STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675645	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesa Springs Healthcare Center	7171 Buffalo Gap Rd Abilene, TX 79606

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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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to follow guidelines for mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS, for 1 of 1 (FY Quarter 4 2025) reviewed for Staffing Data Report. The facility failed to submit staffing information to CMS for FY Quarter 4 2025 (October 1- December 31). The facility's failure could place residents at risk for personal needs not being identified and met, decreased quality of care, decline in health status, and decreased feelings of well-being within their living environment. The findings included: Review of the facility's Staffing Data Report for FY Quarter 4 2025 (October 1- December 31) reflected the facility triggered for Failed to Submit Data for the Quarter. Review of the facility's PBJ nurse staffing levels for October 1 - December 31, 2025 reflected there were 3 hours and 28 minutes HRD on all days for total nurse hours; there were 34 minutes HRD on all days for RN hours; there were 52 minutes HRD on all days for LVN hours; there were 2 hours and 3 minutes HRD on all days for nurse aide hours; there were 13 minutes HRD on all days for PT hours; there were 2 hours and 59 minutes HRD on weekend for total nurse hours; there were 30 minutes HRD on weekend for RN hours. During an interview on 03/19/2026 at 8:22 a.m., the ADMN stated her expectation was for the facility to follow CMS guidelines for submitting PBJ. She stated the facility had upgraded the facility's payroll vendor system in January and February of 2026, and there was an unanticipated increased length of time for the Facility to review and validate the information to be submitted. She stated the PBJ was submitted on February 13th after 5:00 p.m. by that payroll vendor system, but there was an error code that was not identified by the contracted service submission on the PBJ file. She stated the contracted service did not discover the issue until the submission error occurred, and extensive investigation identified the coding error several days past the submission deadline preventing resubmission. She stated she would provide the facility's data that would make the facility in compliance with sufficient staff guidelines. She stated she felt the facility followed the requirement and there was no negative impact to the residents from the data not being accepted on February 13th, 2026.Record review of facility document titled Process Improvement Plan: F851 - Payroll-Based Journal (PBJ) Staffing Data Submission, no date, reflected: Problem Statement CMS PBJ audits and CASPER reports have indicated opportunities for improvement related to one or more of the following: The Facility's PBJ file failed to submit successfully before the submission deadline due to an inadvertent coding error following a system upgrade, causing CMS to reject the entire file. This issue places the facility at risk for noncompliance with F851, resulting in deficiency citations, public reporting impacts, and potential enforcement consequences.Interventions: Standardize PBJ Submission Workflow 1. Contracted service provider will provide preliminary PBJ report to Facility to review and validate within 14 days prior to CMS submission deadline. 2. Facility will review and validate preliminary report. 3. Contracted service provider will submit PBJ report 10 days prior to submission deadline to allow for unforeseen errors and provide opportunity for Facility to correct and (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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	resubmit. 4. Contracted service will provide the validation of successful submission receipt to the facility.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice for 3 (Resident #19, Resident#24 and Resident#31) of 12 residents reviewed for quality of care.The facility failed to ensure Resident #19 and #24's nasal canula was properly stored while oxygen was not in use on 03/17/2026.The facility failed to ensure Resident #31's nebulizer mask was properly stored while not in use on 03/17/2026. These failures could place residents on oxygen therapy at risk of receiving incorrect or inadequate oxygen support and decline in health.The findings include:1. Record review of Resident #19's admission Record dated 03/18/2026 revealed a [AGE] year-old female admitted on [DATE].Record review of Resident #19's History and Physical dated 11/25/2025 revealed resident had a diagnosis of hypoxic respiratory failure (a life threating condition where the lungs cannot adequately transfer oxygen to the blood, resulting in low blood oxygen levels). requiring supplemental oxygen via nasal canula.Record review of Resident # 19's Comprehensive MDS assessment dated [DATE] revealed a BIMS score of 13 indicating intact cognitive function. Section O indicated the use of respiratory treatments to include oxygen therapy.Record review of Resident #19's physician orders revealed an order for oxygen 2-4 liters per minute via nasal canula to keep oxygen greater than 90 percent. The order had a start date of 11/12/2025.Record review of Resident #19's care plan revised on 01/14/2026 revealed Resident #19 had oxygen therapy related to ineffective gas exchange (the lungs cannot properly swap oxygen for carbon dioxide), hypoxemia(low levels of oxygen in the blood) and pleural effusion (excessive accumulation of fluid in the lungs). Interventions included providing an extension tubing or portable oxygen apparatus and administering continuous oxygen at 2-4 liters per minute.Record review of Resident #24's admission Record dated 03/18/2026 revealed