

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: 675462	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2026
NAME OF PROVIDER OR SUPPLIER Parkview Skilled Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Parkway Big Spring, TX 79720	
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 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 (Kitchen A) reviewed for dietary services. The facility failed to allow the food processor container to air dry completely before using it to puree food on 8/4/26 and 8/5/26. This failure could place residents at risk for food contamination and foodborne illness. The findings included: Record Review of a Learn2Serve Certification certificate, dated 1/13/26, revealed the [NAME] had successfully completed the Texas Food Handler Education Training. Observations during the puree process on 8/4/26 from 11:11 AM to 11:41 AM, revealed that the [NAME] pureed carrots and cowboy beans in the food processor. After the carrots were pureed, the [NAME] transferred the food to a smaller container, then the [NAME] washed the food processor container in a 3-compartment sink and then placed the food processor container on a tray to go through a wash cycle in the dishwasher. The food processor container was removed from the tray when the wash cycle was completed. The food processor container was picked up and placed back on the machine with liquid dripping from the food processor container. Cowboy beans were added to the food processor container to puree. The cowboy beans were pureed and transferred to a smaller container. Observations during the puree process on 8/5/26 from 10:28 AM to 11:56 AM, revealed the [NAME] pureed baked chicken, cornbread, broccoli, and dinner rolls in the food processor. After the baked chicken was pureed, the [NAME] transferred the food to a smaller container. Then the [NAME] washed the food processor container in a 3-compartment sink and then placed the food processor container on a tray to go through a wash cycle in the dishwasher. The food processor container was removed from the tray when the wash cycle was completed. The food processor container was then placed on the serving table. Liquid was observed dripping from the food processor container. Cornbread was added to the food processor container and was placed on the machine to puree. The cornbread was pureed and transferred to a smaller container. Then the [NAME] washed the food processor container in a 3-compartment sink and placed the food processor container on a tray to go through a wash cycle in the dishwasher. The food processor container was removed from the tray when the wash cycle was completed and placed on the serving table with liquid dripping from the food processor container. Broccoli was added to the food processor container and was then placed on the machine to puree. The broccoli was pureed and transferred to a smaller container. Then the [NAME] washed the food processor container in a 3-compartment sink and then placed the food processor container on a tray to go through a wash cycle in the dishwasher. The food processor container was removed from the tray when the wash cycle was completed and placed on the serving table with liquid dripping from the food processor container. The [NAME] turned the food processor container upside down and shook it, liquid was observed falling out of the container. The [NAME] placed the food processor container on the serving (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	table, added dinner rolls, and then placed it on the machine to puree. The dinner rolls were pureed and transferred to a smaller container. Observation on 8/5/26 at 12:10 PM, revealed a 5-gallon bucket of Liquid Sanitizer/Multi-use Chlorine Sanitizer/Sodium Hypochlorite Liquid Sanitizer was labeled: Keep out of reach of children. DANGER. This bucket sat next to a 5-gallon bucket of dish machine rinse additive and a 5-gallon bucket of dish machine detergent. All three buckets were stored on a shelf below the dishwasher. During an interview on 8/5/26 at 2:30 PM, the [NAME] stated she prepared lunch which included all meal textures on 8/4/26 and 8/5/26. The [NAME] stated the process of pureeing food was to first wash hands, apply gloves, place the food in the blender, add liquids as needed, and then taste for texture and flavor. The [NAME] stated after one puree she would rinse the food processor container in the dish pit and then run it in the dishwasher for sanitizing. The [NAME] stated she was to let the food processor container and all other dishes dry. The [NAME] stated then she would wash her hands, grab clean supplies for the next items to be pureed and then start the process again. The [NAME] stated all dishes were supposed to be air dry after they were sanitized in the dishwasher so that sanitizer did not get in the food. The [NAME] stated the liquid on wet dishes was sanitizer. The [NAME] stated she was trained in the sanitization and air-dry