STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675723	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nazareth Living Care Center	1475 Raynolds St El Paso, TX 79903

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents were provided services with reasonable accommodation of needs and preferences for _3 of 18_ residents (Resident #1, #4, and #48) reviewed for call lights. The facility failed to ensure resident call lights were within reach for Residents #1, #4, and #48 on 01/06/2026. This failure placed residents at risk of having their needs unmet when they are unable to contact staff. Findings included: Record review of Resident # 1's admission Record dated 01/07/2026 revealed an [AGE] year-old male initially admitted [DATE] and readmitted on [DATE]. Record review of Resident #1's History and Physical dated 01/07/2026 revealed Resident #1 diagnosis of cerebral infarction (the death of brain tissue due to a lack of blood flow). Record review of Resident #1's Quarterly MDS dated [DATE] revealed a BIMS score of 00 indicating severe cognitive impairment. Section GG indicated resident was dependent meaning helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete activities such as activities of daily living. Record review of Resident #1's Care Plan revised on 04/15/2025 revealed Resident #1 had self-care deficits. Interventions included ensuring call light was within reach and answering in a timely manner. Record review of Resident #4's admission Record dated 01/06/2026 revealed an [AGE] year-old male with initial admission date 10/25/2022, and re-admission date 01/05/2026. Record review of Resident #4's Quarterly MDS dated [DATE] revealed no BIMS score. As noted, Resident #4 was rarely/never understood. Section GG- Functional Abilities indicated Resident #4 was dependent with his ADL's, including grooming, hygiene, and transfers. Record review of #4's History and Physical dated 01/07/2026, revealed a medical history of Parkinson's disease (a disease that affects the nervous system which causes tremors or shakiness, muscle stiffness, unstable posture, difficulty walking, and slowed body movements), dysphagia (difficulty swallowing), and Gastrostomy status (meaning resident had a gastrostomy tube or G-tube, which is surgically placed to provide direct access to the stomach for nutrition, hydration, and medication). Record review of #4's Care Plan revised 04/28/2025, revealed resident was at risk for falls and intervention included for staff to be sure to leave the call light within resident's reach. Record review of resident #48's admission Record dated 01/07/2026 revealed a [AGE] year-old female with an original admission date of 10/21/2025 and readmission date on 01/06/2026. Record review of resident #48's MDS record dated 12/5/2025 revealed a medical diagnosis of dehydration, hip fracture, and a urinary tract infection (within the last 30 days). Resident #48 BIMS was a 3 meaning severe cognitive impairment, and was coded as dependent, substantial/maximal, partial/moderate assistance for ADLs and mobility. Record review of resident #48's care plan dated 11/06/2025 revealed the resident's care plan had focus on fall risk with an intervention of encourage resident to ask for assistance and ADL deficits addressed eating with total dependent with 1 person staff assist. Record review of resident #48's physical and health (no date) revealed the resident had a medical history of dementia, seizure disorder, intracranial (brain) bleed with left hemiparesis (weakness to the entire side of the body), cervical cancer, stage IV sacral ulcer, and previously had a nephrostomy tube (a tube that connects to the kidneys and drains urine). An observation and interview on 01/06/2026 at (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9:44 a.m., of Resident #1 in his room, Resident was lying in bed and call light was on the floor next to the bed, out of the reach of the resident. Resident #1 was unable to answer the surveyor's questions. An observation and interview on 01/06/2026 at 9:31 AM of Resident #4 in his room, call light was observed behind the headboard's left side, and out of the resident's reach. Resident #4 was unable to answer the surveyor's questions. Interview conducted on 01/06/2026 at 1:49 PM, Resident #48 stated she did not use the call light and was unable to explain why she did not use the call light. An observation and interview on 01/07/2026 at 12:39 PM revealed Resident #48 was in an upright position slouching to her right side with the call light tucked underneath the pillow on the resident's left side that was affected by her hemiparesis. Resident #48 asked the surveyor to lower the bed and appeared distressed; surveyor notified CNA B who arrived and aided Resident #48 at 12:40 PM. In an interview conducted on 01/07/2026 at 1:44 PM, CNA B stated Resident #48 was seated in bed leaning to her right and had food across her chest, chin, and mouth. She stated that Resident #48 has limited coordination with her right side and no function on her left side. She stated the Resident #48 never used the call light and would always scream to get staffs attention. She stated that the call light was used for residents to notify the staff of needs. She stated the call light was within reach for Resident #48 despite it being on her left side and the resident leaning on her right side. She stated that a resident without access to their call light could be left screaming for assistance. She stated it was not okay for residents to be screaming for assistance because they could feel forgotten. In an interview conducted on 01/07/2026 at 2:28 PM with LVN C who stated the call light was a form of communication for residents to receive assistance. He stated that the call light should be placed within reach of the resident and added for residents with limited range of motion/function the call light should be placed on the resident's dominant side. He stated that a resident who didn't have access to their call light hinders communication to staff. He identified nurses, CNAs, and department heads during angel rounds as individuals responsible for repositioning call lights. He stated a resident could feel unheard if they did not have access to their call light. In an interview conducted on 01/07/2026 at 3:21 PM with the ADON who stated that the call light was supposed to be within reach for residents. She stated the call light is used for residents to call for assistance and have their needs met. She stated the call light should be placed on the dominant side for those residents with a limited range of motion. She identified that all staff were responsible for ensuring that the call light was repositioned for residents. She stated a resident who did not have a call light within reach could fall, cause delay in care, and a resident could be in discomfort. She stated that a call light is a resident's right and necessary to meet the needs of the resident. She stated that call lights are brought up during every morning meeting and did not recall the last staff in-service for call lights. She stated even if residents have a preference to scream for help, the call light needed to be placed within reach. In an interview on 01/09/2026 at 11:52 AM with the DON who stated the purpose of the call light was for residents to communicate with staff. She stated all staff were responsible for ensuring the call light was within a resident's reach, including housekeeping and other staff. She stated that the nurses were responsible for monitoring, which was done 2-3 times per shift during their medication administration. She stated the risks of residents not having their call light within reach were residents not communicating their needs to staff. The DON stated she did not think call lights out of reach were a fall risk; residents were able to yell for help if needed. In an interview on 01/09/2026 at 1:47 PM with the Administrator, she stated the purpose of the call light was for residents to communicate with staff. She stated the call light was to be left within the resident's reach, and every staff member was responsible for ensuring it was. She stated nursing staff round on residents every 2 hours, and that included confirming call lights were within reach of the resident. She stated the facility conducted Angel Rounds, daily from Monday through Friday, which consisted of department heads rounding on their assigned residents and their concerns. The Administrator stated the risk of residents not having their call light within reach included the residents being unable to notify staff about their need for assistance. She stated that the last in-service regarding call lights was 1-2 days (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ago. Record review of facility's Education In-Service Attendance Record, dated 01/07/2026, noted staff signatures and summary notated staff was to ensure call lights were within residents' reach when the patient is in the room. Record review of the facility's policy Call Lights, revised 12/2023, read in part: Policy- The Facility will provide a call light system that is accessible, functional, and responsive to meet the needs of the residents. Procedure- Accessibility: Call lights will be placed within reach of the resident's bed or sitting area in the resident's room.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure the resident was offered sufficient fluid intake to maintain proper hydration and health for 4 (Resident #39, #48, #53, #87) of 4 residents reviewed for access to hydration. The facility failed to ensure staff provided access to hydration and provide fresh water and ice at bedside for Residents (#39, #48, #53, #87) on 01/06/2026 at 10:42 AM, 1:31 PM, 1:49 PM, and 4:02 pm. As per facility policy, residents should be encouraged to consume fluids (6-8 glasses per day) and there was no regular tracking of fluids being provided to residents in-between meals and during periods of physical activity. This deficient practice could place residents who are dependent on staff to become dehydrated by not having access to hydration. The findings included: Record review of Resident #39's admission Record dated 01/07/2026 revealed a [AGE] year-old female with an admission date of 12/04/2025. Record review of Resident #39's MDS record dated 12/09/2025 revealed a medical diagnosis of rhabdomyolysis (condition where damaged skeletal muscles rapidly break down, releasing harmful proteins and electrolytes into the blood stream), a BIMS of 15 meaning cognitively intact, and recognized needing substantial/maximal, partial/moderate, and supervision/touch assistance for completing ADLs and mobility. Record review of Resident #39's care plan with a revision date of 12/30/2025 revealed the resident had a goal to maintain adequate nutrition/fluid intake and will be free from unplanned weight loss or other nutritional complications over the next 90 days. Record review of Resident #39's of the resident's physical and health undated revealed the resident suffered a left distal (further from body) radial (forearm bone leading to the thumb) fracture with complications by rhabdomyolysis (condition where damaged skeletal muscles rapidly break down, releasing harmful proteins and electrolytes into the blood stream), acute kidney injury, and metabolic acidosis (condition where the body has too much acid in it) and required continuous IV fluid resuscitation while at the hospital. Further documentation stated that the resident was found incontinent on her couch, unable to ambulate or drink water. An observation and interview on 01/06/2026 at 1:31 PM in Resident #39's room revealed that the resident was sitting in her wheelchair near the door without water on her bedside table. The resident stated the staff did not bring hydration on a scheduled interval as it must be requested, or she would have to wait for the next meal. Record review of Resident #48's admission Record dated 01/07/2026 revealed a [AGE] year-old female with an original admission date of 10/21/2025 and readmission date on 01/06/2026. Record review of Resident #48's MDS record dated 12/5/2025 revealed a medical diagnosis of dehydration, hip fracture, and a urinary tract infection (within the last 30 days). Resident #48 BIMS was a 3 meaning severe cognitive impairment, and was coded as dependent, substantial/maximal, partial/moderate assistance for ADLs and mobility including eating and drinking. Record review of Resident #48's care plan dated 11/06/2025 revealed the resident's care plan had focus on addressing dehydration, constipation, foley catheter with the intervention of encourage fluid intake and ADL deficits addressed eating with