STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675553	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quitman Wellness & Rehabilitation	1026 E Goode St Quitman, TX 75783

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on interview and record review, the facility failed to develop and implement a Baseline Care Plan within forty-eight hours of admission that included the instructions for resident care needed to provide effective and person-centered care for 5 of 12 residents reviewed for new admissions. (Resident #15, Resident #64, Resident #47, Resident # 67 and Resident #69). 1. The facility failed to ensure Resident #15, Resident #64, Resident #47, Resident #67, and Resident #69's baseline care plan was completed within 48 hours of admission to the facility. 2. The facility failed to ensure Resident #67's baseline care plan was signed off or reviewed by an RN. This failure could place residents at risk of not receiving care and services to meet their needs. Findings included: 1. Record review of Resident #15's face sheet dated 5/05/26 indicated she was [AGE] years old and admitted to the facility on [DATE] with diagnoses including Non-ST elevation myocardial infarction (serious heart attack caused from a partial blockage of blood flow and damages heart muscle), bacteremia (bacteria found in the bloodstream), muscle weakness, retention of urine, hypertension (high blood pressure), chronic obstructive pulmonary disease (lung disease that blocks airflow and makes it difficult to breath), and acute and subacute infective endocarditis(IE) (infection of the heart lining or heart valves, acute IE comes on rapidly and subacute IE progresses slowly, but both require prompt targeted antibiotics (medications to treat infections)). Record review of Resident #15's admission MDS assessment dated [DATE] revealed she admitted to the facility on [DATE] from a short-term general hospital. The MDS indicated Resident #15 had a BIMS score of 9 which indicated she had moderate cognitive impairment. Resident #15 required moderate to substantial assistance completing most ADLs. The MDS indicated Resident #15 had an indwelling catheter (tube inserted into the bladder to drain urine) and she was always incontinent of bowel. The MDS indicated Resident #15 had shortness of breath when lying flat. The MDS indicated Resident #15 required mechanically altered diet. The MDS indicated Resident #15 was at risk for developing pressure ulcers. The MDS indicated Resident #15 received high-risk medications: antibiotics, diuretics (used to reduce fluid levels in the body and lowered blood pressure and reduced swelling), antiplatelet (used to prevent blood clots, could increase risk of bleeding and bruising). The (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDS indicated Resident #15 used oxygen continuously and received intravenous (directly into the vein/bloodstream) antibiotics. The MDS indicated Resident #15 had a PICC (Peripherally Inserted Central Catheter) line (thin, flexible tube inserted into a vein in the arm and threaded to a large vein near the heart for long-term intravenous medication administration). Record review of Resident #15's Baseline Care Plan dated 04/25/26 revealed there were no care areas completed and it had not been signed. During an interview on 05/06/26 at 2:50 PM, the ADON said the purpose of the baseline care plan was to initiate the resident's care for anything that they needed to initiate the resident's care. The ADON said things such as a resident having a urinary catheter, a PICC line, and incontinence, would be things that should be included in the baseline care plan. 2. Record review of Resident #64's face sheet dated 05/06/26 indicated she was [AGE] years old and admitted to the facility on [DATE] with diagnoses including ataxic cerebral palsy (rare, non-progressive neurological disorder which causes shaky, unsteady movements, poor balance, and difficulties with precise coordination), hypertension (high blood pressure), hypercholesterolemia (high cholesterol in the blood), major depressive disorder (serious mental health disorder which causes persistent, severe sadness, loss of interest in activities, significantly impairing daily life), and dementia (decline in cognitive function, such as in memory, thinking, and behaviors that interfere with daily life). Record review of Resident #64's admission MDS assessment indicated it was not due to be completed. Record review of Resident #64's Baseline Care Plan revealed it had been signed on 05/05/26 as completed, which was approximately 96 hours after admission. During an interview on 05/05/26 at 2:30 PM, the ADON looked in Resident #64's EHR and said Resident #64 had a baseline care plan filled out but it had not been signed as completed. The ADON said she would sign it at that time. The ADON looked in Resident #15's EHR and said Resident #15's baseline care plan had been opened on 04/25/26, but it had not been filled out or completed. The ADON said the baseline care plan should be completed within 72 hours of admission, she believed. During an interview on 05/06/26 at 3:09 PM, the DON said the purpose of the baseline care plan was, so they knew how to do the continuity of care for the resident. The DON said she opened the baseline care plans, and it had to be signed off by an RN. The DON said she opened the baseline care plan for Resident #15 on 04/25/26 and it was signed as completed on 05/5/26. The DON said Resident #64's baseline care plan was filled out and she saw it was not signed until 05/5/26. The DON said the baseline care plan should be completed within 48 hours of the resident's admission. During an interview 05/06/26 at 3:32 PM, the ADM said the purpose of the baseline care plan, in layman's terms, was to get to know how to take care of your resident and gave a baseline of where to go from. The ADM said the baseline care plan would include urinary catheters, PICC lines, incontinent status, and code status. The ADM said the baseline care plan should be completed within 48 hours of the resident's admission. The ADM said if the baseline care plan was not completed, the staff would not know how to take care of the resident. The ADM said they were currently in-servicing the nursing staff that baseline care plans had to be completed within 48 hours of the resident's admission. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Record review of the face sheet, dated 05/06/26, reflected Resident #47 was an [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of zoster (also known as shingles, is a painful, blistering rash caused by the reactivation of the dormant varicella-zoster virus which also causes chickenpox) without complication. Record review of the admission MDS assessment, dated 04/27/26, reflected Resident #47 had clear speech, was understood by others, and was able to understand others. She had a BIMS score of 5, which indicated severe cognitive impairment. Record review of Resident #47's baseline care plan, signed as completed by the DON on 05/05/26, reflected Resident #47 admitted to the facility on [DATE]. The baseline care plan was completed and signed 11 days (approximately 264 hours) after admission. 