an [AGE] year-old female with admission date 04/18/2025, and initial admission date 07/10/2023.Record review of Resident #19's History and Physical dated 03/17/2026 revealed a medical history of Chronic Obstructive Pulmonary Disease (COPD) a progressive lung disease making it difficult to breathe).Record review of Resident #24's Quarterly MDS dated [DATE] revealed there was no BIMS completed. Section I-Active Diagnosis noted Asthma and COPD for Resident #24. Section O-Special Treatments, Procedures, and Programs noted Resident #24 was receiving oxygen therapy as a resident in the Nursing Facility. Record review of Resident #24's care plan revised on 12/14/2025 revealed Resident #24 had altered respiratory status/difficulty breathing related to diagnosis of COPD and Asthma. The interventions for staff included to provide oxygen to Resident #24 per Physician order.Record review of Resident #24's Order Summary Report dated 03/18/2026 revealed the physician order of oxygen administration at 2 Liters per minute via nasal cannula, continuous.2. Record review of Resident #31's admission Record dated 03/18/2026 revealed an [AGE] year-old female with admission date 10/06/2025 and initial admission date 06/15/2023.Record review of Resident #31's Quarterly MDS revealed the BIMS was not completed. Section I- Active Diagnoses noted Resident #24 with Asthma or COPD, and Respiratory Failure .Record review of Resident #31's History and Physical dated 03/18/2026 revealed a medical history of Asthma and COPD.Record review of Resident #31's Care plan revised on 03/11/2025 revealed Resident #31 had altered respiratory status/difficulty breathing related to Asthma. The staff interventions included to administer Budesonide (a steroid medication used to prevent Asthma symptoms and making it easier to breathe) per physician's order.Record review of Resident #31's Order Summary Report dated 03/18/2026 revealed Physician order: Budesonide Inhalation Suspension 0.5 MG/2 ML Inhale 2 ML by mouth two times a day for Asthma and COPD.An observation on 03/17/2026 at 09:08 AM in Resident #24's room revealed an empty room with a nasal cannula that was left open to air and on the floor.An observation and interview on 03/17/2026 at 09:12 AM of Resident #31's nebulizer mask on her nightstand revealed it was open to air and uncovered. Resident #31 stated she had Asthma and had (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nebulizer treatments every morning and night. She stated that the staff administered her medication with the nebulizer mask that morning. She stated that it was usually stored in the plastic bag. An observation on 03/17/2026 at 11:15am in Resident #19's room revealed an empty room with a nasal canula left on the bed.An interview on 03/19/2026 at 10:57 a.m., with CNA H revealed nasal cannulas and nebulizer masks should be stored in plastic bags when not in use to prevent contamination. She stated that it was all staff's responsibility to ensure the nasal cannulas and nebulizer masks were stored properly when not in use. She stated the risk of not storing oxygen supplies properly would be the possibility of infection. She stated she could not recall the last in-service over nasal canula and nebulizer mask storage.An interview on 3/19/2026 at 11:35 a.m., with RN I revealed nasal cannulas and nebulizer masks needed to be stored in a bag, when not in use, to prevent contamination. He stated nasal cannulas and nebulizer masks were to be discarded if not stored properly, and there was always a potential risk to the resident if they were to use a contaminated nasal canula or nebulizer mask due to their age and co-morbidities. An interview on 03/19/2026 at 1:29 p.m., with the DON revealed oxygen tubing and masks were to be stored in a bag when not in use. She stated not storing them in bags was an infection control issue that could potentially pose a risk to the resident's health. She stated all staff were responsible for ensuring nasal cannulas and nebulizer masks were stored properly when not in use.Review of the facility's undated policy titled Oxygen Administration did not address storage of oxygen tubing or nebulizer masks when not in use.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to review the risks and benefits of bed rails with the resident or a resident representative and obtain informed consent prior to installation for 3 of 5 residents (Resident #2, Resident #3, and Resident #6) reviewed for bed rail consents. 1. The facility failed to obtain informed consent, or maintain evidence that, Resident #2 and Resident #3 or their representative had been provided with sufficient information so that they could make an informed decision prior to installing bed rails.2. The facility failed to obtain informed consent from Resident #6 when bed rails were installed on his bed. Informed consent was obtained 17 days after bed rail safety evaluation was performed and 23 days after physician order was obtained. This failure could place residents at risk of not being able to make an informed decision due to not having sufficient information on the risks of bed rail usage.Findings included:1. Record review of Resident #2's electronic face sheet, dated 03/18/2026, reflected an [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnosis including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (left sided weakness or immobility following a stroke), and muscle weakness, Record review of Resident #2's quarterly MDS assessment, dated 03/04/2026, reflected a BIMS score of 14 indicating she was cognitively intact. Further review reflected Resident #2 required a helper to do more than half of the effort for bed mobility and transferring from the bed to a chair. And bed rail was not used as a physical restraint.Record review of Resident #2's comprehensive care plan