

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675885	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/08/2026
NAME OF PROVIDER OR SUPPLIER Avir at Caldwell		STREET ADDRESS, CITY, STATE, ZIP CODE 1022 Presidential Corridor Hwy 21 E Caldwell, TX 77836	
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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide an ongoing activity program to support residents in their choice of activities, both facility sponsored group and individual activities, and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 2 (Residents #28 and #40) of 10 residents reviewed for activities. The facility failed to provide activities for Resident #28 and Resident #40 for the months of November and December 2025. This failure could place residents at risks of boredom, depression, behavior, diminished quality of life and decreased cognitive function. Findings included: Review of Resident #28's face sheet, dated 01/07/2026, reflected a [AGE] year-old male admitted on [DATE] with a diagnosis of major depressive disorder, single episode, severe without psychotic features (a mental condition characterized by a persistently depressed mood and long-term loss of pleasure or interest in life, often with other symptoms such as disturbed sleep or feelings of guilt without behaviors), osteoarthritis, unspecified site (gradual loss of joint cartilage, but the exact joint was not specified), and generalized muscle weakness (feeling of lack of strength throughout most of your body, requiring extra effort to move arms, legs, and other muscles, often accompanied by fatigue). Review of Resident #28's Annual MDS, dated [DATE], reflected Resident #28 had a BIMS score of 15 indicated his cognition was intact. Resident #28's activity preferences were the following: doing favorite activities, keeping up with the news, going outside to get fresh air. Review of Resident #28's Quarterly MDS, dated [DATE], reflected Resident #28 had a BIMS score of 14 indicating his cognition was intact. Resident #28 had feelings of feeling down, depressed, or hopeless. Review of Resident #28's Comprehensive Care Plan, dated 12/14/2025, reflected the activity care plan was initiated on 05/14/2025 and reviewed on 12/14/2025. Resident #28 did not want to attend group activities. He enjoyed working on puzzles in his room and visit with other residents. He also enjoyed watching sports on television. Interventions: help Resident #28 glue his puzzles. Record Review on 01/06/2026 at 11:00 a.m. of the activity participation records for the year 2025 and 2026 reflected there were not any participation records for Resident #28 for the months of November 2025, December 2025, and from January 1, 2026, through January 6, 2026. Observation and interview on 01/06/2026 at 7:50 a.m., revealed Resident #28 was sitting in his room sitting in his wheelchair watching news on television. He stated he was bored a lot and there was not a lot of activities to do in the facility. Resident #28 stated he wished there were more activities. He stated he was not sad. Resident #28 stated he wished there was more things for men to do in the facility as a group especially at night and on weekends. He stated it would be fun if the men could get together and watch football on television somewhere and have snacks. Resident #28 stated no one had discussed his activity preferences with him in a long time. He stated he enjoyed doing jigsaw puzzles in his room, but that activity was getting old, and he wanted to do something new. Resident #28 stated he would preferred to discuss options of what activities were available and have input on group activities. He stated he did not always go to Resident Council. He stated he felt more comfortable speaking about his activities preferences in private with staff instead in a group. Resident #28 denied being depressed or sad (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 675885	Facility ID: 675885 If continuation sheet Page 1 of 16

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	during the times he was not attending group activities. He was smiling and stated he enjoyed living at the facility. Record review of Resident #40's face sheet, dated 01/07/2026, reflected a [AGE] year-old female resident admitted on [DATE] with the following diagnoses major depressive disorder, recurrent severe without psychotic features (a mental condition characterized by a persistently depressed mood and long-term loss of pleasure or interest in life, often with other symptoms such as disturbed sleep or feelings of guilt without behaviors), muscle weakness (feeling of lack of strength throughout most of your body, requiring extra effort to move arms, legs, and other muscles, often accompanied by fatigue), and Alzheimer's disease (a progressive brain disorder, that slowly destroys memory, thinking, and reasoning skills, eventually making it hard to perform simple tasks).Record review of Resident #40's Annual MDS Assessment, dated 01/13/2025, reflected Resident #40 had a BIMS score of 13 indicating her cognition was intact. The following activities were Resident #40's preferences: doing things in groups of people, doing favorite activities, participating in religious services or practices, listening to music, having books or magazines to read, and going outside to get fresh air when the weather was good.Record review of Resident #40's Quarterly MDS Assessment, dated 11/14/2025, reflected Resident #40 had a BIMS score of 15 indicating her cognition was intact. She had diagnoses of depression and Alzheimer's disease.Record review of Resident #40's Comprehensive Care Plan, dated 11/16/2025, reflected the activity care plan initiated on 01/23/2024 Resident #40 was active in groups and independent activities. Her activity preferences were church, music, Bible study, crafts, and food related activities. She enjoyed attending mass and receiving communion on Sundays. Interventions were revised on 10/01/2025: Keep dominoes available to play independently. Will provide appropriate activities.Observation and interview on 01/06/2026 at 8:20 a.m. revealed Resident #40 was sitting in her room watching the news on television. She was smiling during conversation. She stated there were not many activities in the facility. She stated she was bored, and she was not aware of any activities in the past month. Resident #40 stated there was someone who came by her room approximately two times a month and gave her communion. She stated she preferred to attend mass. Resident #40 stated she wished there was a mass church service provided on Sundays. Resident #40 stated no one had interviewed her about her activity preferences over 4 months. She stated her activity preferences had changed, and she would prefer to speak with someone about her new activity preferences. Resident #40 stated she did not want to discuss her activity preferences in a group meeting, she preferred for someone to come to her room and discuss her activity preferences with her in private. She stated she did become bored during the week and on weekends. Resident #40 stated she did receive visits from family, however, she wanted to do something to keep active