4. Record review of the face sheet, dated 05/06/26, reflected Resident #67 was an [AGE] year-old male who admitted to the facility on [DATE] with a diagnoses of ventricular tachycardia (a fast, abnormal heart rhythm exceeding 100 beats per minute, originating in the heart's lower chambers (ventricles)). Record review of the MDS list in the electronic charting system, undated, reflected Resident #67's MDS assessments were not due to have been completed. Record review of Resident #67's baseline care plan, signed as completed by LVN E on 05/04/26, reflected Resident #67 admitted to the facility on [DATE]. The baseline care plan was completed and signed 3 days (approximately 72 hours) after admission. There was no RN signature. 5. Record review of the face sheet, dated 05/06/26, reflected Resident #69 was a [AGE] year-old male who admitted to the facility on [DATE] with diagnoses of lung transplant status (meaning he had a lung transplant), squamous cell carcinoma of skin of other parts of face (skin cancer), and chronic obstructive pulmonary disease (chronic, progressive lung disease that makes it difficult to breathe due to damaged airways or sacs). Record review of the MDS assessment list in the electronic charting system, undated, reflected Resident #69's MDS assessments were not due to have been completed. Record review of Resident #69's baseline care plan reflected the following: 1. The DON signed and completed Section 1 on 05/05/26, which was 4 days (approximately 96 hours) after admission. 2. LVN E signed and completed Section 2, 3, 4, and 5 on 05/04/26, which was 3 days (approximately 72 hours) after admission. During an interview on 05/06/26 beginning at 2:25 PM, the ADON stated baseline care plans were the nursing staff's responsibility to complete. She said the admitting nurse was responsible for initiating the baseline care plan because it had to be completed within 48 hours. She stated she or the DON monitored baseline care plan completion by looking in the electronic charting system under assessments. She stated she and the DON discussed the baseline care plan system last week during training as they were both new to the facility and were learning the systems. She was unsure why Resident #47, Resident #67, or Resident #69's baseline care plans were not completed within 48 (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hours. She stated it was not a policy of the company for RNs to sign off on baseline care plans. She stated it was important to ensure baseline care plans were completed within 48 hours because it was a starting point for the staff to be able to provide the appropriate care and services each resident needed. She stated it was important to ensure an RN was involved in the baseline care planning completion and review because it was regulatory. During an interview on 05/06/26 beginning at 2:36 PM, the DON stated she was instructed by the company that RNs did not have to open the baseline care plan. She stated that the admitting nurse was responsible for initiating the baseline care plan. She stated the nursing staff was responsible for ensuring the baseline care plans were completed within 48 hours of admission to the facility. She said she or the ADON were responsible for monitoring to ensure the baseline care plans were completed. She stated she was unsure why Resident #47, Resident #67, or Resident #69's baseline care plan was not completed within 48 hours. She stated the RN should have been signing off and locking the baseline care plan as it was reviewed. She stated it was important to ensure the baseline care plan was completed within 48 hours and an RN signed off on the baseline care plan, so the residents received the proper care and services they needed. During an interview on 05/06/26 beginning at 3:25 p.m., LVN E stated she was not the admitting nurse for Resident #67 or Resident #69. LVN E stated she was asked to complete Resident #67 and Resident #69's baseline care plans by the DON. She stated baseline care plans should have been completed within 48 hours of admission. She stated it was important to ensure baseline care plans were completed within 48 hours, so the staff knew what care and services to provide for each resident. During an interview on 05/06/26 at 10:56 AM, LVN D said she had worked at the facility for about five years. LVN D said the admitting nurse does the admission and the admission was completed as a team and was broken down into sections and three shifts to be completed with 36 hours. LVN D said the baseline care plan would be completed during the last section of the admission process by the third shift. LVN D said the baseline care plan was to put in place precautions such as the resident being a fall risk, having a urinary catheter, was a risk of elopement, skin break risks, diet, and to find out what the resident needed. LVN D said the baseline care plan should be completed within 48 hours of admission. LVN D said she could fill out the baseline care plan, but the RN had to sign off on it. LVN D said if the baseline care plan was not completed, then you would not have a true baseline of what the resident needed, and it could hinder moving forward with care the resident needed and/or could delay the resident's treatment. During an interview on 05/06/26 beginning at 3:55 p.m., the Administrator stated she expected baseline care plans to have been opened and completed within 48 hours of admission. She stated she expected the baseline care plan to have been reviewed and closed by an RN. She said the DON was responsible for monitoring to ensure baseline care plans were completed timely and reviewed by an RN. She stated it was important to ensure baseline care plans were completed timely, so the nursing staff had a care map for the residents. Record review of the Care Planning policy, dated 06/2020, reflected .A Licensed Nurse will initiate the Care Plan.The facility will develop a person-centered Baseline Care Plan for each resident within 48 hours of admission.

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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 provided care in a manner that promoted maintenance or enhancement of his or her quality of life for 1 of 19 residents (Resident #47) reviewed for resident rights. The facility failed to ensure Resident #47's catheter drainage bag was in a privacy bag. This failure could place residents at an increased risk of embarrassment and a diminished quality of life. The findings included: Record review of the face sheet, dated 05/06/26, reflected Resident #47 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of zoster (also known as shingles, is a painful, blistering rash caused by the reactivation of the dormant varicella-zoster virus which also causes chickenpox) without complication and urinary retention (holding urine in the bladder). Record review of the admission MDS assessment, dated 04/27/26, reflected Resident #47 had clear speech, was understood by others, and was able to understand others. She had a BIMS score of 5, which indicated severe cognitive impairment. Record review of Resident #47's baseline care plan, signed as completed by the DON on 05/05/26, reflected Resident #47 had an indwelling urinary catheter. During an observation and attempted interview on 05/04/26 at 9:55 a.m., Resident #47 was lying in her bed with the head of her bed elevated slightly. She was unable to answer questions appropriately as evidenced by confused conversation. Resident #47's urinary catheter drainage bag was hanging on the side of the bed with no privacy cover. There was a large amount of clear, yellow urine in the tubing and bag that was visible from the hallway. During an observation on 05/04/26 at 3:16 p.m., Resident #47 was lying in bed, turned on her right side facing the window. Resident #47's urinary catheter drainage bag was hanging on the side of the bed with no privacy cover. There was a