STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675498	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Heights Rehabilitation Suites	6650 South Soncy Road Amarillo, TX 79119

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure the resident has the right to be free from abuse, neglect, misappropriation of resident property, for 6 residents (Resident #1, Resident #5, Resident #15, Resident #17, Resident #22, and Resident #41) of 83 residents reviewed for abuse and neglect.The facility failed to ensure Resident #1, Resident #5, Resident #15, Resident #17, Resident #22, and Resident #41 were not neglected during the 06:00 PM to 06:00 AM shift beginning on 04/19/26.The facility failed to ensure Resident #1 was not lying in a bed covered in feces.The facility failed to ensure Resident #5 was not lying in a bed soaked in urine.The facility failed to ensure Resident #15 was not lying asleep on a couch in just a soaked brief and t-shirt and later on a soaked couch in just a brief.The facility failed to ensure Resident #17 was not lying in a bed soaked in urine.The facility failed to ensure Resident #22 was assessed upon reporting a fall and was not lying in her bed upside down.The facility failed to ensure Resident #41 was not lying in a bed soaked in urine.These failures could place residents at risk of injury, infection, and/or negatively impacted self-esteem.Findings Included:Record review of Resident #1's admission record dated 04/27/26 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, muscle wasting and atrophy, muscle weakness, difficulty in walking, altered mental status, and cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning).Record review of Resident #1's admission MDS completed 04/20/26 revealed a BIMS of 12 which indicated moderately impaired cognition. Section GG Functional Abilities revealed Resident #1 required substantial maximal assistance defined as Helper dose MORE THAN HALF the effort. Helper lifts or holds truck or limbs and provides more than half the effort with toileting and all transfers.Record review of Resident #1's care plan last reviewed/revised on 04/20/26 revealed he had cognitive loss especially with short term recall. He experienced occasional bladder incontinence related to age. One of the interventions was, Provide incontinent care after each incontinent episode. Resident #1 was at risk for skin breakdown. Interventions included keeping him as clean and dry as possible, minimizing skin exposure to moisture, and keeping his linens clean, dry, and wrinkle free.Record review of Resident #1's active orders dated 04/27/26 revealed the following orders with corresponding start dates:04/09/26 BED MOBILITY with assist of 1-204/09/26 TOILETING with assist of 1-204/09/26 TRANSFER with assist of 1-2During an observation and interview on 04/27/26 at 05:37 AM Resident #1 was lying in bed on his back. When asked if staff took good care of him, he stated, That depends. When asked if there was a time staff did not take good care of him, he did not answer the question.During an observation and interview on 04/27/26 at 10:02 AM Resident #1 was lying in bed on his back. He stated he did not remember a night when the nurse did not check on him, and he ended up in a bed covered in feces. When asked if staff took good care of him on the night shift he looked down and away and stated, I don't want to answer the question.During an interview and observation on 04/27/26 at 10:06 AM Resident #1's skin showed no issues, redness, or irritation. Resident #1 denied any issues and stated he was pleased with his care.Record review of Resident #5's admission record dated 04/27/26 (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, diarrhea, difficulty in walking, cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning), infectious gastroenteritis and colitis (inflammation of stomach and large intestine often resulting in bloody diarrhea, abdominal pain, and cramping.), benign prostatic hyperplasia with lower urinary tract symptoms (the flow of urine is blocked due to the enlargement of prostate the gland; symptoms include increased frequency of urination at night and difficulty in urinating), and muscle wasting and atrophy.Record review of Resident #5's admission MDS completed on 04/15/26 revealed a BIMS of 14 which indicated intact cognition. Section GG Functional Abilities revealed Resident #5 used a wheelchair and had impairment of both lower extremities. He required substantial/maximal assistance defined as Helper dose MORE THAN HALF the effort. Helper lifts or holds truck or limbs and provides more than half the effort for toileting and all transfers.Record review of Resident #5's care plan last reviewed/revised on 04/21/26 revealed he had behavioral symptoms and as an intervention staff were to ensure his physical needs including toileting were met. Resident #5 was noted to have gastroenteritis with frequent diarrhea. He was noted to be incontinent of bowel and bladder, and staff were to provide incontinent care after each incontinent episode. Resident #5 was at risk of falling and staff were to keep his call light in reach at all times. Record review of Resident #5's active orders dated 04/27/26 revealed the following orders and corresponding start dates:04/07/26 AMBULATION with assist of 1-204/07/26 BED MOBILITY with assist of 1-204/07/26 TOILETING with assist of 1-204/07/26 TRANSFER with assist of 1-2During an observation on 04/27/26 at 05:51 AM Resident #5 was lying in his bed with his eyes closed under a blanket.During an observation and interview on 04/27/26 at 08:15 AM Resident #5 was lying in bed on his back with the head of the bed raised slightly. He stated staff took good care of him.During an observation and interview on 04/27/26 at 10:09 AM Resident #5's skin showed no redness or irritation, and he stated he was pleased with his care.During an observation and interview on 04/27/26 at 10:12 AM Resident #5 was lying in his bed on his back. He did not seem to understand when asked about a night when staff did not check on him and he woke up in a soaked brief and bed.Record review of Resident #15's admission record dated 04/27/26 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia with other behavioral disturbance (breakdown of thought process causing disruptive behavior), cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning), muscle wasting and atrophy, muscle weakness, difficulty in walking, insomnia (problems falling and staying asleep), unsteadiness on feet, and frequency of micturition (needing to urinate more often than once every 3-4 hours).Record review of Resident #15's quarterly MDS completed on 03/17/26 revealed a BIMS of 5 which indicated severely impaired cognition. Section GG Functional Abilities revealed Resident #15 used a wheelchair and was dependent for toileting. She required substantial/maximal assistance defined as Helper dose MORE THAN HALF the effort. Helper lifts or holds truck or limbs and provides more than half the effort for transferring from chair/bed-to-chair.Record review of Resident #15's care plan last reviewed/revised on 04/01/26 revealed Resident #15 was a wanderer and at increased risk of falling. One of the interventions was [Resident #15]'s physical needs will be met; . toileting. She was to use a fall mat next to her bed as well as a scoop mattress and be monitored at least every 2 hours while in bed. Resident #15 was noted to be receiving hospice care and one of the interventions was [Resident #15] will be kept clean and comfortable. She was noted to require extensive assistance with toileting and transfers by one staff member. The goal was [Resident #15 will maintain a sense of dignity by being clean, dry, . One of the interventions included, Monitor appearance. Resident #15 was at risk for incontinence. Staff were to, Provide incontinent care after each episode of incontinence. She was at risk for skin breakdown due to incontinence. Staff were to, Keep clean and dray as possible. Minimize skin exposure to moisture. Staff were also to Provide toileting assistance every 2 hours and prn.Record (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of Resident #15's active orders dated 04/27/26 revealed the following orders with corresponding start dates:11/19/25 Brief Check and document wet or dry every 3 hours02/26/26 BED MOBILITY with assist of 1-202/26/26 TRANSFER with assist of 1-2During an observation on 04/27/26 at 05:52 AM Resident #15 was lying in her bed on her right side with her eyes closed. Her bed was in the lowest position, and a fall mat was on the floor next to her bed.During an observation on 04/27/26 at 08:16 AM Resident #15 was lying in bed on her left side with her eyes closed. Her bed was in lowest position and fall mat was on the floor next to the bed. The couch in the entryway of her suite was visible from the hallway.During an observation and interview on 04/27/26 at 10:09 AM Resident #15 was in her bed with HOB raised to seated position. She did not remember a night when she slept on the sofa. She stated staff were kind and took good care of her.During an observation on 04/28/26 at 01:35 PM Resident #15's skin showed no breakdown or redness.Record review of Resident #17's admission record dated 04/27/26 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia, muscle wasting and atrophy, muscle weakness, overactive bladder, difficulty walking, repeated falls, and cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning).Record review of Resident #17's admission MDS completed 03/31/26 revealed a BIMS of 12 which indicated moderately impaired cognition. Section GG Functional Abilities revealed Resident #17 used a walker and required substantial/maximal assistance defined as Helper dose MORE THAN HALF the effort. Helper lifts or holds truck or limbs and provides more than half the effort for toileting. She required partial/moderate assistance defined as Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports truck or limbs but provides less than half the effort for all transfers.Record review of Resident #17's care plan revealed she experienced occasional bladder incontinence due to age. Staff were to provide incontinence care after each incontinent episode. She was noted to have cognitive loss especially in relation to short term recall.Record review of Resident #17's active orders dated 04/27/26 revealed the following orders and corresponding start dates:03/24/26 AMBULATION with assist of 1-203/24/26 BED MOBILITY with assist of 1-203/24/26 TOILETING with assist of 1-203/24/26 TRANSFER with assist of 1-2During an observation on 04/27/26 at 05:41 AM Resident #17 was lying in bed on her left side in the fetal position. She stated staff took good care of her and no one had been unkind to her during her stay in the facility.During an observation on 04/27/26 at 10:13 AM Resident #17's skin showed no redness or irritation. She stated she had no issues and was pleased with her care.Record review of Resident #22's admission record dated 04/27/26 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified lack of coordination, altered mental status, muscle weakness, difficulty in walking, and muscle wasting and atrophy.Record review of Resident #22's quarterly MDS completed on 01/29/26 revealed a BIMS of 9 which indicated moderately impaired cognition. Section GG Functional Abilities revealed she used a manual wheelchair and was dependent for chair/bed-to-chair transfers. Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.Record review of Resident #22's care plan last reviewed/revised on 04/21/2026 revealed she had a history of falling. An intervention to address this issue was to place her in her bed or recliner while she was in her room and not to leave her in her wheelchair. Another intervention was to observe her frequently and place her in a supervised area when out of bed.Record review of Resident #22's orders dated 04/27/26 revealed the following orders and order start dates: 05/24/24 1-2 person assist for ambulation 05/24/24 1-2 person assist for transfer05/24/24 1-2 person assist for toileting dated 05/24/24.05/24/24 at risk for falls02/26/26 1-2 person assist for bed mobilityRecord review of Resident #22's progress notes revealed the following notes:A note by LVN H on 04/20/26 at 09:39 AM This nurse and another nurse entered resident's room at approx 0615 (06:15 AM) and discovered resident laying on right side on the floor beside bed. Blanket was underneath resident and pillow was (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	under left leg. This nurse asked resident what happened? Resident stated ?I guess I fell out of bed' Resident c/o pain to left hip and knee. Assessed for other injuries. Vital signs taken. None noted. Notified on call and administrator. Resident sent to [hospital initials] hospital for eval and treat due to guarding of left hip.A note by LVN H on 04/20/26 at 12:31 PM Returned from hospital via facility transport at approx 1200 (12:00 PM). In wheelchair with no new orders. Hip contusion. Smiling and conversating with no new c/o pain or discomfort at this time.During an observation and interview on 04/27/26 at 10:07 AM Resident #22 was seated in her wheelchair in her room. She stated she remembered the night LVN D worked and would not help her into bed. She stated, She (LVN D) was just hateful. I don't think she was really interested in doing anything. I was very stressed out that night because she had such an attitude. Resident #22 stated she fell out of her bed that night onto the fall mat next to her bed. She did not remember a fall prior to that one.During an observation on 04/28/26 at 01:23 PM Resident #22's skin showed no breakdown or redness.Record review of Resident 41's admission record dated 04/27/26 revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, reduced mobility, need for assistance with personal care, difficulty in walking, cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning), benign hyperplasia without lower urinary tract symptoms (the flow of urine is blocked due to the enlargement of prostate the gland; symptoms include increased frequency of urination at night and difficulty in urinating), muscle wasting and atrophy, and muscle weakness.Record review of Resident #41's quarterly MDS completed 02/25/26 revealed a BIMS of 9 which indicated moderately impaired cognition. Section GG Functional Abilities revealed Resident #41 used a wheelchair was required partial/moderate assistance defined as Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports truck or limbs, but provides less than half the effort for toileting and all transfers.Record review of Resident #41's care plan last reviewed/revised 04/13/26 revealed he could use the sit to stand lift for transfers. One of the interventions was, 2 staff members will use the sit to stand lift to ensure safety. Resident #41 was care planned for having a diagnosis of benign prostatic hyperplasia. One of the interventions was, Keep perineal area clean and dry. Resident #41 was noted to be frequently incontinent of bowel and bladder and to be at risk for skin breakdown, recurrent UTIs, and dignity problem (being embarrassed). The interventions included offering toileting every two hours while awake, assisting with toilet transfers, provide perineal care and provide incontinent care as indicated. Resident #41 was noted to have cognitive loss especially in the area of short-term recall. He was noted to be at risk of skin breakdown related to decreased mobility. Interventions included keeping him as clean and dry as possible and keeping his linens clean, dry, and wrinkle free.Record review of Resident #41's active orders dated 04/27/26 revealed the following orders and corresponding start dates:12/19/24 AMBULATION with assist of 1-2 persons12/19/24 TOILETING with assist of 1-2 persons12/19/24 TRANSFER with assist of 1-2 personsDuring an observation on 04/27/26 at 05:54 AM Resident # 41 was lying on his back in bed with his eyes closed. The head of his bed was slightly raised, and he had 3 pillows under his head.During an observation and interview on 04/27/26 at 10:05 AM Resident #41 was seated in his wheelchair in the doorway of his room. He stated he did not remember a night when staff did not change his brief, and he ended up soaking wet the next morning.During an interview on 04/27/26 at 04:37 AM LVN C stated she was working on 100 hall on the night of 04/19/26 when LVN D, who was working on 400 hall (Resident #22's hall), asked her for assistance. LVN C stated she walked with LVN D to Resident #22's suite and noted Resident #15 asleep on the couch in view of the hall wearing only a t-shirt and a soaked brief. LVN C stated she told LVN D, This is not cool. She stated LVN D told her, Wherever she (Resident #15) wants sleep; she's gonna sleep. LVN C stated LVN D told her she did not have time to baby talk the residents. LVN C stated she assisted LVN D with Resident #22 who stated she had fallen and her knee hurt as a result and she was in her bed upside down to take the pressure off of her knee. LVN C asked if she could assess her knee, and Resident #22 stated she just wanted to (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sleep. LVN C stated she put a pillow between Resident #22's legs and Resident #22 said the pillow relieved the knee pain. LVN C stated this happened at approximately 04:30 AM. She stated she returned to her hall and called the on-call phone to let ADON A know she was worried about the residents on hall 400. She stated she told ADON A about Resident #15 lying on the couch wearing only a soaked brief and T-shirt and about Resident #22 seeming to be afraid of LVN D and saying she had a fall and her knee hurt as a result. She stated ADON A told her she would let ADM know in the morning.During an interview and observation on 04/27/26 at 05:07 AM LVN C sent a text screen shot showing the time of her call to ADON A on the on-call phone was 04:35 AM on 04/20/26.During an interview on 04/27/26 at 05:47 AM LVN E stated leaving residents in wet and soiled briefs was an example of neglect.During an interview on 04/27/26 at 05:57 AM RN F stated she came to work on the morning of 04/20/26 and LVN C asked her to check on the residents on hall 400. RN F stated she joined LVN H on hall 400 and the two of them found Resident #15 asleep on the couch in the entryway to her suite in view of the hall wearing only a t-shirt with a soaked brief on the floor next to the couch RN F stated the couch was soaked with urine around Resident #15. RN F stated Resident #41 was lying bed soaked from the back of his neck down to his knees. She stated Resident #22 was on the floor of her room next to the bed with the head at the foot of the bed and her feet toward the head of the bed. She stated Resident #22 was complaining of pain, so she was sent to the hospital for evaluation. She stated Resident #1 was lying in a bed covered in feces. RN F stated all of the residents on hall 400 required a full bed change due to soaked linens. She stated, I called ADM and let her know my serious concerns. I don't like to throw the word neglect around, but I could say I have serious concerns about the care on that hall overnight or the lack of care on that hall overnight. She stated of hall 400 on the morning of 04/20/26, There was major concerns.During an interview on 04/27/26 at 06:05 AM ADM stated LVN C called in a complaint to the company hotline regarding LVN D's care of residents on the night shift of 04/19/26. She interviewed LVN D and was told Resident #15 said the couch was her bed and refused to get off of the couch. She stated LVN D told her she (LVN D) was overwhelmed and struggled through the night but did the best she could. ADM stated, My day shift nurses were upset because people were wet.During an interview on 04/27/26 at 07:11 AM LVN D stated 04/19/26 was her first time working in the facility. She stated she was shocked when she picked up the night shift to find she was responsible for total care for 6 residents and did not have a CNA to help her. She stated she had a back injury that made it impossible for her transfer residents alone. LVN D said of the residents on hall 400, Everybody was confused, dead weight, couldn't stand by themselves. She stated one resident was on a sofa and had taken her brief off. She refused to get up and go to bed and told me she was in her bed. Apparently, she had taken her brief off and dropped it on the floor. LVN D stated she was capable of assisting with brief changes but I can't solo due to her back injury. She stated of Resident #15, She had taken her brief off and denied care. I had been warned she might refuse care and not take her medications. LVN D stated Resident #41 was too big for her to provide a brief change to him. She stated some residents needed brief changes, but she was unable to change them due to being unable to stay bent over.During an interview on 04/27/26 at 06:50 AM ADM stated LVN D told her she had had 2 back surgeries and was [AGE] years old. ADM stated staff did skin sweeps on all residents on hall 400 on 04/20/26 because the day shift coming on that morning reported all the beds on hall 400 were soaked. She stated the skin sweeps revealed no redness or injury. She stated none of the residents on hall 400 were interviewable.During an interview on 04/27/26 at 07:41 AM LVN D stated, I do want to emphasize that I feel facility management was completely neglectful for not providing adequate staff and support for staff. Been told they are notorious for understaffing and leaving a nurse to do total care without the assistance of a CNA. In the past I would have immediately called the state line and reported them. They figure out who said what and then you get blackballed. She stated she did not tell the facility she could not do the job of nurse and CNA because she did not want to be blacklisted with her agency. When asked if she thought the residents on her hall on the night shift of 04/19/26 were (continued on next page)

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She stated she found one CNA who told her she would be there shortly to help but did not show up. She stated Resident #22 must have put herself on her bed upside down. She stated of Resident #41, I'm quite certain he needed to be changed (brief), but I told him I could not push and lift and roll. Multiple times I went looking for CNAs to help make rounds and check on him and they would say, ?When I get time I'll come over. LVN D stated no CNA ever came to her hall to assist her.During an interview on 04/27/26 at 08:17 AM CMA G stated if she saw a resident in a soaked brief and t-shirt asleep on a couch in view of the hall, she would take care of the resident and then let the charge nurse know how she found the resident. She stated leaving residents in wet or soiled briefs was a form of neglect.During an interview on 04/27/26 at 09:08 AM ADON A stated LVN C called her on the morning of 04/20/26 to say she had concerns about the residents on hall 400. ADON A stated LVN C told her she saw a resident in a soaked brief but did not say anything else. She stated LVN C did not tell her anything about a resident who was in pain and said she fell. ADON A stated she sent a text to the two other nurses in the facility (LVN I and LVN J) asking them to send one of their CNAs to help LVN D. She stated she did not follow up to see if that was done or further check on the residents on hall 400.During an interview on 04/27/26 at 09:47 AM LVN H stated when she came to work on the morning of 04/20/26 LVN D did not give report, just said, Good luck and left the facility. She stated she and RN F found Resident #22 on the floor of her room and sent her to the hospital because she was complaining of pain in her left hip and knee. She stated she found Resident #15 sleeping in just a t-shirt on the couch visible from the hallway. LVN H stated Resident #15's soaked brief was on the floor next to the couch and the couch was also soaked where Resident #15 was seated. She stated Resident #41 was soaking wet from his ankles to his neck. She stated he was begging to get up and saying, I'm wet, I'm wet, I'm wet. She stated he was complaining about being cold. LVN H stated she and RN F let ADM know about the condition of the residents of hall 400 right away. She stated Resident #17 had a brown ring on her bottom and her bed was soaked. She stated Resident #1 had feces all over his bed. LVN H stated Resident #5 was wearing a soaked brief and his bedding was soaked as well. She stated she was in complete shock that morning as she had never come to work to find her residents in the condition they were in. She stated as she was getting all of her residents cleaned up, she did a skin sweep on them and found no redness or irritation. She stated of the residents' skin, There wasn't any extra or new redness or anything like that. Nothing out of the ordinary on them. LVN H stated none of her residents complained about the care they received overnight. She stated for the most part her residents were not interviewable with the occasional exception of Resident #22.During an interview and observation on 04/27/26 at 11:57 AM ADM was asked for the times of the text messages between the on call phone and LVN I and LVN J. ADM showed this surveyor a text exchange on the on-call phone dated 04/20/26 between ADON A, LVN I, and LVN J. At 04:45 AM ADON A asked the two LVNs to send their CNAs to hall 400 if they got the chance.During an observation and interview on 04/27/26 at 12:00 PM ADM, MS, and this surveyor entered a closet in the facility to watch recorded camera footage of LVN D on hall 400 the night of 04/19/26. According to camera footage, LVN D did not enter a resident room until after 10 PM on the night of 04/19/26. ADM stated it was nice to know you pay so much money for agency staff to sit around on their phones. LVN D did enter resident rooms after 10:00 PM but did not remain in any of the rooms for more than 2 minutes except for the instance she and LVN C entered (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Heights Rehabilitation Suites	6650 South Soncy Road Amarillo, TX 79119

