STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675801	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gilmer Nursing and Rehabilitation	703 Titus Street Gilmer, TX 75644

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and provide care in a manner that promotes maintenance or enhancement of his or her quality of life for 3 of 3 residents (Resident #9, Resident #12, and Resident #31) reviewed for resident rights. The facility failed to ensure CNA K did not stand over Resident #9 and Resident #31 while assisting them to eat on 03/11/2026. The facility failed to ensure CNA K was not on her personal cell phone when assisting Resident #9 with eating and while sitting with Resident #12 on 03/11/2026. These failures could place residents at risk of decreased self-worth, loss of dignity, and a diminished quality of life.Findings included: 1. Record review of a face sheet dated 03/11/2026 indicated Resident #9 was an [AGE] year-old male admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease (progressive disease that destroys memory and other important mental functions) and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (paralysis/weakness affecting the left side of the body after a stroke). Record review of Resident #9's Quarterly MDS assessment dated [DATE] indicated he was sometimes understood and sometimes understood others. The MDS assessment indicated Resident #9's BIMS score was 0, which indicated his cognition was severely impaired. Record review of Resident #9's care plan revised 01/23/2026 indicated he required assistance of one staff member with eating. During an observation on 03/11/2026 at 9:30 AM, CNA K assisted Resident #9 with eating his pudding snack. CNA K was standing up next to Resident #9 and started giving him the pudding snack by pressing the spoon against his lips. After a couple seconds Resident #9 realized, she was trying to give him the pudding and he opened his mouth and started eating. While she was assisting Resident #9 with his pudding, she pulled her cell phone out of her pocket, looked at it, and then returned it to her pocket. 2. Record review of a face sheet dated 03/11/2026 indicated Resident #12 was an [AGE] year-old female initially admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease (progressive disease that destroys memory and other important mental functions) and dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life). Record review of Resident #12's Quarterly MDS assessment dated [DATE] indicated Resident #12 was sometimes understood by others and sometimes understood others. The MDS assessment indicated Resident #12 had a BIMS score of 0, which indicated her cognition was severely impaired. Record review of Resident #12's care plan reviewed 12/21/2025 indicated she had a communication problem to anticipate and meet her needs and provide a safe environment. During an observation on 03/11/2026 at 11:55 AM, Resident #12 was sitting at a table in the secure unit's dining area with CNA K. CNA K was utilizing her cell phone while she was sitting at the table with Resident #12. 3. Record review of a face sheet dated 03/11/2026 indicated Resident #31 was an [AGE] year-old male initially admitted to the facility on [DATE] with diagnoses which included chronic systolic congestive heart failure (heart is unable to pump enough force to push enough blood into circulation) and dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere with daily life). Record review of Resident #31's Quarterly MDS (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessment dated [DATE] indicated Resident #31 was sometimes understood by others and sometimes understood others. The MDS assessment indicated Resident #31's BIMS score was 4, which indicated his cognition was severely impaired. Resident #31's MDS assessment indicated he required partial/moderate assistance with eating. Record review of Resident #31's care plan revised 01/04/2026 indicated he had an ADL self-care performance deficit and required supervision with eating as needed. During an observation on 03/11/2026 at 12:28 PM, CNA K was standing over Resident #31 while assisting him to eat his lunch. During an interview on 03/11/2026 at 3:24 PM, LVN L said when they were assisting residents with their meals they should sit down next to the residents because if they were standing up it was demeaning to the residents. LVN L said she was responsible for ensuring the CNAs were doing this. LVN L said she noticed CNA K was standing when assisting residents with their meals, but it didn't click in her mind or she would have told her something. LVN L said when assisting residents with their meals the CNAs should explain to them what they were doing, so the residents would not get scared. LVN L said she noticed CNA K was on her phone while with the residents, and she should not be doing this. LVN L said if CNA K was on her phone she was not providing correct care and not giving the residents the correct attention. LVN L said this could make the residents feel like they did not care about them. During an interview on 03/11/2026 at 3:39 PM, CNA K said when she assisted residents with their meals she should be sitting down next to them. CNA K said when she was assisting the residents she should explain to them what she was doing. CNA K said she should not be on her phone when she was with the residents. CNA K said it did not cross her mind to sit down next to Resident # 9 and Resident #31 when assisting them to eat. CNA K said she was messaging a family member when she was sitting at the table with Resident #12, and she should have stepped away from the resident to use her cell phone. CNA K said using her cell phone in front of the residents could make them feel like she was not paying attention. CNA K said it was important to sit next to the residents to assist them with their meals and explain what she was doing so they would not choke or get irritable. During an interview on 03/13/2026 at 1:10 PM, the DON said the CNAs should be sitting next to the residents while assisting them with their meals so they could have eye contact with them. The DON said when assisting the residents the CNAs should explain what they were doing and direct them face to face. The DON said this was important so the staff could be one on one with the residents, so the residents would not be scared, and so the residents did not have to look up at the staff while they were eating. The DON said the staff should never have cell phones in patient care areas. The DON said the staff should not have their cell phones while assisting the residents with their meals so they could ensure the residents did not choke and to provide direct care to the residents. The DON said the staff having their cell phones in patient care areas could make the residents feel like they were not paying attention to them, and they could get more agitated because the staff were not focused on assisting them with completing their tasks. The DON said the charge nurses were responsible for monitoring the CNAs. During an interview on 03/13/2026 at 1:25 PM, the Administrator said she expected the CNAs to sit in a chair at the residents' level, when they were assisting them with their meals. The Administrator said the charge nurses, DON, DON designee, and herself provided monitoring. The Administrator said she had not noticed the CNAs standing over the residents while assisting them with their meals. The Administrator said it was important to sit at the residents' level, so they did not feel intimidated. The Administrator said she expected the staff to get in the residents' line of sight, introduce themselves, and explain what they were going to do. The Administrator said this was important so the residents understood what was happening with their care and they could participate to the best of their abilities. The Administrator said she expected the staff to engage in resident care and activities and remain off their cell phones when with the residents. The Administrator said the staff having their cell phones when with the residents could make them feel unseen and like they were not getting the attention they needed. Record review of the facility's undated policy titled, Resident Rights, indicated, A facility must treat each resident with respect and dignity and care for each resident in a manner and (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 resident. Respect and dignity - The resident has a right to be treated with respect and dignity, including: 3. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment, for 3 of 6 residents (Resident's #52, #1 and #39) reviewed for care plans.1.The facility failed to ensure Resident #52 and Resident #1 were care planned for use of Eliquis (a prescription anticoagulant (blood thinner) used to reduce stroke risk in nonvalvular atrial fibrillation (fast, uneven heartbeat), to treat or prevent deep vein thrombosis (a serious condition where a blood clot forms in a deep vein, usually in the legs, causing symptoms like swelling, pain, warmth, and redness), and pulmonary embolism (blockage in a lung artery). 2.The facility failed to ensure Resident #39 was care planned for the use of Refresh Tears Ophthalmic Solution (quickly alleviates dryness, irritation, and discomfort by replenishing moisture to the eyes.)These failures could place residents at risk of not receiving appropriate interventions to meet their current needs.Findings included:1. Record review of Resident #52's face sheet, dated 03/16/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #52 had diagnoses which included Atrial fibrillation also known as AFib (is an irregular and often very rapid heart rhythm), stroke, diabetes (high blood sugar), and high blood pressure.Record review of Resident #52's quarterly MDS assessment, dated 12/31/25, reflected Resident #52 sometimes made herself understood and was usually understood by others. Resident #52's BIMS score was 05, which indicated her cognition was severely impaired. Resident #52 used anticoagulant during the 7-day look back period.Record review of Resident #52 ?s physician orders, dated 04/04/25 reflected, Eliquis Oral Tablet 5 milligram (Apixaban) Give 1 tablet by mouth two times a day related to atrial fibrillation.Record review of Resident #52's care plan, last review date of 01/07/26, did not reflect she had an anticoagulant care plan. 2. Record review of Resident #1's face sheet, dated 03/16/26, reflected an [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #1 had diagnoses which included pneumonia (an infection that inflames the air sacs in one or both lungs), dementia (loss of memory), Dysphagia (problem swallowing), and high blood pressure.Record review of Resident #1's admission 5-day MDS assessment, dated 02/27/26, reflected Resident #1 sometimes made himself understood and was sometimes understood by others. Resident #1's BIMS score was 04, which indicated his cognition was severely impaired. Resident #1 used anticoagulants during the 7-day look back period.Record review of Resident #1's physician orders, dated 02/13/26, reflected Eliquis Oral Tablet 5 MG (Apixaban) Give 1 tablet by mouth two times a day related to prevention.Record review of Resident #1?s care plan, dated 02/13/26, did not reflect he had an anticoagulant care plan.3. Record review of Resident #39's face sheet, dated 03/16/26, reflected Resident #39 was an [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #39 had diagnoses which included detachment of the retina of the left eye (a serious eye condition that affects your vision), and macula of the left eye (a small, central area of the retina responsible for sharp, detailed, and color central vision, essential for reading and driving).Record review of Resident #39's quarterly MDS assessment, dated 01/26/26, reflected Resident #39 understood and was understood by others. Resident #39 had a BIMS score of 15, which indicated he was cognitively intact. The MDS assessment did not reflect Resident #39 had received eye medication within the last 7 days of the look-back period. Record review of Resident #39's care plan, last reviewed on 12/12/25, did not reflect a care plan for his dry eyes. Record review of Resident #39's physician order, dated 12/18/25, reflected Refresh Tears Ophthalmic Solution 0.5 % (Carboxymethylcellulose Sodium). Instill 1 drop in both eyes two times a day for dry eyes.During an interview on 03/13/26 at 11:01 a.m., the MDS Nurse (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said she was responsible for long term care residents care plans. She looked at Resident #52, and Resident #1's care plan and said she did not see the medication of Eliquis for anticoagulant or eye drops for Resident #39 on his care plan. She said those medications and interventions should have been added to their care plan when she did their MDS assessment. She said it must have been an oversight. She said care plans reflected the care of the residents, what problems they might have and what staff should be doing to monitor their care. She said the risk of not having medications on their care plan was they could potentially have interventions missed.During an interview on 03/13/26 at 12:13 p.m., the DON looked and verified Resident #52 and Resident #1 did not have a care plan for the medication of Eliquis nor did Resident #39 have a care plan for his eye drops. She said the IDT was responsible for ensuring all care plans were started and/or updated as needed during their weekly meetings. She said she did random checks in their weekly meetings to make sure the care plans were done. She said if care plans were not done, it could place residents at risk of not being properly cared for and nurses not knowing their needs. During an interview on 03/13/26 at 1:04 p.m., the Administrator said the MDS nurse was responsible for care plans. She said care plans were done to paint a picture of the resident care. She said if the care plans were not done the nurses would not know about the residents' care or what they would need to monitor.Record review of the facility's, undated, policy titled, Comprehensive Care Planning, from the Nursing Policy & Procedure Manual, reflected, The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. A comprehensive care plan will be- Developed within 7 days after completion of the comprehensive assessment. The resident's care plan will be reviewed after each Admission, Quarterly, Annual and/or Significant Change MDS assessment, and revised based on changing goals, preferences, and needs of the resident and in response to current interventions.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review the facility failed to ensure menus met the nutritional needs of residents in accordance with established guidelines were followed for 1 of 1 meal (the lunch meal) reviewed for nutritional adequacy. The facility did not ensure 2 fish tacos were given to residents on 03/10/26. This failure could place residents at risk of a decrease in resident choices, diminished interest in meals, and weight loss. Findings include:. Record review of the undated, extended week four menu reflected 2 crispy fish tacos. During an observation and interview during the lunch meal on 03/10/2026 starting at 12:30 PM, seven residents in the secure unit dining room received one fish taco instead of two fish tacos. LVN C stated she did not notice the residents' meal tickets indicated they should have received two fish tacos. LVN C stated she did not check the trays because they were checked by the nurses in the main dining room, LVN A and the Treatment Nurse, and if they checked them, she did not. LVN C stated it was important for the residents to receive their meals as specified on their meal tickets to ensure they received the proper nutrition and protein intake. During an observation of the lunch meal on 03/10/26 starting at 12:38 p.m., seven residents in the main dining room received one fish taco instead of two fish tacos. During an interview on 03/11/26 at 3:56 p.m., [NAME] B stated she was responsible for ensuring the correct portions sizes were served. [NAME] B stated she knew the correct serving size, but the residents did not like this meal, so she only gave them one. [NAME] B stated the residents knew they could ask for more. [NAME] B stated it was important to follow the menu to ensure the residents received the correct calorie count. During a telephone interview on 03/12/26 at 11:42 p.m., the Dietician stated she expected [NAME] B to follow the menu. The Dietician stated the cooks should be reviewing the tray card to ensure it matched the menu and the correct portion size. The Dietician stated the nurses should be checking the tray at the door to ensure all items were available prior to serving residents. The Dietician stated she monitored by checking the test trays monthly for portion sizes and verbally speaking with the Dietary Manager and residents. The Dietician stated it was important menus were followed to meet the residents' needs. During an interview on 03/12/26 at 1:40 p.m., LVN A stated she was responsible for checking the lunch tray ticket to ensure the plate matched the ticket. LVN A stated she was focused on the diet instead of the amount of food. LVN A stated it was important menus were followed to prevent weight loss. During an interview on 03/12/26 at 1:45 p.m., the Treatment Nurse stated she was responsible for checking the tickets to ensure it was the correct portion size prior to serving the residents. The Treatment Nurse stated she was focused on ensuring the residents received the correct diet than the amount. The Treatment Nurse stated it was important menus were followed to prevent weight loss. During an interview on 03/12/26 at 2:21 p.m., the Dietary Manager stated the cook was responsible for the serving of the meal. The Dietary Manager stated [NAME] B should have had the extended menu visible while preparing the trays even if she felt the residents did not like the meal. The Dietary Manager stated the nurses should have reviewed the tray card prior to serving the residents to ensure the tray was accurate. The Dietary Manager stated she monitored by visual observation of meal service and in service staff. The Dietary Manager stated it was important menus were followed to prevent weight loss. During an interview on 03/12/26 at 3:18 p.m., the DON stated she expected the menu to be followed. The DON stated she expected the nurses to check the trays prior to serving the resident. The DON stated her and the ADON were responsible for monitoring and overseeing by observation of meal service. The DON stated it was important menus were followed to ensure the residents received the proper diet. During an interview on 03/12/26 at 3:48 p.m., the Administrator stated [NAME] B should have reviewed the lunch tray card as prepared the trays and as the nurse checked the tray card and diet consistency they would have been mindful of portion size. The Administrator stated the Dietary Manager was responsible for monitoring and overseeing. The Administrator stated it was important menus were followed to prevent (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	weight loss and malnutrition. Record review of the facility's policy titled Standardized Portions, 2012, reflected . We will strive to assure the resident's nutritional needs are provided based on the RDA. The standard menu will ensure nutritional adequacy of all diets, offer a variety of food in adequate amounts at each meal, and standardize food production.4. If any meal served varies from the planned menu, the change and reason for the change shall be noted on the substitution log. 5. The menus will be prepared as written using standardized recipes. The Dietary Service Manager and cooks are trained in and responsible for the preparation and service of therapeutic diets as prescribed.

