STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675904	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windflower Health Center	5500 SW 9th Ave Amarillo, TX 79106

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 2 of 2 kitchens reviewed for kitchen sanitation. 1. The facility failed to ensure food was properly stored, labeled, and dated.2. The facility failed to ensure a safe and sanitary environment.3. The facility failed to ensure 1 of 1 dishwasher reached appropriate temperatures. These failures could place residents who ate food served by the kitchen at risk of food-borne illness, cross contamination, and loss of nutrition.Findings included: In an observation on 06/16/2026 at 8:11 AM, a silver bowl with white powdery substance labeled 6/3 for Thurs dinner written in red on plastic wrap covering bowl- not labeled, a 64 oz Minors Sweet and Sour sauce, located on top pantry shelf, opened 6/9- label stated was to be refrigerated after opening. A 14 oz bottle of Cayenne pepper showed a best by date of 12/5/2024, located on panty 2nd shelf. In an observation on 06/16/2026 at 9:24 AM, 23 bowls containing various fruit were in first refrigerator in Kitchen 1 uncovered, not labeled, and not dated. In an observation on 06/16/2026 at 9:25 AM, the following was discovered in large refrigerator in Kitchen 1: Flour tortillas were not labeled or dated.Corn tortillas were not dated.Open silver container with a ladle hanging out of the right front side of the container with liquid substance in the bottom was uncovered, unlabeled, and undated.In an observation on 06/16/2026 at 9:27 AM, the following was discovered in an ice cream freezer in Kitchen 1:3-gallon [NAME] Valley Vanilla ice cream- not dated, not sealed.3-gallon Blue Bunny Sherbert- not dated, not sealed.3-gallon [NAME] Valley Vanilla ice cream- not sealed.3-gallon [NAME] Valley pink ice cream- not sealed.2 small individual clear ridged bowls with vanilla ice cream uncovered, not labeled, and not dated.In an observation on 06/16/2026 at 9:30 AM, the following was discovered in refrigerator located across from the ice cream freezer in Kitchen 1:2 salads with breaded meat on top- uncovered, not labeled, and not dated.10 small bowls with orange gelatin substance with fruit- uncovered, unlabeled, and undated.40 plates of various desserts- uncovered, unlabeled, and undated.In an observation on 06/16/2026 at 10:56 AM, CK M was observed not wearing a hairnet in Kitchen 2 while walking between stations. In an observation on 06/16/2026 at 11:00 AM, the following was discovered in the refrigerator and freezer in Kitchen 2:33 oz [NAME] Boston Creme Pie was undated.4 boxes of Blue Bunny Chocolate Marble 48 pack, 4 fluid oz undated.Box of 96 Ardmore Farms 4 fluid oz apple juice was undated.Walmart bag with individual Kellogg's [NAME] Krispy Treats not dated.In an observation on 06/17/2026 at 7:48 AM, the EC was observed not wearing a beard cover or gloves while handling food items. Six individual chocolate ice cream, 5 rainbow sherbet, 5 vanilla ice cream, and 1 strawberry in clear single served bowls were not covered, not labeled, and undated. In an observation on 06/17/2026 at 8:00 AM, the dishwasher in Kitchen 1 reached 103 degrees F. A second round was observed and reached 108 degrees F. In an observation on 06/17/2026 at 8:01 AM revealed 22 varied desserts in refrigerator in Kitchen 1 uncovered, undated, and not labeled. In an interview on 06/17/2026 at 7:41 AM, CK M stated that a hairnet/hat was supposed to be worn in the kitchen. CK M stated it was the employee's responsibility to ensure proper headwear was worn and the facility provides hairnets and gloves. CK M stated she (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was not wearing a hairnet yesterday because she forgot. CK M stated a negative outcome could be hair can get in the food. In an interview on 06/17/2026 at 7:43 AM, DMA U stated employees were to wear a hairnet/hat and gloves in the kitchen. DMA U stated it was the department's responsibility to ensure everyone was wearing hairnet or hats. DMA U stated CK M was not wearing a hairnet yesterday during observation. DMA U stated a negative outcome would be hair being a biological contamination. In an interview on 06/17/2026 at 8:07 