STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675851	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Georgia Manor Nursing Home	2611 W 46th Ave Amarillo, TX 79110

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 3 (Resident #1, Resident #37, and Resident #44) of 13 residents reviewed for resident rights.The facility failed to ensure Resident #1, Resident #37, and Resident #44 did not have hairy chins.This failure could put residents at risk of embarrassment, feelings of insecurity, and/or diminished self-esteem.Findings Included:1. Record review of Resident #1's admission record revealed a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of muscle weakness.Record review of Resident #1's quarterly MDS assessment completed on 04/25/26 revealed a BIMS score of 12 which indicated moderately impaired cognition. Section GG Functional Abilities revealed Resident #1 was dependent on staff for toileting and required partial/moderate to supervision/touching assistance across the rest of her ADLs.Record review of Resident #1's care plan completed on 03/18/26 revealed she had an ADL self-care performance deficit and required staff assistance with bathing.Record review of Resident #1's shower documentation in her EHR revealed she was showered on 06/02/26.During an observation on 06/03/26 at 11:17 AM Resident #1 was seated in the dining room at a table participating in an activity. She was neatly dressed and had several white, approximately one-inch-long hairs on her chin.During an observation and interview on 06/04/26 at 08:22 AM Resident #1 had several one-inch-long white hairs on her chin. She grabbed the hairs with her left hand and stated they bothered her. Resident #1 stated, I am waiting on the beauty shop ladies to come because they usually take and shave it (her chin hair) off for me. She stated CNAs never shaved her chin. Resident #1 stated the beauty shop ladies came every 3 weeks.2. Record review of Resident #37's admission record dated 06/03/26 revealed a [AGE] year-old female most recently admitted to the facility on [DATE] with a diagnosis of muscle weakness.Record review of Resident #37's quarterly MDS assessment completed on 05/12/26 revealed a BIMS score of 7 which indicated severely impaired cognition. Section GG Functional Abilities revealed Resident #37 was dependent or required partial/moderate assistance across all ADLs except eating, where she required supervision/touching assistance.Record review of Resident #37's care plan completed on 05/08/26 revealed she had an ADL self-care deficit and required one staff member to assist her with bathing.Record review of Resident #37's shower documentation in her EHR revealed she received a shower on 06/02/26.During an observation on 06/03/26 at 09:01 AM Resident #37 was lying on her back in bed. She had several dark and light grey hairs sprinkled across her chin. The hairs were approximately half an inch long.During an observation on 06/03/26 at 11:11 AM Resident #37 was lying on her back in bed. She had several dark and light grey hairs sprinkled across her chin. The hairs were approximately half an inch long.During an observation on 06/03/26 at 12:19 PM Resident #37 was lying on her back in bed. She had several dark and light grey hairs sprinkled across her chin. The hairs were approximately half an inch long.During an observation on 06/03/26 at 02:12 PM Resident #37 was lying on her back in bed with the head of the bed raised to seated. She had several dark and light grey hairs sprinkled (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	across her chin. The hairs were approximately half an inch long.During an interview on 06/05/26 at 10:19 AM Resident #37's family member stated Resident #37 would not choose to have a beard. Family member stated when at home Resident #37 used a trimmer to remove unwanted chin hair. She stated that CNAs shaved Resident #37's chin when they showered her.3. Record review of Resident #44's admission record dated 06/05/2 revealed a [AGE] year-old female admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Parkinson's disease (chronic and progressive movement disorder that initially causes tremors in one hand and stiffness or slowing of movement), lack of coordination, and muscle weakness.Record review of Resident #44's quarterly MDS assessment completed on 05/29/26 revealed a BIMS score of 7 which indicated severely impaired cognition. Section GG Functional Abilities revealed Resident #44 was dependent across all ADLS except for eating where she required supervision or touching assistance.Record review of Resident #44's care plan completed on 06/03/26 revealed she had impaired cognitive function and an ADL self-care performance deficit. She required the assistance of two staff members for bathing.Record review of Resident #44's shower documentation in her EHR revealed she was showered on 06/02/26.During an observation on 06/03/26 at 08:45 AM Resident #44 had long, white, curling hairs on both sides of her chin.During an observation and interview on 06/06/26 at 09:15 AM Resident #44 stated it bothered her to have chin hair. She stated she did not like it. Resident #44 stated she could shave her chin if she had a razor. She stated CNAs had shaved her chin the past and she did not know why they had not shaved it lately.During an interview on 06/04/26 at 08:46 AM Resident #44's family member stated having chin hair bothered Resident #44. He stated he had never seen Resident #44 with chin hair before she came to the facility. He stated if he brought up the chin hair to Resident #44, she would become emotional and embarrassed. Resident #44's family member stated Resident #44 had always been well-groomed in the past and would never have been seen in public with chin hairs.During an observation on 06/04/26 at 09:45 AM Resident #44 had long, white, curling hairs on both sides of her chin.During an interview on 06/05/26 at 08:58 AM LVN E stated female residents should not have beards unless they wanted them. She stated nurses were responsible to ensure female residents did not have beards. LVN E stated having an unwanted beard could negative affect a female resident by causing her to have low self-esteem.During an interview on 06/05/26 at 09:05 AM RN D, who was working on the hall of all three residents, stated female residents should not have beards unless they wanted them. She stated all staff were responsible to ensure female residents did not have beards. RN D stated a female resident's dignity could be negatively impacted by having an unwanted beard.During an interview on 06/05/26 at 09:12 AM LVN C stated female residents should not have beards unless they wanted them. She stated CNAs were primarily responsible to ensure female residents did not have beards, but all staff members could play a