total dependent with 1 person staff assist. Record review of Resident #48's physical and health (no date) revealed the resident had a medical history of dementia, seizure disorder, intracranial (brain) bleed with left hemiparesis (weakness to the entire side of the body), cervical cancer, stage IV sacral (region where spine and hips meet) ulcer, and previously had a nephrostomy tube (a tube that connects to the kidneys and drains urine). An observation and interview completed on 01/06/2026 at 1:49 PM Resident #48 stated she had to ask staff for water and hydration as they did not bring it on their own. It was observed that the resident was seated upright in bed with her bedside table in front of her with no hydration on the table. Record review of Resident #53's admission Record dated 01/07/2026 revealed a [AGE] year-old male with an original admission date of 11/24/2025 and readmission date of 01/05/2026. Record review of Resident #53's of MDS dated [DATE] revealed he was coded as being dependent, substantial/maximal, partial/moderate, supervision assistance for ADLs and mobility. Record review (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of Resident #53's Care Plan dated 12/09/2025 revealed the resident had a focus for foley catheter, diabetic, and constipation with a goal to encourage fluid intake within dietary limits. Record review of Resident #53's Physical and Health dated 12/30/2025 revealed the resident was admitted to the emergency room due to refusal to eat and drink and a medical history upon admission for a UTI, hypokalemia (low potassium in blood), and chronic kidney disease stage 2. Record review of the Resident #53's MAR dated 01/09/2026 revealed the resident was on a gastronomy tube and was scheduled to receive 250ml every 4 hours beginning 01/06/2026 at approximately 11:00 AM, until 01/07/2026 at approximately 06:00 PM when the resident was hospitalized . An observation made on 01/06/2026 at 10:52 AM revealed resident #53 had the gastronomy equipment in his room but was not in use at the time. Resident #53 could not fully engage in conversation with this surveyor. Resident #53 was observed with chapped dry lips, tremors, sunken eyes, unkept appearance (shirtless with yellow/brownish eye discharge), and a cracked dry tongue. Record review of Resident #87's admission record dated 01/07/2026 revealed a [AGE] year-old female with an admission date of 01/05/2026. Record review of Resident #87's MDS dated [DATE] showed an incomplete MDS. Record review of Resident #87's care plan dated 01/05/2026 showed an incomplete care plan. Record review of Resident #87's physical and health dated 1/2/2026 revealed the resident fell at her home and experienced a fracture in her Lumbar 1 and 2 (lower disc of spine) with a suspected fracture to Thoracic 1 (torso disc of spine). An observation and interview was completed on 01/06/2026 at 4:02 PM, Resident #87 was able to acknowledge surveyor but did not engage in conversation. An observation and interview was completed on 01/06/2026 at 4:03 PM with Resident #87's family member who was present and reported his relative had been in the facility for approximately 24 hours. Resident #87's family member stated there was difficulties getting water for his relative. He had asked staff to bring water on 01/05/2026 and never had the request fulfilled. Resident #87's family member stated they decided to provide their own water for Resident #87. An observation was made of a large water container and various electrolyte bottles on Resident #87's nightstand. Resident #87's family member confirmed the family had provided hydration themselves. An observation and photo taken of the 5-gallon water container located on the Northwest wing was made on 01/07/2026 at 9:30 AM revealed the water container was 4/5th full. A follow-up observation and photo taken of the same water container completed on 01/07/2026 at 11:54 AM revealed no significant change in water level was present after the elapsed time. A third follow-up observation and photo taken of the same water container completed on 01/07/2026 at 1:38 PM revealed the container was approximately 3/5th full. The 5-gallon water container was intended to be used for residents on the Northwest wing of the facility, which amounted to 27 residents on census at the time of observation; only Resident #53 was noted for having water restrictions in place. In an interview conducted on 01/07/2026 at 2:02 PM with CNA A who stated hydration was important for residents because it affected focus, blood pressure, and could influence organs. She added that hydration could affect a resident's healing process and result in delayed recovery. She stated nurses and CNAS oversaw providing hydration for residents while nurses were responsible for monitoring hydration for residents on restrictions and gastronomy tubes. She stated that a resident who appeared dehydrated could resemble dry cracked lips/tongue, visible dryness, variation in nail color, could be mouth breathing, and could experience confusion. She stated that residents who did not receive ample hydration could become dehydrated, develop a UTI, experience constipation, and possibly be hospitalized . In an interview conducted on 01/07/2026 at 2:28 PM with LVN C, he stated hydration was significant to the body because it affected how it runs and noted that humans were 70% water. He stated that residents could contract a UTI due to a lack of water intake and added that organs function better when residents are hydrated. He stated nurses monitor hydration intake for residents on gastronomy tubes and residents with restrictions while CNAs chart fluids consumed during mealtimes. He stated there was no formal system for tracking hydration for residents aside from residents with restrictions and documentation during meals. He stated that a dehydrated resident could have presented themselves with sunken eyes, delayed skin (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	elasticity (stretch and ability to return to original shape), urinate less, had dry lips, and dry phlegm. He stated that Resident #53 was prescribed 250ml every 4 hours and had been non-compliant with treatment. He stated that if a resident was noncompliant, staff were trained to document any changes and notify the provider. He stated that the hydration station was located near the dining room on the west side of the facility. He stated that there was not a set schedule for the residents to be served hydration and was usually upon residents' request. He stated that residents could have delayed healing and may need to be hospitalized for more severe complications due to hydration. He completed hallway observation which resulted in 3 residents (2 being Resident #48 and #53) who were observed without water and 4 residents (1 Resident #39) who stated staff had just brought the water unprompted within the past 10 to 15 minutes. In an interview conducted on 01/08/2026 at 9:21 AM with [NAME] F who stated nursing had not brought the 5-gallon water containers to the kitchen for refill during her previous shifts. She stated she was not aware if kitchen staff were supposed to monitor the volume in the containers throughout the day. She stated The Dietary Manager had more knowledge on the procedures for the 5-gallon water containers. In an interview conducted on 01/08/2026 at 9:39 AM with The Dietary Manager who stated that kitchen staff and nursing were responsible for monitoring the levels of the 5-gallon water container. He stated that the kitchen was responsible for the initial morning refill and refilling throughout the day as requested. He stated his staff did not go to the hydration stations during the day to review its volume. He stated that nursing staff never finished the 5-gallon water container during the day and requested a refill prior to being empty. He stated that when he refilled the water containers in the morning, they were never at the bottom, rather they were maybe at half. In an interview conducted on 01/08/2026 at 3:07 PM with ADON who stated that each resident was provided with a container for water depending on fluid restrictions and added residents had a choice of fluids (water, juice, coffee). She stated that to her knowledge there were not any residents in the 300 halls with fluid restrictions. She stated that the staff was trained to review the residents' cups during rounds and as requested by residents. She stated they did not have a formal monitoring system for hydration unless a resident was on a fluid restriction. She stated the facility had two hydration stations equipped with two 5-gallon water dispensers and ice chests for both wings of the facility. She stated that a resident with insufficient hydration could be lethargic, disengaged, experienced complications with blood pressure, skin integrity and elasticity, and cracked lips. She added that residents could experience severe complications from dehydration in the form of discomfort, cardiac complications, and seizures. She stated she did not recall the last in-service provided to staff regarding hydration; no documentation was provided for the latest in-service on hydration. In an interview conducted on 01/09/2026 at 11:32 AM with the DON who stated the purpose of hydration was to keep patients hydrated and avoid further medical complications. She stated that the residents' hydration was only documented during meals and for residents with water restrictions. She clarified her interpretation of glasses of water from the policy as being a measurement of 40 milliliters (equivalent to 1.4 fluid ounces). She stated that residents had their jugs in the room to drink water from. She stated that staff were trained to report any changes in the residents' status to the provider, family, and nursing department supervisors. She stated the staff was responsible for providing water to residents. She stated that both wings had hydration stations, juice was provided at activities, and residents had to alert staff that they were thirsty. She stated there was no system in place to offer hydration to residents at a scheduled interval and was completed upon residents' request. She was provided photos of the levels of water in the North-West wing 5-gallon water cooler captured on 01/07/2026 at 9:30 AM, 11:54 AM, and 1:38 PM; She was unable to determine if there was significant change in water levels to accommodate hydration needs for 20 residents across a 4-hour time span. She denied receiving hydration-related complaints from residents, family members, or staff. She recognized residents who might need additional assistance to meet hydration needs as residents with limited range of motion and residents with dementia/low cognition. She affirmed with surveyor's statement of, the sensation (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for thirst diminished with age. She stated she did not recall the last in-service provided to staff regarding hydration; no documentation was provided for the latest in-service on hydration. In an interview conducted on 01/09/2026 at 1:39 PM with The Administrator who stated it was important residents had accessible hydration for their well-being and to prevent dehydration. The administrator stated a resident with inadequate hydration could develop an UTI, appear lethargic, down, and could have a dry appearance. She was provided with the facility policy and could not determine a quantitative value of fluid for the word glasses. She stated residents with water restrictions, limited range of motion, and nonintact cognition could be more at risk for not having their hydration needs met. She denied receiving hydration-related complaints from residents, family members, or staff. She stated she was not aware of a hydration administration system or schedule in place. She stated that nursing staff was responsible for monitoring water intake for residents on gastronomy tubes and with water restrictions. She denied knowing how nursing staff monitored hydration intake for residents without water restrictions. She stated there was a refillable water station downstairs and two hydration stations located at both nursing stations. Record review of facility policy titled hydration revised on 06/2019 read in part, . 1. Recommend/encourage fluids (6-8 glasses per day) to patients/residents during and in-between meals and during periods of physical activity . 2. Provide fresh water and ice at bedside except when contraindicated . 3. Closely monitor all patients/residents at risk for dehydration . examples of ?at risk' A. change in mental status B. require extensive assistance C. hand dexterity problems . I. Previous diagnosis of dehydration .