process but could not remember the last time she was trained. The [NAME] stated she was nervous and forgot to let the food processor container air dry before using it to puree the food. The [NAME] stated she was responsible for ensuring the food processor container was dry before she used it. The [NAME] stated She was aware today that she forgot to let the food processor container air-dry but was not aware she had done it yesterday as well. The [NAME] stated a potential negative outcome was cross contamination and residents could get sick. During an interview on 8/6/26 at 11:11 AM, the DM stated she had worked in the kitchen in this facility as a [NAME] prior to becoming the DM. The DM stated all dishes must be air-dry before using them to prepare food. The DM stated dishes must be dry, so the sanitizer did not get into the food. The DM stated she was aware the [NAME] was using a wet food processor container to prepare food when she observed the [NAME] puree food for the last two days. [TW13.1][AL13.2]The DM stated all kitchen staff were trained and had their food handlers training. The DM stated she was responsible for ensuring kitchen staff followed sanitation requirements. The DM stated she expected staff to follow what they learned in their courses and training and to ensure that utensils and dishes were dry. The DM stated she expected dietary staff to prevent cross contamination, complete hand hygiene, and to wear gloves as required. The DM stated a potential negative outcome was that food could get contaminated and residents could get sick. During an interview on 8/6/26 at 12:46 PM, the ADM stated all equipment in the kitchen must be air dry before it could be used to prepare food. The ADM stated she was aware when she observed the puree process that the [NAME] did not allow the food processor container to be air dry before she used it to prepare foods. The ADM stated the dietician monitored dietary staff monthly during their visits. The ADM stated all kitchen staff were trained in food preparation and sanitation. The ADM stated the DM and herself were responsible for ensuring staff followed the requirements. The ADM stated she expected staff to ensure all kitchen equipment and dishes were air dry before they were used. The ADM stated a potential negative outcome was that residents could get sick from bacteria. Record review of the facility guideline titled, General Cleaning and Sanitizing Guidelines, undated, reflected the following: There is an important difference between clean and sanitized. Both attributes are important in the food service department to maintain and health and well-being of the resident's and all others who consume food prepared and served from the food service department. Sanitizing involves reducing the number of germs or bacteria to safe level as judged by public health requirements. Sanitization occurs by enough accumulative heat or concentration of chemicals for (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	enough time to reduce the bacterial count, including harmful bacteria, to a safe level on utensils and equipment. Whenever the food service director instructs an employee to clean equipment, a work surface, a storage area, or utensils or dishes, she/he should be sure the employee understands that the equipment must be sanitized as well as cleaned. Surfaces can look and actually be clean without being sanitized. It is the responsibility of all food service personnel to be aware of the need and the procedures of all food service personnel to be aware of the need and the procedures by which to clean and sanitize all areas of the kitchen. Sanitation can occur by means of application of heat or concentration of chemicals for enough time to reduce the bacterial count on surfaces of equipment and utensils. Common methods of sanitizing are (but not limited to): 5. Mechanical dishwasher using a chemical sanitizer, which is automatically dispensed into the final rinse according to the manufacturer's specification at temperature specified by the manufacturer. Once utensils and equipment have been cleaned and sanitized, they should be allowed to air dry; the use of towels may re-contaminate sanitized surfaces. Once equipment and utensils have been sanitized, they should be handled and stored to protect the equipment and utensil for re-contaminate.