reviewed on 03/17/2026 reflected no evidence that Resident #3 utilized a bed rail.Record review of Resident #2's electronic physician orders on 03/17/2026 reflected no evidence the physician had ordered the bed rail.Record review of Resident #2's electronic medical record reflected a Bed Rail Safety Evaluation, dated 03/11/2026, for bed side rails that reflected IDT Recommendation: Bed rail recommended. Proceed to resident education re: risks and benefits and confirm informed consent has been obtained prior to installation of bedrail. During an observation and interview on 03/17/2026 at 11:04 a.m., Resident #2 was lying in her bed in her room. The bed had quarter rails to both sides. Resident #2 stated she used the rails to help with turning in the bed. She stated she wanted to continue to have the rails on her bed. She could not state the risks of having the rails on the bed. During an interview on 03/18/2026 at 4:25 p.m., RN C stated she worked in the facility since August of 2025. She stated she was not sure when Resident #2 had bed rails placed on her bed, but thought that they had been present since she had been taking care of Resident #2. She stated it was the nurse's responsibility to obtain orders for bed rails and to obtain a consent for bed rails prior to bed rails being placed on the beds. She stated she did not know who would be responsible for obtaining the consent or order for Resident #2 because she did not initiate the bed rails being placed. She stated Resident #2 used the rails to help with turning in the bed and the rails were not to restrict Resident #2 in anyway. During an interview on 03/18/2026 at 4:28 p.m., CNA D stated Resident #2 required two people to help with bed mobility. She stated she did not know how long Resident #2 had bed rails on her bed. She stated the rails were used when the resident was turning in the bed and were not to restrict Resident #2's mobility in any way. During an interview on 03/18/2026 at 4:40 p.m., LVN E stated she had done an audit for residents with bed rails on 03/11/2026 and had performed the bed rail safety evaluation for Resident #2. She stated there should be a physician order for the bed rails and a consent for the bed rails. She stated she was unsure why there was no physician order for the bed rails or no consent for the bed rails. She stated those must have been missed during the audit. Record review of Resident #3's electronic face sheet, dated 03/18/2026, reflected an [AGE] year-old female who was admitted on [DATE] with diagnoses including dementia (loss of memory, thinking, and reasoning skills), muscle weakness, need for (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assistance with personal care, and unsteadiness on feet.Record review of Resident #3's quarterly MDS assessment, dated 01/26/2026, reflected a BIMS score of 0 indicating severe cognitive impairment. Further review reflected Resident #3 required helper to do less than half the effort for bed mobility and was dependent on helper for transferring from bed to chair. And bed rail was not used as a physical restraint.Record review of Resident #3's comprehensive care plan reviewed on 03/17/2026 reflected no evidence that Resident #3 utilized a bed rail.Record review of Resident #3's electronic physician orders on 03/17/2026 reflected no evidence the physician had ordered the bed rail.Record review of Resident #3's electronic medical record reflected a Bed Rail Safety Evaluation, dated 03/12/2026, for bed side rails that reflected IDT Recommendation: Bed rail recommended. Proceed to resident education re: risks and benefits and confirm informed consent has been obtained prior to installation of bedrail.During an observation on 03/17/2026 at 10:08 a.m., Resident #3 was lying in her bed with her eyes closed. There was a quarter rail on the right side of the bed. During a telephone interview on 03/18/2026 at 9:58 a.m., Resident #3's representative stated he had no concerns about the care she received at the facility. He did not know when she had bed rails placed on her bed. He could not remember if he had signed a consent for the rail to be put on her bed.2. Record review of Resident #6's electronic face sheet, dated 03/18/2026, reflected a [AGE] year-old male who was admitted on [DATE] with diagnosis including acquired absence of right leg below knee (right leg amputation below the knee).Record review of Resident #6's admission MDS assessment, dated 02/21/2026, reflected a BIMS score of 15 indicating his cognition was intact. Further review reflected Resident #6 required helper to do less than half the effort for bed mobility and required helper to do more than half of the effort for transferring from bed to chair. And bed rail was not used as a physical restraint.Record review of Resident #6's comprehensive care plan, dated 02/23/2026, Resident #6 had ADL self-care performance deficit r/t recent hospitalization, right BKA (below the knee amputation), and neuropathy (disorder of the nerves affecting feeling in extremities) with intervention SIDE RAILS: Mobility rails per MD order.Record review of Resident #6's electronic physician orders on 03/18/2026 reflected order, dated 02/19/2026, Resident #6 May use mobility bars to aide in easy turning and repositioning while in bed.Record review of Resident #6's electronic medical record reflected a Bed Rail Safety Evaluation, dated 02/24/2026, for assist bars that reflected IDT Recommendation: Bed rail recommended. Proceed to resident education re: risks and benefits and confirm informed consent has been obtained prior to installation of bedrail. Further review of medical record reflected a bed side rail consent was obtained and signed by Resident #6 on 03/14/2026 with the following possible dangers Suffocation.Bed side rail land in bed entrapment.Bed side rail and off bed