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the suite of Resident #15 and Resident #22. The two LVNs remained in the suite for 3 minutes at approximately 4:30 AM on 04/20/26.During an interview on 04/28/26 at 08:26 AM LVN K stated an example of neglect was leaving residents alone when they needed to have their briefs changed. He stated this could lead to skin breakdown and psychologically the residents would be hesitant to trust. He stated it could negatively impact their self esteem as well as cause UTIs.During an interview on 04/28/26 at 08:30 AM CMA L stated not changing a resident's wet brief was an example of neglect. She stated residents might feel embarrassed or isolate themselves if their wet briefs were not changed.During an interview on 04/28/26 at 08:32 AM CNA M stated not changing a resident's brief was an example of neglect and could result in infection.During an interview on 04/28/26 at 08:35 AM CMA G stated leaving residents in wet briefs was an example of neglect and could lead to UTIs, rashes, odor, and decreased self-esteem.During an interview on 04/28/26 at 08:36 AM SC stated leaving residents in wet briefs was an example of neglect and could cause skin breakdown.During an interview on 04/28/26 at 08:39 AM DT stated not checking on resident every 2 hours was an example of neglect and could lead to pressure sores, UTIs, and indecency.During an interview on 04/29/26 at 07:33 AM LVN J stated not changing a resident's brief was an example of neglect. She stated leaving a resident on a couch in a soaked brief and t-shirt overnight was not acceptable because the resident might fall and was not supposed to be out in public undressed. She stated, Another resident can go by and see somebody naked. LVN J stated a possible negative outcome of leaving a resident in an unchanged brief was skin breakdown or sores. She stated she remembered working on the night of 04/19/26 and ADON A asking her to send her CNAs to hall 400 to help LVN D. She stated her CNAs did not go as they had just enough time to finish their last round on her hall. LVN J stated she answered a call light for LVN D because it had been going off for a long time. She stated she was not sure how long but that she had administered a medication and charted and it was still going off. She described the location of Resident #1's room. She stated he was confused and asking about his car. LVN D stated she noticed several of the call lights for hall 400 went off for long periods of time that evening. She stated not answering a call light within 15 minutes, not changing resident briefs, and not dressing residents were examples of neglect. LVN J stated, That is inhumane. You don't do that to anybody.During an interview on 04/29/26 at 09:02 AM SC stated staff were responsible to ensure residents were not left sleeping overnight on a couch in view of the hallway wearing only a t-shirt and brief or just a t-shirt. She stated this could negatively impact the dignity of the resident. SC stated, She has a bed she needs to be in. She stated not assessing a resident for injury after a professed fall could be a form of neglect. SC stated sitting in wet or soiled briefs all night was a form of neglect and resident skin could breakdown.During an interview on 04/29/26 at 09:06 AM LVN K stated it was not okay for a resident to be left overnight sleeping on a couch in just a t-shirt and brief or just a t-shirt. He stated, For one, other patients can see them; invades their privacy and their dignity, self-esteem. We have to advocate for the patient. He stated all facility staff were responsible for ensuring this did not happen to a resident. He stated even if housekeeping walked by and noticed a resident in that position, they were responsible to let the nurse know. He stated not assessing a resident who said they fell could lead to pain, compartment syndrome, and death. LVN K stated the nurse on duty was responsible for assessing the resident.During an interview on 04/29/26 at 09:18 AM RN S stated it was not okay for a resident to be left sleeping on the couch in view of the hallway with just a t-shirt and brief or just a t-shirt for dignity and privacy reasons. She stated the nurse was ultimately responsible to ensure this did not happen to a resident. RN S stated the nurse on duty was responsible for assessing a resident who said they fell. She stated not assessing the resident could lead to the resident having an injury staff did not know about. She stated leaving residents in wet or soiled briefs was a form of neglect.During an interview on 04/29/26 at 09:24 AM LVN T stated it was not okay for a resident to be left sleeping on the couch in view of the hallway with just a t-shirt and brief or just a t-shirt. She stated, It is a dignity issue for one and plus they need to be able to sleep in their bed and g

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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 the professional standards for food service safety for 1 of 1 kitchen reviewed for kitchen sanitation. 1. The facility failed to ensure freezer items were properly stored, labeled, and dated.2. The facility failed to ensure pantry foods were properly stored, labeled, and dated.3. The facility failed to ensure opened foods were discarded according to their policy. These failures could place residents who ate food served by the kitchen at risk of food-borne illness. Findings include:In an Observation of the walk- in freezer on 4/27/26 at 6:40 am revealed the following:1. (1) bag of rolls, no label or date not in original box. 2. (1) box of frozen beef patties, not sealed and open to air.3. (1) box of frozen burritos, not sealed and open to air.4. (1) box of frozen yeast rolls, not sealed and open to air. In an Observation of the walk-in pantry on 4/27/26 at 6:45 am revealed (1) plastic storage container of prepared frosting, labeled Frosting and dated 02-12. In an Observation on 4/28/26 at 9:20 am of the walk-in freezer revealed the following:1. (1) bag of rolls, no label or date not in original box. 2. (1) box of frozen beef patties, not sealed and open to air.3. (1) box of frozen burritos, not sealed and open to air.4. (1) box of frozen yeast rolls, not sealed and open to air. In an Observation of the walk-in pantry on 4/28/26 at 9:25 am revealed (1) plastic storage container of prepared frosting, labeled Frosting and dated 02-12. In an observation and interview on 4/28/26 at 1:50 pm of the walk-in freezer with the DM, revealed the plastic container of frosting dated 02-12 was still on the pantry shelf. The DM stated the facility policy stated to throw all opened or expired foods away after 3 days. She stated that the container lid had broken, and the frosting had been transferred to the plastic container. She stated she did not remember what date it was transferred but it had been a while. She stated the date of 02-12 was the date the food was received. The DM stated she was not sure if the frosting should have been thrown out or not. She stated she had discussed the frosting container with the food representative, and he had no insight for her as to how long the frosting would be good. In an interview on 4/28/26 at 1:55 pm, the DM stated of the opened food products in the freezer, she expected all staff to close food items up after use and she expected all food to be labeled and dated. She stated if foods were not properly wrapped up or labeled and dated this could cause food contamination and sickness to residents. She stated anything could fall into the opened food items. The DM stated she had been trained by the dietician in the duties of the kitchen. was responsible for training staff, and she would retrain them in all issues in the kitchen. Record Review of the facility policy and procedure, dated 2009, titled Safe Food Handling documented: Follow all local state and federal regulations when handling food. Refrigerated foods are properly covered, labeled and dated. All foods removed from the original packaging are stored in a closed container and labeled with the common name of the product and the date it was opened. Leftover foods are properly covered lobed and dated with a use by date. Foods are immediately put in the refrigerator or freezer, and leftovers are discarded after 3 days unless otherwise indicated. The day of preparation is considered Day 1. Follow USDA guidelines for food storage. Follow all state and federal regulations when handling food.

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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** Based on observation, interview, and record review the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 (Resident #15) of 21 residents reviewed for resident rights.The facility failed to ensure Resident #15 was not sleeping on a couch in view of the hallway in a t-shirt and brief and later in just the t-shirt the night of 04/19/2026.This failure could place residents at risk of lack of personal privacy and dignity.Findings Included:Record review of Resident #15's admission record dated 04/27/26 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia with other behavioral disturbance (breakdown of thought process causing disruptive behavior), cognitive communication deficit (difficulty with one or more of the following: attention, memory, perception, language, problem-solving, and reasoning), muscle wasting and atrophy, muscle weakness, difficulty in walking, insomnia (problems falling and staying asleep), unsteadiness on feet, and frequency of micturition (needing to urinate more often than once every 3-4 hours).Record review of Resident #15's quarterly MDS completed on 03/17/26 revealed a BIMS of 5 which indicated severely impaired cognition. Section GG Functional Abilities revealed Resident #15 used a wheelchair and was dependent for toileting. She required substantial/maximal assistance defined as Helper dose MORE THAN HALF the effort. Helper lifts or holds truck or limbs and provides more than half the effort for transferring from chair/bed-to-chair.Record review of Resident #15's care plan last reviewed/revised on 04/01/26 revealed Resident #15 was a wanderer and at increased risk of falling. One of the interventions was [Resident #15]'s physical needs will be met; . toileting. She was to use a fall mat next to her bed as well as a scoop mattress and be monitored at least every 2 hours while in bed. Resident #15 was noted to be receiving hospice care and one of the interventions was [Resident #15] will be kept clean and comfortable. She was noted to require extensive assistance with toileting and transfers by one staff member. The goal was [Resident #15 will maintain a sense of dignity by being clean, dry, . One of the interventions included, Monitor appearance. Resident #15 was at risk for incontinence. Staff were to, Provide incontinent care after each episode of incontinence. She was at risk for skin breakdown due to incontinence. Staff were to, Keep clean and dray as possible. Minimize skin exposure to moisture. Staff were also to Provide toileting assistance every 2 hours and prn.Record review of Resident #15's active orders dated 04/27/26 revealed the following orders with corresponding start dates:11/19/25 Brief Check and document wet or dry every 3 hours02/26/26 BED MOBILITY with assist of 1-202/26/26 TRANSFER with assist of 1-2During an interview on 04/27/26 at 04:37 AM LVN C stated she was working on 100 hall on the night of 04/19/26 when LVN D, who was working on 400 hall (Resident #22's hall), asked her for assistance. LVN C stated she walked with LVN D to Resident #22's suite and noted Resident #15 asleep on the couch in view of the