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure all residents had the right to formulate an advance directive for 2 of 8 residents (Resident #74 and Resident #84) reviewed for advanced directives, in that: The facility failed to ensure Resident #74 and Resident #84 had an Out-of-Hospital Do Not Resuscitate (OOH-DNR) form that did not have missed required information. These failures could place residents at risk for not having their end-of-life wishes honored and incomplete records. Findings included: Resident #74 Record review of Resident #74's admission record, dated [DATE], revealed a [AGE] year-old-male was admitted to the facility on [DATE] with diagnoses to include: Sepsis (life-threatening infection), atherosclerotic heart disease (plaque build-up inside the blood vessels to the heart), and muscle weakness. The admission record also revealed under the advance directive section - DNR-Do Not Resuscitate. Record review of Resident #74's physician order summary dated [DATE] revealed the following order: DNR-Do Not Resuscitate with a start date of [DATE]. Record review of Resident #74's care plan, undated, revealed, Focus: DNR with a date initiated on [DATE]. Record review of Resident #74's OOH-DNR form, date retrieved on [DATE], revealed there was no physician's license number associated with the physician's signature, no date with the physician's signature and the physician had not signed the bottom of the OOH-DNR. Resident #84 Record review of Resident #84's admission record, dated [DATE], revealed a [AGE] year-old-female was admitted to the facility on [DATE] with diagnoses to include: acute kidney failure (kidney problems), atrial fibrillation (irregular heartbeat) and heart failure. The admission record also revealed under the advance directive section - DNR-Do Not Resuscitate. Record review of Resident #84's physician order summary dated [DATE] revealed the following order: DNR-Do Not Resuscitate with a start date of [DATE]. Record review of Resident #84's OOH-DNR form date retrieved on [DATE] revealed in Section B, I am the patient's __Legal Guardian; __agent under Medical Power of Attorney; __or Qualified Relative (see back); and: __I attest to issuance of an Out-of-Hospital DNR by the patient by nonwritten means of communication; or __I am acting under the guidance of a prior Directive to Physicians; or __I am acting upon the known values and desires of the patient; or __I am acting in the patient's best interest based upon the guidance given by the patient's physician. All check mark areas were blank. During an interview on [DATE] at 4:05 PM, the DON stated the OOH-DNR forms were completed in the business office on admission and the clinical nurses were responsible to follow up on the forms to ensure they were correct. During an interview on [DATE] at 4:07 PM, the BOM stated she normally started the OOH-DNR forms for a resident. The BOM stated whoever completes the DNR was responsible to ensure it was correct. The BOM stated she started the OOH-DNR and someone else at the facility looked it over and took it to the physician to have signed. The BOM stated she did not know why Resident #74 and Resident #84's OOH-DNR's were incomplete. The BOM stated she did not know the last time she was trained on OOH-DNR's. The BOM stated RN A was the nurse who usually followed up on the OOH-DNR's at the facility. The BOM stated a potential risk to the residents was it was not a true DNR if the form was incomplete and it could affect the DNR status for the residents. During an interview on [DATE] at 4:12 PM, RN A stated she did not know why Resident #74's and Resident #84's OOH-DNR's were incomplete. RN A stated the ADM reviews all of the OOH-DNR forms and she would follow-up on them as well. RN A stated she did not know the last time she was trained on OOH-DNR forms. RN A stated a potential negative outcome to the residents was they could get to the hospital and then [the hospital staff] not honor it (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and it would be a bad outcome. During an interview on [DATE] at 11:42 AM, the ADM stated whichever staff completed the OOH-DNR was responsible to ensure the form was filled out completely. The ADM stated she double checks every OOH-DNR but was behind and had not reviewed the OOH-DNR's for Resident #74 and Resident #84 yet. The ADM stated the BOM completed about 90 percent of the OOH-DNR's at the facility. The ADM stated she had been trained on advanced directives within the past year but was unsure of the exact date. The ADM stated a potential negative outcome to the residents was a risk for not following their [the residents] wishes, or whoever made the decision. Record review of the facility policy titled, Advanced Directives/CPR/Code Status Policy, undated, reflected the following: It is the policy of [the facility] to honor and respect all resident's choice regarding advanced directives to the best of our capabilities. These choices may include, but are not limited to, accepting or refusing medical or surgical treatment. [The Facility] will assist residents and families with information regarding advanced directives. We strongly recommend all residents have a complete advanced directive with all known wishes clearly outlined. Record review of the document titled, Texas Department of State Health Services Standard Out-of-Hospital Do-Not-Resuscitate Order with a revised date of [DATE] reflected the following on Page 2 of 2: Out-of-Hospital DNR Instructions: The original standard Texas Out-of-Hospital DNR form must be completed and properly executed.		