entrapment.Increased potential of injury due to fall from crawling over the top of bed side rails or out the end of bed over the footboard.Each of these situations sited above have been known to cause injury or even death.During an observation and interview on 03/17/2026 at 2:30 p.m., Resident #6 was sitting in a wheelchair in his room. He had a side rail on the right side of his bed. Resident #6 stated that he used the rail to help him get out of the bed and to help him move while in the bed. During an interview on 03/19/2026 at 9:42 a.m., LVN A stated Resident #6 used the bed rail for mobility. She stated he used to help him in the bed and transfer out of the bed. She stated there should be a consent obtained when bed rail was placed on the bed, and the admissions nurse was responsible for getting informed consent. She stated the ADON monitored that the consent was obtained. During an interview on 03/19/2026 at 10:30 a.m., the DON stated the consent for mobility bars on the bed should not be obtained prior to installation. She stated the bars needed to be installed so that an assessment could be performed then the consent would be obtained if it was determined by the IDT that the bars were appropriate. She stated the nurse manager LVN E had done a bed rail sweep a week ago, and performed the safety assessments at that time, but did not look for consents or orders. She stated she was responsible for making sure consents were obtained and would pull a report on physicians' orders to do so. She stated, since some of the residents who utilized mobility bars did not have a physician order for them, she did not catch that the consent was not in their chart. She stated she (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	believed the residents and their representatives had been informed of the risks, but did not have the consent for Resident #2 or Resident #3 prior to 03/18/2026. She stated the consent should have been obtained sooner for Resident #6. She did not know when Resident #2 or Resident #3's mobility bars had been installed on their beds, but stated she did not believe they had them very long. She stated the nurses were responsible for obtaining the consent and she did not know why the consents were not obtained. She stated the facility did not use the rails to decrease mobility and they were to help residents move more.Record review of the facility's policy titled Bed Rail, no date, reflected Decisions to use or to discontinue the use of a bed rail will be made in the context of an individualized patient assessment using an interdisciplinary team with input from the Resident and/or the Residents representative. PROCEDURES: Resident Assessment 1. Residents will be assessed for the use of bed side rails upon admission, quarterly, annually and with a change of condition that may warrant the use of bed rails. 2. The Interdisciplinary Team (IDT) will review the resident's individualized patient assessment and will make recommendations for the use or to discontinue the use of bed rails. 3. Bed Rails are to be placed on bed for completion of assessment. 4. The Risk and benefits will be explained to the resident and/or their representative and informed consent will be obtained when assessment has been completed and the need for bed rails has been deemed appropriate. 5. When bed rail use has been deemed appropriate following assessment for patient's mobility and/or transferring, for example turning and positioning within the bed and providing a hand-hold for getting into or out of bed, should be accompanied by a care plan.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure each resident received, and the facility provided food and drink that was palatable, attractive, and at safe and appetizing temperatures for reviewed food and nutrition services.The facility failed to adhere to their policy for acceptable serving temperatures on 03/17/26.This failure could place residents at risk of food-borne illnesses, decreased appetite, and overall meal dissatisfaction.Findings included:In an observation on 03/17/26 at 12:10 PM, the Meal Cart for the 100-hall left the kitchen into the 100-hall. The last tray was observed to be served by staff into their room at 12:23 PM. All sample trays were tested for temperature and all meal entrees were under the serving temperature per facility policy. All trays were in transported in a meal cart with the plate covering on. On 03/17/26 at 12:25 PM, the Food Sample Trays tested at the following: Mechanical diet- 114 F Steak Fritters, 118 F [NAME] Beans, and 111 F Red Potatoes; Regular diet- 130 F Steak Fritters, 115 F [NAME] Beans, and 117 F Red Potatoes; Puree diet- 117 F Steak Fritters, 114 F Mashed Potatoes, and 113 F [NAME] Beans.In a confidential resident group meeting on 03/18/26 at 9:30 AM, 6 of 12 residents reported they were not satisfied with the meals provided by the facility. They stated the meals would be cold when received in their rooms, and the appearance was not appealing. They stated these concerns had been reported to staff before.In an interview on 03/19/26 at 9:11 AM with Dietary Aide G, she stated the [NAME] was responsible for the meal temperatures and she monitored all meal entrees twice before serving. She stated cold food and low food temperatures could cause the residents to be upset. She stated other risks of low food temperatures would include potential for illness.In an interview on 03/19/26 at 10:27 AM with the Assistant Dietary Manager, she stated she was also the [NAME] on the weekdays and as needed. She stated she was responsible for the food serving temperatures and monitored them before serving for each meal service. She stated the meal serving temperatures were to be at least 145 F. The Dietary Assistant Manager stated the risks of below serving temperatures for residents included not wanting to eat since it could be unpleasant to eat, stomach aches, or foodborne illnesses.In an interview on 03/19/26 at 10:40 AM with the Dietary Manager, she stated meal serving temperatures were to be 145F or above. She stated none of the test trays met the temperature of 145F or above for hot foods. She stated the cook was responsible for ensuring the food temperatures were 145F and above. She stated the cook monitored the temperatures before serving every meal. She stated the risks of the meal tray temperatures being below 145F included the residents being upset and complaints of their food. She stated other risks to residents included illness and bacteria, depending on the meal entrees such as meat.Record review of facility's Infection Control Policy/Procedure with no date, titled Dietary Department, read in part under Food Preparation and Serving . 