hall wearing only a t-shirt and a soaked brief. LVN C stated she told LVN D, This is not cool. She stated LVN D told her, Wherever she (Resident #15) wants sleep; she's gonna sleep. LVN C stated LVN D told her she did not have time to baby talk the residents. LVN C stated she assisted LVN D with another resident in the suite, returned to her hall, and called the on-call phone to let ADON A know she was worried about the residents on hall 400. She stated she told ADON A about Resident #15 lying on the couch wearing only a soaked brief and T-shirt.During an interview and observation on 04/27/26 at 05:07 AM LVN C was asked what time she called ADON A. LVN C sent a text screen shot showing the time of her call to ADON A on the on-call phone was 04:35 AM on 04/20/26.During an interview on 04/27/26 at 05:47 AM LVN E stated leaving residents in wet and soiled briefs was an example of neglect.During an observation on 04/27/26 at 05:52 AM Resident #15 was lying in her bed on her right side with her eyes closed. Her bed was in the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lowest position, and a fall mat was on the floor next to her bed.During an interview on 04/27/26 at 05:57 AM RN F stated she came to work on the morning of 04/20/26 and LVN C asked her to check on the residents on hall 400. RN F stated she joined LVN H on hall 400 and the two of them found Resident #15 asleep on the couch in the entryway to her suite in view of the hall wearing only a t-shirt with a soaked brief on the floor next to the couch RN F stated the couch was soaked with urine around Resident #15. She stated, I called ADM and let her know my serious concerns. I don't like to throw the word neglect around, but I could say I have serious concerns about the care on that hall overnight or the lack of care on that hall overnight.During an interview on 04/27/26 at 06:05 AM ADM stated she interviewed LVN D and was told Resident #15 said the couch was her bed and refused to get off of the couch. She stated LVN D told her she (LVN D) was overwhelmed and struggled through the night but did the best she could.During an interview on 04/27/26 at 07:11 AM LVN D stated 04/19/26 was her first time working in the facility. She stated she was shocked when she picked up the night shift to find she was responsible for total care for 6 residents and did not have a CNA to help her. She stated she had a back injury that made it impossible for her transfer residents alone. LVN D said of the residents on hall 400, Everybody was confused, dead weight, couldn't stand by themselves. She stated one resident was on a sofa and had taken her brief off. She refused to get up and go to bed and told me she was in her bed. Apparently, she had taken her brief off and dropped it on the floor. LVN D stated she was capable of assisting with brief changes but I can't solo due to her back injury. She stated of Resident #15, She had taken her brief off and denied care. I had been warned she might refuse care and not take her medications.During an interview on 04/27/26 at 07:41 AM LVN D stated, If you need to be lifted up out of a wheelchair and transferred to the bed and I am the only one there I can't do it.During an observation on 04/27/26 at 08:16 AM Resident #15 was lying in bed on her left side with her eyes closed. Her bed was in lowest position and fall mat was on the floor next to the bed. The couch in the entryway of her suite was visible from the hallway.During an interview on 04/27/26 at 09:08 AM ADON A stated LVN C called her on the morning of 04/20/26 and told her she was concerned about the residents on hall 400. ADON A stated LVN C told her about a resident with a soaked brief.During an interview on 04/27/26 at 09:47 AM LVN H stated she came to work on the morning of 04/20/26 and she and RN F found Resident #15 asleep on the couch with her soaked brief on the floor next to the couch. LVN H stated Resident #15's wheelchair was next to her, and she (LVN H) assumed Resident #15 put herself on the couch. She stated Resident #15's bed was not made, and she thought that was probably why Resident #15 put herself on the couch.During an observation and interview on 04/27/26 at 10:09 AM Resident #15 was in her bed with HOB raised to seated position. She did not remember a night when she slept on the sofa.During an observation and interview on 04/27/26 at 12:00 PM ADM, MS, and this surveyor entered a closet in the facility to watch recorded camera footage of LVN D on hall 400 the night of 04/19/26. According to camera footage, LVN D did not enter a resident room until after 10 PM on the night of 04/19/26. ADM stated it was nice to know you pay so much money for agency staff to sit around on their phones. LVN D did enter resident rooms after 10:00 PM but did not remain in any of the rooms for more than 2 minutes except for the instance she and LVN C entered the suite of Resident #15 and Resident #22. The two LVNs remained in the suite for 3 minutes at approximately 4:30 AM on 04/20/26.During an interview on 04/28/26 at 08:26 AM LVN K stated leaving residents in unchanged, wet briefs was an example of neglect of residents. He stated this could result in skin breakdown, decreased self-esteem, possible UTI, and psychologically cause residents not to trust care givers.During an interview on 04/28/26 at 08:30 AM CMA L stated not changing a resident's wet brief was an example of neglect. She stated residents might feel embarrassed or isolate themselves if their wet briefs were not changed.During an interview on 04/28/26 at 08:32 AM CNA M stated not changing a resident's brief was an example of neglect and could result in infection.During an interview on 04/28/26 at 08:35 AM CMA G stated leaving residents in wet briefs was an example of neglect and could lead to UTIs, rashes, odor, and decreased self-esteem.During an interview on 04/28/26 at 08:36 AM SC stated leaving residents in (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wet briefs was an example of neglect and could cause skin breakdown.During an interview on 04/28/26 at 08:39 AM DT stated not checking on resident every 2 hours was an example of neglect and could lead to pressure sores, UTIs, and indecency.During an observation on 04/28/26 at 01:38 PM Resident #15's skin showed no redness or breakdown.During an interview on 04/29/26 at 07:33 AM LVN J stated not changing a resident's brief was an example of neglect. She stated leaving a resident on a couch in a soaked brief and t-shirt overnight was not acceptable because the resident might fall and was not supposed to be out in public undressed. She stated, Another resident can go by and see somebody naked. LVN J stated a possible negative outcome of leaving a resident in an unchanged brief was skin breakdown or sores.During an interview on 04/29/26 at 09:02 AM SC stated all staff were responsible to ensure residents were not left sleeping overnight on a couch in view of the hallway wearing only a t-shirt and brief or just a t-shirt. She stated this could negatively impact the dignity of the resident. SC stated, She has a bed she needs to be in.During an interview on 04/29/26 at 09:06 AM LVN K stated it was not okay for a resident to be left overnight sleeping on a couch in just a t-shirt and brief or just a t-shirt. He stated, For one, other patients can see them; invades their privacy and their dignity, self-esteem. We have to advocate for the patient. He stated all facility staff were responsible for ensuring this did not happen to a resident. He stated even if housekeeping walked by and noticed a resident in that position, they were responsible to let the nurse know.During an interview on 04/29/26 at 09:18 AM RN S stated it was not okay for a resident to be left sleeping on the couch in view of the hallway with just a t-shirt and brief or just a t-shirt for dignity and privacy reasons. She stated the nurse was ultimately responsible to ensure this did not happen to a resident.During an interview on 04/29/26 at 09:24 AM LVN T stated it was not okay for a resident to be left sleeping on the couch in view of the hallway with just a t-shirt and brief or just a t-shirt. She stated, It is a dignity issue for one and plus they need to be able to sleep in their bed and get a good night's sleep. She stated the charge nurse was responsible for ensuring this did not happen to a resident. She stated if the resident insisted on sleeping on the couch the charge nurse should make sure they are clothed and have a blanket and pillow.During an interview on 04/29/26 at 09:30 AM ADON A stated if staff found a resident asleep on the couch in view of the hallway wearing just a t-shirt and brief or just a t-shirt she expected them to get the resident in the room, dressed, and covered. She stated if the resident wanted to sleep on the couch staff should redirect the resident and educate them on safety and comfort. She stated all staff were responsible for ensuring residents did not sleep as described above. ADON A stated it could negatively impact a resident's privacy and/or dignity. She stated a resident staying all night in a wet brief could lead to skin breakdown and lead the resident to think no one cares about them. ADON A stated leaving residents in their beds soaked in urine or feces was an example of neglect.During an interview on 04/29/26 at 09:38 AM ADON B stated he would expect staff to get a resident dressed and into their bed if they were found sleeping on a couch in view of the hallway wearing only a t-shirt and brief or just a t-shirt. He stated all staff were responsible for making sure this did not happen. He stated if the resident insisted on sleeping on the couch staff should cover them and shut the door, so they were not visible from the hallway. He stated otherwise a resident could get really cold and their dignity might be negatively impacted. ADON B stated leaving a resident on the couch as described above was an example of neglect. He stated residents could get UTIs and skin breakdown if left in wet briefs. He stated their dignity could be insulted.During an interview on 04/29/26 at 09:44 AM DON stated if her staff saw a resident sleeping in view of the hallway on a couch in just a t-shirt and brief or just a t-shirt she expected her staff to, Wake patient, take to room, and if they refuse to go to their room at least get them a blanket and pillow. She stated the resident could get too cold or end up getting sick if left as described above. DON stated the resident could fall off of the couch. She stated leaving a resident as described above was an example of neglect. She stated leaving residents in wet or soiled briefs could lead to skin breakdown or infection.During an interview on 04/29/26 at 10:23 AM ADM stated she would hope her staff would assist a resident who was sleeping on the couch in view of the hallway in (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	just a t-shirt and brief or just a t-shirt to make sure that resident was appropriately dressed and clean. She stated any staff member with knowledge of the condition of the resident mentioned above was responsible to intervene. ADM stated leaving the resident as described above would be a dignity issue. She stated leaving residents in wet or soiled briefs could lead to skin breakdown.Record review of facility admission packet page titled Texas Department of Aging and Disability Services revealed the following: You, the resident do not give up any rights when you enter a nursing facility. If anyone . violates your dignity, you have the right file a complaint. You have a right to: . 2. safe, decent and clean conditions; . 4. be treated with courtesy, consideration, and respect; . 6. privacy, .Record review of the facility admission packet page 14-21 titled Resident Rights revealed the following: . The facility protects and promotes the rights of each resident in our care. 1. Basic Rights. Each resident has the right to a dignified existence . 15. Privacy. Each resident has the right to privacy with regard to accommodations, treatment, communications, personal care . 49. Resident Dignity. The facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment, that maintains or enhances his/her quality of life .Record review of facility policy titled Patient/Resident Rights and dated 10/01/20 revealed the following: . The Facility employs measures to ensure patient and resident personal dignity, well-being, and self-determination are maintained . The Facility treats each resident with respect and dignity. The Facility provides care for each resident in a manner that promotes, maintains, or enhances quality of life .

