feet away with Resident #21, near her bedroom. CNA B was observed in the hallway, near Resident #21's bedroom as well. CNA C was heard telling CNA A and CNA B she had not bathed Resident #21 yet. CNA A stated she was told to get Resident #21 up for lunch. CNA C stated she needed Resident #21 to be put back in bed, so she could (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bathe her. CNA C stated CNA A needed to take Resident #21 back to her room. CNA A stated she would take her to the nurse's station until lunch began, as she was instructed to get Resident #21 ready for lunch. CNA C stated, I still have time. CNA C began to raise her voice and approached Resident #21 and stated loudly, I will do it myself. I always do everything by myself. as she began pushing Resident #21's Geri-chair. RN D approached CNA C and instructed her to stop fussing. RN D instructed CNA C to finish patient care with another resident and instructed CNA A and CNA B to take Resident #21 back to bed to prepare her for her bed bath. CNA C was observed shaking her head and told RN D no. CNA C continued to argue in a loud and aggressive tone. CNA C told RN D, I will just do it myself. I always do everything myself. CNA C stated, She is agency. I always have issues with her (indicating CNA B), every time I work with her. RN D advised CNA C to stop arguing and instructed her to finish patient care. Resident #21 was taken back to her room by CNA A and CNA B. CNA C was observed entering another resident's room. There was no further exchange from CNA C. Resident #21 did not demonstrate any physical or emotional reaction during the verbal altercation. During an observation and an attempted interview on 07/29/2025 at 11:16 AM with Resident #21. Resident #21 was observed laying in her bed. Resident #21 did not respond to greetings and/or questions from the surveyor. Resident #21 did not appear upset or agitated during the attempted interview. During an interview on 07/29/2025 at 12:10 PM CNA A stated CNA C was a Hospice aide that came in to bathe several residents receiving Hospice services, weekly. CNA A stated CNA B was an agency CNA that worked at the facility often. CNA A stated she was instructed by her charge nurse, RN D, to get Resident #21 up and ready for lunch. CNA A stated CNA C became upset because she told CNA B not to get Resident #21 out of bed yet because she still needed to bathe Resident #21. CNA A stated she did not hear CNA C ask CNA B not to get Resident #21 out of bed yet, so she and CNA B transferred Resident #21 to her Geri-chair to prepare her for lunch. CNA A stated CNA C became upset and said she always had problems with CNA B when she worked with her. CNA A stated she had never seen an altercation occur between CNA C and CNA B before. CNA A stated she was going to take Resident #21 to the nurse's station, but CNA C asked her to put her back in bed so she could bathe her. CNA A stated CNA B said they would not put her back in bed since she was instructed to get her ready for lunch. CNA A stated, following the altercation, CNA B assisted her with getting Resident #21 back to bed so CNA C could bathe her, as instructed by her charge nurse, RN D. CNA A stated she did not see any physical or emotional reaction by Resident #21 following the altercation. During an interview on 07/30/2025 at 10:30 AM CNA C stated she was a CNA with BSA Hospice. CNA C stated she worked at the facility several days a week providing bathing services to residents who receive Hospice care. CNA C stated she asked CNA B not to get Resident #21 ready for lunch until CNA C bathed her. CNA C stated she was bathing another resident and when she came out of the room she saw CNA A and CNA B with Resident #21. CNA C stated she asked CNA A and CNA B to take Resident #21 back to bed so she could bathe her, but they told her they were taking Resident #21 for lunch. CNA C stated she told CNA A and CNA B that she still had time to bathe Resident #21 before lunch, and she would take her back to her room herself, if they would not help her. CNA C denied yelling or being confrontational. CNA C denied having a verbal altercation with CNA A or CNA B. CNA C stated she was aware the surveyor was present during the exchange, but she denied yelling or speaking inappropriately in front of the resident. CNA C stated she was aware Resident #21 was present during her interaction with CNA A and CNA B. CNA C stated she had been trained not to engage in confrontations in the presence of residents. CNA C stated it would have been better for her to speak with the charge nurse or facility administrator if she had trouble with the facility staff, to request assistance. CNA C stated having an altercation could have negatively impacted a resident by causing a resident to become upset or worried. During an interview on 07/30/2025 at 04:00 PM CNA B stated she was an agency CNA that worked at the facility off and on over the past two