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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 for 1 of 1 kitchen reviewed for food and nutrition services. The facility did not ensure:1. Food items were labeled and dated.2. Hair restraints were worn. 3. Personal items were properly stored. 4. The dome covers, bowls, and trays were not stacked with water pooled between them. 5. The pureed mixer top was free from food debris. These failures could place residents at risk for foodborne illness.Findings included: During the initial tour observation and interview with the Dietary Manager on 03/10/26 beginning at 9:28 a.m., revealed the following: 1. Four boxes of 3 lb. cream cheese were undated in the refrigerator. 2. A green thick substance was noted on the pureed mixer top. 3. The dome covers, bowls, and trays were stacked and remained wet with water pooled in between. 4. A cell phone, and personal drink mug were on the tray rack where food could be stored. 5. A work bag observed under the serving table. During an observation on 03/10/26 at 9:30 a.m., Dietary Aide D and the Dietary Manager's hairnets were not covering their entire head. There was loose hair sticking out. During an interview on 03/11/26 at 3:56 p.m., [NAME] B stated all staff were responsible for dating food products. [NAME] B stated hair nets should always be worn while in the kitchen and covered the entire head without loose hair sticking out. [NAME] B stated personal items should be stored out of sight away from the work area. [NAME] B stated these failures could potentially put residents at risk for foodborne illness and cross contamination. During a telephone interview on 03/12/26 at 11:42 a.m., the Dietitian stated whoever put the food items up was responsible for dating the food products. The Dietician stated hair nets should always be worn while in the kitchen and covered the entire head without loose hair sticking out. The Dietician stated the dome covers, bowls, and trays should be air dried first before stacking. The Dietician stated personal items should be away from the workstation wherever the designated area was located. The Dietician stated she monitored by monthly observations. The Dietician stated these failures could potentially put residents at risk for foodborne illness and cross contamination. During an interview on 03/12/26 at 2:04 p.m., Dietary Aide D stated all staff were responsible for dating food products. Dietary Aide D stated the aides were responsible for ensuring the pureed mixer was cleaned after each use. Dietary Aide D stated hair nets should always be worn while in the kitchen and covered the entire head without loose hair sticking out. Dietary Aide D stated her cell phone, work bag and drink mug should have been stored away from the work area. Dietary Aide D stated the cook was responsible for ensuring the mixer was properly cleaned prior to placing it back on the mixer. Dietary Aide D stated the dome covers, bowls, and trays should be air dried first before stacking. Dietary Aide D stated these failures could potentially put residents at risk for foodborne illness and cross contamination. During a telephone interview on 03/12/26 at 2:17 p.m., Dietary Aide E stated she had only been washing dishes for a couple of days. Dietary Aide E stated she was trained by Dietary Aide D to let the dishes air dry first before stacking. Dietary Aide E stated she was rushing trying to get all the dishes washed, that was why the dome covers, bowls, and trays were stacked wet. Dietary Aide E stated these failures could potentially put residents at risk for foodborne illness and cross contamination. During an interview on 03/12/26 at 2:21 p.m., the Dietary Manager stated cleanliness was important in the kitchen, so her staff were not spreading germs or contaminating anything. The Dietary Manager stated she was responsible for making sure the kitchen was cleaned appropriately. The Dietary Manager stated all food should be dated by the date received. The Dietary Manager stated hair nets should be worn while in the kitchen and covering the entire head without loose hair sticking out. The Dietary Manager stated the pureed mixer top should be free from food debris. The Dietary Manager stated the dome covers, bowls, and trays should be air dried first before stacking. The Dietary Manager stated personal items should not be in the work area and should be stored in the bins in the restroom. The Dietary Manager stated she was responsible for monitoring (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and overseeing by weekly checkoffs, visual observations, and in serviced staff. The Dietary Manager stated these failures could potentially put residents at risk for cross contamination and food borne illness. During an interview on 03/12/26 at 3:48 p.m., the Administrator stated she expected food to be dated, hair nets covering the entire head without loose hair sticking out, personal items stored in the designated area away from the workstation. The Administrator stated dome covers, bowls, and trays should be air dried first before stacking. The Administrator stated the pureed mixer top should be cleaned prior to placing it back on the mixer. The Administrator stated the Dietary Manager was responsible for monitoring and overseeing. The Administrator stated these failures could potentially put residents at risk for cross contamination, and food borne illness. Record review of the facility's policy titled, Dietary Food Service Personnel Policy and Procedures 2012 reflected .Work Conduct: 3. All personal belongings (cell phones, and purses.) must be kept out of the food preparation area.Sanitation and Food Handling: 2. Hair nets or hat covering the hairline are worn at all times. 9. All utensils, pots, and pans must be properly washed and sanitized after use.Dishwashing Preparation and Dishwashing. f. Towel drying of dishes and utensils is not permitted. They must be air dried.Dry Storage and Supplies. the policy did not address dating food products. Record review of FDA 2-402.11, dated 2022, revealed FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE_SERVICE and SINGLE-USE ARTICLES.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to collaborate with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving hospice services for 3 of 6 residents (Resident #10, Resident #12, and Resident #27) reviewed for hospice services. 1.The facility failed to obtain and ensure Resident #10's most current Hospice Plan of Care/ Interdisciplinary Group Reports, Medication Report, Physician Orders, Nurse Visit Notes, Aide Visit Notes, Chaplain Visit Notes, and Social Worker Visit Notes were part of the current clinical record. 2. The facility failed to obtain Resident #27's most current interdisciplinary group notes. 3.The facility failed to obtain Resident #12's most current Hospice Certification of Terminal Illness and Hospice Plan of Care. These deficient practices could place residents at risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs.Findings included: 1. Record review of Resident #10's face sheet, dated 3/13/2026, indicated Resident #10 was a 90-year- old female who was initially admitted to the facility on [DATE]. Resident #10 had diagnoses which included Alzheimer's disease (progressive disease that destroys memory and other important mental functions), generalized anxiety disorder (severe, ongoing anxiety that interferes with daily activities), and memory deficit following other cerebrovascular disease (a group of conditions that affect the blood flow and the blood vessels in the brain). Record review of Resident #10's Quarterly MDS assessment, dated 12/12/2025, indicated Resident #10 was usually understood by others and usually understood others. Resident #10 had a BIMS score of 99, which indicated she was unable to complete the interview. Resident #10 received hospice services while a resident at the facility. Record review of Resident #10's Order Summary Report, dated 3/13/2026, indicated she admitted to hospice services with a diagnosis of Alzheimer's disease with a start date of 4/08/2024. Record review of Resident #10's care plan, revised on 1/17/2026, indicated she had a terminal prognosis and was receiving hospice services with interventions for coping strategies, respecting resident wishes, encouraging support systems of family and friends, and working with nursing staff to provide maximum comfort of the resident. Record review of Resident #10's hospice binder indicated: Plan of care/ Interdisciplinary Group Reports, dated 1/30/2026- 2/12/2026 Medication Report, dated 1/30/2026- 2/12/2026 Physician Orders, dated 1/30/2026- 2/12/2026 Nurse Visit Notes, dated 1/30/2026- 2/12/2026 Aide Visit Notes, dated 1/30/2026- 2/12/2026 Chaplain Visit Notes, dated 1/30/2026- 2/12/2026 (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Social Worker Visit Notes, dated 1/30/2026- 2/12/2026 During an interview on 3/12/2026 at 3:07 PM, the Hospice Agency Executive Director stated the Community Education Representative was responsible for bringing the updated information and placing it into the binders. the Hospice Agency Executive Director stated the Community Education Representative was out on extended leave and the Executive Director had not remembered the binders were not being updated. The Executive Director stated it was important to keep the binders updated to ensure any changes or new orders were communicated. It was important for the best care of the resident. During an interview on 3/13/2026 at 1:10 PM, the Facility Administrator stated she expected the hospice agency to keep the hospice binders up to date. Administrator stated there was no one currently designated to ensure the hospice binders were current. The Facility Administrator stated keeping the hospice binders up to date was important for continuity of care and to guarantee the resident's needs were met. During an interview on 3/13/2026 at 2:45 PM, the DON stated Medical Records was responsible for ensuring the hospice binders were updated. The DON stated the facility did not currently have the Medical Records position filled. The DON stated until the Medical Records position was filled, she and the ADON were responsible for keeping the binders updated. The DON stated it was important to maintain updated hospice records for the continuity of care for the resident. 2. Record review of Resident #27's face sheet, dated 03/11/2026, indicated a [AGE] year-old female who was re-admitted to the facility on [DATE]. Resident #27 had diagnoses which included dementia (loss of memory, language, and thinking abilities that are severe enough to interfere with daily life), frontal lobe and executive function deficit (damage or dysfunction to the brain's prefrontal cortex), myocardial infarction (heart attack caused by cessation of blood flow to the heart), and high blood pressure. Record review of Resident #27's quarterly MDS assessment, dated 02/10/2026, indicated she usually understood others and could usually make others understand her. Resident #27 had a BIMS score of 0, which indicated her cognition was severely impaired. Resident #12 received hospice services while a resident at the facility. Record review of Resident #27's comprehensive care plan, dated 11/7/2025, indicated she required hospice as evidenced by a terminal illness with hospice staff to assist with resident care. Record review of Resident #27's hospice binder indicated: Interdisciplinary Group Meeting was dated 02/11/2026. Record review of Resident #27's Order Summary Report, dated 03/11/2026, indicated admit to hospice services with diagnosis of Cerebral ischemia (critical medical condition in which the blood flow deprives brain tissue of oxygenand nutrients, leading to cell death) with a start date of 11/10/2025. 