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observations, Interviews, and Record Review the facility failed to ensure residents were free from involuntary seclusion for 1 of 22 (Resident #7) residents reviewed for involuntary seclusion. The facility failed to obtain a physician order, documenting the clinical criteria met for placement in the secure/locked unit for Resident #7 on 08/04/2026. This failure could place residents at risk of isolation, decreased quality of life, and psychosocial harm. Findings included: Record review of the face sheet, dated 08/06/2026, revealed Resident #7 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included the following: Alzheimer's disease (progressive, irreversible brain disorder), dementia in other diseases classified elsewhere, severe with agitation (significant cognitive decline along with agitation), dementia in other diseases classified elsewhere, severe with psychotic disturbance (significant cognitive decline along with psychotic symptoms such as hallucinations, paranoia, suspiciousness, or delusions), insomnia (inability to sleep), anxiety disorder (mental health condition that causes excessive fear and worry), and major depressive disorder (mental disorder characterized by at least two weeks of pervasive low mood, low self-esteem, and loss of interest). Record review of Resident #7's quarterly MDS assessment, dated 06/25/2026, revealed Resident #7 had a BIMS score of 01, which indicated severely impaired cognition. Record review of the current care plan for Resident #7, undated, revealed a focus area that stated, The resident has impaired cognitive function/dementia or impaired thought processes r/t: DEMENTIA, ALZHEIMER'S DISEASE, Date Initiated: 03/26/2026., with the intervention and tasks that included, Promptly inform resident's primary physician and family members of any changes in cognitive status. The document included a focus area that stated, Resident is at high risk for elopement. Resident has attempted to leave the facility several times. Resident is appropriate to live on the secure unit due to benefitting from frequent staff interaction, as well as the quieter environment. This is the least restrictive environment for resident at this time. Date Initiated: 08/04/2026., with interventions and tasks that included, Consult with primary care physician and/or psychiatrist as needed. An additional focus area stated, Wander guard: At risk for elopement due to confusion and altered thought process, Date Initiated: 05/22/2026. with interventions and tasks that included, Have resident wear wander guard bracelet as ordered. Record review of the facility document titled, Secure Unit - Agreement to Reside Acknowledgement , dated 08/03/2026, stated the following: I prefer the secure unit and do not wish to move even though I have been offered in the past. I Understand that if I ever change my mind, I can move when a room off of the secure unit is available. Indicate reason for wanting to move: Elopement Risk. The document was signed by Resident #7's Responsible Party on 08/03/2026. Record review of Resident #7's physician orders, dated 08/05/2026, revealed Resident #7 did not have an active physician order for placement in a secure/locked unit. During an observation on 08/04/2026 at 11:30 AM Resident #7 was observed in the common area of the secure/locked unit. During an interview on 08/04/2026 at 12:15 PM RN B stated Resident #7 was moved to the secure/locked unit on this day, 08/04/2026, and Resident #7 was being monitored for behaviors of wandering and agitation. During an attempted interview on 08/04/2026 at 04:20 PM, Resident #7 was unable to articulate where she was currently residing or if she knew the code to open the door to the secure/locked unit. Resident #7 was not oriented with time and/ or place and was not able to be interviewed. During an observation and attempted interview on 08/05/2026 at 12:20 PM, Resident #7 was observed in the common area of the secure/locked unit. (continued on next page)		