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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 observations, 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 4 (Resident #4, Resident #7, Resident # 28, and Resident #77) of 12 residents observed for oxygen management. The facility failed to place an oxygen concentrator air filter on the concentrator for Resident #4, while the oxygen was in use, there was no filter in place on 01/06/2026. The facility failed on 01/06/2026 to clean the oxygen concentrator air filter for Resident #7, Resident #28 and Resident #77, while the oxygen was in use, concentrators were observed with air filters that appeared to have dust, strands of hair and lint collected on them. This failure could place residents on oxygen therapy at risk of receiving incorrect or inadequate oxygen support and decline in health. The findings included: Record review of Resident #4's admission Record dated 01/06/2026 revealed an [AGE] year-old male with initial admission date 10/25/2022, and re-admission date 01/05/2026. Record review of Resident #4's Quarterly MDS dated [DATE] revealed no BIMS score, as noted, Resident #4 was rarely/never understood. Under Section I-Active Diagnoses revealed resident had Respiratory Failure. Under Section O-Special Treatments, Procedures, and Programs, revealed Resident #4 was administered oxygen therapy while a resident. Record review of #4's History and Physical dated 01/07/2026, revealed a medical history of Parkinson's disease (a disease that affects the nervous system which causes tremors or shakiness, muscle stiffness, unstable posture, difficulty walking, and slowed body movements), dysphagia (difficulty swallowing), and Gastrostomy status (meaning resident had a gastrostomy tube or G-tube, which is surgically placed to provide direct access to the stomach for nutrition, hydration, and medication). Record review of Resident #4's Care Plan revised 04/28/2025, revealed resident was on Oxygen Therapy at 2 liters per minute via nasal cannula (a flexible tube with two prongs that fit into the nostrils that delivers supplemental oxygen directly into the nasal passages). The interventions included for staff to monitor signs of respiratory distress. Record review of Resident #4's Physician Order, dated 04/28/2025, noted an order for Oxygen Therapy at 2 liters per minute via nasal cannula continuously. Monitor O2 (Oxygen) saturation every shift and as needed. During an observation on 01/06/2026 at 9:31 AM, Resident #4's oxygen concentrator was observed with no filter and covered in dust. Record review of Resident #7's face sheet dated 12/11/2025, revealed the 95-year -old resident was initially admitted to the facility on [DATE] and readmitted on [DATE]. with diagnosis of chronic obstructive pulmonary disease (a progressive lung disease that blocks airflow, making it hard to breathe). Record review of Resident #7's history and physical dated 12/29/2025 revealed Resident #7 had a diagnosis of amenia (Low red blood cell count). Record review of Resident # 7's Quarterly MDS dated [DATE] revealed a brief interview for mental status score of 09, indicating moderate cognitive impairment. Section O special treatments procedures and programs indicated use of oxygen therapy. Record review of Resident #7's Physician's orders, dated 11/18/2025, revealed an order for oxygen at 1-2 Liters per min via nasal cannula continuously. Monitor 02 saturation every shift. Record review of Resident # 7's care plan revised 11/06/2025, revealed Resident #7 had oxygen therapy related to shortness of breath. Interventions included Administer medications as ordered by physician. Monitor/document side effects and effectiveness. During an observation of Resident #7 in her room on 01/06/25 at 10:22 A.M., revealed that the resident's oxygen concentrator air filter appeared to have dust, strands of hair and lint collected on it. Record review of Resident #28's face sheet dated 01/08/2025, revealed a [AGE] year-old resident admitted to the facility on [DATE]. Record review of Resident #28's history and physical dated 01/07/2026, revealed a diagnosis of chronic obstructive pulmonary disease with acute exacerbation (a progressive lung condition characterized by persistent airflow limitation. Making it hard to breathe). Record review of Resident #28's annual MDS revealed a brief interview for mental status score of 06, indicating severe cognitive impairment. Section O special treatments (continued on next page)

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	675723	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	procedures and programs indicated use of oxygen therapy. Record review of Resident # 28's Physician orders revealed an order for Oxygen via nasal cannula as needed for shortness of breath or decreased oxygen saturation. Titrate between 1-6 Liters per minute of oxygen to keep saturation above 90%. as needed with a start date of 03/07/2025. Record review of Resident #28's care plan revised on 1/05/2026 revealed the use of supplemental oxygen via nasal canula initiated in 12/19/2024. Interventions included monitor and clean the oxygen concentrator filter as needed. During an observation of Resident #28 in his room on 01/06/26 at 10:17 A.M., revealed that the resident's oxygen concentrator was in operation and that the air filter appeared to have dust collected on it. Record review of Resident #77's face-sheet dated 01/07/2026, revealed a [AGE] year-old female with initial admission date 06/19/2019, and re-admission date 08/01/2025. Record review of Resident #77's Annual MDS dated [DATE], revealed a BIMS score of 12, indicating moderate cognitive impairment. Section I-Active Diagnoses notated Resident #77 was dependent on supplemental oxygen. Record review of Resident #77's Care Plan revised 11/04/2025, noted resident required supplemental oxygen via nasal cannula at 2 liter per minute at bedtime to maintain saturation above 90% and included for staff to monitor and clean the oxygen concentrator filter as needed. In an observation on 01/06/2026 at 9:42 AM, Resident #77's oxygen concentrator air filter was observed with lint and hair. In an interview on 01/08/2026 at 12:34 PM with CNA I stated the transportation staff assisted with cleaning the oxygen concentrator filters. She stated she was unsure how often it was cleaned. She stated CNAs were to report dirty oxygen concentrator air filters to the nurse. She stated the potential risk for residents having dirty oxygen concentrator air filters included the risk of residents breathing in dust that could cause illness. In an interview on 01/08/2026 at 1:16 PM with LVN J who stated the transportation staff was responsible for cleaning the oxygen concentrator air filter. She stated that the transporter cleaned the filters once a week on Sundays. She stated nurses were responsible for confirming residents' oxygen concentrator air filters were clean, daily. She stated the potential risk of residents' oxygen concentrator air filters included residents breathing in dust and bacteria, which can cause illness. She stated the last in-service for cleaning oxygen concentrator air filters was in 12/2025. In an interview on 01/09/2026 at 11:08 AM with the ADON who stated she was the Infection Control nurse. She stated the responsibility of monitoring and cleaning residents' oxygen concentrator air filters belonged to Central Supply, but the facility did not have one now. She stated she as the ADON, and the transporter, were responsible for monitoring and cleaning the oxygen concentrator air filters, which were completed weekly or as needed. She stated that nursing staff also monitored the oxygen concentrator air filters daily during their rounds. She stated that the risk of dirty oxygen concentrator filters included the potential for the oxygen concentrator to not function properly, which could cause it to not deliver oxygen properly. She was unsure of the last in-service regarding oxygen concentrators and their maintenance. In an interview on 01/09/2026 at 1:48 PM with the DON who stated that the ADON and the transporter were responsible for cleaning and changing the oxygen concentrator air filters, during the night and once a week. She stated there were no potential risks for residents to have dirty oxygen concentrator air filters and stated it would only affect the oxygen concentrator. She stated though the oxygen concentrators were connected to residents, the oxygen concentrator had an alarm that would go off if there were any issues with the concentrator and that would notify staff, and they would be able to change the filter at that time. Record review of the facility's Educational In-Service Attendance Record titled Oxygen, and dated 01/07/2025, included staff signatures and summary read in part: Night shift CNA's and nursing staff are responsible for changing the oxygen tubing, canister, and mask for nebulizer treatments. Additionally, they must clean the filters of the oxygen concentrator on a weekly basis or whenever they are found to be damaged or visibly dirty. The facility did not provide a policy regarding Oxygen Concentrator Air filters prior to survey exit.

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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. - The facility failed to maintain safe consumable produce as evident by 5 unwrapped and aged lettuces observed on 01/06/2026 8:36 AM - The facility failed to maintain safe consumable produce as evident by 2 visibly molded tomatoes observed on 01/06/2026 at 8:37 AM - The facility failed to maintain safe consumable produce as evident by cross contaminating a box of potatoes with an overripened banana observed on 01/06/2026 at 8:53 AM - The facility failed to ensure staff were following meal service policy as evident by improper meal service handling in the dining room with staff member grabbing residents' cups from the upper portion on 01/06/2026 at 11:57 AM by CMA E. - The facility failed to ensure staff were following safe food handling practices by adhering to handwashing procedures and glove change within the facility policy on 01/06/2026 at 12:03 PM, 12:07 PM and 12:08 PM by [NAME] G and The Dietary Manager and on 01/07/2026 at 10:34 AM, 10:58 AM, 11:10 AM, 11:31 AM, by The Dietary Manager - The facility failed to ensure staff were following safe food handling practices by adhering to safe food temperature procedures within the facility policy as evident by observation of puree meals and preparation of sides on 01/07/2026 at 11:21 AM, 11:26 AM, and 11:35 AM by the Dietary Manager. These failures could place all residents who received meals from the kitchen at risk of food-borne illnesses from cross-contaminated food and beverages. Findings included: During observations on 01/06/206 that started at 8:31 AM in the kitchen, there were 5 lettuces unwrapped with discoloration located in the walk-in fridge at 8:36 AM. At 8:38 AM, 4 tomatoes were in the same walk-in refrigerator with 2 of the 4 tomatoes presented with mold on them and in contact with the other tomatoes. At 8:53 AM, a cardboard box with approximately 35 potatoes in it was located under the preparation table and had a varied range of freshness as some of the produce was sprouted. An overripen banana was located within the same cardboard box as the potatoes. During a dining observation on 01/06/2026 at 11:57 that CMA E grabbed the cup from the opening during meal distribution and served it to a Resident. During meal distribution observation on 01/06/2026 it was observed at 12:03 PM [NAME] G opened the fridge with gloves on and continued serving food by grabbing burger buns without changing gloves or washing hands; and again at 12:07 PM. At 12:08 PM The Dietary Manager opened the fridge with gloves on and continued serving food by grabbing burger buns without changing gloves or washing hands; and again at 12:10 PM and 12:11 PM. During a meal preparation observation on 01/07/2026 it was observed at 11:10 AM that The Dietary Manager's marker fell on the floor and he proceeded to pick it up with gloves on. At 11:11 AM the Dietary Manager resumed work by grabbing the grilled cheeses from the grill and sealing them for lunch without washing hands or changing gloves. During meal preparation observation and interview on 01/07/2026 at 11:21 AM the Dietary Manager was stopped during the beef puree demonstration when he went to add beef stock from a saucepan to the puree and surveyor requested temperature of the beef stock. He stated it was 160 F and proceeded to retake temperature from the saucepan that read 53 F. Staff failed to capture the temperatures for 1 hot side (tater tots) and 1 cold side (apple slices). In an interview conducted on 01/08/2026 at 9:03 AM with Dietary Aide H who stated her responsibilities were to gather head count of residents in the dining room, organize the drinks, review diet tickets and trays, and clean dining and cooking areas. She added that dietary aides assist by retrieving produce and ingredients for the cooks. She stated it was important to discard contaminated food because mold and bacteria could affect the residents if it was consumed. She stated that residents could experience vomiting, diarrhea, and intestine pain if they were to eat contaminated food. She was provided pictures of lettuce, tomatoes, and potatoes from observation and confirmed the ingredients could potentially harm the residents. She demonstrated proper serving techniques by grabbing a cup from the bottom and stated grabbing from the top exposed residents to cross (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	contamination. She stated that upon entry into the kitchen, staff were trained to wash their hands and used gloves when directly handling food and drinks. She clarified that if she were to touch the floor or fridge handle staff needed to change gloves or wash their hands. She was unable to recall the last in-service for food handling, safe temperatures, and hand washing/glove usage. In an interview conducted on 01/08/2026 at 9:21 AM conducted with [NAME] F who stated that the cooks were responsible for ensuring ingredients were in good condition before use. She added food that cooks checked the ingredients about 3 times a week on schedule and monitored for mold growth. She stated that cooks were trained to discard any ingredient that already had mold growth, foul smell, or unusual discoloration. She described unusual produce as loose and leaky vegetables and past their expiration date. She added that the kitchen rarely had spoiled produce because they used them so often. She stated it was usually only bananas that spoiled because they aged rapidly. She was provided with images taken of produce during an initial walk through on 01/06/2026 and confirmed that the images were of spoiled food. She identified potential outcomes as a resident getting sick from their stomach if they ate contaminated food. She confirmed residents with weakened immune systems could result in hospitalization. She stated staff was trained to wash their hands upon entry into the kitchen and whenever they were going from meat to produce. She was unable to recall the last in-service for food handling, safe temperatures, and