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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 advanced directive for 2 of 21 residents (Resident #15, Resident #103) reviewed for advanced directives. The facility failed to ensure the OOH-DNR for Resident #15 included a date by the physician signature. The facility failed to ensure the physician signed Resident #103's OOH-DNR in the required spaces. This failure could place residents at risk of not having an accurate advanced directive such as a DNR (Do Not Resuscitate), recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care and not receiving healthcare as per their or their legal representatives wishes.Findings Included: Resident #15 Record review of Resident #15's face sheet revealed an [AGE] year-old female admitted to the facility on [DATE]. Diagnoses included but are not limited to unspecified dementia with other behavioral disturbance (cognitive decline with behaviors), intermittent explosive disorder (sudden episodes of unwarranted anger), psychotic disorder with delusions due to known physiological condition (hallucinations or delusions occur with a temporary or chronic condition), and major depressive disorder, recurrent severe without psychotic features (multiple episodes of depression that severely impair daily functioning without the presence of delusions or hallucinations). Record review of Resident #15's OOH-DNR ORDER, revealed physician signature under heading PHYSICIAN'S STATEMENT, with no date documented. Record review of Resident #15's quarterly MDS, dated [DATE], revealed a BIMS of 05. Record review of Resident #15's care plan, dated [DATE], with a problem start date of [DATE], revealed Resident #15 is care planned for Advanced Care Planning: Code Status DNR, with an approach of advance directives of Resident #15's choice completed and placed on medical record under advance directive tab or in documents in Matrix. Resident #103 Record review of Resident #103's face sheet revealed a [AGE] year-old male admitted to the facility on [DATE]. Diagnoses include but are not limited to metabolic encephalopathy (diffuse brain function), emphysema (chronic lung condition causing shortness of breath), chronic obstructive pulmonary disease (progressive lung disease that makes it difficult to breathe), acute respiratory failure with hypoxia (lungs cannot adequately oxygenate the blood), chronic viral hepatitis C (inflammation of the liver), and unspecified dementia (decline in cognitive function). Record review of Resident #103's OOH-DNR Order, dated [DATE], under heading All persons who have signed above must sign below, acknowledging that this document has been properly completed, revealed no signature by space titled Attending physician's signature. Record review of Resident #103's care plan indicated an edited goal of Advance Care planning: Code Status DNR on [DATE]. In an interview on [DATE] at 8:44 AM, LVN H was provided with copies of Resident #15 and Resident #103's OOH-DNR. LVN H indicated that physician signature was missing from Resident 103's OOH-DNR and date was missing by physician's signature on Resident #15's OOH-DNR. LVN H stated that she would treat them as a full code. LVN H stated that a negative outcome of advance directives not being completed correctly would be it is not the resident's wishes. In an interview on [DATE] at 8:54 AM, LVN K was provided copies of Resident #15 and Resident #103's OOH-DNR. LVN K stated that Resident #15's OOH-DNR was incorrect because it was missing the date and Resident #103's OOH-DNR was missing the physician signature. LVN K stated that the documents were not complete or intact DNR's. LVN K stated a negative outcome was the resident would be a full code and could die. In an interview on [DATE] at 8:58 AM, SW V and SW P were provided with copies of Resident #15 and Resident #103's OOH-DNR. SW V stated that Resident #103's OOH-DNR was missing the doctor's signature and Resident #15's doctor did not date the form. SW V stated a negative outcome was the residents' wishes wouldn't be honored. SW P stated a negative outcome would be that the facility cannot honor the residents' wishes In an interview on [DATE] at 9:11 AM, the ADON B was provided copies of Resident #15 and (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #103's OOH-DNR. ADON B stated that Resident #15' OOH-DNR form did not have a date for the doctor's signature and Resident #103's OOH-DNR form did not have a doctor's signature at the bottom of the form. ADON B stated the forms would be invalid DNR's. ADON B stated a negative outcome would be the resident would be a legal full code and the facility would have to take drastic measures to keep them alive and that is against their wishes. In an interview on [DATE] at 9:17 AM, the DON was provided copies of Resident #15 and Resident #103's OOH-DNR. The DON stated that the forms were not correct. The DON stated that Resident #103's OOH-DNR form only had one doctor signature and Resident #15's OOH-DNR form was missing a date. The DON stated that a negative outcome would be CPR would have to be done and it would go against their wishes. In an interview on [DATE] at 9:21 AM, the ADM was provided copies of Resident #15 and Resident #103's OOH-DNR. The ADM stated that the forms were not correct. The ADM stated the OOH-DNR forms are missing a date and the doctor is missing signature. The ADM stated that a negative outcome would be patient could either be coded or not coded and their wishes would not be followed up. Record review of policy titled Social Services Policies and Procedures Subject: Advance Directives, revised on [DATE], did not address completion of a valid OOH-DNR form. Additional policies were requested but never provided. Record review of Instructions for Issuing an OOH-DNR Order, revised [DATE], states under section D- If the person is incompetent and his/her attending physician has seen evidence of the person's previously issued proper directive to physicians or observed the person competently issue an OOH-DNR Order in a nonwritten manner, the physician may execute the Order on behalf of the person by signing and dating it in Section D. Under heading In addition, it stated the original or a copy of a fully and properly completed OOH-DNR order of the presence of an OOH-DNR device on a person is sufficient evidence of the existence of the original OOH-DNR Order and either one shall be honored by responding health care professionals.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and Adult Protective Services where state law provides jurisdiction) in accordance with State law through established procedures for 1 (Resident #9) of 21 residents reviewed for reporting of alleged violations. The facility failed to report to the State within 2 hours when Resident #9 was allegedly abused by a staff member. This failure could place residents at risk of ongoing abuse.Findings included: Record review of the intake investigation report for Intake ID#1084554 revealed the following:Incident date and time: 04/18/2026 at 12:35 PM Date facility first learned of Incident: 04/20/26 at 11:00 AM Record review of TULIP Intake Information for Case # 1084554, revealed the following:Case Type: IncidentDate received: 04/20/26 at 12:42 PM Narrative of Incident: Resident #9 alleged that CNA N slapped her while another CNA was assisting her with turning her in bed. Resident #9 reported that CNA N entered the room to and slapped her hip during care. Actions and Notifications:CNA N was suspended pending investigationSkin assessment completed with no injuries notedAbuse/neglect in-service provided Record review of Resident #9's face sheet, printed 04/28/26 revealed a [AGE] year-old female admitted on [DATE] with diagnoses including, but not limited to, bipolar disorder (disorder associated with episodes of mood swings ranging from depressive lows to manic highs), history of opioid abuse, altered mental status, unspecified psychosis, depression (a mood disorder that causes a persistence feeling of sadness and loss of interest), heart failure (a chronic condition in which the heart dose not pump blood as well as it should), rheumatoid arthritis (autoimmune inflammation of the joints), pain, muscle weakness, and muscle wasting and atrophy (breakdown of muscles). Record review of Resident #9's most recent MDS, a quarterly assessment completed 02/23/26, revealed a BIMS score of 11, indicating moderate cognitive impairment. Resident #9 required substantial to maximal assistance with bed mobility, toileting, and transfers. Record review of Resident #9's care plan revealed:-Problem start date 4/20/26: Resident made false accusations regarding staff treatment.Approach: redirect resident when false accusations were made.- Problem start date 1/14/26: Behavioral symptoms related to history of opioid abuse.Approach: monitor for behavioral or physical indicators of substance abuse. Record review of Resident #9's active orders revealed: Use mechanical Lift for all transfers every shift, start date of 04/06/26. Record review of Resident #9's progress notes revealed:04/19/26 at 02:58 AM: Resident refused brief change in bed and requested sit-to-stand transfer despite Hoyer lift orders.04/19/26 at 02:59 AM: On call notified of disagreement at this time. During an interview on 04/27/26 at 5:49 AM, CNA O stated that she was present with CNA N the night of the incident and Resident #9 was irritated. CNA O stated that CNA N asked Resident #9 to roll during brief change and that Resident #9 became aggressive with CNA N. CNA O stated she went back into Resident #9's room later with another CNA to transfer her, Resident #9 stated, you saw CNA N hit me, right?. CNA O replied, no I did not. CNA O stated she did not witness a slap by CNA N to Resident #9. CNA O stated she reported the incident immediately to the charge nurse and she further stated Resident #9 tends to make a lot of false claims resulting in 2 CNA's always being present to do resident care with her. During an interview on 04/27/26 at 5:58 AM, Resident #9 stated that CNA N no longer worked with her due to the incident that was reported. During an interview on 04/29/26 at 8:09 AM, CNA N stated she was suspended pending investigation and returned to work on 04/22/26. She denied striking Resident #9 and stated she was unaware of the allegation until the investigation began. During an interview on 04/29/26 at 9:20 AM, ADON A stated she was on call the night of the incident but does not remember hearing about it. She stated the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident occurred on 04/19/26, while she was on call, and was reported to the State on 04/20/26, which was not timely. She stated delayed reporting could result in continued abuse and could give the appearance of failure to report.During an interview on 04/29/26 at 9:21 AM, the DON stated the ADM was responsible for reporting abuse allegations to the State. She confirmed the incident occurred on 04/19/26, ADON A was on call during that time, and it was not reported until 04/20/26. She stated the delay was not timely and could result in harm to the residents. The DON stated she felt the breakdown happened with on-call weekend staff. During an interview on 04/29/26 at 9:37 AM, the ADM stated she was responsible for ensuring reports to the state were made. She stated the incident was reported to the on-call nurse on 04/19/26 but was not reported to her until 04/20/26. She identified a breakdown in communication and stated delayed reporting could allow abuse to continue. Record review of facility provided policy titled Abuse, Neglect, Exploitation or Mistreatment revised March 2026, revealed the following in part.The facility's leadership prohibits neglect, mental, physical and/or verbal abuse and are reported immediately. 2. The facility shall report immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not result in serious bodily injury to the administrator of the facility and to other officials (including to the State Survey Agency in accordance with state law though established procedures. Record review of facility provided policy titled Resident Rights, from admissions handbook revision date of September 2020 revealed the following in part .#47. Protection from Abuse. The facility must develop and implement written policies and procedures and training that prohibit and prevent the mistreatment, neglect, and exploitation and abuse of residents. The facility must ensure that all alleged violations involving exploitation, mistreatment, neglect or abuse, are reported immediately. All alleged violations-immediately but not later than 1) 2 hours if the alleged violation involves abuse or results in serious bodily injury and 2) 24 hours if the alleged violation does not involve abuse and does not result in serious bodily injury, to the administrator of the facility and to other officials including state survey agency and adult protective services here state law provides for jurisdiction in long term care facilities) in accordance with state law through established procedures.