AM, EC stated beard and hair should be covered. EC stated the facility provides the cover wear. EC stated it was the employee's responsibility to ensure proper coverage was worn in the kitchen and he was not wearing a beard cover. EC stated a sign at the front door stated proper coverage was to be worn in the kitchen. EC stated that a negative outcome was loose hair in food and contamination. In an interview on 06/17/2026 at 8:09 AM, KA P stated sometimes the dishwasher gets hot enough and management was aware. KA P stated a negative outcome was bacteria. In an interview on 06/17/2026 at 8:13 AM, DM stated that employees are required to wear hairnets/beard coverings and gloves. DM stated the facility supplies the hair nets, beard coverings, and gloves. DM stated everyone was responsible for ensuring everyone wears proper attire. DM stated food was supposed to be covered and labeling and dating were required when anything was open. DM stated that individual ice cream should be covered and large containers should be sealed with the lid. DM stated a negative outcome could be whatever kind of germs that the food could get from the hair and food can spoil as well as things could fall in it if items are not stored properly. In an interview on 06/17/2026 at 8:25 AM, DM stated the correct temperature for the dishwasher was 155 degrees F. DM stated a negative outcome of not reaching proper temperatures was that it would not kill the bacteria. In an interview on 06/17/2026 at 8:26 AM, EC stated the ice cream was to be covered and the large containers should be sealed when closed. EC stated the food in the refrigerator should be covered, labeled, and dated. EC stated a negative outcome could be food could dry out, loss of nutrition, something falls in the food or airborne contact. In a record review of policy titled, Preventing Foodborne Illness- Employee Hygiene and Sanitary Practices, revised November 2022, stated under heading Policy Statement- Food and nutrition services employees follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne. illness. Under heading, Hand Washing/Hand Hygiene, line 6- Employees must wash their hands: letter c- whenever entering or re-entering the kitchen. Letter G stated during food preparation, as often as necessary to remove soiled and contamination to prevent cross contamination when changing tasks. Under heading Gloves and Direct Food Contact, line 8: Contact between food and bare (ungloved) hands was prohibited. Under heading Hair Nets, line 15 stated hair nets or caps and/or beard restraints are worn when cooking, preparing or assembling food to keep hair from contacting exposed food, clean equipment, utensils, and linens. In a record review of policy titled Date Marketing and Labeling Food, revised 05/24/2020, stated all food shall be labeled with product name and dated to ensure quality and safety of the food serviced to residents. Under heading Procedures, policy stated Culinary Services Team Members shall use the following product description and date marketing practices: all packaged items will have a received date, open date and discard date. All prepared items will have a product name, prepared date, and discard date. House-prepared time and temperature control for safety food shall be dated with a four-day discard date, starting with day of production as day 1. Non-time and temperature control for safety foods shall be dated with a seven-day discard date, starting with day of production/opening as day 1. All received foods shall be dated with the date of receipt before storage. Opened package foods will be dated with discard date as below (totals include opening day): Dry and frozen goods: 6 months. The Culinary Services leader will: 2. Take corrective action if product description and dating is out of compliance. In a record review of a policy titled Auto-Chlor System, Basic Principles of Low- Temperature Warewashing, not dated, it stated wash and rinse heater elements are also eliminated since low-temperature dish machines use water temperature of 120 degrees F to 150 degrees F. Under heading The Hot Water Supply, it stated the ideal temperature for washing dishes was 140 degrees F. Water below 125 degrees F will not melt the grease for effective washing and will cause suds.