3. hot foods must be kept at 140F or above.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in 1 of 1 kitchen in the facility.1.The facility failed to date a tray of covered cups of milk and fruit cups on 03/17/26.2. The facility failed to keep 2 boxes of Vanilla pudding cups off the floor in the walk-in pantry on 03/17/26.3. The facility failed to ensure the steam table was clean and free from food particles on 03/17/26.4. The facility failed to ensure cookware was properly rinsed and sanitized in adherence to professional standards for food service safety on 03/17/26.These failures could place residents at risk of food-borne illnesses.Findings include:During the brief initial kitchen interview on 03/17/26 at 8:55 AM, the following observations were made: a serving tray with multiple cups of milk covered with plastic wrapping, 3 small bowls of served fruit covered with plastic wrapping, and a cup of gelatin, located in the walk-in refrigerator, was not dated; 2 boxes of Vanilla puddings on the floor in the walk-in pantry. On 03/17/26 at 10:55 AM, the steam table was observed with food particles and brown debris in the metal compartments in the water of the steamtable.In an interview on 03/19/26 at 8:57 AM with Dietary Aide G, she stated that the [NAME] was responsible for cleaning and maintaining the cleanliness of the steamtable. She stated the Dietary Manager was responsible for monitoring the kitchen cleanliness which was done daily. She stated that the Vanilla pudding cups observed on the pantry floor on 03/17/26, was for medical, as the nursing staff used the pudding cups as needed when passing crushed medications. She stated that all staff were responsible for ensuring no food items were on the floor. She stated that the risks of food items being on the floor included contamination and possible risk of illness to residents. Dietary Aide G stated that all staff were responsible for ensuring all food items were labeled. She stated the kitchen staff preparing the tray would be responsible for ensuring it had the date its was served. She stated the Dietary Manager walked through and monitored the kitchen every morning. She stated the risk of not dating served drinks or food included the risk of mold or bacteria, causing illness. She stated dietary aides were responsible for ensuring the sanitation levels were per policy, or the cook if they were washing their cooking utensils, pots, or pans. She stated that if the sanitation levels were below policy, that would mean the dishes were not being cleaned or sanitized correctly. She stated that could place residents at risk for bacteria and illness.In an interview on 03/19/26 at 10:16 AM with the Assistant Dietary Manager, she stated the dietary aides were responsible for dating serving trays with cups and food. She stated it should have the 3-day date meaning the food and drinks on the tray were to be discarded after 3 days of being served. She stated the vanilla pudding cups were not to be on the floor. She stated the pudding cups were for the medical staff as they used the pudding cups for medication administration. She stated that all staff were responsible for ensuring and removing food items off the floor. She stated possible risks of food items on the floor included contamination such as chemical leaks, or rodents, which can cause the residents to become sick. The Assistant Dietary Manager stated the steam table was to be clean, before and after serving meals. She stated that the heat and water cause corrosion (process of gradual deteriotion of metal) causing a brown debris to be observed. She stated she did not think there was a risk to the residents of staff using the steamtable with the observed food particles as the serving trays cover the compartments. She stated that the dishwasher and the [NAME] were responsible for monitoring and confirming the sanitation levels before washing any dishes when cooking. She stated the dishwasher was not monitored for sanitation levels but was reported for issues or concerns. She stated she was not aware of any issues with the dishwasher before 03/17/26, which resulted being a leak in a hose which was repaired by Maintenance that day. She stated the risk of the dishwasher not being at the sanitation levels to residents included illness as the dishes or utensils were not sanitized correctly.In an interview on 03/19/26 at 10:31 AM with the Dietary Manager, she stated the dietary aides who prepped the trays (continued on next page)