3. Record review of a face sheet dated 03/11/2026 indicated Resident #12 was an [AGE] year-old female initially admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease (progressive disease that destroys memory and other important mental functions) and dementia (loss of memory, language, problem solving and other thinking abilities that were severe enough to interfere (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with daily life). Record review of Resident #12's Quarterly MDS assessment dated [DATE] indicated Resident #12 was sometimes understood by others and sometimes understood others. The MDS assessment indicated Resident #12 had a BIMS score of 0, which indicated her cognition was severely impaired. The MDS assessment indicated Resident #12 received hospice services while a resident at the facility. Record review of Resident #12's Order Summary Report dated 03/11/2026 indicated admit to hospice services with diagnosis of Alzheimer's disease with a start date of 09/11/2025. Record review of Resident #12's care plan reviewed 12/21/2025 indicated she had a terminal prognosis and was receiving hospice services to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs were met. Record review of Resident #12's hospice binder indicated: Hospice Certification of Terminal Illness was dated 08/27/2025-10/25/2025. There was no current Hospice Certification of Terminal Illness. Hospice Plan of Care with a certification period of 10/26/2025-12/24/2025. There was no current hospice plan of care. During an interview on 03/11/2026 at 2:49 PM, the Hospice Patient Care Coordinator said the hospice aide took the hospice records to the facility. She said the hospice records such as the certification of terminal illness, interdisciplinary team meetings, notes from the hospice aide, chaplain, nurse, and social worker were taken to the facility every other week after their interdisciplinary team meetings. The Hospice Patient Care Coordinator said she was not aware Resident #12's hospice records were not up to date at the facility. She said it was important for the facility to have the most current hospice documents so they knew what was going on with the resident and so they could see if there were any changes made to the residents' plan of care. During an interview on 03/11/2026 at 3:22 PM, LVN L said she was not aware Resident #12 did not have the most current hospice documents. LVN L said the ADON or DON were responsible for ensuring the hospice documents were available in the facility. LVN L said it was important for the facility to have the hospice documents, so they knew what care to provide for the residents. During an interview on 03/13/2026 at 1:16 PM, the DON said she did not know who was supposed to ensure the residents' hospice documents were available in the facility. The DON said she knew it was not the nursing department's responsibility. The DON said it was important to have the residents' hospice documents so they could see what the residents' plans of care were and for coordination of care. During an interview on 03/13/2026 at 1:33 PM, the Administrator said she expected the residents' hospice records to be available in the facility. The Administrator said the charge nurse should be reviewing the hospice documents and notifying the nurse managers of missing documentation for them to obtain it from the hospice. The Administrator said it was important to have the residents' hospice documentation for continuity of care and to meet the residents' needs for their hospice services. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's undated policy titled, Hospice Services, indicated, The DON or designee will be responsible for ensuring that documentation is a part of the current clinical record. At a minimum, the documentation will include: ˆ The current and past Texas Medicaid Hospice Recipient Election/Cancellation Form (#3071) ˆ Texas Medicaid Hospice-Nursing Facility Assessment Form (#3073) ˆ Physician Certification of Terminal Illness (#3074) ˆ Medicare Election Statement (if dual eligible) ˆ Verification that the recipient does not have Medicare Part A ˆ Hospice Plan of Care ˆ Current interdisciplinary notes to include nurses notes/summaries, physician orders and progress notes, and medications and treatment sheets during the hospice certification period.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the residents had a right to secure and confidential personal medical records and privacy during medical treatments for 1 of 22 residents (Resident #5) reviewed for resident rights. The facility did not ensure the Treatment Nurse used a secure telephonic device to communicate about Resident #5's medications with the facility Medical Director. This failure could place residents at risk for diminished quality of life, loss of dignity, self-worth and breach of confidentiality. Findings included:Record review of Resident #5's face sheet dated 03/12/26, reflected Resident #5 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnosis which included essential hypertension (high blood pressure). Record review of Resident #5's quarterly MDS assessment, dated 12/19/25, reflected Resident #5 usually made herself understood, and usually understood others. Resident #5's BIMS score was 11, which reflected her cognition was moderately impaired. Record review of Resident #5's comprehensive care plan, revised on 12/21/25, reflected Resident #5 had hypertension. The care plan interventions included give anti-hypertensive medications as ordered. Record review of Resident #5's physician order summary report, dated 03/12/26, reflected Resident #5 had an active order for Amlodipine Besylate 5mg; 1 tablet by mouth one time a day related to essential hypertension. The order reflected to hold for SBP (measured the blood was pushing against the artery walls when the heart beats) below 100, DBP (measured the blood pushing against the artery walls when the heart rests between beats) below 60 or heart rate less than 60 with a start date 12/17/25. Record review of Resident #5's physician order summary report, dated 03/12/26, reflected Resident #5 had an active order for Losartan Potassium 50 mg; 1 tablet by mouth one time day related to essential hypertension. The order reflected to hold for SBP (measured the blood was pushing against the artery walls when the heart beats) below 100, DBP (measured the blood pushing against the artery walls when the heart rests between beats) below 60 or heart rate less than 60 with a start date 12/17/25. Record review of a text message dated 03/11/26 beginning at 8:23 a.m. between the Treatment Nurse and the Medical Director reflected a message from her personal cell phone that stated Resident #5's full name that her blood pressure was 177/59 and it was below parameter, but it concerned her and was it ok to still give blood pressure medications. During an interview on 03/11/26 at 1:19 p.m., the Treatment Nurse stated the facility did not have an app to coordinate with the physician. The Treatment Nurse stated she was told by other nurses that the physician preferred to be notified via phone call. The Treatment Nurse stated she had contacted the physician via phone call, but he did not answer so she sent a text message. The Treatment Nurse stated Resident #5 was not a resident that the facility had to contact the physician regularly and she was not sure if he was familiar with her. The Treatment Nurse stated she should have put the resident room number instead of her full name. The Treatment Nurse stated this failure was a HIPPA violation and put Resident #5 at risk for confidentiality of her personal medical records. During a telephone interview on 03/12/26 at 3:23 p.m., the Medical Director stated he would like to be notified via phone or text. The Medical Director stated it was ok for the Treatment Nurse to text the resident full name using her personal cell phone. During an interview on 03/12/26 at 3:18 p.m., the DON stated staff normally notify the physician either by text or phone using their personal cell phone. The DON stated it was ok for the Treatment Nurse to put Resident #5's full name in the text message. During an interview on 03/12/26 at 3:48 p.m., the Administrator stated staff coordinated with the physicians via phone call or text using their personal cell phone. The Administrator stated she was not aware of staff texting the resident's full name. The Administrator stated the ideal would be to text the initials of the resident or their room number. The Administrator stated Resident #5's personal medical records could be comprised. The Administrator stated there was not a system in place for monitoring and overseeing the release of secured information. Record review of facility undated policy titled, Resident Rights did not address confidentiality of personal and medical information.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free from abuse for 1 of 22 residents (Resident #42) reviewed for resident abuse. The facility failed to ensure Resident #42 was not verbally abused by LVN F on 03/10/26, when she told Resident #42 that's why you are in a nursing home. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress.Findings included: Record review of Resident #42's face sheet dated 03/12/26 indicated she was a [AGE] year-old female who re-admitted to the facility on [DATE] with the diagnoses which included dementia (a progressive decline in mental ability that interferes with daily life), major depressive disorder (serious mental health disorder characterized by persistent low mood and low self-esteem), heart disease, and high blood pressure. Record review of Resident #42's quarterly MDS assessment dated [DATE] indicated she made herself understood and she understood others. The MDS also indicated she had a BIMS score of 15 which meant that she was cognitively intact. The MDS also indicated she required total staff assistance with toileting, maximal assistance from staff for transfers, bed mobility, and showers, and she was independent with eating. Record review of Resident #42's care plan revised on 12/30/25 indicated she had a behavior problem related to occasional verbal outbursts (yelling and argumentative) with staff. Resident #42's interventions included for the staff to administer medications as ordered, anticipate and meet resident needs, explain all procedures, and minimize potential for resident behaviors. Record review of Resident #42's undated postoperative care instructions following her oral surgery on 03/10/26 indicated she was prescribed pain medication (hydrocodone-acetaminophen 5-325mg oral tablet), an antibiotic (amoxicillin oral capsule 500mg tablet), and to manage her pain it was recommended to alternate the prescribed pain medication with an NSAID (i.e. Ibuprofen 800 mg every 4 hours) and to swish with warm salt water (1/4 tsp salt +1 cup warm water) 3-4 times day. Record review of Resident #42's order summary report dated as of 03/12/26 indicated she had an order for:1) amoxicillin oral capsule 500 MG Give 1 capsule by mouth four times a day for post oral surgery for 7 days with a start date of 03/11/26 and end date of 03/18/26.2) hydrocodone-acetaminophen oral tablet 5-325mg (hydrocodone-acetaminophen) give 1 tablet by mouth every 6 hours as needed for post oral surgery with a start date of 03/10/26 with no end date. 3) ibuprofen oral tablet 200mg (ibuprofen) give 2 tablets by mouth every 4 hours for pain for 7 days while awake with a start date of 03/11/26 and an end date of 03/18/26.4) swish with warm salt water (1/4 tsp salt +1 cup warm water) 3-4 times a day, especially after eating, every 5 hours as needed for post op oral surgery 1/4 tsp salt+1 cup warm water) with a start date of 03/11/26 and no end date. 5) Tylenol oral tablet 325 MG (acetaminophen) Give 2 tablets by mouth every 6 hours as needed for elevated temperature; pain (2) 325mg tablets to equal 650 mg. not to exceed 3 gram/24 hours from all sources with a start date of 03/10/26 During an observation and interview on 03/11/26 at 8:45 AM, Resident #42 was in her room lying in her bed. Resident #42 said she was upset because LVN F argued with her all night over the medication orders the oral surgeon had given after her oral surgery on 03/10/2026. Resident #42 said after her oral surgery on 03/10/2026 she returned to the facility in the evening, and LVN F refused to listen to her when she told her the instructions were that she receive ibuprofen and Tylenol to help with her pain and swelling. Resident #42 said if LVN had followed the instructions from the oral surgeon, her mouth would not have swollen like it had since she returned to the facility. Resident #42 said when LVN F was walking out of her room she told her, that's why you are in a nursing home. Resident #42 said LVN F made her feel belittled when she told her that's why you are in a nursing home. During an interview on 03/11/2625 at 9:00 AM the surveyor reported to the Administrator that Resident #42 was upset because LVN F argued with her about her medications all night, and then LVN F told Resident #42 that's why you are in a nursing home. The Administrator said she would get the appropriate (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	person to go talk with Resident #42 to determine what happened. During an interview on 03/11/26 at 10:16 AM the Administrator that she and the DON went to speak to Resident #42. The Administrator said Resident #42 told her she was not emotionally