large amount of clear, yellow urine the tubing and bag that was visible from the hallway. During an observation on 05/06/26 at 10:03 a.m., Resident #47 was lying in her bed with the head of her bed slightly elevated. Resident #47's urinary catheter drainage bag was hanging on the side of the bed with no privacy cover. There was a small amount of clear, yellow urine in the tubing and bag that was visible from the hallway. During an interview on 05/06/26 beginning at 2:06 p.m., CNA F stated she was aware Resident #47 did not have a privacy cover on her catheter drainage bag and had reported it to the nurse. She stated she had been trying to keep the catheter drainage bag in a pillowcase, but when therapy brought her back to her room earlier in the day (05/06/26), the therapy staff did not replace the catheter drainage bag inside the pillowcase. CNA F stated she placed the drainage bag back inside the pillowcase when she was passing ice. CNA F stated it was important to ensure Resident #47 had a privacy bag on her catheter drainage bag to maintain her dignity. During an interview on 05/06/26 beginning at 2:10 p.m., LVN B stated she was unaware Resident #47 did not have a privacy cover for her catheter drainage bag. She stated everyone was responsible for ensuring catheter drainage bags had a privacy cover. She stated whoever noticed the privacy cover was missing should have reported it to the nurse. She stated it was important to ensure catheter drainage bags had a privacy cover to maintain the resident's dignity. During an interview on 05/06/26 beginning at 2:36 p.m., the DON stated she expected the nursing staff to ensure catheter drainage bags had a privacy cover. The DON stated whoever noticed a privacy cover was missing was responsible for notifying the nurse, who then supplied a privacy cover out of the central supply. She stated nursing management was responsible for monitoring to ensure catheter drainage bags had privacy covers. She stated it was important to ensure catheter drainage bags had a privacy cover to maintain a resident's dignity. During an interview on 05/06/26 beginning at 3:55 p.m., the Administrator stated she expected facility staff to ensure a catheter drainage bag had a privacy cover at all times. She stated CNAs were responsible for monitoring to ensure catheter drainage bags had a privacy cover. She stated the therapy staff returned Resident #47 to her room earlier in the day (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(05/06/26). She said the therapy staff believed that a catheter drainage bag did not require a privacy cover while the residents were in their rooms. She stated in-service education was provided to the therapy staff on 05/06/26. The Administrator stated it was important to ensure catheter drainage bags had a privacy cover to maintain the residents' dignity. Record review of the Privacy and Dignity policy, dated 01/2026, reflected .Staff assist residents in maintaining self-esteem and self-worth. The policy did not address privacy covers on a catheter drainage bag.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents have the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives and to choose the option he or she prefers for 1 of 5 residents reviewed for the right to be informed. (Resident #47) The facility failed to ensure Resident #47 or her representative provided informed consent prior to taking fluoxetine (an antidepressant medication). These failures could place residents at risk for treatment or services provided without their informed consent. The findings included: Record review of the face sheet, dated 05/06/26, reflected Resident #47 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of zoster (also known as shingles, is a painful, blistering rash caused by the reactivation of the dormant varicella-zoster virus which also causes chickenpox) without complication and major depressive disorder (serious mental health condition characterized by at least two weeks of persistent, severe low mood, loss of interest in activities, and low energy). Record review of the admission MDS assessment, dated 04/27/26, reflected Resident #47 had clear speech, was understood by others, and was able to understand others. She had a BIMS score of 5, which indicated severe cognitive impairment. Resident #47 had little interest and pleasure in doing things and felt down, depress, or hopeless 2 - 6 days during the 14 day look-back period. The MDS reflected Resident #47 had an active diagnosis of depression and took an antidepressant medication during the 7-day look-back period. Record review of Resident #47's baseline care plan, signed as completed by the DON on 05/05/26, reflected Resident #47 was taking psychotropic medications and a current list was provided and reconciled with the representative. Record review of the Order Summary Report, dated 05/06/26, reflected Resident #47 had an order, which started on 04/24/26, for fluoxetine 40 mg - Give one capsule by mouth one time a day related to depression. Record review of the MAR, dated April 2026, reflected Resident #47 received fluoxetine 40 mg on 04/25/26, 04/26/26, 04/27/26, 04/28/26, 04/29/26, and 04/30/26. Record review of the MAR, dated May 2026, reflected Resident #47 received fluoxetine 40 mg on 05/01/26, 05/02/26, 05/03/26, and 05/04/26. Resident #47 refused her medication on 05/05/26 and 05/06/26. Record review of Resident #47's Psychotropic Medication Consent form, effective 05/06/26, reflected consent was given by Resident #47 in person/written. The form was printed on 05/06/26 by Regional MDS Coordinator G but the ADON manually signed the form and dated it for 04/24/26. During an observation and attempted interview on 05/04/26 at 9:55 a.m., Resident #47 was lying in her bed with the head of her bed elevated slightly. She was unable to answer questions appropriately as evidenced by confused conversation. During an interview on 05/06/26 beginning at 2:17 p.m., Regional MDS Coordinator G stated she was asked to provide a psychotropic consent form for Resident #47. She stated she printed the form earlier in the morning on 05/06/26. She stated she was unsure who completed or signed the form. During an interview on 05/06/26 beginning at 2:25 p.m., the ADON stated she was asked to sign Resident #47's psychotropic consent form for her antidepressant and date it for 04/24/26. The ADON stated she signed the form on 05/06/26 earlier in the morning. She stated she was unable to remember who asked her to sign the form. The ADON stated the consent was not obtained from the resident but was unable to remember if she spoke with the family. The ADON stated the admitting nurse was responsible for obtaining the psychotropic consent forms before a medication was given. She stated the nurse management was responsible for monitoring to ensure psychotropic consent forms were obtained. She was unsure why Resident #47's consent form was not obtained. She stated it was important to ensure psychotropic consent forms were obtained prior to receiving the psychotropic medication because the medication was mind-altering and the family and representative needed to be aware of the risks and benefits. During an interview on 05/06/26 beginning at 2:36 p.m., the DON stated she expected psychotropic consent forms to have been obtained prior to administering the psychotropic medication. She stated (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the ADON was responsible for monitoring to ensure psychotropic consent forms were obtained. She stated it was important to ensure psychotropic