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	675645	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with drinks and food were responsible for dating them. She stated a 3-day date of the date it was prepped was also notated on the tray, meaning after 3 days of the drinks and food was to be discarded after it was prepared. She stated she monitored the kitchen daily including trays ensuring they were dated. She stated the potential risks of not dating trays of food and drinks included spoilage and illness. The Dietary Manager stated the boxes of Vanilla puddings on the floor was not acceptable and all kitchen staff were responsible for ensuring all food items were stored off the floor and on the shelves. She said the potential risk of food items on the floor included rodents or roaches getting in the food, causing contamination. She stated the steam table was to be cleaned by the Cooks. She stated if the water from the steam table was observed with food particles or dirty, it was to be cleaned and changed. She stated the potential risk of serving food with the dirty steam table included possible contamination. She stated all staff were responsible for monitoring the dishwasher chemical levels. She stated it was checked daily before use. She stated the potential risk of the dishwasher not meeting the sanitation level was infection control since the plates and utensils were not being sanitized properly.Record review of the facility's Infection Control Policy/Procedure, with no date, read in part: Food Preparation and Serving: 1. All equipment must be cleaned and sanitized before use. It continued Storage of Food: 2. Store food above floor level and away from wall. It continued to read Equipment Care and Storage: 1. Keep all work areas, the floor and dietary equipment as clean as possible throughout the work day.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, 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 16 residents (Resident #2 and Resident #3) reviewed for care plans. The facility failed to ensure Resident #2, and Resident #3 had a care plan in place for bed rails. This failure could affect residents by placing them at risk of not receiving individualized care and services to meet their needs.Findings included:1. Record review of Resident #2's electronic face sheet, dated 03/18/2026, reflected an [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnosis including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (left sided weakness or immobility following a stroke), and muscle weakness, Record review of Resident #2's quarterly MDS assessment, dated 03/04/2026, reflected a BIMS score of 14 indicating her cognition was intact. Further review reflected Resident #2 required a helper to do more than half of the effort for bed mobility and transferring from the bed to a chair. Bed rails were not identified as being used as a physical restraint.Record review of Resident #2's comprehensive care plan reviewed on 03/17/2026 reflected no evidence that Resident #3 utilized a bed rail.Record review of Resident #2's electronic physician orders on 03/17/2026 reflected no evidence the physician had ordered the bed rail.Record review of Resident #2's electronic medical record reflected a Bed Rail Safety Evaluation, dated 03/11/2026, for bed side rails that reflected IDT Recommendation: Bed rail recommended. Proceed to resident education re: risks and benefits and confirm informed consent has been obtained prior to installation of bedrail. During an observation and interview on 03/17/2026 at 11:04 a.m., Resident #2 was lying in her bed in her room. The bed had quarter rails to both sides. Resident #2 stated she used the rails to help with turning in the bed. She stated she wanted to continue to have the rails on her bed.2. Record review of Resident #3's electronic face sheet, dated 03/18/2026, reflected an [AGE] year-old female who was admitted on [DATE] with diagnoses including dementia (loss of memory, thinking, and reasoning skills), muscle weakness, need for assistance with personal care, and unsteadiness on feet.Record review of Resident #3's quarterly MDS assessment, dated 01/26/2026, reflected a BIMS score of 0 indicating severe cognitive impairment. Further review reflected Resident #3 required helper to do less than half the effort for bed mobility and was dependent on helper for transferring from bed to chair. And bed rail was not used as a physical restraint.Record review of Resident #3's comprehensive care plan reviewed on 03/17/2026 reflected no evidence that Resident #3 utilized a bed rail.Record review of Resident #3's electronic physician orders on 03/17/2026 reflected no evidence the physician had ordered the bed rail.Record review of Resident #3's electronic medical record reflected a Bed Rail Safety Evaluation, dated 03/12/2026, for bed side rails that reflected IDT Recommendation: Bed rail recommended. Proceed to resident education re: risks and benefits and confirm informed consent has been obtained prior to installation of bedrail.During an observation on 03/17/2026 at 10:08 a.m., Resident #3 was lying in her bed with her eyes closed. There was a quarter rail on the right side of the bed. During a telephone interview on 03/18/2026 at 9:58 a.m., Resident #3's representative stated he had no concerns about the care she received at the facility.During an interview on 03/18/2026 at 4:25 p.m., RN C stated she had worked in the facility since August of 2025. She stated she was not sure when Resident #2 had bed rails placed on her bed but thought that they had been present since she had been taking care of Resident #2. She stated she did look at care plans, but did not update the care plan. She stated she did not know for sure but thought the ADON and the DON updated the care plans. She stated not having an intervention in the care plan may cause direct care staff, including herself, from knowing the resident utilized bed rails, but she mostly looked in physician orders to see (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	what care was needed. During an interview on 03/19/2026 at 9:42 a.m., LVN A stated Resident #6 used the bed rail for mobility. She stated he used to help him in the bed and transfer out of the bed. She stated bed rails should be on the care plan, but she