and to help prevent her becoming forgetful. She denied being sad or depressed when she became bored. Resident #40 stated she watched catholic church on television, and she never became depressed.Record Review of the activity participation records on 01/06/2026 at 11:00 a.m. for the year 2025 reflected there were not any participation records for Resident #40 for the months of November 2025, December 2025 and from January 1, 2026, thru January 6, 2026.Interview on 01/08/2026 at 11:05 a.m. the Activity Director stated she did not have any participation records for Resident #28 or Resident #40 during the months of November 2025, December 2025 and from January 1, 2026, thru January 6, 2026. She stated she began working at the facility 12/08/2025. She stated she received training through an online activity course and completed her training yesterday on 01/07/2026. The Activity Director stated she was in the process of interviewing all the residents in the facility related to their activity preferences. She stated there were 47 residents in the facility, and she did not have time to finish the interviews within the past few weeks. The Activity Director stated she was not aware Resident #28 and Resident #40 were bored and did not feel there was enough activities in the facility. She stated if a resident was not receiving activities there was a possibility a resident may become depressed, have a decrease quality of life and become isolated in their room. She stated she did provide jigsaw puzzles for Resident # 28. The Activity Director stated she was expected to document resident's independent activities and (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	group activity involvement on participation records. She stated she did provide some activities during months of December 2025 and January 2026, however, she did not remember if she invited Resident #28 or Resident #40 to the activity programs. Interview on 01/08/2026 11:45 a.m. the Administrator stated she expected a variety of activities to be provided for all residents. She stated each resident's activity preference needed to be assessed, and each resident's activity was expected to be planned according to their activity preferences. She stated activities such as independent, in-room, and/or group activities were to be documented on participation records. The Administrator stated she expected all residents to be interviewed, and their activity preferences updated and all care plans to be revised to reflect each resident's activity preferences. She stated the activity department was already discussed and a Performance Improvement Project known as a PIP was in place to improve the activity program in the facility. The Administrator did not recall the exact date the PIP was executed during the QAPI meetings, but it was within the past 7 days. She stated if a resident was not receiving activities there was a potential a resident would have a decline in their cognition, mental status, physical status and quality of life. She stated a resident with a history of depression may become depressed and isolate themselves in their rooms. The Administrator stated the Activity Director was responsible for the activity programming and documentation of all activities department including participation records. She stated she was the Activity Director supervisor. Record review of the Activity Director's Personnel file on 01/08/2026, revealed the Activity Director completed the 45 hours of study and testing for Activity Director and received her activity certification on 01/07/2026. Record review of the Facility Activity Programs Policy, dated 2001, reflected Activity programs are designed to meet the interests and support the physical, mental, and psychosocial well-being of each resident. The activities program was provided to support the well-being of residents and to encourage both independence and community interaction. Activities offered are based on the preferences of each resident. Activities are considered any endeavor, other than routine ADLs, in which the resident participates, that is intended to enhance his or her sense of well-being and to promote or enhance physical, cognitive or emotional health. Our activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs. Residents are given an opportunity to contribute to the planning, preparation, conducting, cleanup and critique of the programs. All activities are documented in the resident's medical record.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for 2 of 3 medication carts (Medication Cart #1 and Medication Cart #2) reviewed for medication storage. The facility failed to ensure Medication Cart #1 and Medication Cart #2 were locked and medications were secured and not accessible to other staff, residents, or visitors. This failure could place residents at risk of having unauthorized access to prescriptions, biologicals, and over-the counter medications. Findings included: Observation on 01/06/2026 at 7:04 a.m. revealed the locking mechanism protruding outward (indicated the medication cart was unlocked) on the Medication cart #1 located in front of one of one nurses' station on unit 3. RN C was standing near room [ROOM NUMBER] and was unable to view the Medication Cart #1. She walked towards the nurses' desk when she observed the surveyor at Medication Cart #1, and she locked the cart immediately. Interview on 10/28/2025 at 7:09 a.m. RN C stated she did not realize the medication cart was unlocked. She stated all medication carts were to be locked except when a nurse was obtaining medications from the cart. RN C stated if a resident did ingest medications the resident was allergic to there was a possibility the resident may have a reaction and possibly die. She stated a resident also had a potential of overdosing on medications or give the medications to another resident. RN C stated she had been in-serviced on locking medication carts; however, she did not recall the date of this in-service. She stated there were all types of medications prescribed by the physician in the Medication Cart #1 except for narcotics. Interview on 01/06/2026 at 8:30 a.m. the ADON stated her expectation was for all medication carts to be locked when the nurse was not administering medications. She stated the staff had been in-serviced on securing the medication carts when not in use. The ADON stated she was starting an in-service today and she did not recall the last time the facility had in-service on locking medication carts with the nurses and medication aides. She stated it was the nurse's responsibility to ensure the medication cart was locked when not dispensing a resident's medication. Observation on 01/07/2025 at 8:35 a.m. revealed Medication Cart #2 the locking mechanism protruding outward (indicated the medication cart was unlocked) in front of room [ROOM NUMBER]. MA D was in room [ROOM NUMBER] and had her back turned to the door and Medication Cart #2. She exited room [ROOM NUMBER] and walked to Medication Cart #2. In an interview on 01/07/2026 at 8:45 a.m. MA D stated the medication cart was to always be locked except when she was dispensing medications from the medication cart. She stated it