| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 675572 | A. Building<br>B. Wing | 01/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Glen Rose Nursing and Rehab Center | 1019 Holden St<br>Glen Rose, TX 76043 |

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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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observations, interviews, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 1 of 1 kitchen reviewed food safety. The facility failed to ensure foods were labeled properly in the kitchen. The facility failed to dispose of foods after the use by / shelf life date.These failures could place residents that eat out of the kitchen at risk for food borne illnesses.Findings includedDuring an observation on 1/13/2026 between 8:48 a.m. and 9:05 a.m., the kitchen revealed: Dry Storage: 1. Opened bag of potato chips in a see-through plastic bag that was closed to air not labeled with open date. 2. Opened bag of what appeared to be ten slices of bread stored outside of the original container not labeled with description, open date, or use by date. Refrigerator:1. Opened bag of sliced white cheese stored outside of the original container not labeled with use by date.2. Opened bag of what appeared to be sliced yellow cheese stored outside of the original container not labeled with description or use by date.3. Opened bag of smoked sliced turkey breast stored in a see-through sealed plastic bag. There was a freeze by date or use by date of 11/25/2025 on the original packaging of the sliced turkey breast. There was a date written on the bag 12/13 with no year and did not specify what the date was for. Freezer: 1. Opened bag of what appeared to be ground meat patties stored outside of the original container not labeled with description, opened date, or use by date.2. Opened see-through plastic bag labeled pepperoni dated 10/12/2025 with shelf life of 3 days written on it (stored 90 days after shelf life).3. Opened see-through plastic bag that was labeled chicken flour tortilla on it with an open date of 1/8/2026 and a use by date of 1/11/2026 (stored 2 days past use by date).4. Opened see-through plastic bag of what appeared to be cookie dough stored outside of the original container not labeled with description, opened date, or use by date.5. Opened see-through plastic bag of beef burritos not labeled with a use by date.6. Opened plastic tub of vanilla ice cream not labeled with an open date.7. Five logs of what appeared to be ground meat in the original package with no description on them.During an interview on 1/13/2026 at 9:14 a.m., the DM stated she expected for all stored items to have an open date and a use by date labeled on them if the item had been opened. She expected items to have a description on them. She stated all staff were responsible for labeling the food items when they were storing them which would include the cook, dietary aides, and activities director. She stated she monitored that items in the storage areas were labeled appropriately. She stated she expected food items stored in the refrigerator that were open to be used in 7 days if there was no use by date labeled on it. She stated she expected items in the freezer to be used or discarded 6 months after they had been opened if there was no use by date labeled on it. She stated she expected items in the dry storage area to be used up or discarded within 3 days of being opened if there was no use by date on the package. She stated not labeling the food items with a use by date could cause the food to be served past the use by date. She stated not labeling the food items with a description could have caused the cook to not know what the food item was. She stated the turkey in the fridge would have been frozen prior to being kept in the refrigerator but would still need to have an open date and a use by date so that staff knew when it was no longer to be used. She stated she was unsure when the turkey had moved to the refrigerator. During an interview on<br>(continued on next page) |

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

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

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1/13/2026 at 9:17 a.m., [NAME] C stated she was trained on food labeling and would have put a label on the food items when she stored them. She stated she had been on vacation for the last two weeks and did not know why food items in the dry storage, refrigerator, and freezer did not have labels. During a telephone interview on 1/14/2026 at 8:28 a.m., the dietician stated foods stored should always have an end date. She stated if food was taken out of its original package, there should have been an expiration date written on the new packaging and it should have a description of the food written on the package. She stated chips were good for seven days once opened and would need an open date written on the package. She stated bread stored outside of original package should have a description written on it and an open date. She stated foods stored in the refrigerator should have a use by date written on the storage container. She stated the recommendation for cheese was to use it by one to two months after the package had been opened and one hundred and eighty days if the package had not been opened. She stated the cheese should have a use