consent forms were obtained so the resident or family understood the risks or benefits of the mind-altering drug. The DON stated she was unaware Resident #47's consent was not obtained for her antidepressant. During an interview on 05/06/26 at 2:51 p.m., Resident #47's responsible party was called on the telephone with no response. A brief message was left with a call back number but was not returned upon exit of the facility. During an interview on 05/06/26 at 3:42 p.m., the ADON stated she reviewed Resident #47's electronic chart and believed Resident #47 had not received her antidepressant medication since being admitted to the facility. She stated Resident #47 had been refusing at least since 04/29/26 according to the progress notes. She stated the MAR reflected she had been getting the medication, but the progress notes clearly reflected that she was refusing. Record review of Resident #47's progress notes, dated between 04/06/26 and 05/06/26, reflected no progress notes regarding refusal of medications or behaviors. Record review of Resident #47's fluoxetine medication card (blister pack) that was received on 04/24/26, reflected there were 8 missing doses. During an interview on 05/06/26 beginning at 3:46 p.m., the Treatment Nurse stated she worked the floor at times. She stated Resident #47 had been receiving and taking her antidepressant medication. During an interview on 05/06/26 beginning at 3:55 p.m., the Administrator stated she expected psychotropic consent forms to have been completed upon admission, prior to receiving the medication. She stated the DON was responsible for monitoring to ensure psychotropic consent forms were completed. She stated it was important to ensure consent forms were obtained so the resident or family knew and agreed to what they were taking. Record review of the Psychotherapeutic Drug Management policy, dated 01/2025, reflected .G. The Licensed Nurse will not administer the psychotherapeutic medication until an informed consent form has been obtained and documented by the Attending Physician form the resident and/or surrogate decision maker, unless it is an emergency situation.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary clean, comfortable, and homelike environment for 1 of 19 residents reviewed for environment. (Resident #3) 1.The facility failed to replace missing pieces from Resident #3's window blinds. This failure could place residents at risk of an uncomfortable environment and a decrease in quality of life and self-worth.Findings included: 1. Record review of Resident #3's face sheet, dated 5/6/26, reflected she was a [AGE] year-old female, initially admitted on [DATE] and re-admitted to the facility on [DATE]. Her diagnosis included anxiety disorder, muscle wasting and atrophy not elsewhere classified, right shoulder, muscle weakness, need for assistance with personal care, cognitive communication deficit and dementia (a decline in mental ability). Record review of Resident #3's comprehensive MDS assessment, dated 3/23/26, reflected that she had a BIMS score of 9, which indicated moderate cognitive impairment. Record review of Resident #3's care plan, dated 3/21/24, reflected Resident #3 has an ADL self-care performance deficit related to left hemiplegia weakness and incontinence. During an observation and interview on 5/4/26 at 3:09 PM, revealed the blinds in Resident #3's room were damaged and sunlight was shining in with the blinds closed. Resident #3 stated the damaged blinds bothered her when the sun shined into her eyes. During an observation on 5/5/26 at 2:55 PM, revealed Resident #3 was lying in bed. Resident #3's blind continued to be damaged. During an interview on 5/5/26 at 2:57 PM, a Family Member of Resident #3 was in the resident's room. The Family Member stated that the blinds in the resident's room had been damaged ever since the resident had been in the room. She stated she could see how the damaged blind could affect Resident #3 during the day, because the light shined in on the resident even when the blinds were closed. She stated she had not told anyone in the facility about the damaged blinds. During an observation on 5/6/26 at 9:29 AM, revealed Resident #3 was lying in be watching television. Resident #3's blinds on window were still damaged and sunlight continued to shine in the room while the blinds were closed. During an interview on 5/6/26 at 11:41 AM, CNA C stated usually she closed the curtain in Resident #3's room, so she did not get too much sunlight from the damaged blinds. She stated she honestly did not know if maintenance was aware of the damaged blinds. She stated maintenance was responsible for replacing the blinds. She stated a negative effect of the damaged blinds was that if the resident was trying to sleep during the day it was too much light coming in. She stated they all liked to sleep with the lights off. During an interview on 5/6/26 at 11:46 AM, the ADON stated she had not noticed the blinds in Resident #3's room. She stated she had not been in Resident #3's room. She stated she expected the residents' blinds to be functionable for the residents' preference. She stated Maintenance was responsible for replacing the blinds, but it was everyone's responsibility for reporting the blinds if they were damaged. She stated a negative effect of the damaged blinds was it could possibly exacerbate the residents' behaviors. She stated if the resident did not get her rest, it could cause behaviors. During an interview on 5/6/26 at 12:12 PM, the Maintenance Director stated he was just notified of the blinds in Resident #3's room about 10 minutes ago. He stated he was responsible for replacing the damaged blinds. He stated he did a walk through of the facility checking the rooms. He stated a negative effect of the damaged blinds was that there was light coming in the room where it should not be and it affects the residents' privacy. During an interview on 5/6/25 at 2:45 P.M., the Director of Nursing stated she expected the residents' blinds to be suitable to block out the sunshine when light comes through for their comfort. She stated maintenance was responsible for repairing or replacing the blinds. She stated a negative effect of the damaged blinds was that the residents may not be able to get rest due to the damaged blinds. During an interview on 5/6/26 at 3:06 P.M., the Administrator said she would agree that the light coming in during the day, with the damaged blinds, was a homelike environment issue. She stated as soon as (continued on next page)

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Quitman Wellness & Rehabilitation	1026 E Goode St Quitman, TX 75783

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility was made aware of the issue, they addressed it and fixed it. She stated she expected damaged blinds to be replaced. She stated maintenance was responsible for replacing damaged blinds. She stated a negative effect was that the blinds were unsightly. Record review of a facility policy titled, Resident Rooms and Environment date revised 08/2020. To provide residents with a safe, clean, comfortable and homelike environment. The Facility provides residents with a safe, clean, comfortable and homelike environment. Facility Staff will provide residents with a pleasant environment and person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences. 1. Facility Staff aim to create a personalized, homelike atmosphere, paying close attention to the following: C. Lighting that is comfortable (minimum glare) yet adequate (suitable to the task) .