part. LVN C stated an unwanted beard could negatively impact a female resident's dignity and self-esteem.During an interview on 06/05/26 at 09:18 AM CNA B stated female residents should not have beards unless they wanted them. She stated CNAs were responsible to ensure female residents did not have beards. CNA B stated female residents with unwanted beards could be subject to ridicule by other residents. She recently told DON staff needed an in-service on shaving. She stated she shaved Resident #44's beard on 06/04/26 and she shaved part of Resident #37's beard on 06/04/26 and asked the LVN on duty to chart that Resident #37 would not let her finish. CNA B stated she shaves female resident's chins every time she bathes them if they need to be shaved. She stated she worked on 06/04/26, but it was her day off. CNA B stated she did not know why Resident #37 and Resident #44 chins were not shaved by CNAs on the other rotation. CNA B stated she did not see Resident #1's beard.During an interview on 06/05/26 at 09:26 AM CNA A, who was working on the hall of all three residents, stated female residents should not have beards unless they wanted them. She stated CNAs were responsible to ensure female residents did not have beards. CNA A stated having an unwanted beard could negatively impact female residents mentally.During an interview on 06/05/26 at 09:30 AM DON stated CNAs were responsible for shaving the female residents who did (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not want beards. DON stated she did not think there would be a negative outcome to a female resident if she had an unwanted beard Unless they are particularly [NAME].During an interview on 06/05/26 at 09:39 AM ADM stated she did not think female residents should have beards. She stated it could negatively impact their dignity. ADM stated all nursing staff were responsible to ensure female residents did not have unwanted beards.During an interview on 06/05/26 at 09:48 AM MDS RN stated female residents should not have unwanted beards. She stated CNAs and nurses were responsible to ensure female residents did not have unwanted beards. MDS RN stated a female resident having an unwanted beard could lead to emotional problems and/or insecurity.Record review of pages 4-6 of the facility's admission packet dated 09/01/25 and titled, Resident's Rights revealed the following: . You have the right to: Be treated with dignity, courtesy, consideration, and respect. Receive all care necessary to have the highest possible level of health.Record review of an undated facility policy titled, Resident Rights revealed the following, . The resident has a right to a dignified existence, . A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment tha t [sic] promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. Respect and dignity - The resident had 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. Self-determination - the resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice. 2. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to determine that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled for 2 out of 2 medication carts (Hall A and Hall B Medication Carts) reviewed for pharmacy services. The facility failed to ensure that drug records for controlled substances were accurately maintained, verified, and periodically reconciled by licensed nursing staff during shift exchanges. This failure could place all residents receiving controlled medications at risk for medication errors, drug diversion, and a lack of therapeutic continuity due to unverified narcotics inventories across 100% of the facility's medication carts (2 out of 2) over a six-month period.Findings Included: During a record review on 06/04/2026 at 9:26 AM, it was noted that narcotic books were not filled out completely with signatures for both morning and night shifts on the Hall A medication cart. It was noted that signatures were missing on 12/30/2025, 1/1/2026, 1/2/2026, 1/19/2026, 1/26/26, 1/30/26, 1/31/2026, 2/12/2026, 3/9/2026, 3/11/2026, 3/26/2026, and 4/2/2026.During an interview on 06/04/2026 at 9:26 AM, LVN G stated that two nurses were not verifying the narcotic count by signing the book, and if the count was off, no one would know who to contact to see why it was off and what happened. LVN G confirmed that accountability rests with both the nurse taking over the cart and the nurse leaving.During an observation on 06/04/2026 at 9:35 AM, the narcotic book for Hall B medication cart were missing signatures on 5/3/2026 and 5/30/2026.During an interview on 06/04/2026 at 9:53AM, LVN F stated that two nurses are not verifying the narcotic count by signing the book, and if the count was off, there is no actual proof to verify two nurses counted, and there was no transfer of responsibility. The LVN confirmed that accountability rests with both the nurse taking over the cart and the nurse leaving.During an interview on 06/04/2026 at 10:35 AM, the DON revealed when the narcotic book lacks signatures, the count could be incorrect, directly affecting the medications the resident receives.During an interview on 06/04/2026 10:37 AM, the ADM revealed missing shift-count signatures can result in an inaccurate count and lead to missing medication doses for the residents.During an interview on 06/04/2026 at 11:01 AM, the CCN stated without the narcotic sheet signatures, there is no physical proof that a medication count was completed and accurate. Record review of the facility's policy and procedures titled Controlled Medications - Administration (dated 4/6/26) revealed the following directives: Policy: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws and regulations. Procedure: At each shift change, a physical inventory of all controlled medications is conducted by two licensed nurses and/or one nurse and a CMA, QMAP, Med Tech or equivalent as allowed by your State regulatory agency and is documented on an audit record. Alternatively, the shift change audit may be recorded on the accountability record if there is a designated column for the audit.