by date written on the package when being stored. The dietician stated the smoked sliced turkey breast should have been dated when it moved from the freezer into the refrigerator. She stated turkey would last seven days after being thawed in the refrigerator. She stated the items in the freezer would need to have a description on them so that staff would know what the item was. She stated frozen meat lasts nine months in the freezer and she did not know why the pepperoni had three-day shelf life written on the bag. She stated frozen ground meat patties would need to be labeled with description and date when it came into the facility. She stated ground meat would be good for three to four months frozen. She stated it was important to label items in storage so people would know what it was, so they would know when to use the food item or when to dispose of that item. She stated not labeling foods with description could cause a resident to get a food that they had an allergy to. She stated if a food item did not have an end date, it could have potentially been served after it had expired. She stated serving food without an open date could have caused a chance of food borne illness. She stated the employee who stored the food was responsible for making sure it was labeled. She stated the DM and the assistant DM were who monitored that food was stored appropriately. She stated the kitchen staff were trained on food labeling through continuing education that they complete on the computer and were educated by the DM, the assistant DM or me as well. She stated the kitchen staff were trained at least annually but did not know for sure how often staff were trained. She stated the DM and herself do in-services when they see issues as needed in the moment. She stated she came to the facility twice a month with another dietician due to the size of the facility. She stated she honestly did not know why the foods would not have been labeled appropriately. Record review of the facility policy titled Food Storage, dated 2023, reflected: Food should be dated as it is placed on the shelves if required by state regulation. Date marking should be visible on all high risk food to indicate the date by which a ready-to-eat food should be consumed, sold or discarded.Plastic containers with tight fitting covers or sealable plastic bags must be used for storing grain products, sugar, dried vegetables and broken lots of bulk foods or opened packages. All containers or storage bags must be legible and accurately labeled and dated.Leftover food should be stored in covered containers or wrapped carefully and securely and clearly labeled and dated before being refrigerated. Leftover food must be used within 7 days or discarded per the 2022 Federal Food Code. Review of the Food Code 2022 https://www.fda.gov/food/retail-food-protection/fda-food-code, accessed 1/14/2026 reflected 3-602.11 Food Labels. (A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317 Labeling, marking devices, and containers. (B) Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement .refrigerated foods must be consumed, sold or discarded by the expiration date. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure residents had the right to formulate an advanced directive for 1 of 18 (Resident #13) residents reviewed for advanced directives. The facility failed to ensure that Resident #13's advanced directive consent, Out of Hospital Do Not Resuscitate (OOH-DNR) order, was signed by physician in section D.This failure could place residents at risk of receiving interventions that go against their personal preferences. Finding includedRecord review of Resident #13's face sheet, dated [DATE], reflected an [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses including COPD. Further review reflected advance directive Do Not Resuscitate.Record review of Resident #13's quarterly MDS, dated [DATE], reflected Resident #13 had a BIMS of 15 meaning her cognition was intact. Further review of the MDS reflected she did not have a life expectancy of less than 6 months.Record review of Resident #13's care plan, initiated on [DATE], reflected Resident #13 had an order for Do Not Resuscitate (DNR), her decision for DNR would be honored, and social services to consult with Resident #13 regarding her decision to continue DNR.Record review of Resident #13's electronic physician orders, reviewed on [DATE], reflected an order for DNR dated [DATE]. Record review of Resident #13's OOH-DNR, dated [DATE], reflected no evidence of physician signature in section D. Declaration by physician. Record review of Resident #13's progress note, dated [DATE] created by SW, reflected a care plan meeting was conducted and DNR code status was chosen. DNR form sent to physician.Record review of Resident #13's progress note, dated [DATE] created by SW, reflected a care plan meeting was conducted and DNR was code status. During an interview on [DATE] at 9:37 a.m., the SW stated she was responsible for making sure OOH-DNR forms were filled out completely and uploaded into the resident's chart. She stated a physician would have needed to sign in section D of Resident #13's OOH-DNR for the form to be completed. She stated she did not know why she had missed that the physician had not signed the OOH-DNR form in Section D and stated she reviewed those forms during care plan meetings that occurred quarterly. She