mainly looked at physician orders to see what care the resident needed. She stated the ADON and the DON were responsible for updating care plans. During an interview on 03/19/2026 at 10:30 a.m., the DON stated bed rails should be included on residents' care plans. She stated care plans were updated by the IDT members during the morning management meetings for new orders and the weekly management meetings for existing orders. She stated the management would pull physician orders to review the needs of the residents, and not having a physician order may have been how the bed rails were not added to the care plans. She stated care plans should reflect the care for residents, and the nursing staff could review to see the residents care needs. She did not state a negative effect for the residents from the mobility bed bars not being listed on the care plan. She stated the bars were used to increase mobility and that was why they were not coded as a restraint on the MDS assessment. Record review of the facility's undated policy titled Bed Rail, reflected When bed rail use has been deemed appropriate following assessment for patient's mobility and/or transferring, for example turning and positioning within the bed and providing a hand-hold for getting into or out of bed, should be accompanied by a care plan. Record review of the facility's policy titled Comprehensive Person-Centered Care Planning, dated December 2023, reflected It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.6. The resident's comprehensive plan of care will be reviewed and/or revised by the IDT after each assessment, including both the comprehensive and quarterly review assessments. 7. The facility IDT includes, but is not limited to the following professionals: A. Attending Physician or Non-Physician Practitioner (NPP) designee involved in resident's care; B. Registered Nurse with responsibility for the resident; C. Nurse Aide with responsibility for the resident; D. Member of the Food and Nutrition services staff; E. To the extent practicable, resident and/or resident representative; d F. Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

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F 0943 Level of Harm - Potential for minimal harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. Based on interviews and record reviews, the facility failed to provide training to their staff that at a minimum educates staff on dementia management for all new and existing staff for 1 of 18 (CNA F) staff reviewed for dementia management. The facility failed to ensure CNA F was educated on dementia management upon hire. This failure could place residents with dementia diagnosis at risk of being inappropriately cared for by uninformed staff. Findings included:Record review of personnel record for CNA F reflected a hire date of 12/30/2025. Further review of personnel record provided by HR reflected CNA F had no evidence she had completed the dementia management training upon hire or while working at the facility. During an interview on 03/19/2026 at 1:13 p.m., the ADMN stated her expectation would be for staff to have appropriate training per regulations. She stated the facility did not have a training policy and went by regulations for staff orientation and annual training. She stated she was sure she had done an in-service on the training but could not find one with CNA F's signature on it. She stated the facility utilized CBT program for training as well and that showed no evidence that CNA F had completed training for dementia management. She stated staff should have all appropriate training and did not know why CNA F had not completed the CBT. She stated she was responsible for making sure all staff were trained and stated training was to inform staff about dementia management. She confirmed that HR monitored staff training as well but she was ultimately responsible for staff being trained. She stated she had no concerns with how CNA F provided resident care since her hire date.During an interview on 03/19/2026 at 2:10 p.m., HR stated she was responsible for making sure facility staff were trained on the CBT program. She stated she was new to her position and that may have led to her not noticing CNA F did not complete the dementia care training. She stated that at the end of the year, the program would drop all of the trainings that had not been completed and that could be why she missed the training. She confirmed she had no evidence that CNA F had training on dementia care. She stated there was no evidence CNA F had completed the training before her hire date of 12/30/2025 because she had quit and was rehired, so CNA F had the training in the past. She stated she was learning how to ensure staff had all required training. Record review of facility's Facility Assessment, dated 2025, reflected Resident Population Profile.Common Diagnoses and Conditions.Alzheimer's disease (a type of dementia that causes memory, thinking, and behavioral issues).Staff training/ education and competencies Our facility makes a good faith effort to provide the staff training/education and competencies necessary to provide the level and types of support and care needed for our resident population.Our facility has identified the following training topics that may be utilized by our staff including.direct care staff.Abuse, neglect, and exploitation: training that, at a minimum, educates staff regarding: Care/management for persons with dementia and resident abuse prevention.Required in-service training for nurse aides. In-service training must: Include dementia management training and resident abuse prevention training.A list of training and competency resources are available in the [CBT program] to provide just-in-time training for various care and assessment activities as well as competency validation.