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure each resident had a right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences for 1 (Resident #37) of 13 residents reviewed for accommodation of needs.The facility failed to ensure Resident #37's call light was in reach on 06/03/26.This failure could place residents at risk of unmet needs, injury, and/or feelings of helplessness and frustration.Findings Included:Record review of Resident #37's admission record dated 06/03/26 revealed a [AGE] year-old female most recently admitted to the facility on [DATE] with diagnoses that included, but were not limited to, vascular dementia with agitation (a decline in thinking skills caused by conditions that block or reduce blood flow to various regions of the brain), intermittent explosive disorder (repeated sudden outbursts of anger), muscle weakness, unsteadiness on feet, and cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it, stroke).Record review of Resident #37's quarterly MDS assessment completed on 05/12/26 revealed a BIMS score of 7 which indicated severely impaired cognition. Section GG Functional Abilities revealed Resident #37 used a wheelchair and had impairment to both sides of her lower extremities. She was dependent or required partial/moderate assistance across all ADLs except eating, where she required supervision/touching assistance. Section H Bladder and Bowel revealed Resident #37 was always incontinent of bladder and bowel.Record review of Resident #37's care plan completed on 05/08/26 revealed she had an ADL self-care deficit and one of the interventions listed was Encourage the resident to use bell to call for assistance. Resident #37 was noted to be at risk for falls. Staff were to encourage her to utilize staff assistance for transfers and Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed.During an observation on 06/03/26 at 09:01 AM Resident #37 was lying on her back in bed. Her call light was on the floor between her bed and the wall at the foot of her bed.During an observation on 06/03/26 at 11:11 AM Resident #37 was lying on her back in bed. Her call light was on the floor between her bed and the wall at the foot of her bed.During an observation and attempted interview on 06/03/26 at 12:19 PM Resident #37 was lying on her back in bed. Her call light was on the floor between her bed and the wall at the foot of her bed. She did not answer when asked if she had a call light or had ever used a call light.During an observation on 06/03/26 at 02:12 PM Resident #37 was lying on her back in bed with the head of the bed raised to seated. Her call light was on the floor between her bed and the wall at the foot of her bed.During an interview on 06/03/26 at 02:54 PM Resident #37's family member stated Resident #37 was capable of using her call light and would sometimes push her call light just to mess with them (staff).During an interview on 06/05/26 at 08:58 AM LVN E stated call lights should be in reach of residents. She stated CNAs and nurses were responsible to ensure call lights were in reach of residents. LVN E stated if a call light was out of reach of a resident the resident could not tell staff what they needed and could have an accident or need to use the bathroom.During an interview on 06/05/26 at 09:05 AM RN D stated call lights should be in reach of residents. She stated all nursing staff were responsible for ensuring correct call light placement. RN D stated call lights out of reach of residents could result in the residents falling or being injured.During an interview on 06/05/26 at 09:12 AM LVN C stated call lights were to be in reach of residents at all times. She stated all staff members were responsible for ensuring call lights were in reach of residents. LVN C stated residents might not receive the help they need or might fall if call lights were out of reach.During an interview on 06/05/26 at 09:18 AM CNA B stated call lights should be in reach of residents at all times. She stated all staff were responsible for ensuring call lights were in reach of residents. CNA B stated residents could fall trying to help themselves or could feel aggravated that no one was helping them if their call lights were out of reach.During an interview on 06/05/26 at 09:26 AM CNA A stated call lights were to be in reach of residents at all times. She stated CNAs were (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible for ensuring call lights were within reach. CNA A stated a resident could be negatively impacted mentally and physically if their call light was out of reach due to not getting the assistance they needed and/or trying to help themselves and getting injured. During an interview on 06/05/26 at 09:30 AM DON stated call lights should be in reach of residents. She stated all staff were responsible for ensuring proper placement of call lights. DON stated if a call light was out of reach of a resident the resident might be in need of help and not get the help they needed.During an interview on 06/05/26 at 09:39 AM ADM stated call lights should be in reach or residents at all times. She stated all staff were responsible for ensuring call lights were in reach of residents. ADM stated a resident could be negatively impacted if their call light was out of reach and something happens and they can't pull (the) call bell. She stated all department heads had several rooms assigned to them which they were responsible for checking twice during each shift and part of the checking included call light placement. ADM stated HR checked Resident #37's room twice a day.During an interview on 06/05/26 at 09:48 AM MDS RN stated call lights should be in reach of residents because that is how they talk to us. She stated all staff were responsible for ensuring call lights were in reach of residents. MDS RN stated a resident could be negatively impacted if their call light was out of reach due to not being able to get needed help.During an interview on 06/05/26 at 09:49 AM HR stated she checked on Resident #37 two times between 08:00 AM and 05:00 PM on 06/03/26. She stated Resident #37's call light was in reach both times.Record review of pages 4-6 of the facility's admission packet dated 09/01/25 and titled, Resident's Rights revealed the following: . You have the right to: Receive all care necessary to have the highest possible level of health.Record review of an undated facility policy titled, Resident Rights revealed the following, . 3. The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences.