stated not having the physician's signature could cause another facility to not honor the resident's wishes. During an interview on [DATE] at 10:10 a.m., the ADMN stated she expected DNR forms to have physician signature in the physician signature part as well as in the bottom of the form. She stated she monitored that the forms were completed, and the facility staff had just done an audit one or two months ago. She stated Resident #13's physician signature on the form had been missed during that audit. She stated not having the signature would not affect the facility's staff responding appropriately to the resident's wishes. She stated the form not being completed could cause another facility to not honor Resident #13's wishes if she was transferred to another facility for treatment. Record review of facility policy titled, Advanced Directives, revised on [DATE], reflected Do Not Resuscitate (DNR) - indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, health care proxy, or representative (sponsor) has directed that no cardiopulmonary resuscitation (CPR) or other life-sustaining treatments or methods are to be used.If the Resident Does not have an Advance Directive 1. If the resident or representative indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. a. The resident or representative is given the option to accept or decline assistance and care will not be contingent on either decision. b. Nursing staff will document in the medical record the offer to assist and the residents decision to accept or decline assistance. 2. Information about whether or not the resident has executed an advance directive is displayed prominently in the medical record in a section of the record that is retrievable by any staff. 3. The attending physician provides information to the resident and legal representative regarding the residents health status, treatment options and expected outcomes during the development of the initial comprehensive assessment and care plan.Record review of website<br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | titled Out of Hospital Do No Resuscitate Program located https://www.dshs.texas.gov/emstraumasystems/dnr.shtm accessed on [DATE] revealed: APPLICABILITY: This OOH-DNR Order applies to health care professionals in out-of-hospital settings, including physicians' offices, hospital clinics and emergency departments. IMPLEMENTATION: A competent adult person, at least [AGE] years of age, or the person's authorized representative or qualified relative may execute or issue an OOH-DNR Order. The person's attending physician will document existence of the Order in the person's permanent medical record. The OOH-DNR Order may be executed as follows:. 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. Order by nonwritten communication to the attending physician, who must sign in Section D and also the physician's statement section. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 8 residents (Resident #55 and Resident #72) reviewed for care plans. The facility failed to address Resident #55's indwelling urinary catheter on her comprehensive resident-centered care plan. The facility failed to include measurable goals and appropriate interventions on Resident #72's comprehensive resident-centered care plan regarding weight loss. These failures could affect residents by placing them at risk of not receiving individualized care and services to meet their needs.The findings included: 1.Record review of Resident #55's electronic face sheet, dated 01/14/2026, revealed a [AGE] year-old female admitted on [DATE] with medical diagnoses of chronic kidney disease and history of urinary tract infections. Record review of Resident #55's admission MDS dated [DATE], revealed in Section C - Cognitive Patterns, subsection C0500 BIMS Summary Score revealed she had a BIMS score of 10 out of 15, indicating moderately impaired cognition. Record review of Resident #55's Care Plan Conference Report dated 08/05/2025, revealed in the section titled Therapy Continent Status, Supra pubic cath was noted. Record review of physician's assessment History and Physical dated 07/29/2025, revealed Assessment and Plan 4. Suprapubic urinary catheter in situ (situated in the original place). Record review of Resident #55's Baseline Care Plan with a date of 08/01/2025 revealed in Section A. Health Condition/Special Treatments 1i1. Other (specify) s/p cath supplies was entered and Section C. Bowel and Bladder 4. Bowel and bladder appliances a. Indwelling catheter (including suprapubic catheter and nephrostomy tube) was selected. Record review of physician orders dated 09/01/2025 revealed Change suprapubic Catheter q28 days and prn complications every 24 hours as needed for suprapubic cath complications and supra-pubic cath care every shift. every shift. Record review of Resident #55's Comprehensive Care Plan with a date of 10/21/2025 as last care plan review completed, revealed no evidence of suprapubic urinary catheter. During an observation on 01/13/2026 at 8:21 am, Resident #55's indwelling urinary catheter collection bag was hanging under her bed on the left side. During an interview on 01/14/2026 at 7:57 am, Resident #55 stated she had problems with kidney stones for years but not since the indwelling catheter had been placed. She stated staff changed the catheter and emptied the collection bag as needed. No complaints were made by the resident concerning the catheter. 