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #7 was not oriented with time and/or place and was not able to be interviewed. During an interview on 08/06/2026 at 11:45 AM the DON stated it was the facility's policy to obtain a physician's order prior to placing a resident in a secure/locked unit. The DON stated prior to placing a resident on the secure/locked unit, the resident was assessed to determine if they met the criteria for the unit, which included an assessment for elopement risk and monitoring for behaviors. The DON stated the facility also included the resident's family/representative and physician in the discussion to ensure all parties were involved in the decision. The DON stated Resident #7 was assessed and met the criteria for the secure/locked unit. The DON stated Resident #7 was exhibiting behaviors that they felt required more supervision, and the decision was made to move her to the secure/locked unit. The DON stated Resident #7 was overstimulated and the secure/locked unit was quieter. The DON stated Resident #7's representative was contacted and also agreed with the decision. The DON stated a consent was signed by Resident #7's representative prior to the move. The DON stated the decision to move Resident #7 to a secure/locked unit was discussed as a possibility with the resident's physician when the resident was first admitted to the facility in March 2026 and ongoing since then. The DON stated a physician's order was not obtained prior to moving Resident #7 to the secure/locked unit. The DON stated the nurse in charge of moving a resident to the secure/locked unit was responsible for obtaining and entering the physician's order prior to moving the resident. The DON stated she was responsible for obtaining the physician's order for Resident #7, but she overlooked obtaining the order. The DON stated the facility completed an audit of all residents' physician orders for the secure/locked unit weekly or bi-weekly. The DON stated the facility would have noticed the missing order when this audit was completed. The DON stated the physician's order was obtained on 08/06/2026 and entered into the Resident's chart online. The DON stated it was her expectation that the physician's order be obtained prior to moving a resident to the secure/locked unit. The DON stated it was important to obtain a physician's order prior to moving a resident to the secure/locked unit to ensure the resident's physician was aware at all times and to ensure the facility was following the physician's orders. During an interview on 08/06/2026 at 12:00 PM the ADM stated the facility's process, prior to moving a resident to a secure/locked unit, included assessing the resident, obtaining consent from the resident's family, obtaining a physician's order, and updating the resident's care plan. The ADM stated she was not aware a physician's order was not obtained for Resident #7 prior to moving the resident to the secure/locked unit. The ADM stated the DON told her she forgot to obtain the order. The ADM stated the DON and ADM were responsible for ensuring the physician's order was obtained. The ADM stated the nurse who initiated the move was responsible for obtaining the physician's order. The ADM stated the DON initiated the move for Resident #7. The ADM stated Resident #7 was moved to the secure/locked unit on 08/04/2026. The ADM stated the physician's order was obtained on 08/06/2026. The ADM stated nursing staff completed an audit of all residents' physician's orders regularly, and the ADM followed up with her own audit to ensure all orders were accurate. The ADM stated the decision to move Resident #7 to a secure/locked unit was discussed with the resident's representative due to the resident exhibiting behaviors of wandering, and the resident was an elopement risk. The ADM stated the facility also felt the resident would benefit from a quieter environment with more supervision. The ADM stated a consent was signed by the resident's representative prior to moving the resident to the secure/locked unit. The ADM stated it was her expectation that the physician's order was obtained timely. The ADM stated it was important to ensure the order was obtained timely, so the resident's physician was aware and agreed with the decision made for residents. An attempted telephone interview was made on 08/06/2026 at 12:20 PM, to the physician for Resident #7 with no response. Record Review of the facility's policy (continued on next page)		