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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 observations, interviews 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 2 (Residents #10 and #89) of 18 residents reviewed for accommodation of needs.The facility failed to ensure Resident #10 and Resident #89's call lights were in reach on 06/16/2026 and 06/17/2026.This failure could place residents at risk of unmet needs, injury, and/or feelings of helplessness and frustration. Findings included:Resident #10Record review of Resident #10's admission record dated 06/17/2026, revealed an [AGE] year-old female admitted on [DATE] with diagnoses that included, but were not limited to, unspecified dementia, moderate, with other behavioral disturbance (a progressive cognitive disorder that impairs memory, judgement, decision making and safety awareness), anxiety disorder(anxious feelings that affect a resident's ability to cope with stress) and weakness(decreased physical strength that may impair mobility). Record review of Resident #10's Significant Change MDS Assessment completed on 04/10/2026 revealed a BIMS score of 04 which indicated severely impaired cognition. Section GG Functional Abilities revealed Resident #10 required supervision or touching assistance with sit to stand and chair to bed transfers. Section J Health Conditions revealed Resident #10 had experienced a fall since admission. Record review of Resident #10's care plan completed on 04/27/2026 revealed the resident was a high risk for falls, with interventions directing staff to ensure the resident's call light remained within reach and to encourage the resident to request assistance. The care plan further identified an ADL self-care deficit related to impaired balance and limited mobility and indicated the resident required staff assistance with transfers between surfaces. Resident #89Record review of Resident #89's admission record dated 06/18/2026 revealed an [AGE] year-old female whose most recent admission occurred on 11/18/2025 with diagnoses that included, but were not limited to senile degeneration of brain (a progressive condition associated with cognitive decline, impaired memory, reduced judgement), major depressive disorder (a condition that affects motivation, communication of needs, participation in daily activities) and history of falling (previous fall events).Record review of Resident #89's quarterly MDS Assessment completed on 05/28/2026 revealed a BIMS score of 03 which indicated severely impaired cognition. Section GG Functional Abilities revealed Resident #89 required supervision or touching assistance with sitting to standing and chair to bed transfer. Record review of Resident #89's care plan completed on 05/26/2026 revealed the resident was at risk for falls, with interventions directing staff to ensure the resident's call light remained within reach and encouraged the resident to request assistance. The care plan further identified an ADL self-care deficit related to dementia and included interventions to encourage the resident to use the call light to obtain assistance. During an observation on 06/16/2026 at 9:12 AM, Resident #10 was observed lying on her back in bed asleep. The resident's call light was observed on the floor, partially underneath the bed and out of the resident's reach. During an observation on 06/16/2026 at 9:23 AM, Resident #89 was observed lying in bed asleep. The resident's call light was observed hanging on the wall across the room and was not accessible to the resident. During an interview and observation on 06/16/2026 at 11:45 AM, Resident #10 was being assisted to her room by an anonymous staff member. The staff member stated Resident #10 was not feeling well and was returning to her room to rest. During an interview and observation on 06/16/2026 at 11:48 AM, Resident #10 was observed sitting in a recliner in her room. The resident's call light was observed hanging on the wall across the room and was not within the resident's reach. Resident #10 stated she returned to her room to rest.During an observation on 06/17/2026 at 11:50 AM, Resident #89 was lying in bed, asleep. The resident's call light was observed hanging on the wall across the room and was not within the resident's reach. During an interview on 06/17/2026 at 11:52 AM, RN A stated call lights were required to remain within residents' reach at all times. RN A stated all staff members were responsible for ensuring residents (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had access to their call lights. RN A further stated residents might be unable to obtain needed assistance and could be at risk for falls if call lights were not in reach. During a telephone interview on 06/18/2026 at 8:49 AM, Resident #89's family member stated Resident #89 was capable of using her call light to request assistance. During an interview on 06/18/2026 at 9:02 AM, the 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. The ADM stated a resident could be negatively impacted if their call light was out of reach including being unable to call for assistance when needed and an increased risk for falls or injury. During an interview on 06/18/2026 at 9:41 AM, CNA J 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 J stated both Resident #10 and Resident #89 were capable of using their call light. CNA J stated if the call light was not accessible to a resident a possible negative outcome would be that a resident could need help and not be able to call.During an interview on 06/18/2026 at 9:44 AM, CNA K stated call lights were to be in reach a resident when a resident was in their rooms. She stated CNAs were responsible for ensuring call lights were within reach of the resident. CNA K stated both Resident #89 and Resident #10 had previously utilized their call lights to request staff assistance. CNA K stated a possible negative outcome would be residents would not be able to call for help when needed. During an interview on 06/18/2026 at 9:47 AM, LVN L stated call lights were to be maintained in a location accessible to the residents. LVN L stated all staff members were responsible for ensuring call lights remained readily accessible, particularly when residents were placed in bed or left resting in their rooms. LVN L further stated a resident could experience negative outcomes if a call light was not within reach, including falling and needing assistance. During an interview on 06/18/2026 at 2:06 PM, the DON stated call lights should be in reach of residents. She stated all staff were responsible for ensuring proper placement of call lights. The DON stated if a call light was out of reach of a resident the resident may not get the help they needed.During an observation and interview on 06/18/26 at 2:22 PM, Resident #10 was observed sitting in a chair outside her room. Resident #10 stated she was able to use her call light to request assistance. Resident #10 stated she had not frequently used the call light in the past; however, she reported she had not been feeling well, had experienced dizziness and had recently been using the call light more often to obtain staff assistance. During an observation and attempted interview on 06/18/26 at 2:36 PM Resident #89 was sitting in her wheelchair, she did not answer when asked if she had a call light or had ever used a call light.Record review of facility's policy titled Resident Call light System/Call System dated 11/08/2024 revealed the following: .The resident's call system will be at each resident's bedside. The Call light will be positioned conveniently for use and within reach .