2.Record review of Resident #72's electronic face sheet, dated 01/14/2026, revealed a [AGE] year-old male initially admitted on [DATE] and readmitted on [DATE] with medical diagnoses of osteomyelitis of vertebra (infection in the spine), anxiety, dysphagia (difficulty swallowing), Alzheimer's disease, spinal stenosis (stiffening of the spine), weakness, high cholesterol, glaucoma, high blood pressure, atrial fibrillation (irregular heart rhythm) and cerebral infarction (stroke). Record review of Resident #72's Significant Change MDS dated [DATE], revealed the following:*Section C - Cognitive Patterns, subsection C0500 BIMS Summary Score revealed he had a BIMS score of 4 out of 15, indicating severe cognitive impairment. *Section K - Swallowing/Nutritional Status, subsection K0300 Weight Loss, 2. Yes, not on physician-prescribed weight-loss regimen. *Section V Care Area Assessment (CAA) Summary, subsection 0200 CAA's and Care Planning, A. CAA Results, Care Area, 12. Nutritional Status, column A. Care Area Triggered was checked and column B. Care Planning Decision was checked with a notation CAA WS dated 01/14/2026. Record review of Resident #72's Comprehensive Care Plan with a date of 01/12/2026 as last care plan review completed, revealed Focus [Resident #72] has nutritional problem or potential nutritional problem (depression). Goal [Resident #72] will maintain adequate nutritional status as evidence by maintaining weight within (X)% of (SPECIFY BASELINE), no s/sx of malnutrition, and consuming at least (X)% of at least (X)<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | meals daily . and Interventions/Tasks Offer activities of choice to help divert attention from food date initiated 10/14/2025. During an interview on 01/15/2026 at 9:23 am, the DON stated she, the ADON, and the MDS Coordinator were responsible for creating care plans. She stated she was responsible for monitoring for accuracy. The DON was unable to provide an explanation as to why Resident # 55's suprapubic catheter was not addressed on the care plan or why Resident #72's goals were not measurable, and why an inappropriate intervention was documented. Her expectation was for the goals to be individualized to meet the needs of the residents. She explained that training on care plans was provided upon hire, when a staff member changes roles to include participation in care planning or when a need for re-education was identified. The DON stated her expectation was for all care plans to be accurate and timely. The DON stated a possible effect on a resident if a care plan was not accurate was that the resident may not receive appropriate care. During an interview on 01/15/2026 at 11:11 am, the MDS Coordinator stated the care plans were a team effort. She explained the DON created the baseline care plan and the MDS Coordinator entered the biggest part. She stated the care plans were updated quarterly after the MDS was completed and after off cycle MDS's, for example a Significant Change MDS. She stated an RN must sign that an MDS was complete and it was her responsibility to monitor for accuracy. She stated occasionally issues may have been missed due to ?human error. The MDS Coordinator stated the effect an inaccurate care plan may have had on a resident was that staff would not be aware of interventions that needed to be implemented or information on a resident would not be readily available. She stated training on MDS's was provided by a corporate MDS nurse and through competency training online. During an interview on 01/15/2026 at 12:17 pm, the ADON stated she was responsible for entering the infection control information on the care plans. She explained her training consisted of 20 years of nursing experience and on the job training. The ADON stated monitoring the accuracy of the care plans was the responsibility of the DON, the MDS Coordinator, Admin, and corporate staff. She was unable to state why a care plan would not have been accurate or why a care area may have been missed. She stated an inaccurate or incomplete care plan could have affected a resident because an issue may not be addressed by staff. She stated catheters should be on the care plan due to the increased risk for infection. Staff may not have known to empty the urinary collection bad which could have caused output to back up into the bladder and caused an infection. During an interview on 01/15/2026 at 1:45 pm, the ADMN stated responsibility for the comprehensive resident-centered care plans was multidisciplinary. She explained specific areas were addressed by identified personnel. The ADMN stated training was provided by a corporate MDS nurse upon hire, annually, and as needed. She explained monitoring for accuracy was the responsibility of each discipline involved. But overall, the DON was responsible for accuracy. The ADMN stated her expectations for accuracy of comprehensive resident-centered care plans was high because she felt the facility had a good team in place. She stated the effect on residents of failure to address care needs on the care plan was not significant. She explained the staff had physician's orders, implemented those orders and followed up on effectiveness of the orders. She stated direct care was mandated by the physician's orders which were more comprehensive. Record review of the