distraught, but LVN F was hateful towards her. During an interview on 03/12/26 at 2:00 PM, the Dietary Manager said on 03/11/26 a little after 4 AM she was making her rounds on the hall, and she overheard LVN F and Resident #42 arguing over pain medications. The Dietary Manager said Resident #42 was telling LVN F she was going to call her doctor because LVN F would not give her the medication, and LVN F told Resident #42 she could not call her doctor that she (LVN F) had to call the facility doctor for new orders. The Dietary Manager said she was just passing by Resident #42's room, and that was all she heard. During an interview on 03/12/26 at 4:56 PM LVN F said she worked on 03/10/26 from 6:00 PM until 03/11/2026 at 6:00 AM. LVN F said she received in report Resident #42 had oral surgery and she had a copy of the postoperative care following oral surgery for Resident #42. LVN F said Resident #42 was a challenge and Resident #42 had an issue every time she entered her room. LVN F said Resident #42 kept asking her to administer ibuprofen. LVN F said she was aware Resident #42's instructions indicated for her to receive ibuprofen as needed, but since there was no order in Resident #42's electronic medical record she did not administer it. LVN F said she should have called the doctor and received clarification for the medications Resident #42 was requesting, and this would have prevented all the problems with Resident #42.LVN F said she did say that's why you are in a nursing home but she was talking to herself, she did not direct it at Resident #42. She said she understood why saying that could have made Resident #42 upset, feel bad, or feel as though she could not rely on her to take care of her. LVN F said she should have just kept telling Resident #42 yes ma'am, and LVN F said it was just a misunderstanding. LVN F said she had 12 hours to try to make Resident #42 happy, and she could not accomplish it. During an interview on 03/13/26 at 1:44 PM the DON said she expected the charge nurses to speak to the residents with respect and dignity. The DON said she could see LVN F saying that's why you are in a nursing home as abuse from the resident's point of view, but the DON said the nurse left out of Resident #42's room because Resident #42 became argumentative. The DON said this placed Resident #42 at risk of anxiety and being upset. During an interview on 03/13/26 at 1:54 PM the Administrator said with LVN F saying that's why you are in the nursing home, she understood to where Resident #42 could have seen it as abuse and she did ask Resident #42 about being under any emotional distress but Resident #42 reported to her that she wanted to have good communication with LVN F about her medications and good communication with LVN F in general. Record review of the facility policy revised 03/29/18, Abuse/Neglect indicated: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart.Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.C. Prevention The facility will provide the residents, families, and staff an environment free from abuse and neglect.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement written policies and procedures that prohibit neglect, and abuse of residents, for 1 of 22 residents (Resident #42) reviewed for abuse. The facility failed to follow their policy to report to HHSC within 2 hours of an abuse allegation, when Resident #42 alleged that LVN F argued with her about her medications and told Resident #42 that's why you are in a nursing home. This failure could place residents at risk of abuse, neglect, physical harm, mental anguish, and emotional distress. Findings included: Record review of the facility policy revised 03/29/18, Abuse/Neglect indicated: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart.Residents should not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.E. Reporting 1.Any person having reasonable cause to believe an elderly or incapacitated adult is suffering from abuse, neglect or exploitation must report this to the DON, administrator, state and/or adult protective services. State law mandates that citizens report all suspected cases of abuse, neglect or financial exploitation of the elderly and incapacitated persons.Facility employees must report all allegations of: abuse. neglect. exploitation, mistreatment of residents. misappropriation of resident property or injury of unknown source to the facility administrator. The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 19-17 dated 7/10/19. a. If the allegations involve abuse or result in serious bodily injury, the report is to be made within 2 hours of the allegation. Record review of Resident #42's face sheet dated 03/12/26 indicated she was a [AGE] year-old female who re-admitted to the facility on [DATE] with the diagnoses which included dementia (a progressive decline in mental ability that interferes with daily life), major depressive disorder (serious mental health disorder characterized by persistent low mood and low self-esteem), heart disease, and high blood pressure. Record review of Resident #42's quarterly MDS assessment dated [DATE] indicated she made herself understood and she understood others. The MDS also indicated she had a BIMS score of 15 which meant that she was cognitively intact. The MDS also indicated she required total staff assistance with toileting, maximal assistance from staff for transfers, bed mobility, and showers, and she was independent with eating. Record review of Resident #42's care plan revised on 12/30/25 indicated she had a behavior problem related to occasional verbal outburst with staff by yelling and argumentative with interventions for the staff to administer medications as ordered, anticipate and meet resident needs, explain all procedures, and minimize potential for resident behaviors. Record review of the facility reported incident 1075295 in Tulip (system used for submitting log-term care licensure applications and health care regulations) indicated the incident was reported on 03/11/2026 at 11:33 AM (2 hours and 33 minutes after it was reported to the Administrator by the surveyor). During an observation and interview on 03/11/26 at 8:45 AM Resident #42 was in her room lying in her bed. Resident #42 said she was upset because LVN F argued with her all night over the medication orders the oral surgeon had given after her oral surgery on 03/10/2026. Resident #42 said after her oral surgery on 03/10/2026 she returned to the facility in the evening, and LVN F refused to listen to her when she told her the instructions were that she receive ibuprofen and Tylenol to help with her pain and swelling. Resident #42 said if LVN had followed the instructions from the oral surgeon, her mouth would not have swollen like it had since she returned to the facility. Resident #42 said when LVN F was walking out of her room she told her, that's why you are in a nursing home. Resident #42 said LVN F made her feel belittled. During an interview on 03/11/26 at 9:00 AM the surveyor reported to the Administrator that Resident #42 was upset and LVN F argued with her about her medications all night and then LVN F told Resident #42 that's why you are in a nursing home. The Administrator said she would get the appropriate person to go talk with (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #42 to determine what happened. During an interview on 03/13/26 at 1:54 PM the Administrator said it took a little more time to input the information into the system as reasoning for the report not being reported within 2 hours. She said she initiated the report of the allegation abuse to HHSC at 10:50 AM or so but she was trying to ensure the staff was not going to be working at the facility until the investigation was completed. The Administrator said to her knowledge, she took everything seriously and was trying to get things in order and submitted timely. The Administrator said she knew the allegation made was an allegation of abuse when the surveyor reported the incident between Resident #42 and LVN F to her. The Administrator said she was the abuse coordinator, and she expected the staff to report to her immediately. The Administrator said allegations of abuse should be reported within 2 hours and other allegations were to be reported within 24 hours, and she felt as though the facility initiated the process immediately.

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Gilmer Nursing and Rehabilitation	703 Titus Street Gilmer, TX 75644

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to make a comprehensive assessment of each residents' needs, strengths, goals, life history, and preferences within 14 calendar days after admission for 1 of 22 residents (Resident #19) reviewed for timeliness of assessments. The facility failed to complete Resident #19's admission MDS assessment, with an assessment reference date of 03/03/2026, within 14 days of admission. This failure could place residents at risk of not having their needs met.Findings included: Record review of a face sheet dated 03/13/2026 indicated Resident #19 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses which included severe dementia with other behavioral disturbance (severe loss of memory, language, problem solving and other thinking abilities severe enough to interfere with daily life with behaviors), hypertension (high blood pressure), and chronic kidney disease stage 3 (moderate reduction in kidney function). Record review of Resident #19's electronic health record on 03/10/2026 and 03/11/2026 indicated her admission MDS assessment with an assessment reference date of 03/03/2026 was in progress. Resident #19's electronic health record on 03/12/2026 indicated her admission MDS assessment had been completed. Record review of Resident #19's Comprehensive MDS assessment with an assessment reference date of 03/03/2026 indicated in Section A0310 it was an admission assessment (required by day 14). The MDS assessment for Resident #19 indicated in Section A1600 an entry date of 02/18/2026. Resident #19's MDS assessment in Section Z0500B was signed completed on 03/04/2026. In Section Z0400 the MDS Coordinator signed Sections I8000H, I8000I, I8000J on 03/12/2026. During an interview on 03/13/2026 at 10:53 AM, the MDS Coordinator said she sent the DON a list of MDS assessments that needed to be signed. The MDS Coordinator said the admission MDS assessment should be completed within 14 days from the date of admission. She said Resident #19's admission assessment should have been completed by 03/03/2026. The MDS Coordinator said Resident #19's MDS assessment with an ARD of 03/03/2026 should have been signed completed by the DON on 03/12/2026, and she must have sent the wrong signature date to the DON. The MDS Coordinator said she completed Resident #19's admission MDS assessment late because she was gathering information. The MDS Coordinator said it was important for the MDS assessments to be completed within the required timeframes for accurate reflection of the residents' care and to update the residents' care plans. During an interview on 03/13/2026 at 1:18 PM, the DON said she believed the admission assessment should be completed within 5 days of admission, but she was not familiar with the required timeframes. The DON said the MDS Coordinator sent her a list of MDS assessments that needed to be signed. The DON said when she signed Resident #19's MDS assessment with the date of 03/03/2026, she did not notice there was a signature from the MDS Coordinator on 03/12/2026. The DON said sine the MDS Coordinator signed sections on 03/12/2026, the MDS assessment should have been signed completed on 03/12/2026. The DON said it was important for the MDS assessments to be completed within the required timeframes to ensure they captured the right amount of care for the residents and so it did not affect billing. During an interview on 03/13/2026 at 1:34 PM, the Administrator said she expected the MDS assessments to be completed by the MDS Coordinator with the required timeframes. The Administrator said it was important for the MDS assessments to be completed within the required timeframes to ensure the best healthcare practices and because it reflected the patient care. During an interview on 03/13/2026 at 2:54 PM, the Regional Compliance Nurse said they did not have a policy for MDS assessments that they followed the Resident Assessment Instrument manual. Record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11 updated October 2023 indicated, For the admission assessment, the MDS Completion Date (Z0500B) must be no later than 13 days after the Entry Date (A1600).