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents who use psychotropic drugs received gradual dose reductions (unless clinically contraindicated) in an effort to discontinue those drugs for 1 (Resident #4) of 5 residents reviewed for unnecessary medications. Resident #4 was on a psychotropic medication with no attempted gradual dose reductions in the past 12 months. This failure could affect residents resulting in excessive sedation, dizziness, blurred vision, weight gain/loss, falls, feelings of isolation, and/or increased depression.Findings included: Record review of Resident #4's face sheet printed 6/16/26 revealed she was a [AGE] year-old female admitted on [DATE] and readmitted on [DATE] with diagnoses to include Alzheimer's (a progressive disease that destroys memory and other important mental functions), psychotic disorder with hallucinations (characterized by a person experiencing false sensory perceptions meaning they see, hear, feel, smell, or state, things that are not actually happening), Parkinson's (a disorder of the central nervous system that affects movements to include tremors), and Major depression (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). Record review of Resident #4's quarterly MDS assessment printed 6/18/26 was completed 4/09/26 listed Resident #4 with a BIMS that could not be evaluated because she was rarely/never understood and she was dependent on staff for her activities of daily living. Record review of the care plan printed 6/18/26 with admission date of 10/09/25 for Resident #4 revealed the following: Focus - I use antidepressant medication r/t Depression Date Initiated: 11/21/24. Record review of Resident #4's Order Summary Report printed 6/18/26 revealed the following order:- Mirtazapine (Remeron) Oral Tablet 15mg (Mirtazapine) Give 1 tablet via PEG tube. Start date: 6/30/25. Record review of the facility document Gradual Dose Reduction Tracking Report provided on 6/18/26 revealed the following:Resident #4 - Mirtazapine (Remeron) Antidepressant, Major Depressive Disorder, Therapy Start: 2/07/25. Next GDR Eval: 2/07/26.During an observation and attempted interview on 06/16/26 at 09:18 AM Resident #4 was observed in bed sleeping. Resident #4 did not wake to knocking or introduction. Resident #4 appeared in good condition.During an interview on 06/18/26 at 1:23 PM the DON reported that she completed GDR reviews quarterly on each resident that was on psych services with the physician. The DON stated, The problem was Resident #4 was not on psych services so she (the DON) was not able to find a GDR at this time. During a group interview on 06/18/26 at 2:22 PM the RDHS and the DON reported they had information from the pharmacy of a review completed on 11/28/25 for Resident #4 with no recommended changes and next review to be completed on 2/07/26 but no physician review had been completed. During a group interview on 06/18/26 2:38 PM the RDHS and the DON reported if the GDR process was not followed then the resident's safety could be at risk and the resident could be on unnecessary medications. Record review of facility policy titled Gradual Dose Reduction of Psychotropic Drugs dated 04/03/25 revealed the following: Policy:Residents who use psychotropic drugs revied gradual dose reeducation and behavioral interventions, unless clinically contraindicated, to be managed at a lower dose or to discontinue these drugs.2. Psychotropic drugs.d. The pharmacist does not need to document continuing irregularity in the report each month if the attending physician has documented a valid clinical rational for rejecting the pharmacist's recommendation.Compliance Guidelines:1. Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medication, the facility will attempt a GDR in two separate quarters (with at least a month between the attempts), unless clinically contraindicated.