hand washing/glove usage. In an initial interview conducted on 01/08/2026 at 9:39 AM with the Dietary Manager who stated that he scheduled his walk-through the kitchen on Tuesdays to ensure all ingredients were safe for consumption and whenever he had a chance. He stated that cooks assisted in discarding spoiled ingredients. He recognized that keeping spoiled ingredients could potentially be used while cooking and served to the residents. He added that this would result in a food borne illness for residents and affect them by making them sick, hospitalized , or expire. He was provided the photos from the initial walk-through on 01/06/2026 and stated the foods condition was not appropriate. He stated the last in service he provided to his staff about handwashing, food-borne illness and safe food handling was 3-4 months ago. In a follow-up interview conducted on 01/09/2026 at 10:11 AM, he stated staff was trained to utilize gloves when directly handling food. He added that staff were trained to practice hand hygiene and glove change once they touched potentially dirty surfaces like fridge handles, boxes, or picked up items from the floor. He stated these examples were potential routes for cross-contamination. He stated that the temperature for vegetables on the steam table was 130-140 F and for meats on the steam table was 140-160 F. He stated the temperature for cold food served was 35-40 F. He added that food that entered the range of 40-130 F could develop bacteria and result in a food borne illness for residents. He stated that the last in service for hand hygiene and glove utilization was in December 2025 and last in service for food temperature was May/June 2025; no documentation provided supporting this claim when requested. In an over-the-phone conducted on 01/09/2026 at 8:56 AM with [NAME] G who stated staff was trained to wash their hands upon entering the kitchen and to wear gloves when directly handling food. She added that staff were not allowed to wear gloves in the hallways and were instructed to change gloves when switching to other meals they were preparing. She stated that she was trained to change gloves, wash hands, and apply new gloves when she used the fridge handle between meal service. She identified this was a potential for cross contamination which would affect the residents if they were to eat cross-contaminated food. She stated that the last in-service she received for hand washing and glove usage was 2 weeks prior. She recognized the temperature for hot food needed to be held at was 135 F and above and for cold foods was 40 F and below. She explained that food that was held at 41-134 F had potential to spoil and develop food borne illness for residents. She stated that the last in-service she received for food temperature monitoring was in December. In an interview conducted on 01/09/2026 at 1:03PM with The Administrator who stated her expectations of the kitchen staff were to properly handle, store, and prepare food by ensuring ingredients were sealed, labeled, and in edible condition. She added that staff were trained to practice hand hygiene and utilize gloves when needed. She identified that no adhering to these practices could (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	result in food becoming cross-contaminated and possibly consumed by residents. She added a resident could be affected by cross-contaminated food by causing stomach problems or could require the resident to be transferred to a higher level of care. She identified The Dietary Manager and herself as persons responsible for ensuring all staff were trained and adhered to facility policies for food handling, hand washing, and glove utilization. She noted that The Dietician provided assistance to the kitchen staff on a varied basis. For dining observations, she stated that staff was expected to wear hairnets and gloves when serving and review the meal ticket. She stated staff was trained to grab cups from the bottom and utensils from the handle portion. She added that if staff were not compliant with this procedure, it was considered cross-contamination. Record review of the facility's policy dated 02/2022, titled Safe Food Temperature read in part: . Minimize the time that TCS food is in the temperature danger zone (40 to 135 F) throughout the food handling process .When hot pureed, ground, or diced food drops into the danger zone, it must be reheated to 165 F for 15 seconds. Record review of the facility's policy dated 02/2022, titled Safe Food Handling read in part: Food acquisition, storage, and distribution will comply with the accepted food handling practices .Sanitary conditions must be present to promote safe food handling .categories of food contamination: Biological-involving pathogens such as bacteria, viruses, toxins, and spores. Record review of the facility's policy dated 06/2019, titled Hand Washing read in part: .Proper handwashing technique will be used when hand washing is indicated . 2. Wash Hands: B. Before starting work, C. Before putting on gloves, when changing into a fresh pair of gloves, and immediately after removing gloves D. Before handling or eating food. Record review of the facility's policy dated 06/2019, titled Indications for Glove Use read in part: .The use of gloves does not eliminate the need for proper hand washing or good hand hygiene . Change gloves whenever an un-sanitized item or surface is touched. Examples include-opening a drawer, touching a dirty plate, opening a trash can, turning on a faucet . Record review of the facility's policy dated 06/2019, titled Meal Service In The Dining Room read in part: The nursing staff/designee will supervise and take measure to promote meal satisfactions for those patients/residents who choose to eat in the dining room .Help patient/resident to be ready at meal time .Serve tray according to tray service . Record review of the facility's Safe Food Temperature in-service was undated and revealed staff signed for completion with the previous Administrator and previous Dietary Manager listed as presenters.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented and systematically organized for one (Resident #1) of two resident records reviewed for wound care. -The facility failed to ensure LVN L documented Resident #12's bruise by appearance, size, color, and site, when informed of the bruise. -The facility failed to ensure LVN M documented the DON and Administrator were notified of Resident #12's acute change, an observed bruise on the left eye. -The facility failed to ensure an incident report was made once staff was made aware on 01/05/2026, of Resident #12's allegation of a fall that allegedly occurred the night of 01/03/2026 or 01/04/2026.These failures could affect the residents in the facility by placing them at risk of not accurately documenting.Findings included: Record review of Resident #12's face-sheet dated 01/07/2025 revealed resident was an [AGE] year-old male with admission date 11/26/25. Record review of Resident #12's admission MDS dated [DATE] revealed a BIMS score of 12, indicating moderate cognitive impairment. Section GG- Functional Abilities noted Resident #12 was dependent, meaning the helper does all the effort and the resident does none of the effort to complete the activity, for the following: rolling left and right, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, shower transfer. It also noted Resident #12 required substantial/maximal assistance from sitting to lying. Record review of Resident #12's Care Plan, revised 01/06/25, revealed the resident was at risk for falls and injuries. Interventions included for nursing staff to: anticipate needs and provide prompt assistance, ensure call light was within reach and was answered promptly, keep frequently used items at resident bedside. On 01/02/2026 therapy screened Resident #12's status post fall. Head to toe assessment completed, Physician notified with no new orders. Record review of Resident #12's History and Physical dated 01/07/2026 revealed medical history: Idiopathic Pulmonary Fibrosis (a lung disease characterized by scarring of lung tissue making it difficult for the lungs to function properly), Chronic Respiratory Failure (a serious condition that occurs when the lungs cannot properly exchange oxygen and carbon dioxide, leading to elevated carbon dioxide levels or insufficient oxygen in the blood), and Liver Cirrhosis (characterized by scarring of the liver tissue, causing the liver to not function properly). Nurse Practitioner O notated a physical assessment was completed on 01/07/2026, and the eyes were noted as atraumatic (meaning without of trauma or injury) and EOMI, or Extraocular Movements Intact, meaning the muscles controlling eye movement were working normally, allowing smooth tracking in all directions without pain, weakness, or double vision. It was noted to continue with the current plan of care. Record review of Resident #12's progress notes revealed Resident #12 had an unwitnessed fall on 01/02/2026 at 10:20 AM, and he was found on the floor. It noted Resident #12 alleged he landed on his buttocks. Progress note dated 01/02/2026 noted neurological checks were ordered and completed.Record review of Resident #12's Neurological Record dated 01/02/2026, revealed: every 15-minute checks for 4 times, every 30-minute checks twice, every 1-hour checks for three times, and every twice a day for 2 days after that, were completed. No issues identified. Record review of Resident #12's progress notes also revealed the following: LVN L notated on 01/05/2026 at 1:47 PM that Resident noted to have bruise [left] eye, asked [Resident #12] about pain he denied, [Resident #12] said ?It's from my previous fall on Friday . and that he would notify the resident's family.Record review of Resident #12's progress notes revealed LVN M notated on 01/05/2026 at 08:09 PM, This nurse resident [family member] discussed his bruising to left eye. Resident states it was a night he rolled out of bed. Nurse educated on Lorazepam and [side effects]. He is on Mirtazapine 15 mg [at bedtime], if does not help resident will notify nurse to report to [Resident #12's Hospice service] of other medications for sleep . Plan of care ongoing. The progress notes did not include if DON, Nurse (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Practitioner, and Administrator, were notified of Resident #12's allegation of rolling out of his bed. Record review of Resident #12's progress notes revealed there was no descriptive documentation regarding Resident #12's bruising to his left eye, including size, shape, and color.Record review revealed there was no incident report relating to resident's allegation of a second fall during the night and allegedly hitting his head on his nightstand next to his bed, located in his room.In an observation and interview on 01/08/2026 at approximately 11:40 AM with Resident #12 and their family at bedside revealed Resident #12 had two falls this past weekend, on Friday 01/02/2026, and possibly Saturday night 01/03/2026 or Sunday night 01/04/2026, per Resident #12's family. Resident #12 was observed with dark purple bruising on the left eye area. There were no cuts or open wounds observed. Resident #12 stated they were unable to recall what night but stated he fell off his bed during the middle of the night and hit his head on the nightstand placed on the left side of his bed. He stated he was unable to recall whether staff assisted him back into his bed, or if he did independently, but stated he would not be able to get himself into bed without help. Resident #12's family stated they visited Resident #12 Saturday morning 01/03/2026, and Resident #12 did not have any bruise on his face. Resident #12's family stated they came on Monday 01/05/2026 and observed Resident #12 with bruising around his left cheek and eye. They stated they went to speak with the nurses to follow up on what caused the bruising, but the nursing staff was unaware and did not find documentation regarding Resident #12's bruise. Resident #12's family stated the resident did not mention anyone helping him back into bed after the second fall, so she did not believe anyone helped him, and believed Resident #12 got himself back into bed. Resident #12 and his family stated they were overall content with the facility and services, and Resident #12 stated he felt safe at the facility. Family stated they were made aware of the fall on 01/02/2026, via phone. she stated she made facility staff aware of Resident #12's bruising to his left eye on Monday 01/05/2026, which the nursing staff allegedly reviewed their progress notes and did not find any documentation relating to Resident #12's bruise to his left eye. In an interview on 01/08/2026 at 1:40 PM with LVN L stated he notified the family and physician about the fall that happened on Friday 01/02/2026, and he was unaware of any other falls after that. He stated he was informed of the bruising to Resident #12's left side of face during the end of his shift on Monday 01/05/2026, and during shift change while giving report to LVN M, and LVN M was present when informed of the new bruise. He stated that LVN M was to report it as she was taking over the shift. He stated he also believed the bruising to Resident #12's eye was related to the fall that happened on 01/02/2026, and stated Resident #12 was already being monitored for neurological changes, for 72 hours post-fall, relating to the fall on 01/02/2026. He denied observing any bruising to Resident #12's left eye during his shift on 01/02/2026, including after the fall. He stated there were no changes or documentation noted relating to Resident #12's bruising to left eye over the weekend of Friday 01/02/2026, until LVN L's next shift that following Monday 01/05/2026. He stated he failed to document the bruise when he was notified during his shift. He stated he was responsible for documenting acute changes as a nurse, and he recognized he failed to do that. He stated that included appearance, including color and size, and site of the acute change. He stated the potential risk of failing to document acute changes or who was notified included miscommunication and staff being unaware of what happened to the resident or who was notified. Interview attempt made to Physician via phone on 01/08/2026 at 2:21 PM and 2:22 PM, no answer and unable to leave contact information or message. Interview attempt made to Nurse Practitioner O via phone on 01/08/2026 at 2:24 PM, no answer. Purpose of call and call back information left. During an interview on 01/08/2026 at approximately 2:30 PM, this surveyor notified ADON, and DON of the phone call attempts made to Nurse Practitioner O. This surveyor requested the ADON and DON to contact Nurse Practitioner O to advise her to speak with this surveyor, they stated they understood and would contact Nurse Practitioner O.In an interview on 01/08/2026 at 3:03 PM with LVN M, she stated she worked the afternoon shift on Friday 01/02/2026 and was aware Resident #12 had a fall during the morning shift. LVN M worked 01/02/2026 afternoon shift. She stated Resident #12's Hospice service, Responsible (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Party, and NP