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR) Level 1 assessment accurately reflected the resident's status for 2 of 5 residents (Resident #2, Resident #6) reviewed for PASRR Level 1 screenings. 1. The facility failed to ensure the PASRR Level 1 screening for Resident #2 was completed and submitted upon admission date of 08/14/24. 2.The facility failed to ensure the accuracy of the PASRR Level 1 screening for Resident #6. The PASRR 1 Level screening did not indicate a diagnosis of mental illness PTSD (post-traumatic stress disorder), although the diagnosis was present upon admission date on 05/01/25. These failures could place residents who had a mental illness at risk of not receiving a needed assessment (PASRR Evaluation), individualized care, or specialized services to meet their needs. Findings included: 1. Record review of Resident #2's face sheet dated 03/12/26 indicated she was a [AGE] year-old female who admitted to the facility on [DATE] with the diagnoses which included dementia (a progressive decline in mental ability that interferes with daily life), bipolar disorder (chronic mental health condition characterized by extreme mood swings), and high blood pressure. Record review of Resident #2's quarterly MDS assessment dated [DATE] indicated she was able to make herself understood and she understood others. The MDS also indicated she had a BIMS score of 4 which indicated she had severely impaired cognition. Record review of Resident #2's PASRR Level 1 screening indicated it was completed after surveyor intervention on 03/12/26. During an interview on 03/12/26 at 4:25 PM the MDS Nurse said she guessed she just missed completing the PASRR Level 1 screening for Resident #2. The MDS Nurse said Resident #2 was private pay so she was unsure of what the risk would have been, but the PASRR Level 1 should have been completed upon admission. 2. Record review of Resident #6's face sheet dated 03/12/26 indicated he was a [AGE] year-old male who admitted to the facility on [DATE] with the diagnoses which included PTSD (mental health condition triggered by experiencing or witnessing terrifying events such as combat, abuse, or disasters), chronic obstructive pulmonary disease (progressive treatable lung disease that causes breathing difficulties), depression (common, serious mental health disorder characterized by low mood and loss of interest), and high blood pressure. Record review of Resident #6's quarterly MDS assessment dated [DATE] indicated he was able to make himself understood and understood others. The MDS also indicated Resident #6 had a BIMS score of 10 which indicated he had moderate cognitive impairment. The MDS also indicated Resident #6 had an active mood disorder, PTSD and depression. Record review of Resident #6's PASRR Level 1 screening dated 05/01/25 indicated it was completed and was marked negative for mental illness, intellectual disability, and developmental disability for Resident #6. Record review of Resident #6's comprehensive care plan dated 06/16/25 indicated he had PTSD and depression. During an interview on 03/13/26 at 11:15 AM The MDS Nurse said she refreshed her brain (thought about the positive PASRR diagnosis again) and should have listed PTSD as a yes on the PASRR for a mental illness. The MDS Nurse said she was unclear of why the correct information for mental illness was missing on the PASRR but knowing Resident #6 prior to admission, she did not realize the PASRR would have been positive. The MDS Nurse said she would have to do another PASRR for Resident #6 and notify the local authority (the company responsible for the PASRR process and inputting the PASRR evaluations into the system) for the facility. The MDS Nurse said the failure of the PASRR not being completed correctly placed a risk for residents not receiving services that residents could have from PASRR. During an interview on 03/13/26 at 2:08 PM the Administrator said she knew the PASRRs were timely and difficult (they took a lot of time and they were difficult to complete) but the completion of the PASRR gets the residents therapy, extra habilitation, and special equipment. The Administrator said she expected the PASRR to be input on admission and she expected them to be input correctly for diagnoses that were active for the residents for the residents to get the services they needed. Record review of the facility policy (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revised 03/06/19, PASRR Level 1 Screen Policy and Procedure indicated: Policy: It is the policy of facilities to obtain a PL1 screening form from the RE (referring entity) prior to admission to the NF. The PL1 will be submitted via Simple LTC (system used for data analytics for long-term care facilities) timely per PASRR Regulatory timeframes. PASRR is a federally mandated program requiring all states to pre-screen all individuals seeking admission to a Medicaid-certified nursing facility, regardless of payor source or age. The PASRR Program is important because it provides options for individuals to choose where they live, who they live with and the training and therapy they need to live as independently as possible.Procedure: 1. The Facility Admissions process will ensure a PL1 Screening Form is obtained from the RE on day of admission or prior to admission. A PL1 is obtained for every individual, regardless of payment type, seeking admission to a Medicaid-certified NF. 4. The Facility will enter the PL1 Form exactly as written except for corrections to identifying data. It is critical to submit timely PL1's due to the following: Late submission can cause delays in obtaining PASRR specialized services; Delays may cause difficulties entering the LTCMI form; HHS interpretive guidelines state the PL1 must be entered into the Portal upon admission or 72 hours after admission at the latest, but not before admission; and Submitting a PL1 months after an individual discharged or passed away (with dates of assessment after the individual left) could be considered fraud.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a baseline care plan for each resident that included the instructions needed to provide effective and person-centered care of the resident that met professional standards of quality care for 1 of 2 residents (Resident #63) reviewed for baseline care plans.The facility failed to address Resident #63's dialysis on his baseline care plan.This deficient practice could place residents at risk of missed care or not receiving necessary care and services.Findings included:1. Record review of Resident #63's face sheet, dated 03/16/26 indicated Resident #63 was a [AGE] year-old male who was admitted to the facility on [DATE] with a diagnosis which included renal failure or kidney failure (occurs when kidneys cannot adequately filter waste from the blood, often resulting from diabetes or high blood pressure).Record review of Resident #63's medical record revealed the resident did not have an MDS in his medical record.Record review of Resident #63's physician order report, dated 03/08/26, indicated dialysis on Tuesday, Thursday, and Saturday chair time at 11:45am for diagnosis of renal failure.Record review of Resident #63's care plan, dated 03/09/26, did not indicate Resident #63 had a baseline care plan that addressed his dialysis.During an interview on 03/11/26 at 10:43 a.m., Resident #63 said he went to dialysis on Tuesday, Thursday, and Saturday. He said he went yesterday (03/10/26). During an attempted interview on 03/12/26 at 10:00 a.m., LVN J did not answer her phone, a message was left (nurse who did the baseline care plan).During an interview on 03/13/26 at 11:01 a.m., the MDS Nurse said she was responsible for long term care residents care plans. She said the charge nurse initiated the baseline care plan and then when she completed the initial MDS assessment she would complete the care plan based off the MDS indicators. She looked and verified Resident #63 did not have a baseline care plan for dialysis. She said care plans reflected the care the resident should receive. She said risk could be interventions could be missed.During an interview on 03/13/26 at 12:13 p.m., the DON looked and verified Resident #63 did not have a baseline care plan for his dialysis. She said the charge nurse was responsible for initiating the baseline care plan and the MDS Nurse was responsible for completing the base line care plans once she completed the first MDS assessment. She said the IDT was responsible for ensuring all care plans were correct and she did random checks of care plans in their weekly meetings. She said if the care plan was not done it could place Resident #63 at risk of not being properly cared for and nurses not knowing his needs. During an interview on 03/13/26 at 1:04 p.m., the Administrator said she expected the baseline care plans to include Resident #63's dialysis. The Administrator said the admission nurses were responsible for starting the baseline care plan. She said the MDS nurse was the overseer of care plans. She said without dialysis being on Resident #63's baseline care plan it could place him at risk because of the nurses not knowing what to look for and/or monitor.Record review of the facility policy titled Baseline Plan of Care, undated indicated, Completion and implementation of the baseline care plan within 48 hours of a resident's admission intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission.This facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure the services provided, as outlined by the comprehensive care plan, met professional standards of quality, for 2 of 6 residents (Residents #47, and #7) reviewed for services provided to meet professional standards. 1. The facility did not ensure LVN A administered 2 puffs of Albuterol (medication used to prevent and treat wheezing, difficulty breathing, chest tightness and coughing) HFA Sulfate Inhalation Aerosol Solution instead of 1 puff to Resident #47. 2. The facility did not ensure LVN A primed Resident #7's Novolog FlexPen (insulin medication) according to the manufacturer's instructions. These failures could place residents at risk of inaccurate drug administration and not receiving the care and services to meet their individual needs. Findings included:1. Record review of Resident #47's face sheet, dated 03/12/26, reflected Resident #47 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnosis which included COPD (chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #47's quarterly MDS assessment, dated 01/05/26, reflected Resident #47 made herself understood, and understood others. Resident #47's BIMS score was 10, which reflected her cognition was moderately impaired. Record review of Resident #47's comprehensive care plan, revised on 08/14/25, reflected Resident #47 had Emphysema (long term lung condition that caused SOB)/COPD. The care plan interventions included give aerosols (spray that deliver medication directly to the lungs) or bronchodilators (medications that relax lung muscles and widen airways to help with breathing) as ordered. Record review of Resident #47's physician order summary report, dated 03/12/26, reflected Resident #47 had an active order for Albuterol HFA Sulfate Inhalation Aerosol Solution:180 (90 base) mcg/act: 2 puffs inhaled orally every six hours for COPD with a start date 03/19/25. During an observation and interview on 03/10/26 at 11:24 a.m., LVN A handed Resident #47 her inhaler and asked her to inhale 1 puff. Resident inhaled 1 puff and LVN A then handed Resident #47 a glass of water to rinse her mouth out. Once Resident #47 rinsed her mouth out, LVN A left the room. The state surveyor asked LVN A if Resident #47 should have gotten 1 puff or 2 puffs of her inhaler. LVN A stated Resident #47 should have gotten 2 puffs. She went back into the room and had Resident #47 inhale a second puff of her inhaler. LVN A said she usually did not walk Resident #47 through the steps of using her inhaler. She said she normally handed Resident #47 the inhaler and Resident #47 knew how to inhale 2 puffs. She stated that since the state surveyor was present, she failed to instruct Resident #47 to inhale 2 puffs. LVN A stated it was important for Resident #47 to receive the accurate dose of her breathing medication to prevent an exacerbation of breathing problems such as shortness of breath or dizziness that could have led to hospitalization. 2. Record review of Resident #7's face sheet, dated 03/12/26, reflected Resident #7 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnosis which included Type 2 diabetes mellitus (chronic condition where the pancreas makes little or no insulin, which leads to high blood sugar levels) with other specified complications. Record review of Resident #7's quarterly MDS assessment, dated 12/10/25, reflected Resident #7 made herself understood, and understood others. Resident #7's BIMS score was 15, which reflected her cognition was intact. Record review of Resident #7's comprehensive care plan, revised 02/24/26, reflected Resident #7 had Diabetes Mellitus. The care plan interventions included diabetes medication as ordered by the doctor, monitor/document for side effects/effectiveness and fasting serum blood sugar as ordered by the doctor. Record review of Resident #7's physician order summary report, dated 03/12/26, reflected Resident #7 had an active order for Novolog FlexPen: inject as per sliding scale. 1 unit.subcutaneously before meals and at bedtime related to diabetes mellitus with a start date 02/10/26. Record review of the licensed nurse proficiency audit dated 12/04/25 completed by the ADON reflected LVN A had been checked for insulin administration. During an observation and interview on 03/11/26 at 11:31 a.m., LVN A prepared Resident #7's Novolog FlexPen by removing the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pen cap, placing a needle onto the pen, and turning the dose knob to 1 unit. LVN A administered the medication to Resident #7's LLQ. LVN A did not prime (removing the air from the needle and cartridge) the insulin pen by turning the dose knob into 2 units before turning the dose knob to 1 unit. LVN A stated she had never primed the insulin pen before administering Resident #7's insulin. LVN A stated it was important to ensure insulin was administered by the manufacturer's instructions to ensure the residents get the correct dosage. During a telephone interview on 03/12/26 at 2:56 p.m., the Pharmacist Consultant stated the insulin pen should be primed 2 units for the 1st use. The Pharmacist Consultant stated she did a medication pass every other month but had not watched insulin administration. The Pharmacist Consultant stated it was not much of a risk if she did not prime the insulin prior to administering the 1 unit. During an interview on 03/12/26 at 3:18 p.m., the DON stated she expected LVN A and the treatment nurse to follow the doctor's order. The DON stated if the Treatment Nurse was within the timeframe, she could have finished her medication pass and went back and got nasal spray out of the nurse's cart and administered the medication. The DON stated her expectation was for an insulin pen to have the needle prime with 2 units by releasing of air and then reset to dose of insulin the resident needed and administer the medication. The DON stated her and the ADON were responsible for medication administration compliance through competency check and random medication administration observations. The DON stated it was important that Resident #47 received 2 puffs instead of 1 puff to prevent SOB or wheezing. The DON stated it was important that Resident #52 received her nasal spray to prevent congestion or worsening of her allergies. The DON stated there was no risk of not priming the insulin prior to administration. During an interview on 03/12/26 at 3:48 p.m., the Administrator stated she expected doctor orders to be followed and administered within the timeframe. The Administrator stated it was best practice to prime the Novolog FlexPen 2 units before administering the 1 unit to get the most accurate dosage. The Administrator stated the DON or designee were responsible for monitoring and overseeing medication administration. The Administrator stated these failures could potentially cause SOB, respiratory distress, allergy discomfort and inaccurate dose. Record review of the manufacturer's guideline titled Novolog (insulin apart) injection Pen fill revised 02/2023, reflected. injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: E. turn the dose select to select 2 units. Record review of the Subcutaneous Injection Administration policy, dated 3/2025, reflected. Insulin Injection. 1. Assure type of insulin, unit dosage. Record review of the Medication Administration and General Guidelines policy, dated 3/2025, reflected. Medications are administered as prescribed. 2. Medications are administered in accordance with written orders of the attending physician. checklist for completing proper steps in the administration of medications. Adhere to the 6 rights of medication administration. (1) right dose. (5) right time.