was her responsibility to ensure the medication cart was locked and secure. MA D stated if residents had accessed the medication cart they could have overdosed, taken wrong medication, had an allergic reaction, and could require admission to the hospital. She stated she had previously been in-serviced on locking the medication carts and could not recall the specific date. She stated she was aware the medication cart should have been locked. MA D stated narcotics was not in the medication cart. She stated all of the other medications prescribed by the physician was in the medication cart. She stated there were too many medications to mention. Interview on 01/08/2026 at 1:00 p.m. the Director of Nurses stated her expectation was for all medication carts to be locked when the nurse was not administering medications. She stated the staff had been in-serviced on securing the medication carts when not in use. The Director of Nurses stated she did not know the exact date of the in-service. She stated residents, other staff, and visitors would have access to the medications in the unlocked medication cart. She stated if a resident ingested medications not prescribed to them, there was a potential the resident may have an allergic reaction or may need to be admitted to the hospital. She stated it was the nurse or MAs responsibility to ensure the medication cart was locked when not dispensing a (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's medication. The Director of Nurses stated she was responsible for monitoring the nurse supervisors. Record review of the facility's Medication Labeling and Storage Policy, dated 2001, reflected The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys.		

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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 observation, interview, and record review, the facility failed to ensure residents had the right to personal privacy and confidentiality of his or her personal and medical records for 1 of 3 residents (Resident #40) reviewed for personal privacy and confidentiality of records The facility failed to ensure MA D provided privacy by locking the privacy screen on the laptop and leaving the laptop unattended in the hallway on the medication cart which displayed Resident #40's medical information on 01/07/2026. This failure could place residents at risk of having medical information, personal or care instructions exposed to others and misuse of personal information. Findings included: Record review of Resident #40's face sheet, dated 01/07/2026, reflected an [AGE] year-old female resident admitted on [DATE] with the following diagnoses: major depressive disorder, recurrent severe without psychotic features (a mental condition characterized by a persistently depressed mood and long-term loss of pleasure or interest in life, often with other symptoms such as disturbed sleep or feelings of guilt without behaviors), muscle weakness (feeling of lack of strength throughout most of your body, requiring extra effort to move arms, legs, and other muscles, often accompanied by fatigue), Alzheimer's disease (a progressive brain disorder, that slowly destroys memory, thinking, and reasoning skills, eventually making it hard to perform simple tasks), type 2 diabetes (your body does not make enough insulin or does not use insulin properly, causing sugar to build up in the blood instead of entering cells for energy, leading to high blood sugar), chronic obstructive pulmonary disease, unspecified (a long term lung condition that obstructs flow, but the specific type was not identified in the medical record, meaning it is a general diagnosis encompassing persistent cough, wheezing from airway inflammation or damage). Record review of Resident #40's Annual MDS Assessment, dated 01/13/2025, reflected Resident #40 had a BIMS score of 13 indicating her cognition was intact. During an observation on 01/07/2025 at 8:35 a.m., revealed the medication cart was parked near Resident #40's room. The screen on the laptop was not secured and displayed Resident #40's medical information such as medications. MA D exited room [ROOM NUMBER] approximately 3 minutes after making observation. She immediately closed the computer screen and enabled the security screen. During an interview on 01/07/2026 at 8:45 a.m. MA D stated she forgot to close Resident #40s information about her medications and diagnoses when she entered Resident #40's room. She stated anytime she walked away from the medication cart she was expected to place the computer screen on privacy to prevent anyone from viewing medical information on any of the residents. MA D stated that was against Resident #40's privacy and resident rights. She stated she had been in-serviced on resident rights and on locking the screen when away from the medication cart. MA D stated she did not recall the date of the in-service. During an interview on 01/07/2026 at 9:05 a.m., the Assistant Director of Nurses stated all computers on medication carts were expected to be locked. She stated anyone could walk by the medication cart and view a resident's medical information such as another resident, a family member and/or unauthorized staff. The Assistant Director of Nurses stated anyone could give medical information to others and may post it on any social platform. She stated all medical records were expected to remain private where unauthorized people did not have any medical information on a resident. She stated that was against a resident's privacy and resident rights. She stated it was a HIPAA violation. The Assistant Director of Nurses stated she had been in-serviced on resident rights, HIPAA and residents' privacy; however, she did not remember the date of the in-service. During an interview on 01/08/2026 at 1:00 p.m. the Director of Nurses stated all electronic screens were expected to be on lock when staff was not in front of the electronic device. She stated MA D was expected to lock the computer screen when she entered Resident #40's room. The Director of Nurses stated no medical information was to be reviewed by any visitor, other residents or unauthorized staff. She stated it was against Resident #40's privacy and resident rights. The Director of Nurses stated anyone could report to another person Resident #40's (continued on next page)		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical information and if Resident #40 learned of her medical information being discussed by other residents or visitors it could be very humiliating to Resident #40. She stated she had been trained on HIPAA, protecting residents' medical information, privacy and resident rights. She stated she did not recall the date of the training. She stated the nurse supervisor was responsible for monitoring the MAs to ensure they were following resident rights for medical privacy. Record review of the facility's resident rights provided during in-service dated 08/08/2024 to 08/14/2024, reflected Privacy and confidentiality: The resident has a right to personal privacy and confidentiality of his or her personal [NAME] records. The resident has a right to secure and confidential personal and medical records.		