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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 observations and interviews the facility failed to ensure the resident has a right to personal privacy and confidentiality of his or her personal and medical records for 1 out of 13 residents (Resident #55) reviewed for privacy/confidentiality of medical records. The facility failed to ensure the protected health information, personal identifiers, and clinical medical charts were adequately safeguarded against unauthorized viewing, public disclosure, on 06/4/2026 at 8:39 AM and 8:42 AM. This failure could result in a breach of personal privacy, lead to medical identity theft, or cause emotional distress and humiliation to the residents due to the unauthorized exposure of their private medical history and diagnoses.Findings Included: During an observation on 06/04/2026 at 8:39 AM of medication pass on Hall B, LVN F was observed walking away from the medication cart to administer medications. The cart's computer monitor was left active and unsecured, visibly displaying the eMAR and private clinical details of a resident. At the time of this observation, the medication cart was positioned in the hallway near rooms [ROOM NUMBERS], exposing the screen to residents passing through the corridor. During an observation on 06/04/2026 at 8:42 AM, LVN F was observed walking away from the Hall B medication cart a second time to retrieve keys from another nurse. The computer screen was again left fully open and active, publicly displaying residents' private eMAR information. During an interview on 06/04/2026 at 8:50 AM, regarding the unsecured computer screen, LVN F acknowledged that leaving a resident's personal health information visible on an open monitor constitutes an unauthorized sharing of patient information and was a HIPAA violation. During an interview on 06/04/2026 at 10:35 AM, the DON stated that the negative outcome of leaving an active computer screen open was that someone could walk by and see information that is supposed to be protected and private. The DON confirmed that maintaining screen security is the sole responsibility of the nurse assigned to that specific cart and unit. During an interview on 06/04/2026 at 10:37 AM, the ADM stated that leaving a computer active with resident information on display is a HIPAA violation that allows other residents and family members to see information that isn't supposed to be shared. The Administrator stated electronic privacy is the responsibility of all staff, particularly the nurse working in that specific hallway. During an interview on 06/04/2026 at 11:01 AM, the CCN stated leaving a computer terminal open with private records allows family members and other residents to access information that is private and not authorized for disclosure. During a record review of the facility's undated policy titled Resident Rights revealed the following mandates under the section Privacy and Confidentiality: The resident has a right to personal privacy and confidentiality of his or her personal medical records.The facility must respect the resident's right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications.The resident has a right to secure and confidential personal and medical records. During a record review of the facility's standard Resident admission Packet, revised on September 1, 2025, revealed that under the Privacy and Confidentiality section, residents are guaranteed the right to: Have facility information about you maintained as confidential.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to ensure the assessment accurately reflected the resident's status for 1 (Resident #7) of 13 residents reviewed for accuracy of assessment.The facility coded Resident #7 as having significant weight loss in the last month when, in fact, he had not had significant weight loss.This failure could place residents at risk of receiving unnecessary care/medication/supplementation.Findings Included:Record review of Resident #7's admission record dated 06/03/26 revealed a 63-yeaer-old male admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified protein-calorie malnutrition and dehydration.Record review of Resident #7's quarterly MDS assessment completed on 03/23/26 revealed a BIMS score of 9 which indicated moderately impaired cognition. Section K Swallowing/Nutritional Status question K0300 was answered with a 2 which indicated Resident #7 had lost 5% or more in the last month or 10% or more in the last 6 months not on physician-prescribed weight-loss regimen.Record review of Resident #7's care plan completed on 03/25/26 revealed the following focus area: The resident has a significant unplanned/unexpected weight loss Poor food intake-also anxiety issues. This focus area was initiated on 10/16/25.Record review of Resident #7's weights for the last 6 months revealed no weight loss of 5% in one month or 10% in 6 months relative to the ARD date (03/22/26) of his quarterly MDS assessment completed on 03/23/26. On 03/22/26 he weighed 119 pounds, on 02/20/26 he weighed 117.2 pounds, and on 09/24/25 he weighed 120 pounds.During an interview on 06/05/26 at 08:58 AM LVN E stated MDS RN was responsible for completing MDS Assessments. She stated an inaccurate MDS assessment could cause delays in getting proper care and could cause the care plan to be inaccurate.During an interview on 06/05/26 at 09:05 AM RN D stated MDS RN was responsible for completing MDS Assessments. She stated an inaccurate MDS assessment could negatively impact resident care and the care plan.During an interview on 06/05/26 at 09:18 AM CNA B stated MDS RN was responsible for completing MDS Assessments. She stated an inaccurate MDS assessment could cause residents to not receive needed assistance with ADLs.During an interview on 06/05/26 at 09:30 AM DON stated MDS RN was responsible for completing MDS Assessments. She stated an inaccurate MDS assessment would not affect resident care. DON stated, It (MDS assessment) doesn't change how we provide care. Regardless of what MDS (assessment) says, we do what we need to do.During an interview on 06/05/26 at 09:39 AM ADM stated MDS RN was responsible for completing MDS Assessments. She stated an inaccurate MDS assessment could cause a resident not to get the care they need.During an interview on 06/05/26 at 09:48 AM MDS RN stated she was responsible for completing MDS assessments. She stated Resident #7's weight had fluctuated and changes in his medications seemed to have affected his weight. She stated that was her reason for coding him for significant weight loss, not any real weight loss during the look back period. She stated she used the RAI as her policy when completing MDS assessments.Record review of facility policy titled, Minimum Data Set (MDS) Policy for MDS assessment Data Accuracy and dated 08/2025 revealed the following, . The purpose of the MDS policy is to ensure each resident receives an accurate assessment by qualified staff to address the needs of the resident who are familiar with his/her physical, mental, and psychosocial well-being.Record review of the Long-Term Care Facility RAI 3.0 User's Manual Version 1.20.1 dated October 2025 revealed the following: . K0300: Weight Loss Steps for Assessment This item compares the resident's weight in the current observation period with their weight at two snapshots in time: At a point closest to 30 days preceding the current weight. At a point closest to 180 days preceding the current weight. The resident's weight captured closest to these two time points are the only two weights considered for this item, . Coding instructions . Code 0, no or unknown if the resident has not experience weight loss of 5% or more in the past 30 days or 10% or more in the last 180 days . Coding Tips A resident may experience weight variances in between the snapshot time periods. Although these require follow up at the time, they are not captured on the MDS.