facility policy titled Care Pans, Comprehensive Person-Centered , dated March 2022, revealed in part A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the residents highest practicable physical, mental, and psychosocial well-being; and 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to assess the resident for risk of entrapment from bed rails, review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation for 2 of 18 (Resident #3 and Resident #19) residents whose records were reviewed for the use of side rails. The facility failed to assess Resident #3 and Resident #19 for risk of entrapment from bed rails prior to installation. The facility failed to review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation of bed rails for Resident #3 and Resident #19. The facility failed to follow the manufacturers' recommendations for maintaining bed rails for Resident #3 and Resident #19.These failures could put any residents who used bed rails at risk for avoidable accidents and could cause residents or their representatives not to be aware of risks from bed rail use.Findings includedRecord review of Resident #3's electronic face sheet, dated 1/15/2026, reflected a [AGE] year-old male admitted on [DATE] and readmitted on [DATE] with diagnoses including muscle wasting and atrophy (decreased muscle mass and strength).Record review of Resident #3's quarterly MDS assessment, dated 11/24/2025, reflected a BIMS score of 10 indicating moderate cognitive impairment. Further review of the MDS reflected he was dependent on staff to roll from left to right, go from sitting to lying, and go from lying to sitting. Record review of Resident #3's care plan, reviewed on 1/14/2026, reflected no evidence that Resident #3 used bed rails. Record review of Resident #3's electronic physician orders assessed on 1/15/2026 reflected no evidence that Resident #3 had an order for bed rails.Record review of Resident #3's care plan conference report, dated 5/02/2024, 3/25/2025, 6/05/2025, & 9/30/2025, reflected no safety devices/risks.Record review of Resident #3's EMR reflected no evidence there was consent for use of bed rails, no evidence that bed rails were being inspected, and no evidence that Resident #3 had an entrapment risk assessment prior to bed rails being used.During an observation and interview on 1/14/2026 at 8:50 a.m., Resident #3 was lying in his bed watching television. Both sides of his bed had bed rails in the up position. Resident #3 stated the bed rails were to keep him in the bed. He stated he did not remember anyone telling him and risk of the bed rails.Record review of Resident #19's electronic face sheet, dated 1/15/2026, reflected an [AGE] year-old male admitted on [DATE] with diagnoses including muscle wasting and atrophy (decreased muscle mass and strength). Further review of the face sheet reflected that Resident #19 was his own responsible party.Record review of Resident #19's quarterly MDS assessment, dated 11/07/2025, reflected a BIMS score of 6 meaning severe cognitive impairment. Further review of the MDS reflected he required supervision to roll from left to right, go from sitting to lying, and go from lying to sitting.Record review of Resident #19's care plan, reviewed on 1/14/2026, reflected no evidence that bed rails were included in care plan prior to 1/14/2026. Further review of care plan reflected Resident #19 should be re-evaluated quarterly and as needed for continued appropriateness of handrails to assist in bed mobility.Record review of Resident #19's electronic physician orders assessed on 1/15/2026 reflected no evidence that Resident #19 had an order for bed rails.Record review of Resident #19's care plan conference report, dated 7/30/2025, 11/11/2025, & 11/18/2025, reflected no safety devices/risks.Record review of Resident #19's EMR reflected no evidence there was consent for use of bed rails, no evidence that bed rails were being inspected, and no evidence that Resident #19 had an entrapment risk assessment prior to bed rails being used.During an observation on 1/15/2026 at 8:55 a.m., Resident #19 was lying in bed. There was a bed rail in the raised position to the left of his bed.During an interview on 1/15/2026 at 10:35 a.m., Resident #19 stated he did not mind the rails being on his bed. He stated he did not remember anyone ever telling him about the risks of having the rails on his bed.During an interview on<br>(continued on next page) |

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| | 675572 | A. Building<br>B. Wing | 01/15/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Glen Rose Nursing and Rehab Center | 1019 Holden St<br>Glen Rose, TX 76043 |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 1/15/2026 at 9:15 a.m., LVN A stated Resident #3 needed a lot of assistance for bed mobility. She stated Resident #3 could grab the bed rail to help staff when turning him in the bed. She stated Resident #19 used bed rails to get out of bed. She stated she did not get consents signed on bed rails. She stated she would get consent when a new order was placed into the resident's chart for new medications requiring consent but had never been told to get consent on bed rails. She stated she did not know where consent for bed rails would have been stored. She stated paperwork that needed to be scanned into the chart would have been placed in a wire basket behind the nurses' station