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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 observation, interview, and record review, the facility failed to develop a baseline care plan that included instructions needed to provide effective and person-centered care of the residents, for 2 of four residents (Resident #53 and Resident #55) reviewed for baseline care plans. A) The facility failed to ensure a baseline care plan was completed within 48 hours of admission that addressed the care needs of newly admitted Resident #53. B) The facility failed to ensure a baseline care plan was completed within 48 hours of admission that addressed the care needs of newly admitted Resident #55. This failure could place residents at risk of not receiving necessary care and services. The findings included: A) Review of Resident #53's face sheet dated 01/08/2026 reflected a [AGE] year-old male admitted on [DATE] with the following diagnoses cerebral infarction (stroke that causes brain damage), diabetes mellitus type 2, and dysphagia (difficulty swallowing). Review of Resident #53's admission assessment dated [DATE] reflected Resident #53 was assessed to be oriented x3 indicating he was cognitively intact. Resident #53 was further assessed to be fed by a gastrostomy tube. Review of Resident #53's EMR for a base line care plan on 01/08/2026 reflected no base line care plan was completed within 48 hours of admission. In an interview on 01/08/2026 at 11:35 AM the ADON stated Resident #53's should have had orders for his G-tube care and maintenance immediately on admission and they should be on his base line care plan. By not having base line care it could cause the Resident #53 to have complications or tube clogging. B) Review of Resident #55's face sheet dated 01/07/2026 reflected an [AGE] year-old male admitted to the facility on [DATE] with the following diagnoses atherosclerotic heart disease, diabetes mellitus type 2, morbid obesity and hypertension. Review of Resident #55 admission assessment dated [DATE] reflected that he was assessed to have a BIMS score of 6 indicating moderate cognitive impairment. Resident #55 was assessed to have wounds. Review of Resident #55's electronic medical record reflected that no base line care plan was completed. In an interview on 01/08/2026 at 8:55 AM the DON stated, It may not be started yet she stated the MDS guy is pretty new. The DON stated after looking in the EMR that she did not see a base line care plan for Resident #55. The DON stated she would work on it now. She stated she knew there should be a baseline care plan done in 48 hours after admission and PCC showed the triggered items already. She stated sometimes they slipped through the cracks, The DON stated she shared the responsibility with the MDS coordinator for the care planning and baseline care plans. In an interview on 01/08/2026 at 11:30 AM the RNC stated that baseline care plans should be completed within 48 hours to ensure the residents receive the appropriate care. Review of the facility's policy Care plans- Baseline dated March 2022 reflected A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative; b. Physician orders. The baseline care plan is used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered comprehensive care plan (no later than 21 days after admission). The baseline care plan is updated as needed to meet the residents' needs until the comprehensive care plan is developed.		