were notified. She stated she did not observe a bruise of Resident #12's face during her afternoon shift on Friday 01/02/2026, which ended at 10:00 PM. She stated she was present during shift change on Monday afternoon 01/05/2026, when Resident #12's family went to the nurse's station to follow up on the observed bruising of Resident #12's face, which was observed on Resident #12's face, around the eye area. She stated she notified Resident #12's hospice service, and stated the NP was notified that day by LVN L, as the NP made their rounds in the morning. She stated Resident #12's medication was discussed to be changed, as she believed the night prescription, Lorazepam, contributed to Resident #12's fall. She stated Resident #12's new bruise to his left eye was considered a Change of Condition, which required nursing staff to notify the Physician or NP, the DON, and Administrator, once made aware. She stated she notified the DON on 01/05/2026 of the Resident #12's alleged second fall. She stated nurses were responsible for documenting who was notified and what orders were given. She stated failing to document accurately included miscommunication between staff as they would not be aware of what happened to the resident and what interventions were done, which would affect the continuity of the resident's care. She acknowledged she did not document if DON, Administrator, and Nurse Practitioner or Physician was notified, and that would look as if no one was notified of Resident #12's second fall, but stated they were notified. She stated that nursing was responsible for their documentation. In an interview on 01/09/2026 at 12:21 PM with the DON stated she was notified of Resident #12's falls and injuries by LVN M. She stated Resident #12 sustained a fall, which he was assessed and reported to the Physician. She stated she did not observe any bruising or acute changes on Resident #12's face on Friday, 01/02/2026. She stated that each nurse was responsible for their own documentation of changes of condition and that they notified the physician. She stated that the purpose of accurate documentation was for the facility to track and review what interventions were done for the residents. She stated the ADON and herself, as the DON, were responsible for monitoring nursing progress notes. In an interview on 01/09/2026 at 02:01 PM with the Administrator, she stated she was unable to recall or confirm if she was notified of Resident #12's bruising of his left eye. She stated staff were responsible for notifying her, as the Administrator and Abuse Coordinator, of incidents such as Resident #12's bruising of his left eye. She stated the expectation was for staff to also notify the physician, family, and Nurse Management, and to complete an incident report for Resident #12's injury. She stated staff were expected and trained to document any changes, incidents, or accidents, observed or informed of the resident, so the care team and Physician were aware of what was going on with the resident. She stated nurses were responsible for their documentation, and nurse management was responsible for monitoring nursing progress notes on a daily basis. Record review of facility's policy Clinical Documentation, revised 11/2025, read in part: Policy-The facility maintains accurate, timely, and resident-centered clinical documentation within [the electronic medical charting system] to reflect care provided in accordance with physician order and the resident's plan of care. Documentation supports continuity of care, clinical decision-making, and communication among the disciplinary team.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 4 of 12 residents (Residents #4, #7, #28, and #73) reviewed for transmission based precautions. The facility failed to ensure Resident #4, and 73's nasal canula was placed correctly on resident on 01/06/2026. The facility failed to ensure that Resident #7 and #28's foley catheter bag remained off the floor on 01/06/2026. These deficient practices could place residents at risk of exposing them to care that could lead to the spread of infections. Findings included: Record review of Resident #4's admission Record dated 01/06/2026 revealed an [AGE] year-old male with initial admission date 10/25/2022, and re-admission date 01/05/2026. Record review of Resident #4's Quarterly MDS dated [DATE] revealed no BIMS score, as noted, Resident #4 was rarely/never understood. Under Section I-Active Diagnoses revealed Resident #4 had Respiratory Failure. Under Section O-Special Treatments, Procedures, and Programs, revealed Resident #4 was administered oxygen therapy while a resident. Record review of #4's History and Physical dated 01/07/2026, revealed a medical history of Parkinson's disease (a disease that affects the nervous system which causes tremors or shakiness, muscle stiffness, unstable posture, difficulty walking, and slowed body movements), dysphagia (difficulty swallowing), and Gastrostomy status (meaning resident had a gastrostomy tube or G-tube, which was surgically placed to provide direct access to the stomach for nutrition, hydration, and medication). Record review of Resident #4's Care Plan revised 04/28/2025, revealed resident was on Oxygen Therapy at 2 liters per minute via nasal cannula (a flexible tube with two prongs that fit into the nostrils that delivers supplemental oxygen directly into the nasal passages). The interventions included for staff to monitor signs of respiratory distress. Record review of Resident #4's Physician Order, dated 04/28/2025, noted an order for Oxygen Therapy at 2 liters per minute via nasal cannula continuously. Monitor O2 (Oxygen) saturation every shift and as needed. Record review of Resident #73's face-sheet dated 01/07/2026, revealed a [AGE] year-old female resident with admission date 12/10/2025. Record review of Resident #73's admission MDS dated [DATE], revealed there was no BIMS score as the resident did not participate. It was noted that Resident #73 was rarely or never understood. Section O- Special Treatments, Procedures, and Programs, revealed Resident #73 was on Oxygen therapy while a resident at the facility. Record review of Resident #73's Health and Physical dated 01/07/2026, revealed a medical history of nontraumatic intracranial hemorrhage (meaning any bleeding that happens within the skull). Record review of Resident #73's care plan revised 12/25/2025, revealed Resident #73 required supplemental oxygen therapy via nasal cannula related to shortness of breath. The interventions included in the care plan were the following: assessing signs of respiratory distress and change tubing when visibly soiled or when contamination was suspected. In an observation on 01/06/2026 at 9:31 AM of Resident #4 having their nasal cannula over their open mouth while they slept and the oxygen concentrator was on. An oxygen mask at bedside was also observed, open to air and not bagged or stored. In an observation on 01/06/2026 at 9:58 AM revealed Resident #73 with her nasal cannula placed over her eyes, while she slept in her wheelchair across the nurse's station. LVN L was notified by this surveyor of observation and requested Resident #73's oxygen levels to be read. However, the oxygen meter did not read results until after LVN J placed the same contaminated nasal cannula back into Resident #73's nasal passages. Resident #73's oxygen level read at 92% on supplemental oxygen via nasal cannula. Resident #73 was observed responsive throughout interaction; no signs of respiratory distress were observed. In an interview on 01/08/2026 at 12:36 PM with CNA I who stated nursing staff were responsible for ensuring nasal cannulas or masks were stored and covered per protocol and not open to air or on the floor if not being used. She stated that nursing staff monitor this daily. She stated if a nasal cannula was observed on the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's eyes or mouth, they were to replace the nasal cannula because it would be considered contaminated or dirty. She stated the potential risk of using dirty nasal cannulas or masks included potential for the residents to become ill. In an interview on 01/09/2026 at 11:10 AM with the ADON who stated she was the Infection control nurse. She stated any staff that used or removed the nasal cannula or mask were responsible for storing it properly. She stated if the nasal cannula or mask was left out in the open or not stored properly, it was an infection control issue. She stated if staff observed a resident with their nasal cannula on the residents' eyes or mouth, they were to place it back on the resident and notify the nurse so they could follow up with the resident. She stated nasal cannulas observed on the eyes or mouth of the resident could be a potential infection control issue, but she was not certain if it was. She was unable to recall the last Infection control in-service. In an interview on 01/09/2026 at 1:50 PM with the DON who stated nursing staff were responsible for maintaining and ensuring nasal cannulas and masks were clean and stored. She stated that the purpose of properly storing nasal cannulas/masks was to prevent contamination. She stated department supervisors conducted Angel Rounds which included daily rounds on residents, which provided an opportunity to identify potential issues including unbagged nasal cannulas or masks. The DON stated nasal cannulas or masks observed on residents' eyes or mouth were considered an infection control issue and nurses were to be notified so it could be replaced. She stated the potential risks for residents using contaminated nasal cannulas or masks included an infection control concern. Record review of Resident #7's face sheet dated 12/11/2025, revealed the 95-year -old resident was initially admitted to the facility on [DATE] and readmitted on [DATE]. Record review of Resident #7's history and physical document dated 12/29/2025 revealed Resident #7 had a diagnosis of amenia (Low red blood cell count). Record review of Resident # 7's Quarterly MDS dated [DATE] revealed a brief interview for mental status score of 09, indicating moderate cognitive impairment. Section O special treatments procedures and programs indicated use of oxygen therapy. Record review of Resident #7's Physician's orders, dated 11/18/2025, revealed an order for oxygen at 1-2 Liters per min via nasal cannula continuously. Monitor 02 saturation every shift. Record review of Resident # 7's care plan revised 11/06/2025, revealed Resident #7 had oxygen therapy related to shortness of breath. Interventions included Administer medications as ordered by physician. Monitor/document side effects and effectiveness. During an observation on 01/06/25 of Resident #7's room, at 10:20 A.M., revealed that the resident's nasal canula was hanging from a nail on the wall while not in use by the resident. Record review of Resident #28's face sheet dated 01/08/2025, revealed a [AGE] year-old resident admitted to the facility on [DATE]. Record review of Resident #28's history and physical document dated 01/07/2026, revealed a diagnosis of chronic kidney disease stage 3 (moderate damage to the kidneys, and are not filtering waste and extra fluid). Record review of Resident #28's annual MDS revealed a brief interview for mental status score of 06, indicating severe cognitive impairment. Section H- Bladder and Bowel indicated use of indwelling catheter. Record review of Resident # 28's Physician orders revealed an order for Suprapubic indwelling urinary catheter: 14 French with 10 milliliters normal saline balloon using a closed drainage system. Change monthly and as needed. Every night shift starting on the 15th and ending on the 15th every month related to CHRONIC KIDNEY DISEASE, STAGE 3 Record review of Resident #28's care plan revised on 1/05/2026 revealed the use of a foley catheter and was at risk for increased urinary tract infections and skin breakdown. Interventions included keeping tubing below the bladder level, non-kinked, and secured tubing via clip as indicated. During an observation of Resident #28 in his room on 01/06/26 at 10:17 A.M., revealed that the resident's foley catheter was lying on the floor next to the bed. In an interview on 01/08/2026 at 12:33 p.m., with CNA I who stated that foley catheter bags were to be kept off the floor and should be kept hanging from the bed below the bladder to prevent UTIs. She stated that a foley bag on the floor was an infection control issue. She stated that it was the responsibility of the CNAs and the nurses to ensure that the bags were not touching the floor. She stead that they check placement of the bags every time they round, she stated the CNAs round every (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2 hours and as needed. She could not recall the last Inservice conducted. In an interview on 01/08/2026 at 1:25p.m.,with LVN J who stated the foleys bag purpose was to collect urine. She stated that the foley bag should be hanging from the bed, below the resident's bladder to avoid urine backflow potentially causing a urinary tract infection. She stated that the foley bag should not be touching the floor because that was an infection control issue. She stated that it was the responsibility of all nurses and CNAs to ensure that the foley bags were off the floor upon rounding with residents every 2 hours or as needed. She stated that the facility provided an Inservice regarding foley care in November. In an interview on 01/09/2026 at 12:34 p.m., with the DON who stated that foley bags were supposed to be hung on the bed below the bladder. She stated that the foley bag was not supposed to be on the floor because it was an infection control issue. She stated that it was the responsibility of the nurses and CNAs to ensure that the foley bags were not on the floor throughout the shift while rounding. She stated that the facility also does angel rounds every morning where the department heads were assigned rooms, and they were to round on those rooms and ensure that foley bags were correctly placed. She stated that she could not recall the last in-service conducted regarding foleys. Record review of facility's Education In-Service Attendance Record, dated 06/30/2025, noted staff signatures and summary notated staff were trained over catheter care. Record review of the facility's Education In-Service Attendance Record, dated 01/07/2025, noted staff signatures and a summary of training session, read in part: oxygen administration must always be conducted in accordance with the orders provided by the medical doctor or nurse practitioner. Nurses must monitor oxygen saturation levels as prescribed to ensure that the resident is achieving the recommended saturation range. CNAs are required to report any issues pertaining to oxygen equipment, as well as any changes in behavior concerning the oxygen tubing, such as taking off the nasal cannula. Review of the facility policy and procedure titled Infection Control Program revised on 06/2024 read in part . Environmental safety measures involve the prevention of cross-contamination between different areas of the facility and the implementation of protocols for safe handling and storage of infectious waste .