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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 an accurate MDS assessment was completed for 2 of 19 residents (Resident's #11 and #47) reviewed for MDS accuracy. 1. The facility did not ensure Resident #11's admission MDS assessment was accurately coded to reflect her tobacco use. 2. The facility did not ensure Resident #47's admission MDS assessment was accurately coded to reflect her indwelling catheter. These failures could place residents at risk of not receiving care and services to meet their needs.The findings included: 1. Record review of the face sheet, dated 05/06/26, reflected Resident #11 was a [AGE] year-old female who initially admitted to the facility on [DATE] with diagnoses of benign neoplasm of meninges (slow-growing noncancerous brain tumor) and tobacco use. Record review of Resident #11's smoking assessment, dated 02/20/26, reflected Resident #11 smoked and was safe to smoke with minimal supervision. Record review of the admission MDS assessment, dated 03/19/26, reflected Resident #11 had clear speech, was understood, and was usually able to understand others. She had a BIMS score of 13, which indicated no cognitive impairment. The MDS reflected Resident #11 was not coded for current use of tobacco products. Record review of the comprehensive care plan, dated 03/18/2026, reflected Resident #11 used tobacco products, smoking, chewing, or snuff. During an observation and interview on 05/04/26 beginning at 11:27 a.m., Resident #11 was lying in her bed with the head of the bed elevated slightly. Resident #11 stated she smoked during the scheduled smoking times at the facility. During an observation on 05/05/26 at 3:30 p.m., Resident #11 was in the smoking area with staff members. She was smoking a cigarette. 2. Record review of the face sheet, dated 05/06/26, reflected Resident #47 was an [AGE] year-old female who admitted to the facility on [DATE] with diagnoses of zoster (also known as shingles, is a painful, blistering rash caused by the reactivation of the dormant varicella-zoster virus which also causes chickenpox) without complication and urinary retention (holding urine in the bladder). Record review of the admission MDS assessment, dated 04/27/26, reflected Resident #47 had clear speech, was understood by others, and was able to understand others. She had a BIMS score of 5, which indicated severe cognitive impairment. The MDS reflected Resident #47 was not coded for indwelling catheter. Record review of Resident #47's baseline care plan, signed as completed by the DON on 05/05/26, reflected Resident #47 had an indwelling urinary catheter. During an observation on 05/04/26 at 3:16 p.m., Resident #47 was lying in bed facing the window. Resident #47's urinary catheter drainage bag was hanging on the side of the bed. There was a large amount of clear, yellow urine the tubing and bag. During an interview on 05/06/26 beginning at 2:17 p.m., Regional MDS Coordinator G stated she had been completing MDS assessments for the facility over the last month because they were in between MDS Coordinators. She stated Regional MDS Coordinator H had also been helping complete MDS assessments. She stated the MDS Coordinator completing the MDS assessment was responsible for making sure the MDS was completed accurately. Regional MDS Coordinator G stated she completed Resident #11's MDS assessment. She stated Resident #11 had been discharged from the facility and readmitted sometime in March of 2026. She stated when she completed the MDS assessment, the smoking assessment had not been re-done, and the progress notes did not indicate Resident #11 smoked. She stated she did not ask Resident #11 if she was smoking as the MDS assessments were being completed remotely. Regional MDS Coordinator G stated she was unsure why Regional MDS Coordinator H missed coding Resident #47's indwelling catheter. She stated it was important to ensure MDS assessments accurately reflected the resident's status for continuation of care and to ensure the facility and state had an accurate representation of the residents. During an interview on 05/06/26 beginning at 3:55 p.m., the Administrator stated she expected MDS assessments to have been completed accurately. The Administrator stated the Regional MDS Coordinators have been filling in until the ADON resumed the role. She stated the Regional MDS Coordinator and DON were responsible for monitoring to ensure (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the MDS assessments were completed accurately. She stated it was important to ensure MDS assessments were completed accurately for payment purposes and to ensure the facility staff knew how to serve the residents. The policy on MDS accuracy was requested. The Administrator stated the Care Planning policy was what the facility used for MDS accuracy. Record review of the Care Planning policy, dated 06/2020, did not address MDS accuracy. Record review of the Resident Assessment Instrument 3.0 User's Manual, last revised October 2024, reflected J1300: Current Tobacco Use. Steps for Assessment. 1. Ask the resident if they used tobacco in any form during the 7-day look-back period. 2. If the resident states that they had used tobacco in some form during the 7-day look-back period, code 1, yes. 3. If the resident is unable to answer or indicates that they did not use tobacco of any kind during the look-back period, review the medical record and interview staff for any indication of tobacco use by the resident during the look-back period. H0100: Appliances. Steps for Assessment.1. Examine the resident to not the presence of any urinary or bowel appliances. 2. Review the medical record, including bladder and bowel records, for documentation of current or past use of urinary or bowel appliances.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary services to maintain personal hygiene for 1 of 24 residents reviewed for ADLs (Residents #54.)The facility failed to provide Resident #54 with a shower the week of 4/27/26-5/03/26.This failure could place residents at risk of not receiving care and services to meet their needs which could result in poor care, risk for skin breakdown, feelings of poor self-esteem, lack of dignity and health.Findings included:Record review of Resident #54's face sheet dated 5/05/26 indicated she was [AGE] years old and admitted to the facility on [DATE]. Resident #54 had diagnoses which included Parkinson's disease (movement disorder), right knee pain, difficulty walking, dementia (forgetfulness), chronic pain syndrome and osteoarthritis (degenerative joint disease that breaks down the cartilage and underlying bone, causing pain, stiffness, and reduced mobility).Record review of Resident #54's annual MDS dated [DATE] indicated she understood others and was understood. Resident #54 had a BIMS with a score of 13, which indicated she was cognitively intact. The MDS indicated Resident #54 did not reject care. Resident #54 required moderate staff assistance with shower/bathing and most ADLs including personal hygiene.Record review of Resident #54's undated care plan indicated she had an ADL self-care deficit related to weakness and required partial/moderate assist by one staff with shower and personal hygiene.Record review of the facility's shower schedule sheet updated 3/23/26 indicated Resident #54 was scheduled for a shower on Tuesdays, Thursdays, and Saturdays before breakfast.Record review of Resident #54's CNA Shower Forms dated from 4/28/26-5/05/26 indicated the resident refused showers on 4/28/26 and 4/30/26. There was no Shower Form for Resident #54 on 5/02/26. There was a Shower Form for Resident #54 dated 5/05/26 indicating she was showered on 5/05/26.During an observation and interview on 5/04/26 at 12:05 PM, Resident #54 was sitting up in her wheelchair in her room. Resident #54 appeared well groomed and no odors were noted. Resident #54 said the staff treated her good and usually answered her call light timely. Resident #54 said the staff did the best they could and she thought they were short staffed. Resident #54 said she had not had a shower in over a week and had asked for one on her scheduled days and still did not get it. Resident #54 said they had moved her from the Monday, Wednesday, and Friday shower schedule to the Tuesday, Thursday, and Saturday schedule not long ago because there were too many showers for the shower aide