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	675851	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 perform a preadmission screening for individuals with a mental disorder and individuals with intellectual disability for 1 (Resident #53) of 13 residents reviewed for preadmission screening.The facility failed to perform an accurate preadmission screening for Resident #53 prior to admission on [DATE].This failure could place residents at risk of not receiving needed services. Findings Included:Record review of Resident #53's admission record dated 06/03/26 revealed a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of bipolar disorder unspecified with a diagnosis date of 05/27/26.Record review of Resident #53's baseline care plan initiated on 05/27/26 revealed no mention of her bipolar diagnosis except in the list of her diagnoses on the last page of the care plan.Record review of Resident #53's care plan completed on 06/04/26 revealed no mention of her bipolar diagnosis except in the list of her diagnoses on the last page of the care plan. Record review of Resident #53's admission MDS assessment completed 06/03/26 revealed a BIMS of 14 which indicated intact cognition. Section I Active Diagnoses revealed a diagnosis of bipolar disorder.Record review of Resident #53's PL 1 revealed it was completed at a local hospital on [DATE]. Resident #53 was coded as having no mental illness.During an interview on 06/05/26 at 09:30 AM DON stated MDS RN was responsible for completing PL 1's at or prior to admission. She stated if a resident was coded by the hospital as having no mental illness but had an active diagnosis of mental illness the facility would correct the PL 1.During an interview on 06/05/26 at 09:39 AM ADM stated MDS RN made sure the facility had a PL 1 prior to a resident being admitted . She stated if a resident was coded on the PL 1 as having no mental illness but had a diagnosis of mental illness they might not receive PASARR services timely.During an interview on 06/05/26 at 09:48 AM MDS RN stated she was responsible for ensuring residents had correctly coded PL 1's at or prior to admission. MDS RN stated when she received a PL 1 from a hospital she checked it for accuracy against the resident's diagnoses. She stated she had recently taken time off and that was probably why she missed Resident #53's inaccurate PL 1. She stated if a resident was coded as having no mental illness but had a diagnosis of mental illness, They don't get the treatment they need.Record review of facility policy titled, PASRR Level 1 Policy and Procedure and dated 03/06/19 revealed the following: . It is the policy of [name of corporate] facilities to obtain a PL 1 screening form from the RE prior to admission to the NF. 3. The facility will review the PL 1 screening for completion and correctness prior to admission. The facility will maintain PL 1 Best Practices as followed: . Review the PL 1 Form for completion and correctness before admission.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement a comprehensive care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment and describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 (Residents #8 and #53) of 13 Residents reviewed for comprehensive care plans. -The facility failed to address the diagnosis of PTSD in Resident # 8's care plan. -The facility failed to address the diagnosis of bipolar disorder in Resident # 53's care plan These failures could result in residents not being able to attain or maintain their highest practicable physical, mental, and psychosocial well-being. Findings included: Resident #8Resident #8's admission record revealed she was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of major depressive disorder, (a mood disorder that causes a persistent feeling of sadness) , schizophrenia (a mental condition that can cause visual and auditory hallucinations), PTSD (a condition triggered by experiencing or witnessing a terrifying or life-threatening event), and alcohol dependence.Record Review of Resident #8's Quarterly MDS assessment dated [DATE] documented a BIMS score of 6 out of 15 which indicated severely impaired cognition. Section I Active Diagnoses revealed Resident #8 had an active diagnosis of PTSD.Record review of Resident #8's Care Plan dated 3/11/26 documented resident was incontinent, at risk for falls, required antidepressant medications, and had impaired visual function. Record review of Resident # 8 Comprehensive Care Plan Treatment Administration Record revealed there was no documentation of trauma informed care or PTSD and did not have behavior monitoring specific approaches, measurable objectives or the residents' goals for care.Record review of Resident # 8 Treatment Administration Record did not have any documentation of behavior monitoring specific approaches, measurable objectives or the residents' goals for care related to PTSD. In an interview on 6/3/26 at 11:30 am, Resident #8 stated she had PTSD and her main trigger was leaving the facility. She stated she got anxious when she had to go out of the facility. She stated she only had to go to dr appointments. She stated no one in the facility had ever spoken to her about her PTSD or being anxious. She stated she did not think staff knew she did not like to leave the facility. She stated she often had to ride the van to go to dr appointments and the van driver had never said anything to her about being anxious. Resident #53Record review of Resident #53's admission record dated 06/03/26 revealed a [AGE] year-old female admitted to the facility on [DATE] with a diagnosis of bipolar disorder unspecified with a diagnosis date of 05/27/26. Record review of Resident #53's admission MDS assessment completed 06/03/26 revealed a BIMS of 14 which indicated intact cognition. Section I Active Diagnoses revealed a diagnosis of bipolar disorder. Record review of Resident #53's baseline care plan initiated on 05/27/26 revealed no mention of her bipolar diagnosis except in the list of her diagnoses on the last page of the care plan. Record review of Resident #53's care plan completed on 06/04/26 revealed no mention of her bipolar diagnosis except in the list of her diagnoses on the last page of the care plan. During an interview on 06/05/26 at 09:48 AM MDS RN stated she was responsible for completing care plans. She stated a diagnosis of bipolar disorder should be included in a care plan. MDS RN stated if the diagnosis was not included in the care plan the resident might not get the care or the medication they need. She stated PTSD should be included in a resident's care plan because staff would need to know what might