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop, implement, and maintain an effective training program for all new and existing staff consistent with their expected roles for 3 of 8 employees (The Administrator, The Dietary Manager, and LVN N) reviewed for personnel files. -The facility failed to ensure The Administrator and LVN N had completed communication training on 01/08/2026 at 1:48 PM when staff had been employed for several months; the Administrator was employed for 2 and a half months and LVN N was employed for 5 and a half months. -The facility failed to ensure the Dietary Manager, the Administrator, and LVN N had completed orientation training for Restraint Reduction on 01/08/2026 at 1:48 PM when staff had been employed for several months; the Administrator was employed for 2 and a half months, the Dietary Manager was employed for 9 months, and LVN N was employed for 5 and a half months These deficient practices could result in staff not being appropriately trained to improve resident safety, create a more person-centered environment, and reduce the number of adverse events or other resident complications. Findings included: In an record review conducted during personnel files task on 01/08/2026 at 1:19 PM it was revealed that The Administrator and LVN N were not provided with communication training. It was additionally revealed that The Dietary Manager, The Administrator, and LVN N were not provided with an orientation of Restraint Reduction for new hires. It was reviewed that 6 of the employees had the same date of completion (06/25/2025) for communication training; Training completed in June was titled communication. Additionally, 5 of the employees reviewed had the same date of completion (03/27/2025) for restraint reduction training; Training completed in March was titled behavioral health and had notes on restraint reduction. Further investigation was prompted due to the observations made. In an interview conducted on 01/08/2026 at 1:48 PM with the Human Resources Director who stated the facility implements monthly Town Hall meetings to conduct annual trainings for all staff. He added that if an employee was a new hire, they complete an orientation and adhere to the monthly schedule of trainings to cover topics not included in the orientation. He stated that there was no policy in place as to when new hires were expected to complete mandatory training. He identified himself as the person responsible for ensuring training was completed by staff prior to providing direct care. He identified himself as the person responsible for maintaining documentation for training completion. He stated that a staff member who had not received training might not know how to handle the concern in question or who to seek assistance from. He stated that the communication training was completed in an all-staff session in June. He added that resident restraint training was a portion covered in the facility's behavioral health training conducted in 3/27/2025. He stated the facility was a physical/chemical restraint free facility, and staff were made aware at the time of hiring. He stated that it was unacceptable for staff to work with uncompleted training. He stated that town hall meetings were conducted by himself along with department leadership (DON, AODN, Administrator, Dietary Manager, Social Worker) dependent on the topic. He stated that the customer service section in the facility's orientation packet counted as communication training. In a follow up interview conducted on 01/08/2026 at 3:35 PM, he stated that the corporate office recognized the employee handbook (dated 01/2019) as a communication training because it was reviewed during the orientation and referenced page 4 under section titled Union Free. In a follow up interview conducted on 01/09/2026 at 10:25 AM, he presented printed PowerPoint slides from orientation and asked if they were sufficient to meet training requirements. No policy was provided for adequate training qualifications for communication. In an interview conducted on 01/09/2026 at 1:20 Pm with The Administrator, she stated corporate offices assigned monthly trainings conducted through town hall meetings. She recognized The Human Resources Director as the individual responsible for maintaining training records. She explained that the communication training received during orientation was about (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	skills to communicate with coworkers and residents. She stated training was essential because it provided staff with proper tools and knowledge. She stated that the orientation for new hires counted as an information session and as training. She added that the employee handbook counted as a form of training as well because all employees sign a form of acknowledgement. She stated that an employee that has not completed training could affect a resident by how staff communicated and assisted them. She confirmed that it placed a liability on the facility to have untrained staff providing direct care. Record review of the corporate policy and procedure titled Education dated on 12/2024 read in part: This program will cover essential information, skills, and expectations to promote competence and confidence in Job performance .Procedures . Education calendar: Monthly education topics will align with regulatory requirements, clinical needs, and organizational priorities .Tracking and Compliance: missed education must be completed via a ?Make-Up Packet' assigned and monitored by HR. Once the ?Make-Up Packet' is completed, this should be notated on the appropriate sign-in sheet .Identify and include any facility-specific topics or regulatory requirements for the upcoming meeting . Monitoring and Reporting: Review compliance reports and address concerns with individual employees as needed . Record review of the corporate orientation packet titled [NAME] up for Excellence: General Orientation Schedule undated read in part: Employee acknowledgement . I certify i have attended the general orientation program for this facility. I acknowledge that i have received verbal, written, video and/or online instruction regarding the facilities policies, procedures and guidelines. I recognize it is my responsibility to read and review the written guidelines provided to me during orientation and to seek clarification from my supervisor, department head, administrator or the human resources department if I have any questions regarding and of the facilities policies, procedures or guidelines . The only mention of training in the orientation packet is noted under Dementia Training. Record review of the facility's Employee Handbook revised on 02/2024 read in part: .the facility will not utilize physical or chemical restraints imposed for purpose of discipline or convenience that are not required to treat a resident's medical symptoms pursuant to applicable state and federal regulations . Under the title Employee Relations Philosophy and Problem Resolution of the Employee Handbook read in part: Union Free (subtitle) . It is the policy of the company to treat each employee with the respect and dignity that recognizes each person as an individual. The Company will make every effort to develop and maintain the kind relationship with its employees that will make The Company the choice in the long-term care industry. We believe that an open, honest, and direct line of communication with the employees is a critical link to success for all of us . Record review of the facility's document titled Facility Assessment undated, presented a table format with rows and columns. One column titled, Role with rows of positions in the facility read in part, Administrator .Licensed Nurses .Dietary Manager. An additional column titled Training Requirements that read in part, All Staff Training/Education was designated in the rows as a requirement for the Roles of Administrator . Licensed Nurses . Dietary Manager.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the facility treated each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the residents for 1 of 8 residents (Resident #87) reviewed for dignity. The facility failed to provide a privacy bag for Resident #87's foley bag. It was observed that the foley bag was visible on Resident #87's bedframe from the hallway on 01/06/2026 at 1:46 PM. This failure placed the residents at risk of poor self-esteem and decreased self-worth. Findings included: Record review of Resident #87's admission record dated 01/07/2026 revealed a [AGE] year-old female with an original admission date of 01/05/2026. Record review of Resident #87's MDS dated [DATE] reflected an incomplete MDS. Record review of Resident #87's care plan dated 01/05/2026 reflected an incomplete care plan. Record review of Resident #87's physical and health dated 1/2/2026 revealed the resident fell at her home and experienced a fracture in her Lumbar 1 and 2 (lower spine disc) with a suspected fracture to Thoracic 1 (torso spine disc). An observation and interview made on 01/06/2026 at 1:46 PM revealed Resident #87 foley-bag was without a privacy bag and could be seen from the hallway. An interview was attempted at 4:02 PM with Resident #87 who acknowledged surveyor but didn't engage in conversation verbally or by nonverbal means. In an interview conducted on 01/07/2026 at 1:53 with CNA B who stated that the foley bag was used for when residents had a catheter in place. CNA stated that she checked them every 1-2 days and assisted with emptying the foley bags. She identified nurses were responsible for ensuring the integrity and function of the tubing and foley bag. She stated that foley bags were not supposed to be without a privacy-bag and added that she did not know why they needed to be covered. She recognized fellow CNAs and nurses as people responsible for ensuring the resident's foley bag had a privacy cover. In an interview conducted on 01/07/2026 at 2:43 PM with LVN D who stated that the foley bag should have been placed below the entry point of the catheter and was used to collect/measure urine output. She stated that privacy bags were used to uphold residents' privacy as some individuals might feel embarrassed if their foley bags were visible. She stated that privacy bags for the foley were required for all residents as it was their right. She identified the individuals responsible for ensuring foley bags were covered as CNAs, nurses, and those who provide direct patient care. She stated that the last in-service for respect and dignity was within the last month. In an interview conducted on 01/08/2026 at 3:11 PM with the ADON who stated the purpose of the foley bag was to contain the urine released from through the catheter. She stated that the placement of the foley bag should be below the bladder but off the floor to prevent an infection. She stated that a foley bag also required a privacy bag as this was a dignity concern for residents without a privacy bag. She stated that without the privacy cover, other residents could see the foley bag, and a resident could feel uncomfortable because it was a personal condition. She stated it was a resident's right to have a privacy bag for their foley bag. She stated that staff were trained to cover foley bags with privacy covers. She was unable to recall the last in service on foley bags; no documentation was provided for the latest in-service on foley bags when requested. In an interview on 01/09/2026 at 12:34 p.m. with The DON revealed that foley catheter bags were to be in a privacy bag and not touching the floor. She stated that the privacy bag was to conserve the residents' dignity. She stated that foley bags should be in privacy bags while in the room and out in the hallway. She stated that the foley not being in a privacy bag could cause the resident to feel embarrassed. She stated that it was the responsibility of the CNAs and nurses to ensure that the foley bags were in a privacy bag upon rounding. She stated that CNAs and nurses conduct rounds every two hours and as needed. She could not recall when the last in-service completed; no documentation was provided for the latest in-service on foley bags (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when requested. Record review of facility's Education In-Service Attendance Record, dated 06/30/2025, noted staff signatures and summary notated staff were trained over catheter care. Record review of the facilities policy and procedure titled Catheter Care revised on 02/2024 read in part . Store the catheter bag in a privacy bag to maintain dignity .