to give on Monday, Wednesday, and Fridays. Resident #54 said she enjoyed a good shower.During an observation and interview on 5/05/26 at 10:00 AM, Resident #54 was sitting in her recliner, dressed and appeared well groomed. Resident #54 said she still had not had a shower in over a week. Resident #54 said she was supposed to receive her showers on Tuesday, Thursdays, and Saturdays, and she should receive a shower today (5/05/26).During an observation and interview on 5/05/26 at 3:07 PM, Resident #54 said she still had not received her shower and today (5/05/26) was supposed to be her day. Resident #54 asked Do you reckon I will get a shower today? Resident #54 said she had asked several staff about getting her shower after not receiving a shower on her scheduled days and they told her they would try to give her a shower if they had time. Resident #54 said she did not refuse showers and enjoyed a good shower.During an observation and interview on 5/06/26 at 9:49 AM, Resident #54 was sitting up in her recliner with damp hair and was using a hair pick to comb her hair. Resident #54 said she received a shower that morning but did not get it on her scheduled day yesterday (Tuesday, 5/05/26). Resident #54 said she did not want her hair dried and preferred it to dry naturally.During an interview on 5/06/2026 at 9:55 AM, CNA A said he had worked at the facility for about seven months. CNA A said there were two aides for approximately 37 residents and shower aides were supposed to work every day except Sundays. CNA A said there was a shower sheet with what residents were on what days. CNA A said the aides got the residents ready with their clothes and took the resident to the shower room and then the shower aide bathed the resident and would bring the resident back to their room when done. CNA A said the residents would (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sure let them know if they did not get their showers. CNA A said then they had to tell the resident they would try to work them in for a shower if they get caught up with keeping everyone changed. CNA A said Resident #54 said she had not had a shower in a week that morning and they got her one today (5/06/26). CNA A said Resident #54 should have had a shower Saturday (5/02/26) and yesterday (5/05/26). CNA A said the CNAs, nurses and everyone were responsible for ensuring the residents were bathed. CNA A said if the residents were not getting their showers, it could make them feel neglected.During an interview on 5/06/26 at 10:27 AM, CNA J said she was the shower aide on Mondays, Wednesdays, and Fridays and was planning to pick up an extra day starting Thursday next week. CNA J said she filled out a paper shower form for each shower she gave. CNA J said sometimes some residents would refuse but she was able to knocked out most of her residents. CNA J said the CNAs were responsible for ensuring the residents were showered. CNA J said the aides on the floor got the residents ready and brought the residents to her at the shower, unless the resident was walkie talky and she would grab them herself. CNA J said she has had some residents say they did not get their showers. CNA J said she had some residents refuse today (5/06/26) and she was able to give Resident #54 a shower today (5/06/26). CNA J said it mentally bothered the residents when they did not get their showers, and some residents had told her that nobody cared about them and were upset about it. CNA J said she picked up extra showers when she could. CNA J said she did not complete documentation in the EHR but gave the completed shower forms to the nurse and then the nurse signed it and then turned it in to either the ADON or DON.During an interview on 5/06/26 at 10:50 AM, the ADON said the shower aide for Tuesdays, Thursdays, and Saturdays had been out last week and this week. The ADON said she did not know who the DON had doing showers while the shower aide had been off.During an interview on 5/06/2026 at 10:46 AM, CNA C said she had worked at the facility for a little over a year and normally worked the day shift (6 AM- 6 PM). CNA C said they had enough staff to complete her tasks and care for the residents. CNA C said residents have told her about not getting their showers, usually every other day. CNA C said the residents usually complain on the days CNA J was not there, so it would be the Tuesday, Thursday, ant Saturday residents. CNA C said she reported to the DON and ADM when residents told her they had not received their shower. CNA C said if she had time, she would get the resident a shower when they told her they had not had a shower or wanted a shower. CNA C said there were only two aides managing the floor (keeping everyone turned, incontinent care, getting residents up for meals, laying residents down, ect.) CNA C said she wished they had a 3rd person because, if the shower aide did not show up, then they do not have enough time to do showers on top of caring for almost 40 residents. CNA C said if it was her and she was missing showers, then she would feel dirty. CNA C said residents normally should be receiving three showers a week, unless they refuse.During an interview on 5/06/2026 at 10:56 AM, LVN D said she had worked at the facility for about five years. LVN D said the nurses were responsible for ensuring the residents receive their showers. LVN D said their shower aide gave them the completed shower sheets and then they compared it to the list of who was supposed to have been showered. LVN D said if she found out that a resident was not showered, she would ask the shower aide and aides what happened and report it to the DON. LVN D said she knew there had been an issue with having 40 residents for one shower aide and she could not provide showers to all the residents if there was not another shower aide. LVN D said it could affect the resident's mood, skin integrity, and their quality of life if not receiving their showers. During an interview on 5/06/26 at 2:27 PM, CNA K said she had worked at the facility for about eight years and normally worked the 6 AM - 6 PM shift and every other weekend. CNA K said they have a shower list to go by to know who was supposed to be showered and when. CNA K said they had a shower aide, CNA J, for Mondays, Wednesdays, and Fridays and CNA J came faithfully. CNA K said they did not have a Tuesday, Thursday, and Saturday shower aide at this time. CNA K said then it was if someone wanted to work extra to do showers on Tuesday, Thursday, and Saturdays, or it was left to the aides on the floor to do the showers on those days. CNA K said there were only two CNAs and a shower aide, on the days they have one. CNA K (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said there were about 38-40 residents on her end (South end). CNA K said she tried to do the showers that she could but could not get everyone's showers completed. CNA K said she told the nurse when showers were not completed. CNA K said the department heads knew there was not a shower aide there on Tuesdays, Thursdays, and Saturdays and did not know what they expected them to do. CNA K said Resident #54 was scheduled for Tuesdays, Thursdays, and Saturday showers but they did not have a shower aide yesterday and she did not get a shower. CNA K said she did not work Resident #54's hall 5/05/26) but if she had to guess Resident #54 probably asked to have a shower. CNA K said CNA L was actually assigned to Resident #54's hall, but herself and CNA L work a lot as a team due to several residents required two people. CNA K said it could cause skin issues if the resident was not receiving showers and could make them feel neglected. On 5/06/26 at 2:37 PM and 4:10 PM, called CNA L. There was no answer and a detailed voicemail was left requesting a return call. CNA L did not return the call prior to the surveyor exiting the facility.During an interview on 5/06/26 at 2:50 PM, the ADON said the DON got other people to fill in when the shower aide was not there. The ADON said when all the staff were there, everything ran smoothly. The ADON said the shower aide had not been completing the documentation for the showers in the EHR and was filling out the paper forms. The ADON said with herself and the DON having to work the floor a lot in the month they had been there; they had not been able to go through the shower sheets to see who had gotten showers and who had not. The ADON said going forward