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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, based on comprehensive assessment of resident, that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choice for 1 of 6 residents (Resident #42) reviewed for quality of care. The facility failed to ensure LVN F clarified orders for ibuprofen (a non-steroidal anti-inflammatory drug used to decrease pain and swelling), after Resident #42 had oral surgery on 03/10/26, and her postoperative recommendations indicated to administer ibuprofen for pain and swelling. This failure could place residents at risk of a delay in treatment for the residents' conditions.Findings include: Record review of Resident #42's face sheet, dated 03/12/26, indicated a [AGE] year-old female who was re-admitted to the facility on [DATE]. Resident #42 had diagnoses which included dementia (a progressive decline in mental ability that interferes with daily life), major depressive disorder (serious mental health disorder characterized by persistent low mood and low self-esteem), heart disease, and high blood pressure. Record review of Resident #42's quarterly MDS assessment, dated 01/27/26, indicated she made herself understood and she understood others. Resident #42 had a BIMS score of 15, which meant she was cognitively intact. Resident #42 required total staff assistance with toileting, maximal assistance from staff for transfers, bed mobility, and showers, and she was independent with eating. Record review of Resident #42's care plan indicated: Resident #42 had a behavior problem related to occasional verbal outburst with staff yelling and argumentative with interventions for the staff to administer medications as ordered, anticipate and meet resident needs, explain all procedures, and minimize potential for resident behaviors with date initiated 10/31/25. Resident #42 had mouth surgery to monitor vital signs and report changes as needed with date initiated 03/11/26. There were no interventions included to address management of her pain after her mouth surgery. Record review of Resident #42's, undated, postoperative care instructions following her oral surgery on 03/10/26 indicated she was prescribed pain medication (hydrocodone-acetaminophen 5-325mg oral tablet), an antibiotic (amoxicillin oral capsule 500mg tablet), and to manage her pain it was recommended to alternate the prescribed pain medication with an NSAID (i.e. Ibuprofen 800 mg every 4 hours) and to swish with warm salt water (1/4 tsp salt +1 cup warm water) 3-4 times day. Record review of Resident #42's order summary report, dated as of 03/12/26, indicated she had an order for:1) amoxicillin oral capsule 500 MG Give 1 capsule by mouth four times a day for post oral surgery for 7 days with a start date of 03/11/26 and end date of 03/18/26.2) hydrocodone-acetaminophen oral tablet 5-325mg (hydrocodone-acetaminophen) give 1 tablet mouth every 6 hours as needed for post oral surgery with a start date of 03/10/26 with no end date. 3) ibuprofen oral tablet 200mg (ibuprofen) give 2 tablets by mouth every 4 hours for pain for 7 days while awake with a start date of 03/11/26 and an end date of 03/18/26.4) swish with warm salt water (1/4 tsp salt +1 cup warm water) 3-4 times a day, especially after eating, every 5 hours as needed for post op oral surgery 1/4 tsp salt+1 cup warm water) with a start date of 03/11/26 and no end date. 5) Tylenol oral tablet 325 MG (acetaminophen) Give 2 tablets by mouth every 6 hours as needed for elevated temperature; pain (2) 325mg tablets to equal 650 mg. not to exceed 3 gram/24 hours from all sources with a start date of 03/10/26 During an observation and interview on 03/11/26 at 8:45 AM, Resident #42 was in her room lying in her bed with some noted swelling to her mouth. Resident #42 said she was upset because LVN F argued with her all night over the medication orders the oral surgeon had given after her oral surgery on 03/10/2026. Resident #42 said after her oral surgery was on 03/10/2026, she returned to the facility in the evening, and LVN F refused to listen to her when she told her the instructions were that she received ibuprofen and Tylenol to help with her pain and swelling. Resident #42 said if LVN had followed the instructions from the oral surgeon, her mouth would not have swollen like it had since she returned to the facility. During an interview on 03/12/26 at 4:56 PM, LVN F said she worked (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 03/10/26 from 6:00 PM until 03/11/2026 at 6:00 AM. LVN F said she received information in report that Resident #42 had oral surgery and she had a copy of the postoperative care following oral surgery for Resident #42. LVN F said Resident #42 was a challenge and Resident #42 had an issue every time she entered her room. LVN F said Resident #42 kept asking her to administer ibuprofen. LVN F said she was aware Resident #42's instructions indicated for her to receive ibuprofen as needed, but since there was no order in Resident #42's electronic medical record she did not administer it. LVN F said she should have called the doctor and received clarification for the medications Resident #42 was requesting, and this would have prevented all the problems with Resident #42, but she said she did not have time. LVN F said she did say that's why you are in a nursing home but she was talking to herself, she did not direct it at Resident #42. She said she understood why saying that could have made Resident #42 upset, feel bad, or feel as though she could not rely on her to take care of her. During an interview on 03/13/26 at 1:44 PM, the DON said the instructions Resident #42 arrived at the facility with, after her oral surgery, were only recommendations. The DON said she expected LVN F to listen to Resident #42, if she was requesting pain medications, and call the doctor to get orders for the ibuprofen, which was recommended on 03/10/26. The DON said failure of LVN F not getting orders clarified to start ibuprofen on 03/10/26 could have caused Resident #42 increased swelling or pain. The DON said she did not notice Resident #42 had facial swelling/bruising on 03/11/2026 when she observed her. During an interview on 03/13/26 at 1:54 PM, the Administrator said when Resident #42 returned to the facility after her oral surgery with postoperative recommendations LVN F should have called the doctor and received clarification for the medications recommended. The Administrator said not receiving clarification on the medications to administer to Resident #42 for her pain placed Resident #42 at risk of having discomfort. During an interview on 03/13/26 at 2:16 PM, the Administrator said they did not have a policy on quality of care. Record review of the facility's, undated, Physician's Orders policy indicated, Purpose: To monitor and ensure the accuracy and completeness of the medication orders, treatment orders, and ADL order for each resident. Person responsible: Medical Records/Designee Written Orders by the Physician or Nurse Practitioner 1. Nurse will review the order and if needed contact the prescriber for any clarifications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675801	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gilmer Nursing and Rehabilitation	703 Titus Street Gilmer, TX 75644

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the resident environment was as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for 1 of 6 residents (Resident #2) reviewed for accidents and hazards. The facility failed to ensure Resident #2's fall mat on her left side of her bed was in place on 03/11/26 while she was in her room lying in bed. This failure could place residents at risk of accidents that could result in serious injury, harm, impairment, or death.Findings included: 1. Record review of Resident #2's face sheet, dated 03/12/26, indicated a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included dementia (a progressive decline in mental ability that interferes with daily life), bipolar disorder (chronic mental health condition characterized by extreme mood swings), and high blood pressure. Record review of Resident #2's quarterly MDS assessment, dated 12/10/25, indicated she was able to make herself understood and she understood others. Resident #2 had a BIMS score of 4, which indicated she had severely impaired cognition. Resident #2 required total staff assistance for bathing, toileting, and transfers, and moderate assistance from staff for bed mobility, and setup for eating. Record review of Resident #2's order summary report, dated as of 03/12/26, indicated she had an order for:May have fall mats at bedside every shift for falls with a start date of 06/02/25 with no stop date. Record review of Resident #2's care plan, revised on 02/14/26 indicated she was risk for falls with interventions in place for fall mats to be at bedside while in bed. Record review of the facility incident reports dated 03/10/26 indicated Resident #2 had a fall from her bed to the fall mat on 03/9/26. During an observation on 03/11/26 at 9:35 AM revealed Resident #2 was in her room lying in bed. Resident #2's right side floor mat was on floor next to her bed and Resident #2's left side was not in place. The left side floor mat was standing against her bed. During an interview on 03/13/26 at 12:47 PM, LVN A said she expected the fall mats to be on the floor on both sides of Resident #2's bed. LVN A said it was possible that the CNAs changed her in the bed and forgot to replace the left side floor mat. LVN A said nurses and CNAs were responsible for ensuring the fall mats were in place and she would remind the CNAs. LVN A said she made rounds on the hallways to keep her eyes on the fall mats and call lights. LVN A said the failure placed a risk for falls with injury. During an interview on 03/13/26 at 1:49 PM, the DON said she expected the care plan to be always followed when Resident #2 was in bed. She said it was the nurses and CNAs responsibility and the failure of both fall mats not being in place, placed a risk for falls with injuries. During an interview on 03/13/26 at 2:12 PM, the Administrator said she expected the CNAs to ensure all interventions were in place for all residents. The Administrator said the failure off the fall mat not being in place was a risk for injury. Record review of the facility's undated, policy Fall Policy did not address the use of fall mats.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 2 of 6 residents (Resident #'s 7 and 39) reviewed for medications.1.The facility failed to administer Refresh Tears Ophthalmic Solution 0.5 % (quickly alleviates dryness, irritation, and discomfort by replenishing moisture to the eyes) for Resident #39 on 03/10/26.2. The facility did not ensure LVN A primed Resident #7's Novolog FlexPen (insulin medication) according to manufacturer's instructions.This failure could place residents at risk for not receiving the therapeutic effects of their medications to include a diminished health status. Findings included:1.Record review of Resident #39's face sheet, dated 03/16/26 indicated Resident #39 was an [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE] with a diagnosis which included detachment of the retina of the left eye and macula (a small, specialized, yellowish area in the center of the retina at the back of the eye) of the left eye.Record review of Resident #39's quarterly MDS assessment dated [DATE], indicated Resident #39 understood and was understood by others. The MDS assessment indicated Resident #39 had a BIMS score of 15, indicating he was cognitively intact. The MDS assessment did not indicate Resident #39 had received any eye medication within the last 7 days of the look-back period. Record review of Resident #39's physician order dated 12/18/25, indicated Refresh Tears Ophthalmic Solution 0.5 % (Carboxymethylcellulose Sodium) Instill 1 drop in both eyes two times a day for dry eyes.Record review of Resident #39's Medication Administration Record dated 03/01/26 through 03/31/26 revealed Refresh Tears Ophthalmic Solution 0.5 % (Carboxymethylcellulose Sodium) Instill 1 drop in both eyes two times a day for dry eyes was not administered per physician order on 03/10/26 . Record review of Resident #39's progress notes on 03/10/26 revealed no documented rationale for not administering Refresh Tears Ophthalmic per physician's order.During an observation and interview on 03/11/2026 at 10:34 a.m., Resident #39 was sitting up in his recliner rubbing his eyes with a tissue. He said his eyes were stinging. He said he did not receive his eye drops last night nor this morning .During an interview on 03/11/26 at 10:38 a.m., LVN K said she had not completed her medication pass.During an interview on 03/11/26 at 10:50 a.m., Resident #39 said he had received his eye drops and his eyes felt better.During a phone interview on 03/12/26 at 4:59 p.m., LVN F said she was Resident #39's nurse. She said she worked 03/10/26. She said she does not recall giving Resident #39 his Refresh Tears Ophthalmic eye drops. She said she believed it was a busy night and she just forgot. She said she does not recall why he had an order for the eye drops but said it was prescribed by his physician then she should have given them. She said risk could be eye issues such as irritation. During an interview on 03/13/26 at 12:13 p.m., the DON said charge nurses were responsible for giving medication according to the orders. She said nurses should be reading the MAR and giving medication as indicated on the MAR. She said she was the overseer of the nurses. She said they had a clinical meeting every morning and would pull a report to see if any medications were missed on the prior day. She said she had identified that LVN F did not give Resident #39 his eye drop medication on 03/10/26. She said she did an incident report on the medication being missed. She said Resident #39 had dry eyes and he should be receiving his medication to prevent his eyes from drying out which could cause irritation.During an interview on 03/13/26 at 1:14 p.m., the Administrator stated the nurses were responsible for giving medication. She said they should be following the physician's orders. She said the DON was the overseer of the nurses. She said since Resident #39 had eye issues it was important for him to receive his eye drops.Record review of the incident report dated 03/11/26 at 1:58 p.m., indicated LVN F did not give Resident #38 his Refresh Tears Ophthalmic on 03/10/26. It revealed the physician was notified and no new orders were given. 