set it (PTSD) off. She stated a resident could be negatively affected if PTSD was not in their care plan because they might not get the care or feeling of safety they need. MDS RN stated the care plan should include what triggers the resident had and staff should be educated on said triggers so they (staff) could provide trauma-informed care for the resident. During an interview on 06/05/26 at 08:58 AM LVN E stated nursing staff were responsible for completing care plans. She (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated a diagnosis of bipolar disorder should be included in the care plan or a resident's behavior would not be addressed. She stated residents might not get the medication they need if staff are unaware of a mental illness diagnosis and therefore overlook behaviors. During an interview on 06/05/26 at 09:05 AM RN D stated MDS RN was responsible for completing care plans. She stated a diagnosis of bipolar disorder and PTSD should absolutely be included in the care plan. RN D stated a resident might not receive correct treatment if a diagnosis of mental illness was not included in the care plan. She stated a negative outcome of not knowing residents had PTSD would be possibly causing harm to the residents or others by not knowing about the behaviors. During an interview on 06/05/26 at 09:12 AM LVN C stated care plans were completed by several staff members including nursing staff and MDS RN. She stated a diagnosis of bipolar disorder should be included in the care plan because it is important to know. LVN C stated staff would know better how to care for a resident and what to expect from a resident if the care plan included any mental illness diagnoses. During an interview on 06/05/26 at 09:18 AM CNA B stated several staff members were responsible for completing portions of care plans with MDS RN being responsible for the final product. She stated a diagnosis of bipolar disorder and PTSD should be included in a care plan so staff would know how to approach and care for the resident. During an interview on 06/05/26 at 09:26 AM CNA A stated DON and MDS RN along with other staff members were responsible for completing care plans. She stated a diagnosis of bipolar disorder and PTSD should be included in the care plan. She stated staff might not know how to properly care for a resident if a mental illness diagnosis was not included in the resident's care plan. During an interview on 06/05/26 at 09:30 AM DON stated MDS RN was ultimately responsible for completing care plans. She stated if a resident was not receiving medication for a mental illness diagnosis the diagnosis might not need to be in the care plan. She stated she did not think there would be a negative outcome to a resident if a diagnosis of bipolar disorder was not included in the resident's care plan. During an interview on 06/05/26 at 09:39 AM ADM stated care plans were completed by an interdisciplinary team. She stated a diagnosis of bipolar disorder should be included in a care plan. ADM stated otherwise the mental illness could go untreated which could lead to a negative outcome for the resident. During an interview on 6/5/26 at 9:40 am, the DON stated Trauma Informed Care was from past trauma. She stated all staff were trained to pay attention to residents' behaviors. She stated staff did not always know all of the triggers a resident may have. She stated if the behaviors affected the care the CNAs should know what the triggers were. The DON stated knowledge about the trauma would come from the SW and the Care Plan. The DON stated she did not know if the triggers were on the care plan for each resident but thought they should be. During an interview on 06/05/26 at 09:48 AM MDS RN stated she was responsible for completing care plans. She stated a diagnosis of bipolar disorder should be included in a care plan. MDS RN stated if the diagnosis was not included in the care plan the resident might not get the care or the medication they needed. She stated PTSD should be included in a resident's care plan because staff would need to know what might set it (PTSD) off. She stated a resident could be negatively affected if PTSD was not in their care plan because they might not get the care or feeling of safety they need. MDS RN stated the care plan should include what triggers the resident had and staff should be educated on said triggers so they (staff) could provide trauma-informed care for the resident. Record review of the undated facility policy titled, Comprehensive Care Planning revealed the facility will develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives timeframes to meet a residents medical nursing, mental and psychological needs that are identified in the comprehensive assessment. Person-centered care plans make an effort to understand what each resident is communicating verbally and nonverbally, identifying what is important to each resident, and having an understanding of a resident's life before residing in the nursing home. Residents' goals set the expectation for the care and services he/she wishes to receive. Measurable objectives describe the steps toward achieving the residents' goals and can be measured, quantified and /or verified. The care plan will reflect interventions to enable each resident (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to meet his/her objectives. Interventions are the specific care and services implemented. Record review of the facility policy dated 10/2022, titled Trauma Informed Care Policy revealed: Purpose: The facility must ensure residents who are trauma survivors receive culturally competent, trauma informed care by professional standards of practice and accounting for residents' experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident. Care Planning to address Past Trauma: The facility should collaborate with resident trauma survivors and family members, friends and any other health care professionals to develop and implement individualized interventions. Facilities are responsible to try to identify triggers that may retraumatize the resident and develop care plan interventions that minimize or eliminate the effect of the trigger on the resident. Trigger specific interventions should identify ways to decrease the resident's exposure to triggers that retraumatize resident as well as identify ways to mitigate or decrease the effect of the trigger on the resident.