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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 interviews and record reviews, the facility failed to develop and implement a person-centered comprehensive care plan to meet the preferences and goals of each resident and address the resident's medical, physical, mental and psychosocial needs for 2 of 7 residents (Residents #1 and #5) reviewed for care plans. The facility failed to ensure Resident #1's care plan was comprehensive and updated to reflect Resident #1 was on Enhanced Barrier Precautions. The facility failed to ensure Resident #5's care plan was comprehensive and updated to reflect Resident #1 was on Enhanced Barrier Precautions. This deficient practice could place residents at risk of not receiving appropriate interventions to meet their current needs. The findings included: Record review of Resident #1's face sheet, accessed on 1/06/2026, revealed the resident was an [AGE] year old male admitted to the facility on [DATE] and again on 10/04/2025 with diagnoses including metabolic encephalopathy (brain dysfunction), hypokalemia (a condition where the potassium levels in the blood are lower than normal), cerebral infarction (a serious condition that occurs when blood flow to the brain is blocked, causing brain tissue to die), and type II diabetes (a chronic condition where the body does not use insulin effectively or does not produce enough insulin, leading to high blood sugar levels). Record review of Resident #1's quarterly MDS assessment dated [DATE] revealed a BIMS of 03, indicating the resident had severe cognitive impairment. Section H-Bladder and Bowel reflected Resident #1 has an indwelling catheter. Record review of Resident #1's consolidated physician's orders accessed on 01/07/2026 revealed there was an order on 9/18/2025 for Enhanced Barrier Precautions: Resident requires enhanced barrier precautions. Wear PPE per facility protocol. Record review of Resident #1's comprehensive care plan, last review completed 09/15/2025, revealed a focus area indicating: I have indwelling catheter r/t diagnosis of other obstructive and reflux uropathy (urine flows backward from the bladder into the kidneys). Date Initiated: 09/15/2025. Revision on: 10/14/2025. The goal was to be/remain free from catheter-related trauma, and show no s/sx of urinary infection r/t catheter use. Interventions did not include EBP and further review of the comprehensive care plan did not indicate a focus area indicating enhanced barrier precautions. Record review of Resident #5's face sheet, accessed on 01/06/2025, revealed a [AGE] year-old male admitted to the facility on [DATE] with diagnoses including nontraumatic intracerebral hemorrhage in hemisphere, cortical (medical condition when blood vessel in the brain ruptures), dysphagia, oropharyngeal (swallowing disorder), and other encephalopathy (disease of the brain). Record review of Resident #5's quarterly MDS assessment dated [DATE] revealed a BIMS of 14, indicating the resident had full cognition. Section K0520 reflects Resident #5 has a feeding tube. Record review of Resident #5's consolidated physician's orders accessed on 01/07/2026, revealed there was an order upon admission on [DATE] for enhanced barrier precautions. Record review of Resident #5's comprehensive care plan, completed 08/07/2025, with an uncompleted scheduled review date of 10/27/2025, revealed a focus area indicating: The resident requires tube feeding r/t. The goal The resident will remain free of side effects or complications related to tube feeding through review date. The resident's insertion site will be free of s/sx of infection through the review date. Interventions did not include EBP and further review of the comprehensive care plan did not indicate a focus area indicating enhanced barrier precautions. In an interview conducted on 01/08/2026 at 12:17 PM, the MDS nurse stated he had been with the facility since March 2025. He stated that responsibility for ensuring enhanced barrier infection control precautions were included in the resident's comprehensive care plan rests with the MDS nurse, ADON, DON, Nursing, and the SW. He stated that all identified disciplines were responsible for adding these interventions to the care plan. The MDS nurse stated that MDS nurses were trained on when enhanced barrier precautions were required and that residents were assessed and identified based on their clinical conditions, including the presence of wounds, catheters, or PEG (feeding tube) tubes. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MDS nurse stated that enhanced barrier precautions should be incorporated into the resident's comprehensive care plan; however, he was unable to explain why the precautions were not included. He stated that staff were informed of enhanced barrier precautions through signage posted outside the resident's room and through review of the resident's electronic medical record. The MDS nurse stated that failure to include enhanced barrier precautions or failing to timely revise the comprehensive care plan placed the resident at risk for harm, including an increased risk of infection. In an interview conducted on 01/08/2026 at 12:34 PM, the ADON stated that the MDS nurse was responsible for completing care plans; however, the facility was now transitioning to a team-based approach. She stated that infection control was everyone's responsibility, with primary responsibility resting with nursing staff. The ADON stated that residents with foreign objects, including catheters, G-tubes (device for access to stomach for feeding), tracheostomies (surgical hole through neck to help with breathing), wounds, or IVs, are assessed for the need for enhanced barrier precautions upon admission, at the time of any new physician order, or upon a change in condition as identified through the ADL assessment. She stated that when enhanced barrier precautions were identified, they should be incorporated into the resident's comprehensive care plan. The ADON stated that nursing staff had access to resident information through the facility's electronic medical record system. She stated that if enhanced barrier precautions were not timely incorporated into the resident's comprehensive care plan, the resident could be at risk for infection or bacterial transmission. The ADON stated she was unable to explain why the enhanced barrier precautions were not previously included in the care plans; however, she stated that all care plans were updated approximately 30 minutes prior to the interview. The ADON stated the facility had implemented a new care plan library and that the enhanced barrier precaution information should now be reflected in the residents' comprehensive care plans. In an interview conducted on 01/08/2026 at 12:54 PM, the DON stated