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that an assessment accurately reflected a resident's status for 1 (Resident #9) of 21 residents reviewed for accuracy of assessments. The facility failed to accurately assess Resident #9 for the use of a restraint on the MDS assessment. This failure could place residents at risk for inaccurate and incomplete MDS assessments, which could result in residents not receiving appropriate care and services. Findings included: Record review of Resident #9's face sheet, printed 04/28/26 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses including, but not limited to, heart failure (a chronic condition in which the heart does not pump blood as well as it should), rheumatoid arthritis (an autoimmune condition causing inflammation of the joints), pain, muscle weakness, and muscle wasting and atrophy (breakdown of muscle tissue). Record review of Resident #9's most recent MDS, a quarterly assessment completed 02/23/26 revealed a BIMS score of 11, indicating moderate cognitive impairment. The assessment indicated the resident required substantial to maximal assistance with bed mobility. Section P0100 - Physical Restraints indicated that Resident #9 used bed rails daily. Record review of Resident #9's care plan, with a problem start date of 10/16/25 revealed the following:Resident was in need of side/rail assist bar r/t increased weakness. Approach: utilize side rail/assist bar. Record review of the clinical record for Resident #9 revealed an Order Summary Report with the following active order:Resident requires the use of a side/rail assist bar as an enabler for the benefit of transfers and/or repositioning. Start Date: 10/16/25. During an observation on 04/28/2026 at 8:36 AM, Resident #9 did not have any bedrails on her bed. During an interview on 04/28/2026 at 11:36 AM, the MDS RN stated she was the MDS Coordinator for the facility and used the RAI manual policy as guidance. She stated bed rails were not to be used for restricting movement and were not considered restraints. The MDS RN stated bed rails should not have been coded as a restraint on Resident #9's MDS assessment and the assessment would be corrected. She further stated inaccurate MDS coding could result in incorrect care planning and could impact reimbursement. During an interview on 4/29/26 at 9:30 AM, RN F stated bed rails were not to be used as restraints. She stated the facility did not use bed rails and if a resident required positioning assistance, physical therapy would evaluate as needed. RN F stated if the MDS coordinator coded bed rails as a restraint, it could be problematic. She stated the MDS coordinator was responsible for coding MDS assessments, and inaccuracies could impact resident care through incorrect care plans and affect reimbursement. During an interview on 04/29/26 at 9:27 AM, the DON stated the MDS coordinator was responsible for completing MDS assessments and that bed rails should not be coded as restraints. She stated the facility did not utilize bed rails, only assist bars. The DON stated inaccurate MDS assessments could be detrimental to the residents and could also impact reimbursement. During an observation and interview on 04/29/26 at 9:33 AM, Resident #9's bed revealed no bed rails. Resident #9 stated she had never had bed rails on her bed. During an interview on 04/29/26 at 9:35 AM, the ADM stated the MDS coordinator was responsible for completing MDS assessments. She stated bed rails were not used as restraints and should not be coded as such. The ADM stated inaccurate MDS assessments could impact reimbursement and resident care. Record review of the facility policy titled Nursing Policies and Procedures: Minimum Data Set (MDS), dated 09/28/23,revealed in part:Policy: An MDS, which is a comprehensive, accurate, standardized reproducible assessment will be completed for each resident, using the RAI process. Record review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1, dated October 2025 revealed the following: SECTION P: RESTRAINTS AND ALARMSP0100. Physical RestraintsPhysical Restraints are many manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Enter Codes in BoxesUsed in Bed-A. Bed rail-B. Trunk restraint-C. Limb restraint-D. Other

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to based on the comprehensive assessment of a resident, ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for 1 (Resident #22) of 21 residents reviewed for quality of care.The facility failed to follow their fall management policy and assess Resident #22 after she reported falling on the night of 04/19/26.The facility failed to follow their on-call policy and provide support and staffing for the provision of quality resident care on the night of 04/19/26.These failures could place residents at risk of harm due to untreated/unrecognized injuries.Findings Included:Record review of Resident #22's admission record dated 04/27/26 revealed an [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified lack of coordination, altered mental status, muscle weakness, difficulty in walking, and muscle wasting and atrophy.Record review of Resident #22's quarterly MDS completed on 01/29/26 revealed a BIMS of 9 which indicated moderately impaired cognition. Section GG Functional Abilities revealed she used a manual wheelchair and was dependent for chair/bed-to-chair transfers. Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.Record review of Resident #22's care plan last reviewed/revised on 04/21/2026 revealed she had a history of falling. An intervention to address this issue was to place her in her bed or recliner while she was in her room and not to leave her in her wheelchair. Another intervention was to observe her frequently and place her in a supervised area when out of bed.Record review of Resident #22's orders dated 04/27/26 revealed the following orders and order start dates: 05/24/24 1-2 person assist for ambulation 05/24/24 1-2 person assist for transfer05/24/24 1-2 person assist for toileting dated 05/24/24.05/24/24 at risk for falls02/26/26 1-2 person assist for bed mobilityRecord review of Resident #22's progress notes revealed the following notes:A note by LVN H on 04/20/26 at 09:39 AM This nurse and another nurse entered resident's room at approx 0615 (06:15 AM) and discovered resident laying on right side on the floor beside bed. Blanket was underneath resident and pillow was under left leg. This nurse asked resident what happened? Resident stated ?I guess I fell out of bed' Resident c/o pain to left hip and knee. Assessed for other injuries. Vital signs taken. None noted. Notified on call and administrator. Resident sent to [hospital initials] hospital for eval and treat due to guarding of left hip.A note by LVN H on 04/20/26 at 12:31 PM Returned from hospital via facility transport at approx 1200 (12:00 PM). In wheelchair with no new orders. Hip contusion. Smiling and conversating with no new c/o pain or discomfort at this time.During an interview on 04/27/26 at 04:37 AM LVN C stated she was working on 100 hall on the night of 04/19/26 when LVN D, who was working on 400 hall (Resident #22's hall), asked her for assistance. LVN C stated she walked with LVN D to Resident #22's suite and was in the entry way to the suite when she heard Resident #22 saying, Help. LVN C stated she entered Resident #22's room and Resident #22 was on her bed with her head at the foot board and her feet at the headboard with no blanket on. She stated Resident #22 told her she did not want to talk to LVN D. LVN C stated resident #22 said her leg and knee hurt and they did not start hurting until she fell. LVN C stated at this point LVN D interjected and said Resident #22 did not fall and she did not know why Resident #22 kept saying that. LVN C stated Resident #22 shut down and would not talk for a bit after she heard LVN D's voice. LVN C stated she asked Resident #22 if she could assess her knee and Resident #22 said no. LVN C stated she put a pillow between Resident #22's legs, covered her with a blanket, and returned to hall 100. She stated this happened at approximately 04:30 AM. She stated she then called ADON A on the facility on-call phone and told her she had concerns for the residents on hall 400 to include Resident #15 lying in a soaked brief on the couch and Resident #22 reporting a fall and seeming to be intimidated by LVN D. She stated ADON A said she would let ADM know in the (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	morning and she could not move any of the CNAs off of the other halls to help on 400 hall because ADM wanted them on their own halls.During an interview on 04/27/26 at 05:57 AM RN F stated she came to work the morning of 04/20/26 and LVN C asked her to check on the residents on hall 400. RN F stated she joined LVN H on hall 400 and the two of them found Resident #22 on the floor of her room next to her bed with her head toward the footboard and her feet toward the headboard. She stated Resident #22 was complaining of pain in her left leg and was displaying guarding behavior with her left leg, so she was sent to the hospital for further evaluation.During an interview on 04/27/26 at 06:05 AM ADM stated LVN C called on-call phone and spoke to ADON A. She stated LVN C called the company's complaint hotline and reported her concerns on the hotline as well. ADM stated ADON A did not perceive what LVN C told her as abuse or neglect or she (ADON A) would have called me (ADM).During an interview on 04/27/26 at 06:33 AM LVN C stated she told ADON A about Resident #22 saying her knee was not hurting until she fell and LVN D saying to Resident #22, You didn't fall.During an interview on 04/27/26 at 07:11 AM LVN D stated 04/19/26 was her first time to work in the facility. She stated she was shocked when she picked up the night shift to find she was responsible for total care for 6 residents and did not have a CNA to help her. She stated she received report and learned, in part, that Resident #15 would sometimes refuse care and/or medication. She stated she had a back injury that made it impossible for her transfer residents alone. LVN D said of the residents on hall 400, Everybody was confused, dead weight, couldn't stand by themselves. She stated Resident #22 had stayed in her wheelchair a good portion of the evening because she said she could not stand or support herself. She stated she had LVN C help her reposition Resident #22 because she had her head at the foot of the bed and her feet at the head of the bed. She stated Resident #22 did not want to be repositioned. LVN D stated she never found Resident #22 on the floor. She stated, Nobody said anything to me about a fall.During an interview on 04/27/26 at 07:41 AM LVN D stated Resident #22 told her she wanted to go to bed and LVN D told her she (LVN D) was not able to put her to bed alone and would try to find someone to help. LVN D stated she went down halls and could not find CNAs to help her. She stated she found one CNA who told her she would be there shortly to help but did not show up. LVN D stated, If your life is in jeopardy, I am the one you want there. If you need to be lifted up out of a wheelchair and transferred to the bed and I am the only one there I can't do it. She stated Resident #22 must have put herself on her bed upside down.During an interview on 04/27/26 at 09:08 AM ADON A stated LVN C called her on the morning of 04/20/26 to say she had concerns about the residents on hall 400. ADON A stated LVN C told her she saw a resident in a soaked brief but did not say anything else. She stated LVN C did not tell her anything about a resident who was in pain and said she fell. ADON A stated she sent a text to the two other nurses in the facility (LVN I and LVN J) asking them to send one of their CNAs to help LVN D. She stated she did not follow up to see if that was done or further check on the residents on hall 400.During an interview on 04/27/26 at 09:47 AM LVN H stated when she came to work on the morning of 04/20/26 LVN D did not give report, just said, Good luck and left the facility. She stated she and RN F found Resident #22 on the floor of her room and sent her to the hospital because she was complaining of pain in her left hip and knee.During an observation and interview on 04/27/26 at 10:07 AM Resident #22 was seated in her wheelchair in her room. She stated she remembered the night LVN D worked and would not help her into bed. She stated, She (LVN D) was just hateful. I don't think she was really interested in doing anything. I was very stressed out that night because she had such an attitude. Resident #22 stated she fell out of her bed that night onto the fall mat next to her bed. She did not remember a fall prior to that one.During an interview on 04/27/26 at 10:33 AM LVN I stated she did not have any texts from the on-call phone on the night shift of 04/19/26. She stated she looked through her text messages and did not find any texts from ADON A on the night shift of 04/19/26. She stated ADON A did not text and ask her to have her CNAs assist on 400 hall.During an interview on 04/27/26 at 11:51 AM ADM stated if a resident reported a fall it was treated as an unwitnessed fall and the protocol was to file an incident report. She showed this surveyor a copy of a (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blank incident report that was to be filed.During an interview and observation on 04/27/26 at 11:57 AM ADM showed this surveyor the on-call phone with text messages between ADON A and LVN I and LVN J. ADON A asked the two LVNs in a text to have their CNAs check on the residents on hall 400 if they had a chance.During an observation and interview on 04/27/26 at 12:00 PM ADM, MS, and this surveyor entered a closet in the facility to watch recorded camera footage of LVN D on hall 400 the night of 04/19/26. According to camera footage, LVN D did not enter a