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure in response to allegations of abuse, neglect, exploitation, or mistreatment the facility had evidence that all alleged violations were thoroughly investigated and prevent further abuse, neglect, exploitation, or mistreatment while the investigation was in progress for 1 of 10 residents (Residents #12) reviewed for abuse/neglect. The facility failed to investigate an allegation of neglect of Resident #12 on 01/05/2026 when Resident #12 was noted to have bruising to the left eye by LVN L and LVN M. Resident allegedly fell off the bed during an unknown night. These failures could place residents at risk for abuse, neglect, emotional distress, physical harm, and trauma.the findings included: Record review of Resident #12's face-sheet dated 01/07/2025 revealed resident was an [AGE] year-old male with admission date 11/26/25. Record review of Resident #12's admission MDS dated [DATE] revealed a BIMS score of 12, indicating moderate cognitive impairment. Section GG- Functional Abilities noted Resident #12 was dependent, meaning the helper does all the effort and the resident does none of the effort to complete the activity, for the following: rolling left and right, lying to sitting on side of bed, sit to stand, chair/bed-to-chair transfer, toilet transfer, shower transfer. It also noted Resident #12 required substantial/maximal assistance from sitting to lying. Record review of Resident #12's Care Plan, revised 01/06/25, revealed the resident was at risk for falls and injuries. Interventions included for nursing staff to: anticipate needs and provide prompt assistance, ensure call light is within reach and is answered promptly, keep frequently used items at resident bedside, 01/02/2026 therapy screened status post fall. Head to toe assessment completed, Physician notified with no new orders. Record review of Resident #12's History and Physical dated 01/07/2026 revealed medical history: Idiopathic Pulmonary Fibrosis (a lung disease characterized by scarring of lung tissue making it difficult for the lungs to function properly), Chronic Respiratory Failure (a serious condition that occurs when the lungs cannot properly exchange oxygen and carbon dioxide, leading to elevated carbon dioxide levels or insufficient oxygen in the blood), and Liver Cirrhosis (characterized by scarring of the liver tissue, causing the liver to not function properly). Nurse Practitioner O notated a physical assessment was completed on 01/07/2026, and the eyes were noted as atraumatic (meaning without of trauma or injury) and EOMI, or Extraocular Movements Intact, meaning the muscles controlling eye movement were working normally, allowing smooth tracking in all directions without pain, weakness, or double vision. It was noted to continue with current plan of care. Record review of Resident #12's progress notes revealed Resident #12 had an unwitnessed fall on 01/02/2026 at 10:20 AM, and he was found on the floor. It noted Resident #12 alleged he landed on his buttocks. Progress note dated 01/02/2026 noted neurological checks were ordered and completed.Record review of Resident #12's progress notes also revealed the following: LVN L notated on 01/05/2026 at 1:47 PM that Resident noted to have bruise [left] eye, asked him about pain he denied, he said ?It's from my previous fall on Friday . It also revealed LVN M notated on 01/05/2026 at 08:09 PM, This nurse resident [family member] discussed his bruising to left eye. Resident states it was a night he rolled out of bed. Nurse educated on Lorazepam and [side effects]. He is on Mirtazapine 15 mg [at bedtime], if does not help resident will notify nurse to report to [Resident #12's Hospice service] of other medications for sleep . Plan of care ongoing. The progress notes from 01/02/2026 to 01/05/2026, had not included any documentation regarding Resident #12's allegation of falling during the night and hitting his head, or bruising to his left eye, until notated by LVN L on 01/05/2026 at 1:47 PM. Record review of Resident #12's Neurological Record dated 01/02/2026, revealed: Q 15-minute checks for 4 times, Q 30-minute checks twice, Q 1-hour checks for three times, and Q twice a day for 2 days after that, were completed. No issues identified. Record Review of Resident #12's Order Summary report dated 01/08/2026 revealed Resident #12 was not taking or prescribed anticoagulant medications. Record review revealed there was no incident report relating to resident's allegation of a second fall during (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the night and allegedly hitting his head on his nightstand next to his bed, located in his room.In an observation and interview on 01/08/2026 at approximately 11:40 AM with Resident #12 and their family at bedside revealed Resident #12 had two falls this past weekend, on Friday 01/02/2026, and possibly Saturday night 01/03/2026 or Sunday night 01/04/2026, per Resident #12's family. Resident #12 was observed with dark purple bruising on the left eye area. There were no cuts or open wounds observed. Resident #12 stated they were unable to recall what night but stated he fell off his bed during the middle of the night and hit his head on the nightstand placed on the left side of his bed. He stated he was unable to recall whether staff assisted him back into his bed, or if he did independently, but stated he would not be able to get himself into bed without help. Resident #12's family stated they visited Resident #12 Saturday morning 01/03/2026, and Resident #12 did not have any bruise on his face. Resident #12's family stated they came on Monday 01/05/2026 and observed Resident #12 with bruising around his left cheek and eye. They stated they went to speak with the nurses to follow up on what caused the bruising, but the nursing staff was unaware and did not find documentation regarding Resident #12's bruise. Resident #12's family stated the resident did not mention anyone helping him back into bed after the second fall, so she did not believe anyone helped him, and believed Resident #12 got himself back into bed. Resident #12 and his family stated they were overall content with the facility and services, and Resident #12 stated he felt safe at the facility.In an interview on 01/08/2026 at 1:40 PM with LVN L stated he notified the family and physician about the fall that happened on Friday 01/02/2026, and he was unaware of any other falls after that. He stated he was informed of the bruising to Resident #12's left side of face during the end of his shift on Monday 01/05/2026, and during shift change while giving report to LVN M, and LVN M was present when informed of the new bruise. He stated that LVN M was to report it as she was taking over the shift. He stated he also believed the bruising to Resident #12's eye was related to the fall that happened on 01/02/2026, and stated Resident #12 was already being monitored for neurological changes, for 72 hours post-fall, relating to the fall on 01/02/2026. He denied observing any bruising to Resident #12's left eye during his shift on 01/02/2026, including after the fall. He stated there were no changes or documentation noted relating to Resident #12's bruising to left eye over the weekend of Friday 01/02/2026, until LVN L's next shift that following Monday 01/05/2026. He stated the potential risk for residents' injuries or accidents not being reported to DON, Administrator, and Physician, included a potential risk for internal bleeding being undetected as no one would be aware of monitor acute changes. He stated that Resident #12's Hospice service was notified. He stated nurses were responsible for reporting accidents or injuries to the DON, Administrator, and Physician, though he stated he was not sure if the on-going or off-going nurse were responsible during a shift change. Interview attempt made to Physician via phone on 01/08/2026 at 2:21 PM and 2:22 PM, no answer and unable to leave contact information or message. Interview attempt made to Nurse Practitioner O via phone on 01/08/2026 at 2:24 PM, no answer. Purpose of call and call back information left. During an interview on 01/08/2026 at approximately 2:30 PM, this surveyor notified ADON, and DON of the phone call attempts made to Nurse Practitioner O. This surveyor requested the ADON and DON to contact Nurse Practitioner O to advise her to speak with this surveyor, they stated they understood and would contact Nurse Practitioner O.In an interview on 01/08/2026 at 3:03 PM with LVN M, she stated she worked the afternoon shift on Friday 01/02/2026 and was aware Resident #12 had a fall during the morning shift. LVN M worked 01/02/2026 afternoon shift. She stated Resident #12's Hospice service, Responsible Party, and NP were notified. She stated she did not observe a bruise of Resident #12's face during her afternoon shift on Friday 01/02/2026, which ended at 10:00 PM. She stated she was present during shift change on Monday afternoon 01/05/2026, when Resident #12's family went to the nurse's station to follow up on the observed bruising of Resident #12's face, which was observed on Resident #12's face, around the eye area. She stated she notified Resident #12's hospice service, and stated the NP was notified that day by LVN L, as the NP made their rounds in the morning. She stated Resident (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#12's medication was discussed to be changed, as she believed the night prescription, Lorazepam, contributed to Resident #12's fall. She stated Resident #12's new bruise to his left eye was considered a Change of Condition, which required nursing staff to notify the Physician or NP, the DON, and Administrator, once made aware. She stated she notified the DON on 01/05/2026 of the Resident #12's alleged second fall. In an interview on 01/09/2026 at 11:12 AM with the ADON, she stated she was not notified of Resident #12's bruising on the left side of his face because she was not the Nurse Management on-call that afternoon. She stated nursing staff were trained and expected to report new findings or acute changes to the physician, DON, Unit Manager, and family or Responsible Party of the involved residents. She stated she was unable to recall last Abuse, Neglect, and Exploitation, in-service. In an interview on 01/09/2026 at 12:20 PM with the DON, she stated she was notified of Resident #12's falls and injuries by LVN M. She stated Resident #12 sustained a fall, which he was assessed and reported to the Physician. She stated she did not observe any bruising or acute changes on Resident #12's face on Friday, 01/02/2026. She stated that the nurse was responsible for monitoring residents and reporting incidents or injuries to the physician, DON, and Administrator. She stated changes in condition were to be investigated, specifically for Resident #12, to confirm the fall and what happened. She stated it was also investigated to confirm there was no abuse. She stated self as the DON, and the Administrator were responsible for monitoring and investigating allegations of Abuse, Neglect, and Exploitation, and Injuries with unknown origin. In an interview on 01/09/2026 at 02:01 PM with the Administrator, she stated she was unable to recall or confirm if she was notified of Resident #12's bruising of his left eye. She stated staff were responsible for notifying her, as the Administrator and Abuse Coordinator, of incidents such as Resident #12's bruising of his left eye. She stated the expectation was for staff to also notify the physician, family, and Nurse Management, and to complete an incident report for Resident #12's injury. She stated that the purpose of notifying the Administrator and Abuse coordinator was for the facility to investigate and ensure the safety of the residents. Record review of the facility's policy Risk Management- Incidents & Accidents, revised 01/2024, read in part: Policy- The Facility will assess residents for risk factors of potential accidents/hazards. The facility will recognize the signs of incidents/accidents and assist residents, staff members, and visitors as indicated. The facility will conduct a thorough investigation as indicated to determine underlying causes and contributing factors to incidents and accidents; and will put interventions in place from the investigative findings and IDT input. Additionally, it stated under Special Considerations- the Facility Administrator should determine incidents/accidents that require thorough investigations and ensure completion. Record review of the facility's policy Abuse, Neglect, and Exploitation (ANE) Prohibition, revised 10/2024, read in part: The Nursing Facility strictly prohibits abuse, neglect, exploitation, or any mistreatment of residents by anyone at the facility . The Administrator or appointed desginee serves as the ANE Prohibition Coordinator, overseeing the policy and investigations. Under Investigation, the policy noted The Facility will conduct a timely investigation of any alleged abuse/neglect, exploitation, mistreatment, injuries of unknown origin, or misappropriation of resident property. The investigation should include gathering evidence, interviewing witnesses, conducting surveys as indicated, reviewing medical records, and examining any relevant documentation.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and record review, the facility failed to ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for two of twelve residents (Resident# 6, and Resident #80) reviewed for ADL care. -The facility failed to ensure Resident #6 face was clean and free of facial hair on 01/06/26.