years. CNA B stated CNA C never asked her to wait to get Resident #21 out of bed until she bathed her. CNA B stated she was advised by her charge nurse, RN D to prepare Resident #21 for lunch, so she and CNA A transferred Resident #21 to her (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Geri*chair. CNA B stated CNA C was providing patient care to another resident, and as she came out of that resident's room she raised her voice and told CNA B, I told you I was going to get her up. CNA B stated CNA C never told her that. CNA B stated CNA C began yelling, I will do it myself. CNA B stated she had worked with CNA C in the past, but she had never had any other altercations occur. CNA B stated she did not witness any emotional or physical reaction from Resident #21 following the verbal altercation. CNA B stated she had received training on not having verbal altercations in front of residents. CNA B stated this could have had a negative impact on residents by causing the resident to be disrespected. During an interview on 07/31/2025 at 11:00 AM RN D stated she was unaware Resident #21 had not received her bed bath yet, and she advised CNA A and CNA B to prepare Resident #21 for lunch. RN D stated she heard CNA C yelling at her nursing staff (CNA A and CNA B), so she intervened. RN D stated she redirected CNA C and instructed her to stop arguing and return to her patient care. RN D stated she had never had a concern with CNA C in the past. RN D stated CNA C works for BSA Hospice and provides bathing assistance to residents who receive Hospice services. RN D stated it was never acceptable for nursing staff to have a verbal altercation in the presence of a resident, regardless of the situation. RN D stated she did not observe any physical or emotional reaction to the altercation from Resident #21. RN D stated all nursing staff have received training pertaining to Resident Rights and how to conduct themselves in front of residents. RN D stated it was her expectation for her nursing staff to request assistance from their charge nurse if they encounter issues with other staff. RN D stated if staff had verbal altercations in front of residents, it could have caused distress to a resident. During an interview on 07/31/2025 at 10:30 AM the DON stated after speaking with staff she determined CNA C became upset with CNA A and CNA B after they got Resident #21 up for lunch because she was going to give her a bed bath. The DON stated CNA A and CNA B were advised to get Resident #21 up by RN D. The DON stated RN D told CNA C the staff would get Resident #21 back to bed for her bed bath, but CNA C still confronted staff about getting her up before she was bathed. The DON stated it was her expectation that nursing staff would have come to her if they had an issue with other staff. The DON stated she had spoken with her staff about ensuring they assist the Hospice aides with their residents, and she had not had any complaints that her staff was not helping. The DON stated she had spoken with CNA C in the past about bringing any concerns to her if the facility staff were not helping her. The DON stated it was never acceptable for a staff to engage in a verbal altercation in the presence of a resident. The DON stated having a verbal altercation in front of the resident could cause the resident to become upset or have anxiety. During an interview on 07/31/2025 at 11:35 AM the ADM stated it was his expectation that nursing staff would have brought any issues within staff to him or the DON for assistance. The ADM stated he expected his staff to provide additional assistance to the Hospice staff as his staff were more familiar with the residents and their needs The ADM stated it was never acceptable to have a verbal altercation in front of a resident. The ADM stated he was not aware of any previous issues with the Hospice aides and his nursing staff. The ADM stated he would address the concerns with BSA Hospice The ADM stated having a verbal altercation in front of a resident could have caused emotional distress or anxiety to the resident. Record review of the facility's policy titled, Quality of Life - Dignity, undated, revealed the following: Policy Statement:Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality.Policy Interpretation and Implementation:I . Residents shall be treated with dignity and respect at all times.2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on interviews, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 1 of 8 residents (Resident #5) reviewed for care plans. Resident #5 did not have a care plan for Cognitive Loss/Dementia, Communication, Urinary Incontinence, Pressure Ulcers, and did not include her diagnosis of Alzheimer's Disease with late onset. This failure could place residents at risk of not receiving the care required to meet their individualized needs. Findings included: Record review of the face sheet, dated 07/29/2025, revealed