that responsibility for updating comprehensive care plans currently lies with all members of the interdisciplinary team. She stated that the MDS Coordinator was new to the role and transitioned into the MDS position approximately one month ago. The DON stated that residents with indwelling devices, including IVs, catheters, or wounds, are assessed for the need for enhanced barrier precautions to prevent infection. She stated that enhanced barrier precautions should be included in each affected resident's comprehensive care plan. The DON acknowledged that the enhanced barrier precaution interventions were missed on the care plans and stated she was not going to lie about the omission. The DON stated that nursing staff, including nurse aides, were informed of enhanced barrier precautions through in-services, signage posted outside residents' rooms, and notifications within the facility's electronic medical record system. The DON stated that the potential harm or adverse outcome of failing to timely revise the resident's comprehensive care plan was that staff or others could introduce germs to the resident, placing the resident at increased risk for infection. In an interview conducted on 01/08/2026 at 1:49 PM, the ADM stated she had been employed at the facility since March 2025. She stated her expectation was that comprehensive care plans were revised in a timely manner when residents' needs change and that revisions are completed in accordance with facility policy. The ADM stated that a new baseline care plan is initiated upon admission and that the comprehensive care plan was completed within the required timeframe. She stated that the entire interdisciplinary team was responsible for adding appropriate interventions to the care plan. The ADM stated that enhanced barrier precautions should be included in the comprehensive care plans for all residents who require them. She stated the facility was aware that multiple care plans required updating and that the facility has a new MDS nurse in the role. The ADM stated that the potential harm of not timely updating comprehensive care plans was that critical information could be missed by staff, which could negatively affect resident care and outcomes. Record review on 1/08/2026 of facility policy Care Plans, Comprehensive Person-Centered revised March 2022 revealed, Policy Statement : A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	implemented for each resident. Policy Interpretation and Implementation 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; (2) any specialized services to be provided as a result of PASARR recommendations; and (3) which professional services are responsible for each element of care; c. includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions. 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been a significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from a hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents receive care consistent with professional standards of practice, to prevent pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and once developed, failed to ensure necessary treatment and services to promote healing for one of three residents reviewed for pressure ulcers. (Resident #46) The facility failed to ensure Resident #46's unavoidable sacral unstageable pressure ulcer (a severe type of wound where the full depth cannot be assessed due to the presence of necrotic tissue, slough or eschar covering the wound base) treatment was done per physician orders. These failures could cause severe pain, and lead to systemic infections for residents that have or are at risk for pressure ulcers. Findings: Review of Resident #46's face sheet dated 01/08/2026 reflected she was admitted on [DATE] and readmitted on [DATE] with the following diagnoses unspecified intracranial injury, schizophrenia, Diabetes Mellitus Type II and intellectual disabilities. Review of Resident #46's Significant change in status assessment dated [DATE] reflected that she was assessed to have a BIMS score of one indicating severe cognitive impairment. Resident #46 was further assessed to be dependent on staff for all ADLs. Resident #46 was assessed to be at risk of developing pressure ulcers/injuries and was assessed to have unhealed pressure ulcers/injuries. Resident #46 was further assessed to have one unstageable pressure ulcer which was present upon admission/reentry. Resident #46 was also assessed to be on hospice care. Review of Resident #46's comprehensive care plan reflected a focus are dated 11/24/2025 which reflected I am receiving hospice care related to a terminal illness, and my goal is to focus on comfort, dignity, and quality of life during my remaining time. Further review reflected a focus area dated 12/05/2025 I have an unstageable pressure ulcer to the coccyx related to immobility. Interventions included Administer my medication and treatment as ordered. Review of Resident #46's Wound Assessment Report dated 12/26/2025 reflected the wound was classified as an unstageable end of life skin failure to the sacrum with measurements of 9.40cm x 4.8 cm x 0.4cm. The wound was classified as stable with 30% slough and 30% eschar. Treatment was documented as Cleanse with wound cleanser use Dakins (a dilute solution of sodium hypochlorite (bleach) moistened fluffed gauze and cover with superabsorbent dressing. (the order did not include an order for Santyl (an enzymatic debridement agent). Review of Resident #46's consolidated physician orders reflected an order dated 12/27/2025 Clean sacrum with wound cleanser pat dry apply Dakins moistened fluffed gauze to base of wound secure with superabsorbent dressing until resolved two times a day for wound care may use normal saline if Dakins unavailable. Observation on 01/07/2026 at 9:55 AM revealed LVN A outside of Resident #46's room to gather supplies for wound care. LVN A got a bottle of wound cleanser, a tube of Santyl, a bottle of betadine and two bordered gauze dressings. LVN A took all items into Resident #46's room in the original packaging and placed them on a towel on Resident #46's overbed table. LVN A removed a dressing from Resident #46's sacrum that was dated 01/06/2025. (The dressing was a bordered gauze dressing. No wound packing was removed from the wound.) Resident #46's sacral pressure ulcer had substantial depth > (greater than) 0.4 cm with undermining (erosion beneath the wound edges, leading to a larger wound area with a smaller visible opening) from 12 o'clock to 3 o'clock, the wound bed was covered in slough. Resident #46's wound edges were necrotic; and the peri wound was red and excoriated (missing top layer of skin). LVN A cleaned the wound edges and peri wound (refers to tissue surrounding a wound, extending up to 4cm outside the wound edge) with wound