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled Guidelines for Restraints , undated, revealed the following: PURPOSE:If a resident is evaluated and needs a physical restraint, a systematic approach will be followed to assure all areas are addressed during the initiation or change of a restraint. GUIDELINE::1) If an evaluation indicates a risk for safety, and the Interdisciplinary Team concurs that restraint usage is necessary, the resident will be evaluated for intervention, as appropriate. Recommendation will be an interdisciplinary process.a. The least restrictive device for the resident will be determined, based on individual needs.b. Orders will be obtained from the physician. c. Consent form will be presented to the resident and/or family for signature.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals used in the facility were stored and maintained in accordance with currently accepted professional standards for 1 of 2 medication carts (Medication Cart 1) reviewed for storage. The facility failed to ensure CMA C ensured Medication Cart 1 was locked before walking into room [ROOM NUMBER] on 8/5/2026. This failure could result in misappropriation of medication, or medication errors. The findings include: During an observation of Hall 3 on 08/05/2026 at 11:28AM, Medication Cart 1 was found to be unlocked. The drawers 3 and 4 on the medication cart were able to be opened and contained resident's medications with no staff within sight or reach of Medication Cart 1. CMA C was observed opening the door to room [ROOM NUMBER] and exiting the room. CMA C walked to Medication Cart 1. During an interview on 08/05/2026 at 11:29AM, CMA C stated she was responsible for Medication Cart 1 at that time. She stated she was passing out medication to residents and forgot to lock it before entering room [ROOM NUMBER]. She stated a potential negative risk could be residents getting into the medication cart, or someone taking medication that is not theirs. CMA C confirmed the Medication cart 1 had not been locked. During an interview on 8/06/2026 at 11:11AM, the DON stated staff had been trained on medication carts and training is conducted monthly. She stated the training goes over medication cart cleanliness, storage, and stocking medication. She stated if staff walked away from the medication carts, and are not within reach or direct eyesight, then the medication carts need to be locked. She stated a potential negative outcome could be medication errors, or misappropriation of medication. She stated the pharmacy consultant also conducts observation rounds during their visits and monitors the medication carts and if there are any concerns. She said the consultant would discuss concerns with the DON. During an interview on 8/06/2026 at 11:30AM, the ADM stated staff are trained on medication carts annually and as needed. She stated staff should be locking the medication carts when they are not actively being used. She stated a potential negative outcome of medication carts being left open could be residents getting into the cart. Record review of facility policy titled Storage of Medication Guidelines undated revealed The purpose of this guideline is to ensure that medications are stored in a safe, secure, and orderly manner. 40) compartments containing medication are locked when not in use.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675462	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/06/2026
NAME OF PROVIDER OR SUPPLIER Parkview Skilled Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Parkway Big Spring, TX 79720	
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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, interviews, and record reviews, the facility failed to ensure menus were followed for 1 of 2 meals observed. (Lunch meal 8/4/26) The facility failed to follow the week 5 menu for pureed lunch meals served at the facility on Tuesday 8/4/26 by not serving or substituting all food items listed on the menu. This failure could place residents that eat food from the kitchen at risk of poor intake, and/or weight loss. The findings included: Record review of the Tuesday (Day 31) Week 5 menu, dated 2026, revealed the lunch menu was mustard fried catfish, cowboy beans, steamed baby carrots, hush puppies, garnish: lemon wedge, and ambrosia. Observation on 8/4/26 at 12:15 PM of dining room revealed pureed lunch meal trays served included mustard fried catfish, cowboy beans, and steamed baby carrots. No pureed hush puppies were observed on the plates nor was there a food item served to substitute the missing hush puppies. Observation on 8/4/26 at 1:05 PM of the dining room revealed pureed lunch meal trays served in the dining room on the secured unit included mustard fried catfish, cowboy beans, and steamed baby carrots. No pureed hush puppies were observed on the plates. During an interview on 8/5/26 at 2:30 PM, the [NAME] stated she prepared and served the lunch puree meals on 8/4/26. The [NAME] stated she should have served pureed hush puppies with the lunch meal on 8/4/26. The [NAME] stated she realized the hush puppies were missing when she served the last couple of trays. The [NAME] stated she got nervous and forgot to puree the hush puppies. The [NAME] stated all