Resident #5 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included the following: unspecified Dementia, unspecified severity without behavioral disturbance, mood disturbance, anxiety (memory loss that deteriorates over time), psychotic disorder with hallucinations due to known psychological condition (severe mental health disorders that cause abnormal thinking and perceptions), psychotic disorder with delusions due to known psychological condition(), and Major Depressive Disorder (severe mental health disorders that cause abnormal thinking and perceptions). Record review of Resident #5's admission MDS assessment, dated 02/03/2025, revealed in Section C - Cognitive Patterns, Resident #5 had a BIMS score of 08, which indicated moderate cognition impairment. The document also indicated in Section V - Care Area Assessment (CAA) Summary the following Care Planning Revision Areas: 02. Cognitive Loss/Dementia (dated 02/12/2025)04. Communication (dated 02/12/2025)05. ADL Functional/Rehabilitation Potential (dated 02/12/2025)06. Urinary Incontinence and Indwelling Catheter (dated 02/12/2025)11. Falls (dated 02/12/2025)12. Nutritional Status (02/12/2025)16. Pressure Ulcer (dated 02/12/2025)17. Psychotropic Drug Use (dated 02/12/2025)19. Pain (dated 02/12/2025) Record review of the current care plan for Resident #5, undated, included the following focus areas: I have potential for disturbed thought process r/t dx of psychotic disorder with hallucinations and delusions. (Date Initiated 01/28/2025). With an intervention that included: Administer medications as per physician orders. I am on quetiapine Date Initiated: 01/28/2025. I have disturbed thought process related to delusions/hallucinations. (Date Initiated 01/28/2025) with interventions that included: Monitor and record s/sx of non-verbal pain: Changes in breathing (noisy, deep/shallow, labored, fast/slow); Vocalizations (grunting, moans, yelling out, silence); Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion); Eyes (wide open/narrow slits, glazed, tearing, no focus); Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing). Notify Physician if pain is new, increasing or non relieved. Record review of Resident #5's active physician's order, dated 7/29/2025, included the following diagnoses: unspecified Dementia, unspecified severity without behavioral disturbance, mood disturbance, anxiety (memory loss that deteriorates over time), psychotic disorder with hallucinations due to known psychological condition (severe mental health disorders that cause abnormal thinking and perceptions), psychotic disorder with delusions due to known psychological condition(severe mental health disorders that cause abnormal thinking and perceptions), and Major Depressive Disorder (mood disorder that causes a persistent feeling of sadness and loss of interest). Resident #5's active physician's order included the following medications: Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) (Give 1 tablet by mouth every 8 hours as needed for pain related to CHRONIC (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PAIN SYNDROME), Tylenol Extra Strength Oral Tablet 500 MG (Acetaminophen) (Give 1000 mg by mouth every 6 hours as needed for Moderate Pain), Quetiapine Fumarate Oral Tablet 25 MG (Quetiapine Fumarate) (Give 1 tablet by mouth at bedtime related to PSYCHOTIC DISORDER WITH HALLUCINATIONS DUE TO KNOWN PHYSIOLOGICAL CONDITION), and Sertraline HCl Oral Capsule 200 MG (Sertraline HCl) (Give 1 capsule by mouth one time a day related to MAJOR DEPRESSIVE DISORDER, RECURRENT SEVERE WITHOUT PSYCHOTIC FEATURES).-- During an interview on 07/31/2025 at 10:00 AM, the MDS nurse stated she was responsible for completing and updating residents' care plans. The MDS nurse stated care plans were completed upon admission and updated immediately as changes arise, as well as reviewed quarterly for accuracy. The MDS nurse stated the DON also helped to review care plans for accuracy. The MDS nurse stated they reviewed a resident's diagnoses, medications, and areas of care to personalize each resident's care plan based on their current needs. The MDS nurse stated she was not aware Resident #5's care plan was not completed fully, to include all CAA areas indicated on Resident #5's MDS. The MDS nurse stated this was overlooked. The MDS nurse stated all CAA areas should have been included on Resident #5's care plan, as they applied to her current care. The MDS nurse stated the facility had a system to review care planning tasks at their IDT meetings as well. The MDS nurse stated she would ensure Resident #1's care plan was updated that day, 07/31/2025. The MDS nurse stated if a care plan was not updated or completed properly, it would not be specific to the resident's current care needs. During an interview on 07/31/2025 at 10:45 AM, the DON stated the MDS nurse was responsible for completing and updating care plans for residents. The DON stated