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to ensure residents who were trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident for 2 (Residents #8 and #44) of 13 residents reviewed for quality of care. The facility failed to ensure nursing staff were aware of residents who were diagnosed with PTSD and their triggersThe facility failed to develop and ensure staff were educated in PTSD triggers and interventions for Resident's #8 and #44. The facility failed to monitor for signs and symptoms of anxiety, depression and suicidal thoughts for Resident #44 This failure could put residents at an increased risk for severe psychological distress due to re-traumatization. Findings included: Resident #8Resident #8 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of major depressive disorder, (a mood disorder that causes a persistent feeling of sadness), schizophrenia (a mental condition that can cause visual and auditory hallucinations), PTSD (a condition triggered by experiencing or witnessing a terrifying or life-threatening event), and alcohol dependence.Record Review of Resident #8's Quarterly MDS dated [DATE] documented a BIMS score of 6 out of 15 which indicated severely impaired cognition. Section I Active Diagnoses documented Resident #8 had an active diagnosis of PTSD.Record review of Resident #8's Care Plan dated 3/11/26 documented resident was incontinent, at risk for falls, required antidepressant medications, and had impaired visual function.Record review of Resident #8's Treatment Administration Record revealed there was no documentation of behavior monitoring specific approaches, measurable objectives or the residents' goals for care related to PTSD. In an interview on 6/3/26 at 11:30 am, Resident #8 stated she had PTSD and her main trigger was leaving the facility. She stated she got anxious when she had to go out of the facility. She stated she only had to go to dr appointments. She stated no one in the facility had ever spoken to her about her PTSD or being anxious. She stated she did not think staff knew she did not like to leave the facility. Resident #44Resident #44 was a [AGE] year-old female admitted to the facility on [DATE] with diagnoses of diabetes, PTSD (a condition triggered by experiencing or witnessing a terrifying or life threatening event), chronic pain, generalized anxiety disorder, obesity, and major depressive disorders (a mood disorder that causes a persistent feeling of sadness).Record review of Resident #44's MDS dated [DATE] documented a BIMS score of 5 out of 15 which indicated severely impaired cognition. Section I Active Diagnoses documented Resident #44 had an active diagnosis of PTSD.Record review of Resident #44's Care Plan dated 6/3/26 documented resident had limited physical mobility, was incontinent, and needed assistance with ADLs. Care Plan also documented: Focus: Resident had a history of trauma/PTSD that may have had a negative impact. The trauma was past sexual and physical abuse from loved ones. Goal: Staff will assist in avoiding triggers through next review date. Date initiated:11/1/24 Interventions: Arrange to License Mental Health Provider. Consult with family regarding resident's conditions as appropriate. Monitor for escalating anxiety, depression, or suicidal thought and report immediately to the nurse. included monitor for escalating anxiety, depression or suicidal thought and report immediately to the nurse.Record review of Resident #44's Comprehensive care plan did not have any documentation of behavior monitoring specific approaches, measurable objectives or the residents' goals for care related to PTSD. Record review of Resident # 44's Treatment Administration Record did not have any documentation of behavior monitoring specific approaches, measurable objectives or the residents' goals for care. Record review of Resident #44's Psychological Services progress note, dated 5/30/26 revealed: Current Risk Factors: trauma screening positive with current symptoms. Mental Status Exam revealed resident was depressed anxious and felt worthless. Patient stated to the therapist that she felt anxious, sad and depressed. There were no interventions listed. In an interview on 6/5/26 at 9:10 am LVN E stated she had been (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trained on trauma informed care and knew what PTSD was. She stated she was not aware of the residents who had PTSD in the facility. She stated she had not been aware that Resident #44 and Resident #8 had been listed as having PTSD. She stated she did not know what the triggers were for either resident. She stated the consequences of not knowing who had PTSD and not knowing the triggers for each resident could cause residents to have more behaviors. LVN D stated she looked at care plans, and stated PTSD would be in the resident's care plan. In an interview on 6/5/26 at 9:15 am, RN D stated she did not know about Trauma Informed Care and had not been trained by the facility on Trauma Informed Care or PTSD. She stated there were no residents in the facility with PTSD at that time. She stated a negative outcome of not knowing residents had PTSD would be that you could cause further harm to the residents or others by not knowing about the behaviors. In an interview on 6/5/26 at 9:20 am CNA B stated she was aware of Trauma Informed Care and she had not been aware Resident # 44 or Resident #8 were listed as having PTSD. She stated she had not been aware of their triggers and did not know if the residents had been care planned for trauma. She stated a negative outcome of not knowing about trauma could be causing outbursts and behaviors in residents. In an interview on 6/5/26 at 9:40 am, the DON stated Trauma Informed Care was from past trauma. She stated all staff were trained to pay attention to residents' behaviors. She stated staff did not always know all of the triggers a resident may have. She stated if the behaviors affected the care, the CNAs should know what the triggers were. The DON stated knowledge about the trauma would come from the SW and the Care Plan. The DON stated she did not know if the triggers were on the care plan for each resident, but thought they should be. She stated the SW would know what the triggers were and would let the staff know what the triggers were by discussing it with staff. The DON stated as behaviors came up the staff dealt with it. When asked about Resident # 8, she stated she was not aware of what trauma she had in the past and did not know what her triggers were. She stated of Resident # 44 she was not aware of what her trauma was and was not sure what her triggers were. An interview by phone was attempted on 6/5/26 with the SW at 9:45 am. A message was left with no return calls received. In an interview on 6/5/26 at 10:05 am, the MDS RN stated she was aware trauma informed care referred to PTSD. She stated she was aware there were several residents in the facility with PTSD. She stated sometimes staff were not aware of trauma and did not understand what trauma was and did not understand what triggers were. She stated the SW would do an informal training on trauma when a behavior came up. She stated PTSD should be included in a