cleanser. LVN A then retrieved the tube of Santyl and using her finger as an applicator applied the ointment to the wound edges and peri wound. LVN A performed hand hygiene and changed her gloves and applied the boarded gauze dressing over the wound. LVN A did not pack the wound and did not use a superabsorbent dressing to cover the wound. LVN A took all the treatment supplies she brought into the room back to her chart. In an interview on 01/07/2026 at 10:15 am LVN A stated she (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not pack the wound because the facility was out of Dakins' solution. LVN A further stated they had been out of the solution since 01/06/2026. When asked why she did not use normal saline as a substitute she stated Resident #46's order stated to just put a dry dressing on if the Dakins solution was not available. She stated she did Resident #46's treatment yesterday the same and stated she did not pack it because she did not have the Dakins solution In an interview on 01/07/2026 at 11:06 am the Wound Care NP stated Resident #46's sacral wound was an end of life skin failure possibly a Kennedy ulcer (is a rapidly developing skin wound that typically appears on the sacrum during the final stages of life). Resident #46's NP stated the wounds were unavoidable due to the number of things she has going on, and the resident was on hospice. Resident #46's NP stated the facility should be packing the wound. He stated he wanted them to use Dakins solution but if it was unavailable using normal saline or wound cleanser moistened gauze would be an appropriate substitute. He stated that by not packing the wound it could cause accumulation of fluid which could lead to structural failure, infection or abscess formation. Resident #46's NP stated he expected the facility nurses to do the appropriate treatments. He stated they should not be using Santyl, that the order was changed after his 12/26/2025 visit. He stated the facility nurses should never apply Santyl to the wound edges or healthy skin because it would cause skin breakdown and should only be used on a wound bed with slough. He further stated the nurses should be using a superabsorbent dressing like Gentell (an Opti foam dressing that pulls the exudate away from the wound) to prevent the peri wound from declining. Resident #46's NP stated he did not expect Resident #46's wound to heal but appropriate treatment needed to be done to prevent setbacks. In a follow-up interview on 01/07/206 at 11:20 AM LVN A stated she should have packed Resident #46's wound. She stated she went over the treatment with her DON and stated she went back down to Resident #46's room and packed her wound with normal saline gauze. She stated that the times she had seen Santyl being used that it was applied to the peri wound she did not know that it was not to be applied to normal skin. She stated the order for Santyl was not on the treatment order but was listed under her medications and that was why she used it. She stated she used the boarded gauze dressing because she thought that was what was ordered. In an interview on 01/07/2026 at 11:30 AM the DON stated Resident #46's sacral pressure ulcer treatment should have been done as ordered. She stated the order did reflect that normal saline could be used. She further stated everyone should know that Santyl was a debridement agent and should not be used on healthy skin or the peri wound because it could cause skin breakdown. She stated by staff doing the wrong treatment it could cause delayed healing, decline in the wound or infection. In an interview on 01/07/2026 at 11:35 AM the RNC stated the Dakins solution was ordered Friday (01/02/2026). She stated LVN A was provided a wound competency prior to doing wounds but would be taken off treatment and would be trained. She stated that Santyl should not be used on healthy skin or on the peri wound. She stated she expected the nursing staff to follow physician orders while performing wound care to ensure wounds do not decline. Review of the facility's policy Wound Care dated 10/2010 reflected The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. 1. Verify that there is a physician's order for this procedure. 2. Review the resident's care plan to assess for any special needs of the resident. a. For example, the residents may have PRN orders for pain medication to be administered prior to would care. 3. Assemble the equipment and supplies as needed. Date and initial all bottles and jars upon opening. (Note: This may be performed at the treatment cart.) . 1. Use disposable cloth (paper towel is adequate) to establish clean field on resident's overbed table. Place all items to be used during procedure on the clean field Arrange the supplies so they can be easily reached.2. Wash and dry your hands thoroughly. 3. Position resident. If necessary, place disposable cloth next to resident (under the wound) to serve as a barrier to protect the bed linen and other body sites. 4. Put on exam gloves. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly (hand sanitizer can be used). 6. Put on gloves. Gown as indicated based on EBP definition. Masks and eyewear will only be necessary if splashing of blood or other body fluids into your eyes or (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mouth is likely. 7. Use no-touch technique. Use tongue blades and applicators to remove ointments and creams from their containers. 8. Pour liquid solutions directly on gauze sponges on their papers. 9. Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over the wound. 10. Wear gloves when physically touching the wound or holding a moist surface over the wound. 11. Wash tissue around the wound that is usually covered by the dressing, tape or gauze with antiseptic or normal saline solution. 12. Apply treatments as indicated. 13. Dress wound. 14. Be certain all clean items are on clean fields. 15. Remove the disposable cloth (if applicable) next to the resident and discard into the designated container. 16. Discard disposable items into the designated container. Discard all soiled laundry, linen, towels, and washcloths into the soiled laundry container. Remove disposable gloves and discard them into designated containers. Wash and dry your hands thoroughly. 19. Disinfect overbed table. 21. Wipe reusable supplies with alcohol as indicated (i.e., outsides of containers that were touched by unclean hands, scissor blades, etc.). Return reusable supplies to residents' drawer in treatment cart. 22. Take only the disposable supplies that are necessary for the treatment into the room. Disposable supplies cannot be returned to the cart.