ingredients on the menu add up to a certain amount of nutrition and calories and all residents were supposed to get each food group on each meal. The [NAME] stated it was important for residents to get all food items because their body needed the nutrition. The [NAME] stated she was trained in following the menu and substitutions but was not sure when her last training was. The [NAME] stated she was responsible for ensuring the hush puppies were served on the pureed food trays. She stated the negative outcome was that residents could get sick and their body could start shutting down. During an interview on 8/6/26 at 11:11 AM, the DM stated they must serve all food items listed on the menu because it was approved by the dietitian and was based on the residents' requirements of what they could and could not eat. The DM stated all textures must get everything served on the menu for that meal or the item must be replaced by an approved substitution. The DM stated she was not aware residents were not served all items listed on the menu. The DM stated the system they used to ensure menus were followed was that the resident's ticket indicated what they're supposed to get served. The DM stated the cooks were supposed to serve the items listed on the resident's meal ticket. Then the aides were supposed to check the trays to ensure all the food on the tray matched the meal ticket before they put the trays on the warming cart. The DM stated then the aide that passed the food to residents was supposed to check the meal ticket and tray before serving the tray to the residents. The DM stated staff were trained on the following menus by herself and the previous dietary manager. The DM stated herself, the aides, and the cooks were all responsible for ensuring all food items listed on the meal tickets were followed. The DM stated she expected staff to ensure the correct food items were on the trays, portions, and dietary restrictions were followed. The DM stated potential negative outcomes were that residents would not get the nutritional value they need to maintain their health, prevent hunger, and it could affect reactions from their meds and their immunity from sickness. During an interview on 8/6/26 at 11:51 AM, the DON stated all food listed on the meal tickets must be served and match the ingredients and correct texture for each resident. The DON stated she was aware of previous general complaints of missing food items by complaints from residents and that staff fixed them. The DON stated the (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dietary staff were responsible for serving the correct items and then the staff who served the tray was responsible for double checking the tickets and trays to ensure all food items were on the tray before it was given to the resident. The DON stated it was usually a nursing staff that served the trays to the residents. The DON stated staff were trained on following menus and checking trays as part of their new hire training. The DON stated there were also monthly staff meetings where they discussed any concerns and addressed them. The DON stated the person serving the tray to the resident was responsible for ensuring all food listed on the meal tickets were on the trays. The DON stated it was important to ensure residents met their nutrition goals. The DON stated she expected staff to ensure the food on the trays was correct. The DON stated potential negative outcomes were weight loss, fluctuations of blood sugars, and nutritional deficits. During an interview on 8/6/26 at 12:46 PM, the ADM stated dietary staff must follow the menu. The ADM stated she was not aware the menus were not followed. The ADM stated she expected the dietary staff to follow the menu and serve all items listed. The ADM stated staff were to monitor each meal served and ensure residents received all items being served for the meal. The ADM stated it was important so residents would get proper nutrition. The ADM stated staff were trained in serving trays and following menus. She stated the potential negative outcome was that residents would not receive proper nutrition. Record review of the Menu Planning Guideline, undated, revealed in part: Nutritional needs of individuals will be provided. Based on a facility's reasonable efforts, menus should reflect the religious, cultural, and ethnic needs of the population served, as well as input received from individuals and groups. Procedure: 5. Menus will be served per the posted menus and if not available temporary changes in the menu will be noted on the menu substitution sheets.		