she also assisted with reviewing care plans and ensuring they were updated with any changes that may arise. The DON stated all CAA areas on a resident's MDS assessment should have been included as focus areas on a resident's care plan. The DON stated it was her expectation that all triggered care areas have a focus area on a resident's care plan to ensure the resident is receiving care for all of their identified needs. The DON stated she was not aware Resident #5's care plan was not completed fully. The DON stated if a care plan was not accurate, the resident may not have received the care they needed. During an interview on 07/31/2025 at 11:40 AM, the ADM stated care plans were the responsibility of the MDS nurse. The ADM stated the MDS nurse was responsible for reviewing and completing care plans, and the DON also reviewed care plans to ensure accuracy. The ADM stated care plans were completed upon admission and reviewed quarterly. The ADM stated any changes would have been added as soon as the change of condition was known. The ADM was not sure if all MDS CAA areas should have been listed on Resident #5's care plan. However, he stated he would follow up to ensure it was updated accurately. The ADM stated care planning tasks were also discussed during the facility's IDT meetings, and any changes or updates were added, as needed, by each department head. The ADM stated it was his expectation that all critical areas were addressed on a resident's care plan. The ADM stated if a resident's care plan was not completed accurately, the resident could have been negatively impacted because expectations could be missed if they were not listed in the care plan. Record review of the facility's policy titled, Care Plans, Comprehensive Person-Centered undated, reflected the following:Policy Statement:A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.Policy Interpretation and Implementation:1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen reviewed for dietary services, in that: The facility failed on 07/29/2025 to properly wash hands during food preparation. This failure could place residents at risk for food contamination and foodborne illness. The findings included: The following observation was made on 07/29/2025 during observation of puree at 10:30 AM: [NAME] E placed piece of fish into puree processor bowl and removed gloves. [NAME] E took sheet pan to dirty dish room. [NAME] E returned to prep area and put on gloves and started puree process of fish. [NAME] E add water to fish in puree processor bowl. [NAME] E removed gloves and went to dry storage room. [NAME] E picked up container of thickener off bottom shelf and placed on prep table across from steam table and scooped thickener into Styrofoam cup. [NAME] E went back to puree prep area and put on gloves and poured small amount of thickener into puree processor bowl with fish. [NAME] E removed puree fish from puree processor bowl into bowl and placed in microwave. [NAME] E removed gloves and took puree processor bowl, lid and blade to dirty dish area. [NAME] E washed hands. No observation of [NAME] E washing hands between glove changes or task change. During an interview on 07/30/25 at 01:35 PM with [NAME] E, he stated he should have washed his hands between glove changes and anytime he changed task. He stated he was nervous and forgot. He stated he has been trained. He stated the potential negative outcome could be cross contamination and spreading bacteria to food or someone. During an interview on 07/30/25 at 01:25 PM with the DM, she stated hands should be washed with any glove change and task change. She stated the cook should have washed his hands when he changed gloves and changed task. She stated she was aware the cook did not wash his hands when he went to the dirty dish area. She stated all staff had been trained on hand washing. She stated she was responsible for monitoring and training kitchen staff. She stated the potential negative outcome could be food borne illness and cross contamination of food. During an interview on 07/30/25 at 01:45 AM with ADM, he stated hands should be washed between glove changes and when changing task. He stated [NAME] E had been trained on hand washing. He stated the DM was responsible for training and monitoring staff on handwashing. He stated the facility does mock audits and [NAME] E had passed, so he must have just been nervous. He stated the potential negative outcome could be cross contamination of food and making residents sick. Record review of the facility's policy, titled Handwashing dated January 2024, reflected the following: Policy:Employees are to wash hands: .Between handling of dirty and clean dishes, equipment/utensils, and food.After touching objects that may be a source of contamination in the next contact with the hands is food or food contact surfaces.Procedure: .4. The use of gloves or the use of hand sanitizer does not replace handwashing.