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident who is fed by enteral means received appropriate treatment and services for 1 of 1 resident reviewed for feeding tubes. (Resident #53) The facility failed to ensure Resident #53 had physician's orders for care of his gastrostomy tube site treatment, tube placement checks, or water flushes. The facility further failed to have a plan of care in place for Resident #53's gastrostomy tube. This failure placed residents with tube feedings at risk of injury, pain, and/or significant changes in condition. Findings Include: Review of Resident #53's face sheet dated 01/08/2026 reflected a [AGE] year-old male admitted on [DATE] with the following diagnoses cerebral infarction (the pathologic process that results in an area of necrotic tissue in the brain.), diabetes mellitus type 2, and dysphagia (swallowing problems). Review of Resident #53's admission assessment dated [DATE] reflected Resident #53 was assessed to be oriented to person, place and time indicating he was cognitively intact. Resident #53 was further assessed to be fed by a gastrostomy tube. Review of Resident #53's base line care plan reflected no base line care plan was completed within 48 hours of admission. Review of Resident #53's consolidated physician's orders dated 01/05/2026 reflected an order dated 01/05/2026 Glucerna 1.5 calorie oral liquid (nutritional supplements) give one can via G-tube four times a day for nutrition. The consolidated physician's orders reflected no other orders for the treatment or care of Resident #53's G-Tube. Observation and interview on 01/06/2026 at 11:00 AM revealed Resident #53 in his room in bed. Resident #53 stated he came to the facility yesterday. He stated he was fed through his G-Tube. He stated he had not had any issues so far with his care. In an interview on 01/08/2026 at 11:30 AM the RNC stated the physician's orders for immediate care should be completed right away. In an interview on 01/08/2026 at 11:35 AM the ADON stated Resident #53's should of had orders for his G-tube care and maintenance immediately on admission. By not having the orders it could cause the Resident #53 to have complications or tube clogging. In an interview on 01/08/2026 at 11:46 PM LVN A stated she admitted Resident #53. She stated after looking in his record that the resident did not have physician's orders for checking his tube placement or flushing the tube with water to prevent clogging. LVN A stated she should have called the physician after he got to the facility to make sure, he had all the necessary orders for treatment. She stated she should have also checked with her ADON or DON to make sure he had everything in place. She stated, We should have noticed there wasn't any flush or placement check orders. LVN A stated Resident #53 should have an order for treatment of his G-Tube site and she did not see one. Review of Resident #53's care plan initiated 01/08/2026 after surveyor interventions reflected The resident requires tube feeding (related to Dysphagia, Chewing problem, Swallowing problem). Interventions included The resident needs the head of bed elevated 45 degrees during and thirty minutes after tube feed. Check for tube placement and gastric contents/residual volume per facility protocol and record. Hold feed if greater than (SPECIFY) cc aspirate. Listen to lung sounds: Monitor/document/report PRN any signs or symptoms of: Aspiration- fever, SOB, Tube dislodged, Infection at tube site, Self-extubating (removing), Tube dysfunction or malfunction, Abnormal breath/lung sounds, Abnormal lab values, Abdominal pain, distension, tenderness, Constipation or fecal impaction, Diarrhea, Nausea/vomiting, and Dehydration. Provide local care to gastrostomy tube site as ordered and monitor for signs or symptoms of infection. On 01/07/2026 at 2:00 PM a policy for gastrostomy tubes was requested and not provided prior to exit.		

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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 2 of 25 residents (Resident #56 and Resident #27) reviewed for infection control practices during medication pass. MA B failed to sanitize the blood pressure cuff during medication pass before and after using it on Resident #56 and Resident #27. These failures could place residents at risk for cross-contamination and infections. Findings include: Review of Resident #56's face sheet dated 01/07/2026 reflected a [AGE] year old male admitted to the facility on [DATE] with the following diagnoses congestive heart failure (long-term condition in which your heart can't pump blood well enough to meet your body's needs.), diabetes mellitus type II (A condition results from insufficient production of insulin, causing high blood sugar.) and hypertension (High pressure in the arteries). Review of Resident #27's face sheet dated 01/07/2026 reflected a [AGE] year-old male admitted to the facility on [DATE] with the following diagnosis hypertension (High pressure in the arteries). Observation on 01/06/2026 at 7:38 AM revealed MA B outside of Resident #56 room to prepare for medication administration. MA B grabbed the rolling blood pressure machine from the hall on her way to the room. MA B went into Resident #56's room and took his blood pressure without cleaning the blood pressure cuff. Observation on 01/06/2026 at 8:02 AM revealed MA B outside of Resident #27's room to prepare his medication for administration. MA B using the same blood pressure machine used on Resident #56 entered Resident #27's room and took his blood pressure without cleaning the blood pressure cuff. In an interview on 01/06/2025 at 8:10 am MA B stated she should have cleaned the blood pressure cuff prior to using it on Resident #56 and Resident #27. MA B stated she did not have any wipes on her cart and stated she would have to go to another unit to get sanitizing wipes. She stated by not cleaning the blood pressure cuff it could spread germs. In an interview on 01/07/2025 at 1:10 PM the DON stated she expected staff to clean reusable resident equipment between residents to prevent cross contamination. Review of the facility's policy Standard Precautions dated September 2022 reflected Standard precautions are used in the care of all residents regardless of their diagnoses or suspected or confirmed infection status. Standard precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. Personnel are trained in the various aspects of standard precautions to ensure appropriate decision-making in various clinical situations. Resident-Care Equipment a. Resident-care equipment soiled with blood, body fluids, secretions, and excretions are handled in a manner that prevents skin and mucous membrane exposure, contamination of clothing, and transfer of microorganisms to other residents and environments. b. Reusable equipment is not used for the care of more than one resident until it has been appropriately cleaned and reprocessed. c. Single use items are properly discarded.		