resident room until after 10 PM on the night of 04/19/26. ADM stated it was nice to know you pay so much money for agency staff to sit around on their phones. LVN D did enter resident rooms after 10:00 PM but did not remain in any of the rooms for more than 2 minutes except for the instance she and LVN C entered the suite of Resident #15 and Resident #22. The two LVNs remained in the suite for 3 minutes at approximately 4:30 AM on 04/20/26.During an interview on 04/29/26 at 09:02 AM SC stated if a resident fell or told her they fell she would tell the nurse. She stated if the resident was not assessed by the nurse, They could have been hurt when they fell, and we didn't to an assessment to check to see. Would be a form of neglect.During an interview on 04/29/26 at 09:06 AM LVN K stated the nurse was responsible for doing an assessment on a resident who said they fell. He stated not assessing the resident and following fall protocol could mean a missed fracture which could lead to compartment syndrome (pressure build up inside a group of muscles cutting off blood flow and causing severe pain and potential tissue damage) and even death.During an interview on 04/29/26 at 09:18 AM RN S stated the nurse was responsible for assessing a resident if the resident reported a fall. She stated if a resident was not assessed and hit their head it could negatively impact the resident.During an interview on 04/29/26 at 09:24 AM LVN T stated if a resident said they fell it was to be treated as an unwitnessed fall and assessment and neurological checks were to be done by the nurse to ensure the resident did not have any injuries or a brain bleed.During an interview on 04/29/26 at 09:30 AM ADON A stated she expected staff to assess residents who reported falling. She stated if a resident obtained an injury in the fall and was not assessed it could lead to death. ADON A stated when an allegation of neglect was made the staff member accused was suspended pending an investigation which was started immediately. She stated not starting an investigation immediately and notifying ADM could result in continued neglect and injury to residents. ADON A stated when LVN C called the on-call phone on the night shift of 04/19/26 she did not ask LVN C any follow up questions about her concerns for the residents on hall 400.During an interview on 04/29/26 at 09:38 AM ADON B stated staff were to assess a resident who reported a fall, complete required paperwork, and report the fall to the nurse on call. He stated a possible negative outcome of not assessing a resident who reported a fall was the resident might be injured and staff would not know about the injury.During an interview on 04/29/26 at 09:44 AM DON stated she expected her staff to immediately assess a resident who reported a fall. She stated, We have to take them (residents) at their word. DON stated a possible negative outcome of staff not following facility fall protocol and assessing residents who reported a fall was injuries would go unnoticed.During an interview on 04/29/26 at 10:23 AM ADM stated she expected staff to follow the facility's fall protocol when a resident reported a fall. She stated a resident could have an undetected injury if fall protocol was not followed.Record review of a screen shot from LVN C of the call she made to the on-call phone on 04/20/26 to express her concern for the residents on hall 400 revealed the call was made at 04:35 AM and lasted 1 minute.Record review of text messages between on call phone, LVN I, and LVN J revealed a text sent to LVN I and LVN J at 04:45 AM on 04/20/26 from the on-call phone asking them to send their CNAs to hall 400 if they had time. LVN J texted on call phone at 04:54 AM on 04/20/26 and stated LVN D's call lights had been going off over an hour at a time the whole night.Record review of facility admission packet page titled Texas Department of Aging and Disability Services revealed the following: You, the resident do not give up any rights when you enter a nursing facility. You have a right to: 1. all care necessary for you to have the highest possible level of health .Record review of the facility admission packet pages 14-21 titled Resident Rights revealed the following: .46. Freedom from Abuse, Neglect and (continued on next page)

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	675498	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Heights Rehabilitation Suites	6650 South Soncy Road Amarillo, TX 79119

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Exploitation. The resident has the right to be free from . neglect . 48. Quality of Life. Each resident must receive, and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. You have a right to: 1. all care necessary for you to have the highest possible level of health; .Record review of facility policy titled Patient/Resident Rights and dated 10/01/20 revealed the following: .The Facility provides care for each resident in a manner that promotes, maintains, or enhances quality of life .Record review of facility policy titled Abuse, Neglect, Exploitation, or Mistreatment and dated 11/01/17 revealed the following: . 1. The facility's Leadership prohibits neglect . 6. The facilities Leadership will implement appropriate and necessary guidelines, which prohibit the mistreatment or neglect of the patient/resident. 6. Neglect is the failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. 4 Adequate supervision of staff is maintained to identify and prevent inappropriate behaviors, such as: . C. Ignoring the patient's/residents needs requests, etc. 2. Neglect is the failure to provide goods and services or treatment and care necessary to avoid physical harm, mental anguish . We are committed to ensuring our patients/residents are free from neglect .Record review of facility policy titled Fall Management and dated 05/05/23 revealed the following: . 5. Qualified staff evaluates patient/resident for injury from a fall, identify and treat for pain related to fall, and determine contributing causes, including ascertaining what the resident was trying to do before he or she fell, addresses the risk factors for the fall such as the resident's medical condition(s), facility environment issues, or staffing issue; and determines interventions to prevent future falls and completes a Fall Investigation Worksheet. 7. Neurological evaluations will be preformed for a resident who sustains an unwitnessed fall, regardless of the resident's cognitive status at the time of the incident. 8. The physician and family are promptly notified, and an incident report is completed.Record review of facility policy titled On-Call Policy and dated March 2026 revealed the following: Purpose: To ensure proper support and staffing for the provision of quality resident/patient care.Record review of blank facility form titled Accident/Incidents/Falls Checklist revealed the following items: . INCIDENT DATE WITNESSED OR UNWITNESSED.PROGRESS NOTE.NEUROLOGICAL EVALUATION.FOCUSED PAIN ASSESSMENT.

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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 interview and record review, the facility failed to ensure that the resident environment remained as free from accident hazards as possible and that each resident received adequate supervision and assistance devices to prevent accidents for 1 (Resident #83) of 21 residents reviewed for accident hazards.The facility failed to ensure Resident #83 did not fall from the Hoyer lift on 01/10/2026.This failure could place residents at risk for serious physical injury, including fractures, head trauma, or internal bleeding resulting from falls. Findings Included:Record review of Resident #83's admission record dated 04/27/2026 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, multiple sclerosis (is an autoimmune disease that affects the central nervous system, leading to damage of the myelin sheath that protects nerve fibers, resulting in a range of physical and cognitive symptoms), type 2 diabetes mellitus without complications, essential (primary) hypertension (high blood pressure), neuromuscular dysfunction of bladder (occurs when nerve or brain problems disrupt the normal control of bladder muscles, leading to difficulty storing or emptying urine), personal history of urinary (tract) infections, dysphagia (difficulty swallowing), hypokalemia (low potassium), insomnia, pain, hyperlipidemia (high cholesterol), nausea with vomiting, cognitive communication deficit, other reduced mobility, constipation, difficulty in walking, muscle wasting and atrophy, muscle weakness, unspecified lack of coordination, hypothyroidism (low thyroid levels which slows down metabolism), immobility syndrome (paraplegic) (a person who experiences paralysis in the lower half of their body, usually due to spinal cord injury or neurological conditions)Record review of Resident #83's quarterly MDS completed on 04/10/2026 revealed a BIMS score of 14 which indicated no cognitive impairment. Section GG Functional Abilities revealed she had impairment on both sides to both upper and lower extremities and utilized a wheelchair. She was noted to require substantial/maximal assistance with eating and oral hygiene. She was noted to be dependent for toileting hygiene, shower/bathe self, upper and lower body dressing, putting on and taking off footwear, and personal hygiene.Record review of Resident #83's progress notes revealed the following:on 01/10/26 she had a witnessed fall without injuries while being transferred with the Hoyer (a mechanical device designed to safely transfer individuals with limited mobility from one surface to another, reducing physical strain on caregivers and minimizing the risk of injury) lift by staff.Record review of her care plan showed an update for fall on 01/14/2026 and she was care planned for usage of a Hoyer lift dated 10/17/2025. Record review of Resident #83's orders revealed an order dated 10/17/2025 May use Hoyer lift for transfers.During an interview with Resident #83 on 04/27/2026 at 8:37 AM Resident stated that she fell from a Hoyer lift while being transferred by staff back to bed. She stated when staff went to lift her in the sling a strap on the sling came off of the lift causing her to slide out of the sling and onto the ground. Resident stated she did not sustain any injuries but now double checks the straps on the sling before staff lifted her up.During an interview 04/28/2026 at 1:42 PM DON stated she recalled the incident involving Resident #83 falling from the mechanical lift on 01/10/26. She said CNA Q and CNA R were putting the resident back to bed when the strap of the sling slipped off of the lift and the resident fell to the ground. She also stated the resident was assessed but not injured. DON stated in-services were completed on transfer techniques and fall precautions. During an interview 04/28/2026 at 1:45 PM CNA Q stated that him and another CNA (he didn't remember her name) were transferring the resident from her chair to her bed and the sling on the other CNAs side came off on the back, but he was unsure as to how it happened. CNA Q stated Resident #83 slid out of the sling onto the floor but was not injured. He stated he reported it to the nurse on duty (does not remember who it was at the time) and that the nurse assessed the resident and called the resident's family member. CNA Q stated he thinks they do training with the Hoyer lift every other month but is unsure. He stated a resident (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could be seriously injured if staff were not trained on proper use of the Hoyer lift and did not ensure the hooks were properly secured.During an interview on 04/28/2026 at 1:56 PM DON stated Physical Therapy (PT) oversees Hoyer lift trainings.During an interview on 04/28/2026 at 2:17 PM DON stated she misunderstood and thought PT did the training on Hoyer lifts but stated that they do not and that it was her job and no education was completed. During an interview on 04/29/2026 at 8:30AM CNA R stated she had worked for the facility for 2 years. CNA R stated that her and CNA Q were attempting to put the resident back to bed using the Hoyer lift when they lifted her up in the sling the strap came off of the front side and the resident slid out of the sling and fell onto the floor. She was unsure how the strap came off. She stated she notified the nurse, and the nurse assessed Resident #83 and called Resident #83's family member. No injuries were noted. CNA R stated she did not receive training on how to use the Hoyer lift before or after the incident and a negative outcome was the resident could get seriously hurt. During an interview on 04/29/2026 at 8:40 AM DON stated a negative outcome of staff not being properly trained on how to use a Hoyer lift was it could affect patient safety and both staff and residents could get injured. When asked if any Hoyer lift training was done on hire, DON stateed CNAs were instructed during orientation to always use 2 people and never do it alone. During an interview on 04/29/2026 at 8:43 AM Mechanical Lift and Accident and Hazards Policies and Procedures were requested.During an interview on 04/29/2026 at 8:45 AM ADON B stated he recalled an incident with Resident #83 on 01/10/2026 where she fell out of the Hoyer lift sling. He stated he notified of the incident. When asked if in-services were completed, he stated he thinks a verbal one was done but is unsure. He stated quarterly staff competency trainings included how to use a Hoyer lift. He stated the DON would have proof of staff competencies. He stated a negative outcome of not training staff on using Hoyer lifts was injury to patient or staff. During an interview on 04/29/2026 at 8:46 AM with DON Surveyor requested employee competencies for use of Hoyer lift, and DON stated she does not have them because she just started it last night. During an interview on 04/29/2026 at 8:52 AM ADON A stated she had been working for the facility for almost 2 years. ADON A stated a negative outcome of not training staff on how to use a Hoyer lift was it was a safety issue and could result in injury to residents. During an interview 04/29/2026 at 8:55 AM ADON B stated that he was incorrect about Hoyer lift training, and it is supposed to be completed by the DON, and she was unaware she was supposed to be doing it. A record review of in-services for January shows an in-service on transfer techniques dated 01/02/2026 and fall precautions dated 01/22/2026. Upon further review nothing was noted to have mechanical lifts or use of Hoyer lifts in training. Record review of document entitled Staff Education/Orientation Policies and Procedures for Assisting Resident from Bed to Chair dated 01/12/2024 does not mention transferring with a Hoyer lift.No other policies given during investigation.