resident's care plan because staff would need to know what was causing a behavior. She stated a resident could be negatively affected if PTSD was not in their care plan because they might not get the care or feeling of safety they needed. The MDS RN stated the care plan should include triggers the resident had and staff should be educated on said triggers so they (staff) could provide trauma-informed care for the resident. An interview by phone was attempted on 6/5/26 with the SW at 11:35 am. A message was left with no return calls received. An interview by phone was attempted on 6/5/26 with the SW at 1:00 pm. A message was left with no return calls received. Record review of the facility's policy dated October/2022 titled Trauma Informed Care Policy revealed: Purpose: The facility must ensure residents who are trauma survivors receive culturally competent, trauma informed care by professional standards of practice and accounting for residents experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident. Assessment: Facilities should use a multi-pronged approach to identifying a residents history of trauma as well as his or her cultural preferences. This would include asking a resident about triggers that would be stressors as well as the RAI, admission assessment, history and physical and others. Triggers: Facilities must identify triggers that may retraumatize residents with a history of trauma. These interventions will also recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery. In situations where a trauma survivor is reluctant to share their history, the facility will still try to identify triggers which may re-traumatize the resident and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident-specific approaches must be developed and included in the resident's care plan. These interventions must be provided consistently, and supervising staff should monitor the delivery of care and staff interactions with the resident to assure they are implemented as written. Care Planning to address Past Trauma: The facility should collaborate with resident trauma survivors and family members, friends and any other health care professionals to develop and implement individualized interventions.Facilities are responsible to try to identify triggers that may retraumatize the resident and develop care plan interventions that minimize or eliminate the effect of the trigger on the resident.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and a review of facility records, the facility failed to safely store all drugs and biologicals in locked areas at the correct temperatures. Additionally, the facility failed to ensure that all medications were properly labeled with professional instructions, cautionary warnings, and valid expiration dates for 2 out of 2 medication carts and the only medication storage room reviewed for pharmacy services. The facility failed to ensure that medication carts were kept free of loose, unidentified pills. The failed to maintain a consistent tracking system for medication refrigerator temperatures to protect the stability and therapeutic potency of stored pharmaceuticals. These failures could result in residents receiving degraded or ineffective medications from unmonitored temperature variations, or lead to medication errors and accidental ingestion from loose, unaccounted-for pills left inside medication carts.Findings Included: An observation and inspection of the Hall B medication cart on 06/04/2026 at 8:46 AM, in the presence of LVN F, revealed one loose, small, light-purple tablet inside the cart drawer. At the surveyor's request, LVN F removed and identified the medication as Levothyroxine 75 mcg. During an interview on 06/04/2026 at 8:49 AM, regarding the loose medication, LVN F stated the negative outcome of having unsecured pills in the cart was that it could be given to a resident who it doesn't belong to. LVN F also stated that it could throw off medication counts and impact residents by preventing them from receiving all the medications they paid for. An observation and inspection of the Hall A medication cart was conducted on 06/04/2026 at 9:26 AM in the presence of LVN G. The inspection revealed one loose, large, red, oval-shaped tablet inside the cart drawer. When asked to remove and identify the tablet, LVN G was unable to identify the medication. The unknown tablet was subsequently disposed of by LVN G. An inspection of the facility's single medication storage room on 06/04/2026 at 9:46 AM revealed that the medication refrigerator temperature logs were incomplete. Daily temperature recordings were omitted for the AM shift on June 1, 2026, as well as both the AM and PM shifts on June 3, 2026. During an interview on 06/04/2026 at 9:46 AM, about the missing temperature records, LVN G stated that failing to monitor refrigerator temperatures could affect the medications and their effectiveness, and it was the responsibility of both the day and night shift floor nurses. During an interview on 06/04/2026 at 10:35 AM, the DON stated the negative outcomes of failing to monitor refrigerator temperatures include medications becoming too hot or frozen, which renders them not as effective to residents. The DON confirmed that floor nurses are responsible for completing these temperature checks every shift. Regarding loose pills, the DON stated they must be discarded due to contamination, and not knowing who it belongs to could cause residents to miss a dosage or incur financial costs for replacement pills. During an interview on 06/04/2026, the ADM stated that failing to check temperatures directly threatens the effectiveness of the medications. Regarding loose pills, the Administrator stated that medications are wasted, residents can miss critical doses, and it negatively affects pharmacy reordering schedules. During an interview on 06/04/2026 at 11:01 AM, the CCN stated that unmonitored storage temperatures negatively impact the effectiveness of meds and them not working as well for the residents. For loose pills, she noted the facility is forced to reorder medications prematurely, which causes financial costs to the facility and increases the risk of residents missing a dose. A record review of the facility policy and procedures titled Storage of Medication (dated 3/3/2002) revealed the following procedure mandate: The provider pharmacy dispenses medications in containers that meet legal requirements, including requirements of good manufacturing practices where applicable. Medications are kept and stored in these containers. A record review of the facility policy titled Medication Storage (dated 3/3/2002) revealed the following requirement: Medications and biologicals are stored safely, securely, and properly following manufacturers' recommendations or those of the supplier.