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F 0944 Level of Harm - Potential for minimal harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on interviews and record review, the facility failed to include as part of its QAPI program mandatory training that outlines and informs staff on the elements and goals of the facility QAPI program for all new and existing staff for 1 of 18 (CNA F) staff reviewed for training on QAPI. The facility failed to ensure CNA F was educated on the facility's QAPI program upon hire. This failure could place residents at risk of their quality of care not being improved upon when a known issue had occurred from staff not being informed on the goals and various elements of the QAPI program.Findings included:Record review of personnel record for CNA F reflected a hire date of 12/30/2025. Further review of personnel record provided by the HR reflected CNA F had no evidence she had completed QAPI training upon hire or while working at the facility. During an interview on 03/19/2026 at 1:13 p.m., the ADMN stated her expectation would be for staff to have appropriate training per regulations. She stated the facility did not have a training policy and went by regulations for staff orientation and annual training. She stated she was sure she had done an in-service on the training but could not find one with CNA F's signature on it. She stated the facility utilized CBT program for training as well and that showed no evidence that CNA F had completed training for QAPI. She stated staff should have all appropriate training and did not know why CNA F had not completed the CBT. She stated she was responsible for making sure all staff were trained and stated training was to inform staff about the QAPI program. She confirmed that HR monitored staff training as well but she was ultimately responsible for staff being trained. She stated she had no concerns with how CNA F provided resident care since her hire date.During an interview on 03/19/2026 at 2:10 p.m., the HR stated she was responsible for making sure facility staff were trained on the CBT program. She stated she was new to her position and that may have led to her not noticing CNA F did not complete the QAPI training. She stated that at the end of the year, the program would drop all of the trainings that had not been completed and that could be why she missed the training. She confirmed she had no evidence that CNA F had training on QAPI. She stated there was no evidence CNA F had completed the training before her hire date of 12/30/2025 due to she had quit and was rehired, so CNA F had the training in the past. She stated she was learning how to ensure staff had all required training. Record review of facility's Facility Assessment, dated 2025, reflected Our facility has identified the following training topics that may be utilized by our staff including.direct care staff.Quality Assurance Performance Improvement (QAPI).A list of training and competency resources are available in the [CBT program] to provide just-in-time training for various care and assessment activities as well as competency validation.

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F 0946 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide training in compliance and ethics. Based on interviews and record reviews, the facility failed to include as part of its compliance and ethics program (1) an effective way to communicate the program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program; (2) annual training if the operating organization operates 5 or more facilities for all new and existing staff for 1 of 18 (CNA F) reviewed for training on compliance and ethics.The facility failed to ensure that CNA F was educated on compliance and ethics upon hire.This failure could affect residents and place them at risk of being uninformed of compliance and ethics program due to lack of staff training.Findings included:Record review of personnel record for CNA F reflected a hire date of 12/30/2025. Further review of personnel record provided by the HR reflected CNA F had no evidence she had completed compliance and ethics training upon hire or while working at the facility. During an interview on 03/19/2026 at 1:13 p.m., the ADMN stated her expectation would be for staff to have appropriate training per regulations. She stated the facility did not have a training policy and went by regulations for staff orientation and annual training. She stated she was sure she had done an in-service on the training but could not find one with CNA F's signature on it. She stated the facility utilized CBT program for training as well and that showed no evidence that CNA F had completed training for compliance and ethics. She stated staff should have all appropriate training and did not know why CNA F had not completed the CBT. She stated she was responsible for making sure all staff were trained and stated training was to inform staff about compliance and ethics for organizations who operate five or more facilities. She stated her organization operated more than five facilities and that compliance and ethics was appropriate for the facility's staff. She confirmed that HR monitored staff training as well but she was ultimately responsible for staff being trained.During an interview on 03/19/2026 at 2:10 p.m., the HR stated she was responsible for making sure facility staff were trained on the CBT program. She stated she was new to her position and that may have led to her not noticing CNA F did not complete the compliance and ethics training. She stated that at the end of the year, the program would drop all of the trainings that had not been completed and that could be why she missed the training. She confirmed she had no evidence that CNA F had training on compliance and ethics. She stated she was learning how to ensure staff had all required training. Record review of facility's Facility Assessment, dated 2025, reflected Our facility has identified the following training topics that may be utilized by our staff including.direct care staff. There was no mention of compliance and ethics training.