the shower aide would complete her own documentation in the EHR then they could pull reports to be able to follow up. The ADON said everyone liked to be clean. The ADON said the resident would probably be upset about not getting their showers and it could affect their self-worth or something.During an interview on 5/06/26 at 3:09 PM, the DON said she had been the DON at the facility for about a month. The DON said the shower aide for Tuesday, Thursday, and Saturday was out last week and this week. The DON said if the shower was scheduled on the weekends, the aides were expected to do their own showers. The DON said they did have agency staff last Saturday. The DON said their policy said to bathe the residents at a minimum of once a week, but they scheduled the residents' showers for three times a week and if they requested a shower. The DON said the residents needed their showers for dignity issues and continuity of care. During an interview on 5/06/26 at 3:32 PM, the ADM said their policy was for the residents to have a minimum of one shower a week. The ADM said they scheduled the resident showers three days a week in hopes to get at least one shower completed weekly. The ADM said they tried to accommodate the best they could when residents asked for showers. The ADM said CNA J, the shower aide on Monday, Wednesday, and Fridays had a heavy schedule. The ADM said if the shower aide was not able to bathe the resident and the resident requested a shower; she would expect the resident to get a shower. The ADM said if the resident did not receive their shower, it could cause the resident to feel unclean.Record review of the facility's undated policy titled Showering a Resident, indicated . a shower bath is given to the resident to provide cleanliness, comfort and prevent body odors . residents are offered a shower at a minimum of once weekly and given per resident request .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 19 (Resident #14) reviewed for adequate supervision and assistive device to prevent accidents. The facility failed to ensure Resident #14 did not use Mentholatum ointment (topical rub to relieve minor aches, pains and cold symptoms) while nasal canula delivering oxygen was in place. These failures could place residents at an increased risk for injury.Findings included: Record review of Resident #14's face sheet dated 5/6/26 indicated Resident #14 was an 82-years-old female initially admitted on [DATE] and readmitted on [DATE] to the facility. Resident #14 had diagnoses including dementia (is a general term for a decline in mental ability severe enough to interfere with daily life), chronic obstructive pulmonary disease with (acute) exacerbation (a progressive, treatable lung disease that restricts airflow, making it hard to breathe) and chronic respiratory failure with hypoxia (a long-term, serious condition where the lungs cannot adequately transfer oxygen into the blood, resulting in consistently blood oxygen levels). Record review of Resident #14's quarterly MDS assessment dated [DATE] indicated Resident #14 was usually understood and usually had the ability to understand others. Resident #14 had a BIMS score of 5 which indicated severe cognitive impairment. Pulmonary indicated chronic obstructive pulmonary disease with (acute) exacerbation (a progressive, treatable lung disease that restricts airflow, making it hard to breathe). Pain assessment indicated pain present. Record review of Resident #14's care plan dated 8/8/25 indicated over-the-counter medication will sometimes be found in room that was provided by family. Intervention included education provided to Resident #14 and family. Record review of Resident #14's care plan dated 8/8/25 indicated altered respiratory status/ difficulty breathing related to chronic obstructive pulmonary disease with (acute) exacerbation (a progressive, treatable lung disease that restricts airflow, making it hard to breathe). Interventions included administer medication/puffers as ordered. Monitor for effectiveness and side effects. Record review of Resident #14's order summary report dated 5/4/26 indicated oxygen at 2-4 liters via nasal cannula continuous every shift continuous. Start date 7/31/25. Further review revealed there was no physician order for Mentholatum ointment (topical rub to relieve minor aches, pains and cold symptoms). During an observation on 5/4/26 at 11:01 AM, Resident #14 was not in room. Resident #14 had Mentholatum original ointment (topical rub to relieve minor aches, pains and cold symptoms) on her bed and she used an oxygen concentrator. During an observation on 5/4/26 at 2:49 PM, Resident was not in room but had Mentholatum original ointment (topical rub to relieve minor aches, pains and cold symptoms) on her bed. During an observation on 5/5/26 at 2:30 PM, Resident #14 had Mentholatum original ointment (topical rub to relieve minor aches, pains and cold symptoms) on bed. Resident sitting up in wheelchair with oxygen in place. Resident #14 said she used the Mentholatum ointment (topical rub to relieve minor aches, pains and cold symptoms) for her nose. Resident #14 said with her being on oxygen; the nasal cannula made her nose dry and hard, but the ointment reduces the hardness and dryness. During an observation on 5/6/26 at 9:33 AM, Resident #14 was lying in bed asleep with her oxygen in place with Mentholatum ointment (topical rub to relieve minor aches, pains and cold symptoms) on bed. During an observation on 5/6/26 at 10:47 AM, Resident #14 was not in room. Resident had Mentholatum original ointment (topical rub to relieve minor aches, pains and cold symptoms) lying on the bed. During an interview on 5/6/26 at 11:08 AM, CNA B said he was not aware of the Mentholatum ointment (topical rub to relieve minor aches, pains and cold symptoms) in Resident #14's room. He said if he found medication in a resident's room, he would have notified the nurse immediately of what he found. He said a negative effect of the medication in the resident's room was she could have too much of the medication at one time. During an interview on 5/6/26 at 11:12 AM, the Director of Nursing stated all staff were responsible for ensuring the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675553	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Quitman Wellness & Rehabilitation	1026 E Goode St Quitman, TX 75783

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents do not have medications in their rooms. She stated she expected all medications to be administered by the nurse. She stated the negative effect of Mentholatum ointment (topical rub to relieve minor aches, pains and cold symptoms) in the resident's possession was it had petroleum in it and the resident was on oxygen. She stated petroleum with oxygen could be a fire hazard. During an interview on 5/6/26 at 11:46 AM, the ADON said she did not see the Mentholatum ointment (topical rub to relieve minor aches, pains and cold symptoms) medication in Resident #14's room. She said the staff does ambassador rounds to check the residents' rooms. She stated the negative effect was that the Mentholatum ointment (topical rub to relieve minor aches, pains and cold symptoms) could blow up the resident's room, because the petroleum ointment and oxygen used together is flammable. During an interview on 5/6/26 at 3:07 PM, the Administrator said Resident #14 liked to keep things tucked under her while in bed. She said she expected residents to not have medications in their rooms. She said staff educated her Resident #14 about not having medications in her room, but she was not going to remember. She said staff would be educating the family on not bringing medications to Resident #14. She stated the negative effect of the Mentholatum ointment (topical rub to relieve minor aches, pains and cold symptoms) in Resident #14's room was that she cannot use it with the oxygen, because it could cause a fire. Record review of a facility's Oxygen Administration policy revised 01/2026 indicated, To provide guidelines for the safe and effective administration of oxygen to prevent or reverse hypoxemia and ensure adequate tissue oxygenation. Safe Handling of Oxygen/ Equipment: C. Oil, alcohols, and petroleum products are not to be used around the resident's face .