2.Record review of (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #7's face sheet, dated 03/12/26, reflected Resident #7 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnosis which included Type 2 diabetes mellitus (chronic condition where the pancreas makes little or no insulin, which leads to high blood sugar levels) with other specified complications.Record review of Resident #7's quarterly MDS assessment, dated 12/10/25, reflected Resident #7 made herself understood, and understood others. Resident #7's BIMS score was 15, which reflected her cognition was intact.Record review of Resident #7's comprehensive care plan, revised 02/24/26, reflected Resident #7 had Diabetes Mellitus. The care plan interventions included diabetes medication as ordered by the doctor, monitor/document for side effects/effectiveness and fasting serum blood sugar as ordered by the doctor.Record review of Resident #7's physician order summary report, dated 03/12/26, reflected Resident #7 had an active order for Novolog FlexPen: inject as per sliding scale. 1 unit.subcutaneously before meals and at bedtime related to diabetes mellitus with a start date 02/10/26.Record review of the licensed nurse proficiency audit dated 12/04/25 completed by the ADON reflected LVN A had been checked for insulin administration.During an observation and interview on 03/11/26 at 11:31 a.m., LVN A prepared Resident #7's Novolog FlexPen by removing the pen cap, placing a needle onto the pen, and turning the dose knob to 1 unit. LVN A administered the medication to Resident #7's LLQ. LVN A did not prime (removing the air from the needle and cartridge) the insulin pen by turning the dose knob into 2 units before turning the dose knob to 1 unit. LVN A stated she had never primed the insulin pen before administering Resident #7's insulin. LVN A stated it was important to ensure insulin was administered by the manufacturer's instructions to ensure the residents get the correct dosage.During a telephone interview on 03/12/26 at 2:56 p.m., the Pharmacist Consultant stated the insulin pen should be primed 2 units for the 1st use. The Pharmacist Consultant stated she did a medication pass every other month but had not watched insulin administration. The Pharmacist Consultant stated it was not much of a risk if she did not prime the insulin prior to administering the 1 unit.During an interview on 03/12/26 at 3:18 p.m., the DON stated her expectation was for an insulin pen to have the needle prime with 2 units by releasing of air and then reset to dose of insulin the resident needed and administer the medication. The DON stated her and the ADON were responsible for medication administration compliance through competency check and random medication administration observations. The DON stated there was no risk of not priming the insulin prior to administration.During an interview on 03/12/26 at 3:48 p.m., the Administrator stated it was best practice to prime the Novolog FlexPen 2 units before administering the 1 unit to get the most accurate dosage. The Administrator stated the DON or designee were responsible for monitoring and overseeing. The Administrator stated these failures could potentially cause inaccurate dose.Record review of the manufacturer's guideline titled Novolog (insulin apart) injection Pen fill revised 02/2023, reflected. injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: E. turn the dose select to select 2 units.Record review of the Subcutaneous Injection Administration policy, dated 3/2025, reflected. Insulin Injection. 1. Assure type of insulin, unit dosage.Record review of facility policy titled, Medication Administration, by Pharmcare USA P&P (policy and procedure) dated 2025, indicated, Policy: Medications are administered as prescribed, in accordance with State Regulations using good nursing principles and practices and only by persons legally authorized to do so. Procedure: #1. Medications are prepared, administered, and recorded only by licensed nursing, medical, pharmacy, or other personnel authorized by state laws and regulations to administer medications. #2. Medications are administered in accordance with written orders of the attending physician. # The resident's MAR is initialed by the person administering a medication, in the space provided under the date and on the line for that specific medication dose administration. Or if utilizing an Electronic Medical Record, the initials of the nurse are electronically stamped into the record.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that its medication error rate was not 5 percent or greater. The facility had a medication error rate of 10%, based on 2 errors out of 30 opportunities, which involved 2 of 6 residents (Residents #47 and #7) reviewed for medication administration. 1. The facility did not ensure LVN A administered 2 puffs of Albuterol (medication used to prevent and treat wheezing, difficulty breathing, chest tightness and coughing) HFA Sulfate Inhalation Aerosol Solution instead of 1 puff to Resident #47. 2. The facility did not ensure LVN A primed Resident #7's Novolog FlexPen (insulin medication) according to the manufacturer's instructions. These failures could place residents at risk of not receiving therapeutic effects of their medications and possible adverse reactions. Findings included:1. Record review of Resident #47's face sheet, dated 03/12/26, reflected Resident #47 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnosis which included COPD (chronic inflammatory lung disease that causes obstructed airflow from the lungs). Record review of Resident #47's quarterly MDS assessment, dated 01/05/26, reflected Resident #47 made herself understood, and understood others. Resident #47's BIMS score was 10, which reflected her cognition was moderately impaired. Record review of Resident #47's comprehensive care plan, revised on 08/14/25, reflected Resident #47 had Emphysema (long term lung condition that caused SOB)/COPD. The care plan interventions included give aerosols (spray that deliver medication directly to the lungs) or bronchodilators (medications that relax lung muscles and widen airways to help with breathing) as ordered. Record review of Resident #47's physician order summary report, dated 03/12/26, reflected Resident #47 had an active order for Albuterol HFA Sulfate Inhalation Aerosol Solution:180 (90 base) mcg/act: 2 puffs inhaled orally every six hours for COPD with a start date 03/19/25. During an observation and interview on 03/10/26 at 11:24 a.m., LVN A handed Resident #47 her inhaler and asked her to inhale 1 puff. Resident #47 inhaled 1 puff and LVN A then handed Resident #47 a glass of water to rinse her mouth out. Once Resident #47 rinsed her mouth out, LVN A left the room. The state surveyor asked LVN A if Resident #47 should have gotten 1 puff or 2 puffs of her inhaler. LVN A stated Resident #47 should have gotten 2 puffs. She went back into the room and had Resident #47 inhale a second puff of her inhaler. LVN A said she usually did not walk Resident #47 through the steps of using her inhaler. She said she normally handed Resident #47 the inhaler and Resident #47 knew how to inhale 2 puffs. She stated that since the state surveyor was present, she failed to instruct Resident #47 to inhale 2 puffs. LVN A stated it was important for Resident #47 to receive the accurate dose of her breathing medication to prevent an exacerbation of breathing problems such as shortness of breath or dizziness that could have led to hospitalization. 2. Record review of Resident #7's face sheet, dated 03/12/26, reflected Resident #7 was a [AGE] year-old female, admitted to the facility on [DATE] with diagnosis which included Type 2 diabetes mellitus (chronic condition where the pancreas makes little or no insulin, which leads to high blood sugar levels) with other specified complications. Record review of Resident #7's quarterly MDS assessment, dated 12/10/25, reflected Resident #7 made herself understood, and understood others. Resident #7's BIMS score was 15, which reflected her cognition was intact. Record review of Resident #7's comprehensive care plan, revised 02/24/26, reflected Resident #7 had Diabetes Mellitus. The care plan interventions included diabetes medication as ordered by the doctor, monitor/document for side effects/effectiveness and fasting serum blood sugar as ordered by the doctor. Record review of Resident #7's physician order summary report, dated 03/12/26, reflected Resident #7 had an active order for Novolog FlexPen: inject as per sliding scale. 1 unit.subcutaneously before meals and at bedtime related to diabetes mellitus with a start date 02/10/26. Record review of the licensed nurse proficiency audit dated 12/04/25 completed by the ADON reflected LVN A had been checked for insulin administration. During an observation and interview on 03/11/26 at 11:31 a.m., LVN A prepared Resident #7's Novolog FlexPen by removing the (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pen cap, placing a needle onto the pen, and turning the dose knob to 1 unit. LVN A administered the medication to Resident #7's LLQ. LVN A did not prime (removing the air from the needle and cartridge) the insulin pen by turning the dose knob into 2 units before turning the dose knob to 1 unit. LVN A stated she had never primed the insulin pen before administering Resident #7's insulin. LVN A stated it was important to ensure insulin was administered by the manufacturer's instructions to ensure the residents get the correct dosage. During a telephone interview on 03/12/26 at 2:56 p.m., the Pharmacist Consultant stated the insulin pen should be primed 2 units for the 1st use. The Pharmacist Consultant stated she did a medication pass every other month but had not watched insulin administration. The Pharmacist Consultant stated it was not much of a risk if she did not prime the insulin prior to administering the 1 unit. During an interview on 03/12/26 at 3:18 p.m., the DON stated she expected LVN A and the treatment nurse to follow the doctor's order. The DON stated if the Treatment Nurse was within the timeframe, she could have finished her medication pass and went back and got nasal spray out of the nurse's cart and administered the medication. The DON stated her expectation was for an insulin pen to have the needle prime with 2 units by releasing of air and then reset to dose of insulin the resident needed and administer the medication. The DON stated her and the ADON were responsible for medication administration compliance through competency check and random medication administration observations. The DON stated it was important that Resident #47 received 2 puffs instead of 1 puff to prevent SOB or wheezing. The DON stated it was important that Resident #52 received her nasal spray to prevent congestion or worsening of her allergies. The DON stated there was no risk of not priming the insulin prior to administration. During an interview on 03/12/26 at 3:48 p.m., the Administrator stated she expected doctor orders to be followed and administered within the timeframe. The Administrator stated it was best practice to prime the Novolog FlexPen 2 units before administering the 1 unit to get the most accurate dosage. The Administrator stated the DON or designee were responsible for monitoring and overseeing medication administration. The Administrator stated these failures could potentially cause SOB, respiratory distress, allergy discomfort and inaccurate dose. Record review of the manufacturer's guideline titled Novolog (insulin apart) injection Pen fill revised 02/2023, reflected. injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: E. turn the dose select to select 2 units. Record review of the Subcutaneous Injection Administration policy, dated 3/2025, reflected. Insulin Injection. 1. Assure type of insulin, unit dosage. Record review of the Medication Administration and General Guidelines policy, dated 3/2025, reflected. Medications are administered as prescribed. 2. Medications are administered in accordance with written orders of the attending physician. checklist for completing proper steps in the administration of medications. Adhere to the 6 rights of medication administration. (1) right dose. (5) right time.