for medical records to upload them.During an interview on 1/15/2026 at 9:21 a.m., CNA B stated Resident #3 used the bed rail during bed mobility with staff present. She stated he was able to move around in bed with the rails in place. She stated Resident #19 used the rails to help with exiting the bed.During an interview on 1/15/2026 at 9:31 a.m., Med Rec stated if there was any consent for bed rails, it would have been in the documents section in EMR. He stated he would have scanned documents into the EMR, and no documents were waiting to be uploaded for Resident #3 or Resident #19.During an interview on 1/15/2026 at 9:34 a.m., Maint D stated he did put on the bed rails but did not have a schedule to go back and assess the bed rails unless he was told that they had issues. He stated he did not perform inspections of bed rails or perform any entrapment risk assessments. He stated the nurses and CNAs would have let him know of issues by documenting them in the maintenance binder behind the nurses' station.During an interview on 1/15/2026 at 9:48 a.m., the DOR stated Resident #3 was on physical, occupational and speech therapy services that he used the bed rails to roll and sit up. She stated Resident #19 was on occupational therapy because he had a fall. She stated Resident #19 used bed rails to get out of bed. She stated the therapy department would have assessed that staff were using bed rails for mobility. She stated she had not performed any entrapment risk assessment or education residents or their representatives of risks of using the bed rails. She stated during care plan meetings, she would discuss whether the bed rails were still appropriate for mobility.During an interview on 1/15/2026 at 1:00 p.m., the ADMN stated the initial observation for bed rails would have been done by the nurses or therapy services within 72 hours of bed rail use. She stated therapy was involved in all care plan meetings and the resident's capabilities would have been discussed during the care plan meetings quarterly to make sure there were no changes needed. She stated the residents, and their families were involved in those care plan meetings. She stated she did not know if there was an assessment for entrapment risk when utilizing bed rails. She stated the beds were ordered and bed rails would have come in the package with the bed. She stated the bed rails were made specifically for the bed. She stated she believed that rails used were enablers and did not need alternative treatments, informed consents, or physician orders prior to being installed. She stated that if any of the rails were deemed as a restraint, then an assessment would be done to determine the justification of the bed rail, and a consent would have been obtained. She stated the DOR would review the equipment needs, benefits, and/or risks during the care plan meetings. The ADMN could not give date of when Resident #3 or Resident #19 had bed rails initiated. She stated she did not sit in on every care plan but that the facility utilized a checklist of things that were discussed during the care plan meetings and that checklist could be where risks would be documented. She stated she expected the facility's policy to be followed on bed rails but had not considered enable bars bed rails. She stated the effect of not performing entrapment risk assessments on residents with bed rails installed potentially could have led to an injury of the resident. Review of facility policy titled Bed Safety and Bed Rails, revised on August 2022, reflected For the purpose of this policy bed rails include: a. side rails; b. safety rails; and c. grab/assist bars.3. The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for us of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. 4. Prior to the installation or use of a side or bed rail, alternatives to the use of side or bed rails are attempted. Alternatives may include: a. roll guards; b. foam bumpers; c. lowering the bed; and/or d. use of concave mattresses to reduce rolling<br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | off the bed. 5. If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails. This interdisciplinary evaluation includes: a. an evaluation of the alternatives to bed rails that were attempted and how these alternatives failed to meet the resident's needs; b. the resident's risk associated with the use of bed rails; c. input from the resident and/or representative; and d. consultation with the attending physician. 6. The resident assessment to determine risk of entrapment.7. The resident assessment also determines potential risks to the resident associated with the use of bed rails, including the following: a. Accident hazards; (1) The resident could attempt to climb over, around, between, or through the rails, or over the foot board; and/or (2) A resident or part of his/her body could be caught between rails, the openings of the rails, or between the bed rails and mattress. b. Restricted mobility:.c. Psychosocial outcomes:.8. Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent: a. The assessed medical needs that will be addressed with the use of bed rails; b. The resident's risks from the use of bed rails and how these will be mitigated; c. The alternatives that were attempted but failed to [NAME] the resident's needs; and d. The alternatives that were considered but not attempted and the reasons.Review of the instructions for use service manual of The Liberty Bed, dated May 2015, reflected The guidelines set forth by the FDA Guidance layout specific dimensional limitations on potentially injury-threatening gaps and spaces that can occur between bed system components, such as rails, when not properly installed.recommended maintenance every 6 months inspect all fasteners for wear and looseness.optional half rail installation.WARNING: When assessing the Risk of Entrapment, consider the bed, mattress, headboard, footboard, assist devices (i.e. rails and assist bars) and other accessories as an entire system.Review of the owner's manual of 1000-Flex bed, no date, reflected Visually inspect bed and accessories for broken welds or cracks, and check for loose hardware on a monthly basis. |