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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 establish and 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 1 of 6 (Resident #9) residents reviewed for infection control. The facility failed to ensure CNA B utilize EBP during wound care for Resident #9 on 8/05/2026. This failure could place residents at risk for cross contamination and infection. The Findings include: Record review of Resident #9's face sheet revealed an [AGE] year-old female originally admitted to the facility of 9/21/2022. Resident # 9 had a medical history of irritable bowel syndrome, cough, unspecified dementia, and pressure ulcer (bedsore) of sacral (triangular bone at the base of the spin) region. Record review of Resident #9's quarterly MDS dated [DATE] revealed Section C- Cognitive Patterns a BIMS score of 8 which indicated Resident #9 had moderate cognitive impairment. Record review of Resident #9's physician orders revealed Clean stage II [a shallow open sore] injury to her coccyx [tailbone]. with a start date of 8/06/2026. Physician orders revealed Initiate Enhanced Barrier Precautions (EBP) for chronic wound until wound is resolved with a start date of 8/06/2026. During a wound care observation on 8/05/2026 at 9:25AM for Resident #9, an EBP sign and PPE storage box were noted in Resident #9's room. CNA B entered the room without utilizing hand hygiene and put on gloves. CNA B assisted in turning Resident #9 onto her left side and removing her pants while LVN D provided wound care. CNA B did not utilize a gown while assisting LVN D in turning Resident #9. LVN D completed wound care and CNA B assisted Resident #9 in adjusting in bed. During an interview on 8/05/2026 at 9:33AM CNA B stated he was hired on June 2026 and did not think he had been trained on infection control. He stated he had some training on EBP and PPE. He stated PPE was used for residents when they are on contact precautions or things like that. He stated he was not aware he had to use EBP with Resident #9. He stated he had seen the EBP sign on her door but did not think it applied to her. He stated EBP was used on Residents when staff need protection from Residents' bodily fluids. He stated PPE was used to protect the staff from illnesses and disease. He stated it can help protect the Residents too, but it was primarily used for staff. He stated he had forgotten to use hand hygiene when he entered the room. He stated, I was aware of the EBP sign on the door to an extent. what I mean is, I had seen the sign on the door, but I didn't see other people using it, so I didn't think it applied to me. He stated he had been trained by multiple CNAs upon hire, and the DON had trained him but it was a classroom type setting and did not include EBP. During an interview on 8/06/2026 at 11:02AM, the DON stated she was the infection preventionist. She stated staff were trained on EBP with monthly in-services. She stated the in-services covered the EBP signs, how to identify residents who required EBP and the instructions on the EBP signage. She stated EBP was used for any resident who may have an open wound, sore, IV line, or any form of artificial opening. She stated if staff saw the signage on the door, they should be utilizing hand hygiene, gowns and gloves before assisting the resident in any of the task listed on the EBP sign and then removal of PPE and hand hygiene when complete. She stated the potential negative outcome of not using EBP could be enhanced infection risk for the residents. She stated if staff are assisting during wound care, they should be utilizing EBP as well. She stated CNA B had been trained on EBP and he had multiple staff educate him on EBP and infection control when he had been hired. During an interview on 8/06/2026 at 11:20AM, the ADM stated the DON was the infection preventionist. She stated staff are trained on EBP annually and monthly. She stated EBP was used for Residents that may have wounds, catheters, and any open areas. She stated staff (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should utilize gowns, gloves, and hand hygiene before and after providing Residents with care. She stated a potential negative outcome could be infection to the Resident. She stated if staff are assisting with any form of wound care, they were expected to follow EBP. Record review of facility document titled In-service Training Report dated 7/16/2026 revealed CNA B's signature and raining included .60. EBP- wear gown/gloves and [NAME] before leaving room, Resident on EBP are labeled with A or B on the sign on the door. Record review of facility document titled Competency Checklist for Certified and Non-certified nurse aids dated 6/26/2026 for CNA B revealed he had been trained and checked off on Infection control including the use of PPE. Record review of facility policy titled Enhanced Barrier Precautions undated revealed, 1. Enhanced barrier precautions are used as an infection prevention and control intervention to reduce the spread of multidrug-resistant organisms to residents .3. Examples of high contact resident characteristics requiring the use of gown and gloves for EBP's include a. Dressing b. bathing c. transferring d. providing change linen e. changing briefs or assisting with toileting f. device care or use h. wound care. 4. EBPs are indicated for residents with wounds and or in dwelling medical devices.8. Standard precautions applied to the care of all residents regardless of suspected or confirmed inspections or colonization status 9. Staff are trained to care for residents on EBP 10. signs are posted on the door or wall outside the residence room indicating the type of precautions and PPE required.		