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received and the facility provided food that accommodated resident allergies, intolerances, and preferences for 1 of 1 resident (Resident #54) reviewed for food preferences and the accommodation of resident's meal choices. The facility failed to ensure Resident #54's preference for dislike of corn was honored on 03/10/26. This failure could result in a decrease in resident choices, diminished interest in meals, and weight loss. Findings include: Record review of Resident #54's face sheet, dated 03/12/26, reflected Resident #54 was an [AGE] year-old female, admitted to the facility on [DATE] with a diagnosis which included Alzheimer's (progressive disease that destroys memory and other important mental functions). Record review of Resident #54's quarterly MDS assessment, dated 01/29/26, reflected Resident #54 usually made herself understood, and usually understood others. Resident #54's BIMS score was 4, which reflected her cognition was severely impaired. Resident #54 was independent with eating. Record review of Resident #54's comprehensive care plan, revised on 08/25/25, reflected Resident #54 had a diet order of regular and was at risk for unplanned wight loss or gain. The care plan interventions included determined food preferences and provided within dietary limitations. Record review of Resident #54's order summary report, dated 03/12/26, reflected there was not an order for Resident #54 dislikes. Record review of Resident #54's lunch meal ticket reflected Resident #54 disliked corn. During an observation and interview on 03/10/26 at 12:46 p.m., Resident #54 was served corn. Resident #54 stated she could not have corn due to her diverticulitis (inflammation of irregular bulging pouches in the wall of the large intestines). During an interview on 03/11/26 at 3:56 p.m., [NAME] B stated she was responsible for ensuring Resident #54 received an alternative if corn was on the menu. [NAME] B stated she was unaware Resident #54 did not like corn. [NAME] B stated she should have reviewed the lunch meal ticket before preparing Resident #54's tray. [NAME] B stated she got nervous when the state surveyor was in the building. [NAME] B stated it was important for Resident #54's food dislikes to be followed because it was her right. During a telephone interview on 03/12/26 at 11:42 p.m., the Dietician stated the cooks should be observing the lunch tray card to make sure the residents preferences were being honored. The Dietician stated the nurses should be checking the trays also before the resident was served. The Dietician stated she monitored by observing meal service monthly. The Dietician stated it was important for Resident #54's food dislikes to be followed to meet the resident's needs. During an interview on 03/12/26 at 1:45 p.m., the treatment nurse stated she was responsible for ensuring Resident #54's dislike was not on the tray. The treatment nurse stated she was paying more attention to the diet. The treatment nurse stated it was important for Resident #54's food dislikes to be followed to prevent potential weight loss and her preference was honored. During an interview on 03/12/26 at 2:21 p.m., the Dietary Manager stated the cook was responsible for ensuring she received an alternative if those items were on the menu. The Dietary Manager stated when Dietary Aide D gave [NAME] B the tray, [NAME] B should have read the lunch tray card and reviewed the dislikes/likes. The Dietary Manager stated the nurses should have checked the trays and reviewed the tray card prior to serving the resident to ensure the tray was accurate. The Dietary Manager stated she monitored by observing meal services 2-3 times a week and in serviced staff. The Dietary Manager stated it was important for Resident #54's food dislikes to be followed to honor her wishes. During an interview on 03/12/26 at 3:18 p.m., the DON stated she expected food preferences/dislikes to be followed. The DON stated the nurses should be checking the trays prior to serving the residents and ensure an alternative was given. The DON stated her and the ADON monitored by observing meal service. The DON stated it was important for their food preferences/dislikes to be followed to prevent weight loss or an upset stomach. During an interview on 03/12/26 at 3:48 p.m., the Administrator stated she expected food preferences/dislikes (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to be followed. The Administrator stated the Dietary Manager was responsible for monitoring and overseeing meal service. The Administrator stated it was important for their food preferences to be followed to prevent a flare up and to honor Resident #54's preference. Record review of the facility's undated policy titled Resident Meal Service and HS Snack reflected, . Mealtimes can be adjusted per resident preference.3. If a resident, make food choices that do not include food items from all of the food groups, this will be addressed individually in the resident's care plan.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident received it and the facility provided food prepared in a form designed to meet individual needs for 1 of 6 residents (Resident's #38) reviewed for food and drinks.The facility failed to ensure Resident #38, received her health shake on 03/10/26.This failure could place residents at risk for weight loss, and unmet nutritional needs.Findings Included:Record review of Resident #38's face sheet, dated 03/16/26, indicated a [AGE] year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #38 had diagnoses which included malnutrition (a critical health condition caused by a diet lacking, or excessive in, nutrients and calories, leading to deficiencies, obesity, or chronic health issues), dementia (loss of memory), and dysphagia (problem swallowing).Record review of Resident #38's quarterly MDS assessment, dated 1/26/26, indicated Resident #38 was usually understood and was usually understood by others. Resident #38's BIMS score was 03, which indicated she was severely impaired. Resident #38 required assistance with dressing, personal hygiene, toileting, bathing, bed mobility, transfers, and set up for eating. The MDS during the 7-day look-back period did not indicate Resident #38 had weight loss.Record review of Resident #38?s physician orders, dated 03/07/24, indicated pureed texture, regular consistency, with divided plate, no straws and house supplement with meals.Record review of Resident #38?s care plan, revised date of 11/29/25, indicated Resident #38 had potential nutritional problems related to regular diet, pureed texture. The intervention was for staff to provide and serve diet and supplements as ordered.During an observation and interview on 03/10/26 at 12:46 p.m., Resident #38 was in her room being assisted by CNA G to eat her lunch. Her tray card read health shake with meals. Resident #38 did not have a health shake on her tray. CNA G read Resident #38's tray card and said it read health shake with meals. She said Resident #38 did not have a health shake on her tray. She said she was not aware who served Resident #38's lunch tray but said she came to assist her with her meal. CNA G said the nurses usually checked the trays before the CNAs passed them out. She said she was not aware why Resident #38 was supposed to have a health shake but said maybe for nutrition. During an interview on 03/10/26 at 1:10 p.m., the Dietary Manager looked and verified Resident #38 did not have a health shake on her lunch tray. She said Dietary Aide E was new and must have missed where it indicated for a health shake. She said she would get Resident #38 a health shake. She said health shakes were given for weigh loss.During an interview on 03/12/26 at 11:30 a.m., Dietary Aide E said she was responsible for ensuring health shakes were on the tray. She said she was new to the facility and still learning the process. She said she guessed she overlooked the health shake being written on Resident #38's tray card. During an interview on 03/13/26 at 12:03 p.m., LVN A said she checked lunch trays on Tuesday (03/10/26). She said she could not recall Resident #38's tray specifically but knew she was supposed to have a health shake for weight loss. She said when she checked trays and the health shake was missing; she would ask the dietary department to give her a health shake. During an interview on 03/13/26 at 12:13 p.m., the DON said she expected the diet order to be followed. She said the dietary department was supposed to put the health shake on the tray and the nurses should be checking the trays before they were served to ensure the tray ticket matched the tray. The DON said the Dietary Manager was responsible for monitoring the kitchen. She said the risk of not receiving the health shakes could lead to weight loss.During an interview on 03/13/26 at 1:04 p.m., the Administrator said it was a 2-step process for ensuring the residents were receiving what was ordered. She said the dietary staff placed the health shake on the tray and the nurses were responsible for ensuing it was on the tray before it was served. She said the dietary manager was responsible for the kitchen and the DON was responsible for the nurses. She said it was important for residents to receive supplements to nutritional issues or weight loss. Record review of the facility's, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675801	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy titled, Supplements, given out of the Dietary Services Policy & Procedure Manual dated 2012, indicated, We will provide supplements to residents in a safe and sanitary manner. Physician ordered supplements will be prepared and delivered by the Food and Nutrition Department according to facility policies.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 5 residents (Resident #4) reviewed for infection control. The facility failed to ensure the Wound Treatment Nurse donned a gown when she provided wound care to Resident #4 on 3/12/2026. This failure could place residents at risk for cross-contamination and the spread of infection. Findings include: 1. Record review of Resident #4's face sheet, dated 3/13/2026, indicated an [AGE] year-old male who re-admitted to the facility on [DATE]. Resident #4 had a diagnosis which included non-ST elevation myocardial infarction (a heart attack caused by a partial blockage of a coronary artery, restricting blood flow and causing heart muscle damage). Record review of Resident #4's MDS admission assessment dated [DATE], indicated he was able to make himself understood and understood others. Resident #4's BIMS score was 14, which indicated his cognition was intact. Resident #4 was occasionally incontinent of bladder and often incontinent of bowel. Resident #4 had MASD (Moisture Associated Skin Damage) to the right and left buttock. Record review of Resident #4's comprehensive care plan, revised on 3/6/2026, indicated Resident #4 had actual impairment to skin integrity related to fragile skin and was at risk for frequent infections, pressure/venous/stasis ulcers. Care plan interventions included follow facility protocols for treatment of injury, and monitor/document/report to doctor as needed for signs and symptoms of infections to any open areas such as redness, pain, heat, swelling or pus formation. Record review of Resident #4's Order Summary Report, dated 3/12/2026, indicated: Nursing intervention: Enhanced barrier precautions every day and night shift Moisture Acquired Skin Damage-Left Buttock: Cleanse with Hibiclens, pat to dry, apply zinc, may leave to open air- Every day and night shift to promote wound healing.Moisture Acquired Skin Damage-Right Buttock: Cleanse with Hibiclens, pat to dry, apply zinc, may leave open to air- Every day and night shift to promote wound healing. During an observation and interview on 3/12/2026 at 2:25 PM, the Wound Care Nurse performed wound care for Resident #4 and did not wear PPE (gown). Observed was an EBP sign on the outside of the door and supplies at the doorway. The Wound Care Nurse stated she did not wear a gown while performing care because the order was new and she forgot. The Wound Care Nurse stated it was important to follow the ordered enhanced barrier precautions to prevent the spread of infection. During an interview on 3/13/2026 at 2:45 PM, the DON stated she expected nurses and anyone involved with patient care to follow enhanced barrier precautions when ordered. The DON stated EBP was necessary to prevent the spread of infection to other residents and staff. During an interview on 3/13/2026 at 1:10 PM, the Facility Administrator stated she expected all orders to be followed, which included EBP orders. The Facility Administrator stated it was best practice and necessary to stop the potential for the spread of infection and protect the staff. Record review of the facility's protocol Enhanced Barrier Precautions, dated 4/1/2024, indicated Enhanced Barrier Precautions are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. Based on observation, interview and record review the facility failed to establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also took into account nonsmoking residents for 1 of 1 facility reviewed for smoking policies. The facility failed to ensure Dietary Aide H followed the smoking policy, when she did not use the facility's assigned smoking area to smoke on 03/12/2026. This failure could place residents at risk of an unsafe smoking environment and an increased risk of injury related to smoking.Findings included: During an observation on 03/12/2026 at 11:38 AM, Dietary Aide H was smoking a cigarette on the sidewalk located in front of the facility that led up to the kitchen's back door. Dietary Aide H extinguished her cigarette on the ground in the dirt and went inside the kitchen. During an interview on 03/12/2026 at 1:11 PM, Dietary Aide H said when she smoked, she went inside her truck to smoke, or she could sit in the rocking chairs in front of the facility to smoke. Dietary Aide H said she was not supposed to smoke in the resident's designated smoking area. Dietary Aide H said if she was outside of the facility she could smoke anywhere. Dietary Aide H said she did not leave the cigarette butts on the ground she extinguished them and put them in her pocket. During an interview on 03/13/2026 at 1:39 PM, the Administrator said the designated smoking area was across from the dining area, and that was where she expected the staff and residents to smoke for safety. The Administrator said staff should not be smoking on the sidewalk that led up to the kitchen's back door because it was a safety risk and it did not provide a homelike environment to the residents. The Administrator said when employees were hired the Human Resources Coordinator gave them a tour of the facility and showed them where the designated smoking area was located. The Administrator said it was important for the employees to smoke only in the designated smoking area for safety and to provide a homelike environment. During an interview on 03/13/2026 at 1:44 PM, the Human Resources Coordinator said when new employees were hired, she showed them around the facility and showed them the designated smoking area across from the dining area. The Human Resources Coordinator said the smoking area for the employees was the same as for the residents. The Human Resources Coordinator said she did not remember if she was the Human Resources Coordinator when Dietary Aide H was hired. The Human Resources Coordinator said it was important for smoking to only take place in the designated smoking area because that was where the fire extinguisher and proper ash trays were located and for safety. Record review of the facility's undated Smoking Policy, indicated, Residents and employees are prohibited from smoking in any of the facility's buildings except in the designated smoking area. The designated smoking areas will be environmentally separate from all resident care areas and equipped with exhaust fans. The restrictions are intended to restrict smoking to a minimum and reduce risks to residents who smoke, including possible adverse effects on treatment; reduce risks of passive smoking for others; and reduce the risk of fire. Employees, medical staff, residents, and visitors are expected to adhere to the no smoking policy. Employees, medical staff, residents, and visitors must smoke in the designated outdoor area only. Employees, medical staff, residents, and visitors will receive instruction on the smoking policy upon employment/admission to the facility.