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| F 0577<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.<br><br>Based on observation, record review and interview, the facility failed to have reports with respect to last 3 surveys, certifications and investigations made respecting the facility and any plan of correction in effect with respect to the facility available for any individual to review upon request for 3 of 3 days (01.13.2026, 01.14.2026, 01.15.2026). The facility failed to have surveys and investigation reports with the plan of corrections available for family members and residents (11.16.2025, 12.22.2025 and 12.26.2025) [JW1] to review. This failure could affect residents who resided in the facility and could result in a lack of awareness of the investigation results and the plan of corrections by visitors, family and residents.The findings included: During an observation on 01.15.2026 at 10:55 a.m. the survey results binder was observed in a file holder outside the door to the administrative offices. The survey results binder only contained the last re-certification results date 10.10.2024. The survey results binder did not contain the results for last 3 surveys or for the last investigation surveys dated 11.16.2025, 12.22.2025 and 12.26.2025. During an interview on 11.15.2026 at 11:40 a.m. the ADM stated she thought only the last full book survey results should have been kept in the survey results book. The ADM stated not having the investigation survey results in the survey book would have meant anyone wanting to look would not have all the information. The ADM stated this failure occurred due to her not knowing the investigation surveys results should have been in the book. The ADM stated she was responsible for ensuring the survey results book was kept up to date. The ADM stated the facility did not have a policy regarding the posting of survey results. |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>Based on interviews and record reviews, the facility failed to ensure nursing staffing information was posted in a prominent place readily accessible to resident and visitors that included: the census, the total number and the actual hours worked by the registered nurses, licensed practical nurses or licensed vocational nurses and certified nurse aides directly responsible for resident care per shift on 1 of 3 days (01.15.2025) reviewed for required postings. The facility failed to ensure the daily staffing information for licensed and unlicensed nursing staff was posted in a prominent location on 01.15.2026 with the census, the total number and the actual hours worked by the registered nurses, licensed practical nurses or licensed vocation nurses and certified aides directly responsible for resident care per shift. This failure could place residents, their families and visitors at risk of not knowing how many nursing staff were currently working and the total number of hours were to be worked by nursing staff to provide care on all shifts.Findings included: During an observation on 11.15.2026 at 11:04 a.m. the daily nursing staffing was located on 1 of 4 units in the nurse's station. The form did not have the daily census, the total number and the actual hours worked for the Registered Nurse, the LVN's or the CNAs. The daily nursing staffing was not posted on any of the other 3 units in the facility. During an interview on 01.15.2026 at 11:40 AM the DON stated the daily staffing should have the total number of hours an RNorking that day, the total number of hours LVNS were working that day and the total number of hours CNAs were working that day as well as how many of each discipline are working. The DON stated this information should have been available to anyone who wanted to see it. The DON stated the public might view this as how it could affect care. The DON stated the staffing coordinator was responsible for ensuring the daily staffing was posted. The DON stated she was responsible for monitoring this task. The DON stated this failure may have occurred due to switching computer systems. During an interview on 01.15.2026 at 11:45 a.m. the ADMN stated her expectations were that the daily nursing staffing be posted each day on the table in the front lobby and on each unit. The ADMN stated not having the daily nursing staffing posted would have kept the residents and visitors from knowing how many staff were working that day. The ADMN stated she did not know how this failure occurred. The ADMN stated the facility did not have a policy regarding the posting of the daily nursing staff. |