-The facility failed to ensure Resident #80's fingernails were clean and free from debris on 01/06/26. This failure could place residents who required assistance with ADL's at risk for unmet care needs. Record review of Resident #6's face-sheet dated 01/07/2026, revealed a [AGE] year-old female with initial admission date 05/20/2022, and re-admission date 08/11/2024. Record review of Resident #6's Quarterly MDS dated [DATE], revealed a BIMS score of 12 indicating moderate cognitive impairment. Section GG-Functional Abilities notated Resident #6 was dependent on assistance, meaning the helper does all the effort to complete activities, for personal hygiene including shaving. Record review of Resident #6's Health and Physical dated 01/05/2026, revealed a medical history of depression (a mental health condition that consists of persistent feelings of sadness and loss of interest in daily activities), cerebral infarction (occurs when the blood vessel in the brain is blocked, leading to tissue damage and cell death due to lack of oxygen), and hemiplegia (a condition characterized by paralysis on one side of the body, meaning loss of motor function, impaired coordination, and changes in sensation on the affected side). Record review of Resident #6's Care plan revised 03/12/2024, revealed resident had an ADL Self Care Performance deficit related to generalized weakness. The interventions noted Resident #6 required extensive assistance with x1 staff participation with personal hygiene and oral care. Record review of Resident #80's face sheet dated 06/19/25 revealed resident was an [AGE] year-old male with an initial admission date 09/10/24. Record review of Resident #80's health and physical dated 01/07/2026 revealed medical diagnoses of transient ischemic Attack and cerebral infarction without residual deficits (a temporary blockage of blood flow to brain, causing stroke like symptoms without causing permanent brain damage). Record review of Resident #80's Quarterly MDS dated [DATE] revealed a BIMS score of 06 indicating severe cognitive impairment. Section GG-Functional Abilities notated Resident #80 was dependent on assistance, meaning the helper does all the effort to complete activities to maintain personal hygiene. Record review of Resident #80's care plan revised on 12/09/25 revealed resident has an ADL self-care deficit and called for staff to provide assistance as needed with grooming, bathing, and personal hygiene with one person staff. In an observation and interview on 01/06/2026 at 9:55 a.m., Resident #80 was observed to have long fingernails with dark debris under nails on right hand. He stated that his nails had not been cut, and that staff had not asked if he would have to like them trimmed. He stated that he would like them to be trimmed. In an observation and interview on 01/06/2026 at 9:56 AM with Resident #6, she was observed with hair on her chin. She stated she did not answer personal questions and declined to answer the question regarding grooming. In an observation on 01/07/2026 at approximately 1:20 PM, nursing staff were shaving Resident #6's facial hair in the resident's room. In an interview on 01/08/2026 at 12:33 P.M., with CNA I stated that nails were trimmed at least once a month but were checked every time residents were showered; she stated that residents were showered three times a week. She stated that if a resident was noticed to have long dirty fingernails, they would verify if the resident was not a diabetic resident as they were not allowed to cut those residents fingernails, if they were not diabetic they would ask the resident if they would like them cut, and if the resident said yes they would cut them and if they said no they were to respect the resident. She stated that risks of having long dirty fingernails were that residents ran the risk of becoming sick from their stomach because they eat with their hands and long fingernails harbor bacteria. She stated that CNAs and nurses were responsible for ensuring that all fingernails were cleaned and trimmed. She stated that the last Inservice over ADLS was provided last (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	month. CNA I also stated residents were offered or shaved residents during their scheduled shower days, which was every other day. She stated nursing assistants were trained to monitor residents and offer grooming services such as shaving if it was observed, especially for female residents. She stated the nurse monitor and were notified if the resident refused, so another attempt could be made before calling family for assistance if needed. CNA I stated the risks of female residents having facial hair included negatively affecting their self-esteem and confidence. In an interview on 01/08/2026 at 1:21 PM, LVN J revealed that nails were cut once a month by nurse and CNAs. She stated that both nurses and CNAs were responsible for ensuring the residents' nails were clean and trimmed. She stated that the risk for residents having long dirty fingernails was the potential risk of exposure to bacteria that grows under the fingernails when they eat food or touch their face. She stated that the facility provided an ADL Inservice last month. LVN J also revealed that CNAs were responsible for shaving residents. She stated residents were offered shaving during the resident's scheduled shower days, or if a resident was observed with facial hair for females, or too long of facial hair in males. She stated nursing was responsible for monitoring residents; including for grooming. She stated the risks of a female resident having facial hair included resident's dignity being negatively affected. In an interview on 01/09/2026 at 11:15a.m., the ADON revealed that nails were cut depending on necessity. She stated that nails were observed with every shower; residents were showered three times a week. It was the responsibility of CNAs and nurses to ensure that residents' fingernails were cleaned and trimmed. She stated that residents with long fingernails could potentially injure themselves by scratching themselves and could be an infection control issue because of the bacteria that can be found under long fingernails. She stated that she would verify the date of the last ADL Inservice. In an interview on 01/09/2026 at 12:13 p.m., DON stated that fingernails were checked with every shower; residents were showered every other day. Nurses and CNAs were responsible for ensuring that residents' nails were clean and trimmed. She stated heads of departments were assigned rooms, and every morning residents were rounded on. These rounds included checking residents' nails and overall appearance. She stated that the risk posed to residents with long fingernails included infection control because residents eat and touch their faces. She stated that she needed to verify the date of the last ADL Inservice for the facility provided. The DON also stated CNA's were responsible for monitoring residents' facial hair and need for shaving. She stated nurses were responsible for monitoring and confirming that these services were provided. She stated the potential risks of females having facial included for her to be bullied by other residents and could possibly affect her dignity unless resident declined to be shaven. In an interview on 01/09/2026 at 1:54p.m., the Administrator revealed that she was not sure about how often nails were trimmed or if there was a scheduled day for nails to be trimmed. She stated that residents with long nails were at risk of injuring themselves by scratching themselves. She stated that competencies were done yearly, and those included ADL training. The Administrator stated the CNA's were responsible for grooming including nails and facial hair. She stated nursing management monitored CNA's and nurses, but she was unsure how often. She stated the potential risk for a female resident with facial hair was a dignity issue. Record review of the facility's Education In-Service Attendance Record titled Monthly Education-ADL's . dated 10/06/2025, included staff signatures and summary of training session which included nail care, grooming. Review of the facility's policy Activities of Daily Living-Highest Level of Functioning, revised 03/2019, read in part: Policy: It is the policy of this facility to provide care and services to ensure that a resident is able to maintain their ability to self-perform their activities of daily living, at their level of functioning prior to facility admission, unless circumstances of the individual's clinical condition demonstrate that diminishment in ability was unavoidable. The facility is responsible to provide necessary care to all residents who are unable to carry out activities of daily living on their own to ensure they maintain proper nutrition, grooming, and hygiene. Definitions- Activities of daily living (ADLs), refer to tasks related to personal care including grooming .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that 1 (Resident #4) of 8 Residents reviewed for professional standards, received care in accordance with professional standards of practice and the comprehensive person-centered care plan. -The facility did not ensure that Resident #4 was provided with repositioning at least every two hours on 01/06/2025, Resident #4 was observed sitting up in his bed, facing the TV placed in front of his bed at the following times: 9:31 AM, 11:38 AM, 1:40 PM, and 3:00 PM. This failure could affect the residents requiring staff assistance for repositioning, placing them at risk for skin breakdown and discomfort. The findings included: Record review of Resident #4's admission Record dated 01/06/2026 revealed an [AGE] year-old male with initial admission date 10/25/2022, and re-admission date 01/05/2026. Record review of Resident #4's Quarterly MDS dated [DATE] revealed no BIMS score. As noted, Resident #4 was rarely/never understood. Section GG- Functional Abilities noted Resident #4 was dependent on staff to roll left and right, or transferring, meaning the helper does all the effort to complete the activity. Record review of #4's History and Physical dated 01/07/2026, revealed a medical history of Parkinson's disease (a disease that affects the nervous system which causes tremors or shakiness, muscle stiffness, unstable posture, difficulty walking, and slowed body movements), dysphagia (difficulty swallowing), and Gastrostomy status (meaning resident had a gastrostomy tube or G-tube, which was surgically placed to provide direct access to the stomach for nutrition, hydration, and medication). Record review of Resident #4's Care Plan revised 04/28/2025, revealed resident was at risk for alteration in comfort, and at risk for pain. The care plan included the following interventions for staff: Assist with turning and repositioning every 2 hours and as needed to aide in comfort. During observations on 01/06/2026, Resident #4 was observed sitting up in his bed, facing the TV placed in front of his bed at the following times: 09:31 AM, 11:38 AM, 1:40 PM, and 3:00 PM. During an observation and interview on 01/06/2026 at approximately 03:05 PM with LVN K, she was requested to perform a skin assessment on Resident #4. The resident's buttocks area was observed with redness. LVN K stated the redness could be caused by sitting in the same position for a prolonged period of time. She stated CNA's were responsible for repositioning residents every 2 hours to prevent pressure ulcers or wounds. She stated nurses were responsible for monitoring and ensuring residents were in fact being repositioned every 2 hours. She stated nurses round on residents 2-3 times a shift. In an interview on 01/08/2026 at 12:45 PM with CNA I stated residents were to be repositioned every 2 hours. She stated nurses were responsible for monitoring residents and making sure residents were being repositioned. CNA I stated nurses round daily in the beginning of their shifts. She stated the potential risks for residents being in the same position for a long time, more than 2 hours, including pressure ulcers being developed. In an interview on 01/09/2026 at 12:10 PM with the DON stated Resident #4 was dependent on staff to assist with repositioning. She stated residents were to be repositioned every 2 hours, to prevent redness or development of wounds. She stated nurses round and reposition residents 2-3 times a day. She stated the ADON and self as the DON, monitor nursing staff and ensure residents were being repositioned every 2 hours. In an interview on 01/09/2026 at 1:56 PM with the Administrator, who stated she was unsure how often nursing staff reposition residents, but she was aware nursing staff would complete round on residents every 2 hours. She stated nursing management monitor nursing staff to make sure they repositioned residents. She stated the possible risk for residents sitting in the same position for a long time included the risk of pressure ulcers. Record review of the facility's Education In-Service Attendance Record titled Monthly Education-ADL's . dated 10/06/2025, included staff signatures and summary of training session which included repositioning residents. Record review of the facility's policy Turning and Repositioning, revised 06/2019, read in part: The turning/repositioning programs should be individualized to the resident. It should be organized, planned, documented, monitored, and evaluated based on an assessment of the resident's needs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675723	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nazareth Living Care Center	1475 Raynolds St El Paso, TX 79903

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to dispose of garbage and refuse properly for 1 of 1 facility dumpster. The facility failed to ensure the facility dumpster was closed by the 2 top lids and 2 sliding metal side doors on 01/07/2026 at 1:15 PM. The facility failed to ensure the surrounding area was free of debris as observed on 01/07/2026 at 1:17 PM where a mattress, hospital bed, and wooden pallet were abandoned on the exterior of the facility dumpster. This failure could result in an infestation of rodents and insects in the dumpster and facility. Findings included: An observation conducted on 01/07/2025 at 1:15 PM of the exterior dumpster revealed 3 of the 4 access points (2 side sliding metal doors, 1 plastic overhead lid) to the dumpster were left open. Additional observation revealed a mattress, a hospital bed, and wooden pallet were left as waste around the exterior of the facility dumpster. In an interview conducted on 01/07/2026 at 1:16 PM with the Dietary Manager who stated the dumpster was not in appropriate condition because it was left open for rodents and insects to access. He added it was left open by landscaping and recognized self as the person responsible for maintaining the dumpsters cleanliness and closure. He identified the kitchen doors as the nearest opening from the dumpster and stated there was potential for a dumpster infestation to enter the kitchen. He stated kitchen infestation could affect the residents by exposing them to contamination of food and food-borne illnesses. In an interview conducted on 01/08/2026 at 9:13 AM with Dietary Aide H who stated that every department in the facility used the dumpster. She stated she was trained to apply gloves, collect trash in the kitchen/dining, discard in the dumpster, close the dumpster, and wash her hands upon reentry. She stated all staff members were responsible for closing the dumpster but assumed the kitchen staff primarily responsible because they were the closest to the dumpster. She stated that the trash needed to be closed at all times to prevent infestation of insects and rats. She added that the insects and rats could potentially enter the facility through the kitchen which would affect the residents. She stated she never received an in-service for waste disposal. In an interview conducted on 01/08/2026 at 12:46 PM with the Director of Maintenance, he stated the dumpster needed to be closed when not in use due to the potential for cross contamination and infestation of rodents and insects. He identified that every staff member and contractor was responsible for ensuring the trash can was closed following usage. He stated debris cannot be around the dumpster because it presents a bad image of the facility. He denied having a policy in place for dumpsters, trash cans, or waste. In an interview conducted on 01/09/2026 at 11:42 AM with the DON, she stated staff needed to ensure the bags were tied and closed before discarding them in the dumpster. She added that staff needed to close the dumpster after use to prevent insects and mice from accessing the dumpster. She stated that if insects and mice were in the trash, they could eventually enter into the facility. She stated it would be an infection control issue and hazard to the residents if the facility had insects and mice inside. She stated there was no recent in-service or training for waste disposal provided to nurses and CNAs. In an interview conducted on 01/09/2026 at 1:28 PM with the Administrator who stated that all the employees and vendors used the dumpster. She added that it was expected that all staff members would maintain and monitor the dumpster when they used it to prevent overflow and infestation. She described the dumpster should be free of debris in the surrounding area and to be closed by the lids and side doors. She stated that this was done to prevent the dumpster from attracting insects and rodents. She clarified that if this wasn't done, the insects and rodents could potentially enter the facility. She stated that insects and rodents in the facility would be a health hazard that affected the residents. Record review of the facility's policy dated 06/2019, titled Waste Disposal read in part: waste will be disposed of in a manner to prevent the transmission of disease, nuisance or breeding place for insects and feeding places for rodents and other mammals . 5.Cover waste containers and close dumpsters at all times . 7. Keep area around the refuse dumpster clean, odor and rodent free.