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care for 1 (Resident #83) of 21 residents reviewed for staff competency.The facility failed to train nurse aides on use of Hoyer lifts.This failure could place residents at risk of injury or harm.Findings Included:Record review of Resident #83's admission record dated 04/27/2026 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, multiple sclerosis (is an autoimmune disease that affects the central nervous system, leading to damage of the myelin sheath that protects nerve fibers, resulting in a range of physical and cognitive symptoms), type 2 diabetes mellitus without complications, essential (primary) hypertension (high blood pressure), neuromuscular dysfunction of bladder (occurs when nerve or brain problems disrupt the normal control of bladder muscles, leading to difficulty storing or emptying urine), personal history of urinary (tract) infections, dysphagia (difficulty swallowing), hypokalemia (low potassium), insomnia, pain, hyperlipidemia (high cholesterol), nausea with vomiting, cognitive communication deficit, other reduced mobility, constipation, difficulty in walking, muscle wasting and atrophy, muscle weakness, unspecified lack of coordination, hypothyroidism (low thyroid levels which slows down metabolism), immobility syndrome (paraplegic) (a person who experiences paralysis in the lower half of their body, usually due to spinal cord injury or neurological conditions)Record review of Resident #83's quarterly MDS completed on 04/10/2026 revealed a BIMS score of 14 which indicated no cognitive impairment. Section GG Functional Abilities revealed she had impairment on both sides to both upper and lower extremities and utilized a wheelchair. She was noted to require substantial/maximal assistance with eating and oral hygiene. She was noted to be dependent for toileting hygiene, shower/bathe self, upper and lower body dressing, putting on and taking off footwear, and personal hygiene.Record review of Resident #83's progress notes revealed the following:on 01/10/26 she had a witnessed fall without injuries while being transferred with the Hoyer (a mechanical device designed to safely transfer individuals with limited mobility from one surface to another, reducing physical strain on caregivers and minimizing the risk of injury) lift by staff.Record review of her care plan showed an update for fall on 01/14/2026 and she was care planned for usage of a Hoyer lift dated 10/17/2025. Record review of Resident #83's orders revealed an order dated 10/17/2025 May use Hoyer lift for transfers.During an interview with Resident #83 on 04/27/2026 at 8:37 AM Resident stated that she fell from a Hoyer lift while being transferred by staff back to bed. She stated when staff went to lift her in the sling a strap on the sling came off of the lift causing her to slide out of the sling and onto the ground. Resident stated she did not sustain any injuries but now double checks the straps on the sling before staff lifted her up.During an interview 04/28/2026 at 1:42 PM DON stated she recalled the incident involving Resident #83 falling from the mechanical lift on 01/10/26. She said CNA Q and CNA R were putting the resident back to bed when the strap of the sling slipped off of the lift and the resident fell to the ground. She also stated the resident was assessed but not injured. DON stated in-services were completed on transfer techniques and fall precautions. During an interview 04/28/2026 at 1:45 PM CNA Q stated that him and another CNA (he didn't remember her name) were transferring the resident from her chair to her bed and the sling on the other CNAs side came off on the back, but he was unsure as to how it happened. CNA Q stated Resident #83 slid out of the sling onto the floor but was not injured. He stated he reported it to the nurse on duty (does not remember who it was at the time) and that the nurse assessed the resident and called the resident's family member. CNA Q stated he thinks they do training with the Hoyer lift every other month but is unsure. He stated a resident could be seriously injured if staff were not trained on proper use of the Hoyer lift and did not ensure (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the hooks were properly secured.During an interview on 04/28/2026 at 1:56 PM DON stated Physical Therapy (PT) oversees Hoyer lift trainings.During an interview on 04/28/2026 at 2:17 PM DON stated she misunderstood and thought PT did the training on Hoyer lifts but stated that they do not and that it was her job and no education was completed. During an interview on 04/29/2026 at 8:30AM CNA R stated she had worked for the facility for 2 years. CNA R stated that her and CNA Q were attempting to put the resident back to bed using the Hoyer lift when they lifted her up in the sling the strap came off of the front side and the resident slid out of the sling and fell onto the floor. She was unsure how the strap came off. She stated she notified the nurse, and the nurse assessed Resident #83 and called Resident #83's family member. No injuries were noted. CNA R stated she did not receive training on how to use the Hoyer lift before or after the incident and a negative outcome was the resident could get seriously hurt. During an interview on 04/29/2026 at 8:40 AM DON stated a negative outcome of staff not being properly trained on how to use a Hoyer lift was it could affect patient safety and both staff and residents could get injured. When asked if any Hoyer lift training was done on hire, DON stateed CNAs were instructed during orientation to always use 2 people and never do it alone. During an interview on 04/29/2026 at 8:43 AM Mechanical Lift and Accident and Hazards Policies and Procedures were requested.During an interview on 04/29/2026 at 8:45 AM ADON B stated he recalled an incident with Resident #83 on 01/10/2026 where she fell out of the Hoyer lift sling. He stated he notified of the incident. When asked if in-services were completed, he stated he thinks a verbal one was done but is unsure. He stated quarterly staff competency trainings included how to use a Hoyer lift. He stated the DON would have proof of staff competencies. He stated a negative outcome of not training staff on using Hoyer lifts was injury to patient or staff. During an interview on 04/29/2026 at 8:46 AM with DON Surveyor requested employee competencies for use of Hoyer lift, and DON stated she does not have them because she just started it last night. During an interview on 04/29/2026 at 8:52 AM ADON A stated she had been working for the facility for almost 2 years. ADON A stated a negative outcome of not training staff on how to use a Hoyer lift was it was a safety issue and could result in injury to residents. During an interview 04/29/2026 at 8:55 AM ADON B stated that he was incorrect about Hoyer lift training, and it is supposed to be completed by the DON, and she was unaware she was supposed to be doing it. A record review of in-services for January shows an in-service on transfer techniques dated 01/02/2026 and fall precautions dated 01/22/2026. Upon further review nothing was noted to have mechanical lifts or use of Hoyer lifts in training. Record review of document entitled Staff Education/Orientation Policies and Procedures for Assisting Resident from Bed to Chair dated 01/12/2024 does not mention transferring with a Hoyer lift.No other policies given during investigation.

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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 1 (Resident #68) of 5 residents reviewed for infection control. -RN F did not follow EBP precautions when administering medications via Resident #68's PEG tube. This failure could place residents at risk for the spread of infections, tissue breakdown, and feelings of isolation related to poor hygiene.Findings include: Record review of Resident #68's admission record dated 04/28/2026 revealed a [AGE] year-old female admitted to the facility originally on 07/01/2025 and readmitted on [DATE] with diagnoses to included cerebral palsy (a group of permanent neurological disorders affecting movement, muscle tone, and posture caused by abnormal brain development or damaged before, during, or shortly after birth), malnutrition (lack of proper nutrition), muscle wasting (the loss of muscle mass and strength due to disease, injury, or lack of use), and gastrostomy (an opening into the stomach from the abdominal wall).Record review of Resident #68's clinical record revealed her last MDS was a quarterly completed 03/09/2026 listing her with a BIMS score of 00 indicating she was severely cognitively impaired, she had a functionality of being dependent on staff for her activities of daily, and she was listed as having a feeding tube. Record review of Resident #68's physician's orders printed 04/28/2026 revealed the following order: EBP Precautions for PEG Tube and Ostomy (a surgically created opening) (x2) once a day. Start dated: 03/03/2026. Record review of Resident #68's care plan with admission date of 07/01/2025 revealed the following: Problem:Problem Start Date: 11/07/2025. Resident is on Enhanced Barrier Precautions(EBP) related to PEG Tube/ ostomy x2. During an observation on 04/28/2026 at 8:09 AM RN F was observed administering 7 medications through Resident #68's PEG tube to include checking placement of the PEG tube by aspirating (the process of drawing in or out using a suction motion) a small amount of stomach contents and pre and post flushing of the PEG tube with water. RN F took a gown into the room, placed the gown on the back of Resident #68's wheelchair but did not put the gown on when providing care for the PEG tube. During an interview on 04/28/2026 at 8:33 AM RN F reported she was placed on light duty due to a recent surgery and was responsible for checking the facility for infection control to include the correct precautions were in place such as the EBP. RN F reported Resident #68 was on EBP for her feeding tube and she brought a gown in the room for the EBP precautions but forgot to put it on. RN F reported that since she did not follow the EBP she could have brought something into the resident or she could have carried something out to another resident. During an interview on 04/29/2026 at 8:19 AM the DON reported that when a resident was on EBP, staff should wear gloves and a gown when in the room providing direct care. The DON reported that any resident with a device such as a catheter, IV, feeding tube, dialysis, or a wound would require EBP. The DON reported if a staff member does not implement EBP correctly then they could contaminate themselves, the resident, or they could take whatever is in the room to other people. During an interview on 04/29/2026 8:47 AM ADON A reported she was the current ICP for the facility. ADON A reported for EBP all staff should wear a gown and gloves when providing care to a resident with a hole in their body that does not belong such as an IV, PEG tube, Tracheostomy (a surgically created opening), Foley, or wound. ADON A reported that a staff member that does not follow the EBP correctly can introduce infection to the residents or they can carry an infection to another resident. Record review of the facility training provided 04/23/2026 by the DON revealed the following: Inservice Title: Enhanced Barrier Precautions (EBP).Enhanced Barrier Precautions (EBP) are to be used for any high contact Resident Care. Gloves and gowns are to be donned prior to care being provided.The following patients/Residents are considered high contact-Peg Tubes-signed by RN F Record review of the facility provided policy titled Infection Prevention and Control Policy and Procedures revised 05/15/2023, revealed the following:- Subject: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Transmission Based Precaution, and Enhanced Barrier Precautions.5. Health care workers will implement enhance barrier precautions according to policy.Precautions:B. EBP will be implemented during the following high-contact resident care activities.7) Device care or use: .feeding tube.C. EBP required the following:2) Gown.