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to store all drugs and biologicals in locked compartments for 1 of 19 (Resident #14) reviewed for medications in room. 1 of 3 medication carts reviewed (Nurse medication cart for the Front Halls) 1.The facility failed to ensure Resident #14 did not have over the counter medication Mentholatum ointment (topical rub to relieve minor aches, pains and cold symptoms) in room on 5/4/26, 5/5/26 and 5/6/26. The facility failed to ensure LVN B secured and locked the nurse medication cart for Front Halls. 2.This failure could place residents at risk of not having their medications available as prescribed or possible drug diversions. Findings included: 1.Record review of Resident #14's face sheet dated 5/6/26 indicated Resident #14 was an 82-years-old female initially admitted on [DATE] and readmitted on [DATE] to the facility. Resident #14 had diagnoses including dementia (is a general term for a decline in mental ability severe enough to interfere with daily life), chronic obstructive pulmonary disease with (acute) exacerbation (a progressive, treatable lung disease that restricts airflow, making it hard to breathe) and chronic respiratory failure with hypoxia (a long-term, serious condition where the lungs cannot adequately transfer oxygen into the blood, resulting in consistently blood oxygen levels). Record review of Resident #14's quarterly MDS assessment dated [DATE] indicated Resident #14 was usually understood and usually had the ability to understand others. Resident #14 had a BIMS score of 5 which indicated severe cognitive impairment. Pulmonary indicated chronic obstructive pulmonary disease with (acute) exacerbation (a progressive, treatable lung disease that restricts airflow, making it hard to breathe). Pain assessment indicated pain present. Record review of Resident #14's care plan dated 8/8/25 indicated over-the-counter medication will sometimes be found in room that was provided by family. Intervention included education provided to Resident #14 and family. Record review of Resident #14's care plan dated 8/8/25 indicated altered respiratory status/ difficulty breathing related to chronic obstructive pulmonary disease with (acute) exacerbation (a progressive, treatable lung disease that restricts airflow, making it hard to breathe). Interventions included administer medication/puffers as ordered. Monitor for effectiveness and side effects. Record review of Resident #14's order summary report dated 5/4/26 indicated oxygen at 2-4 liters via nasal cannula continuous every shift continuous. Start date 7/31/25. Further review revealed there was no physician order for Mentholatum ointment (topical rub to relieve minor aches, pains and cold symptoms). During an observation on 5/4/26 at 11:01 AM, Resident #14 was not in room. Resident #14 had Mentholatum original ointment (topical rub to relieve minor aches, pains and cold symptoms) on her bed and she used an oxygen concentrator. During an observation on 5/4/26 at 2:49 PM, Resident was not in room but had Mentholatum original ointment (topical rub to relieve minor aches, pains and cold symptoms) on her bed. During an observation on 5/5/26 at 2:30 PM, Resident #14 had Mentholatum original ointment (topical rub to relieve minor aches, pains and cold symptoms) on bed. Resident sitting up in wheelchair with oxygen in place. Resident #14 said she used the Mentholatum ointment (topical rub to relieve minor aches, pains and cold symptoms) for her nose. Resident #14 said with her being on oxygen; the nasal cannula made her nose dry and hard, but the ointment reduces the hardness and dryness. During an observation on 5/6/26 at 9:33 AM, Resident #14 was lying in bed asleep with her oxygen in place with Mentholatum ointment (topical rub to relieve minor aches, pains and cold symptoms) on bed. During an observation on 5/6/26 at 10:47 AM, Resident #14 was not in room. Resident had Mentholatum original ointment (topical rub to relieve minor aches, pains and cold symptoms) lying on the bed. During an interview on 5/6/26 at 11:08 AM, CNA B said he was not aware of the Mentholatum ointment (topical rub to relieve minor aches, pains and cold symptoms) in Resident #14's room. He said if he found medication in a resident's room, he would have (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notified the nurse immediately of what he found. He said a negative effect of the medication in the resident's room was she could have too much of the medication at one time. During an interview on 5/6/26 at 11:12 AM, the Director of Nursing stated all staff were responsible for ensuring the residents do not have medications in their rooms. She stated she expected all medications to be administered by the nurse. She stated the negative effect of Mentholatum ointment (topical rub to relieve minor aches, pains and cold symptoms) in the resident's possession was it had petroleum in it and the resident was on oxygen. She stated petroleum with oxygen could be a fire hazard. 2. Record review of a Daily Census provided by the facility on 5/4/26 indicated a census of 50. During an observation on 5/5/26 at 12:30 PM, it was revealed while walking on the Front Hall that the nurse cart was unlocked in front of the nurse's station. During an interview and observation on 5/6/26 at 12:32 PM, LVN B stated she was responsible for Front hall nursing cart. She came from the nurses' station to the cart and noticed the cart was unlocked, then she said she was responsible for the unlocked medication cart. She said the nurse assigned to the cart was responsible for ensuring the cart was locked. She said a negative effect of the cart unlocked was that a resident could get into the cart. During an interview on 5/6/26 at 11:46 AM, the ADON said she did not see the Mentholatum ointment (topical rub to relieve minor aches, pains and cold symptoms) medication in Resident #14's room. She said the staff does ambassador rounds to check the residents' rooms. She stated the negative effect was that the Mentholatum ointment (topical rub to relieve minor aches, pains and cold symptoms) could blow up the resident's room, because the petroleum ointment and oxygen used together is flammable.She said the nurse who was assigned to the cart was responsible for ensuring the cart was locked. She said a negative effect of the cart being unlocked was that demented residents or anyone could get into the cart and take the medication. During an interview on 5/6/26 at 2:50 PM, the Director of Nursing said she expected the nurses to have the medication carts locked while not in use. She said the nurse with the keys meant that the cart was assigned to them was responsible for ensuring the medication cart was locked. She said a negative effect of the unlocked medication cart was that anyone could get into it. During an interview on 5/6/26 at 3:07 PM, the Administrator said Resident #14 liked to keep things tucked under her while in bed. She said she expected residents to not have medications in their rooms. She said staff educated her Resident #14 about not having medications in her room, but she was not going to remember. She said staff would be educating the family on not bringing medications to Resident #14. She stated the negative effect of the Mentholatum ointment (topical rub to relieve minor aches, pains and cold symptoms) in Resident #14's room was that she cannot use it with oxygen, because it could cause a fire. She said as soon as the surveyor noticed the medication cart was unlocked; she was in serviced the nurse right away. She said she expected the nurses to keep the medication carts locked when not in use. She said the nurses were responsible for ensuring the medication carts were locked. She said a negative effect of the unlocked medication cart was it could be medications missing from it. Review of the facility Medication Storage Policy revised dated 01/2026 indicated, To establish standards that safeguard residents by preventing unauthorized access to medications and ensuring compliance with applicable federal and state pharmacy regulations. Medication carts must remain locked and always secured unless under direct and continuous supervision of authorized personnel during medication administration. These standards are required to ensure resident safety and regulatory compliance. Security & Access: Medication rooms, carts, and cabinets must remain locked at all times. 1. Locking Requirements: When turning away from the cart. When more than arm's reach from the cart. After completing a medication pass.