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 and implement a baseline care plan within 48 hours of being admitted for 1 of 18 Residents (Resident #104) that included the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care Resident #44 did not have a baseline care plan that reflected bed being in the lowest position and a fall mat for safety within 48 hours of being admitted to the facility. This failure could place all newly admitted patients at risk for lack of care, needs not being met, and resident safety.Findings Included: Record review of Resident #104's face sheet, dated 06/16/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included but were not limited to unspecified dementia, unspecified severity, without behavioral disturbance (cognitive decline and memory loss), hypothyroidism (thyroid gland doesn't produce enough thyroid hormone), and hyperlipidemia (high cholesterol). Resident #104 was on hospice. Records review of Resident #104's physical baseline care plan, dated 06/18/2026, revealed Resident #104 was on hospice. Resident #104 required substantial/maximal assistance with eating, oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/taking off footwear, personal hygiene, rolling left and right, sitting to lying, and chair/bed-to-chair transfer. Resident #104 was dependent on toilet and tub/shower transfers. Section H, Safety Risks, revealed that Resident #104 does have a history of falls. Resident #104's baseline care plan did not address a fall mat. Page 12 of 12 revealed RN H completed Resident #104's care plan on 06/18/2026. In an observation on 06/16/2026 at 9:34 AM, Resident #104 was lying in bed. Resident #104's bed was in the lowest position with fall mat in place. In an observation on 06/16/2026 at 3:24 PM, Resident #104 was lying in bed. Resident #104's bed was in the lowest position with fall mat in place. In an observation on 06/17/2026 at 3:01 PM, Resident #104 was lying in bed. Resident #104's bed was in the lowest position with fall mat in place. In an observation and interview on 06/18/2026 at 10:20 AM, Resident #104 was lying in bed. Resident #104's family member was in the room and had made a bed out of the floor mat by Resident #104's bed. Resident #104's bed continued to be in the lowest position. In an interview on 06/17/2026 at 3:09 PM, the ADM stated the facility follows the RAI manual for MDS assessments and care plans. In an interview on 06/18/2026 at 10:24 AM, RN H stated that fall mats should be care planned as everyone doesn't use fall mats. RN H stated that Resident #104 was not care planned for a fall mat. RN H stated a negative outcome for a fall mat not being care planned could hinder Resident #104's recovery and could be a risk if it (fall mat) was not care planned. In an interview on 06/18/2026 at 10:47 AM with MDS R and MDS S revealed floor nurses complete baseline care plans. MDS S stated that they review the ADL's, assessment that was in electronic medical record was completed, reviewed and uploaded. At the time of this interview, Resident #104's baseline care plan had not been uploaded to the electronic medical record. MDS S stated the facility utilizes the RAI manual for guidance for care plans and MDS assessments. In an interview on 06/18/2026 at 11:05 AM, the DON stated care plans were patient centered and can include anything regarding the resident's care. The DON stated that MDS nurses assist with care planning. The DON stated fall mats would be carefully planned as it was a part of another incident. The DON stated if it is part of the care plan it was what the resident needed for safety to take care of them. The DON stated a negative outcome was resident safety and it was not documented on the assessment. Record review of the RAI, dated October 2025, on page 2-43, under heading CAA(S) Completion, revealed, within 48 hours of admission to the facility, the facility must develop and implement a Baseline Care plan for the resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of care.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet residents' medical, nursing, and mental and psychosocial needs for 1 of 18 residents (Resident #64) whose care plans were reviewed. The facility failed to care plan Resident #64 for utilizing a stand to lift assist for activities of daily living. This failure could place residents at risk of receiving inadequate care and increased safety risks.Findings included:In a record review of Resident #64's face sheet, dated 06/16/2026, revealed an [AGE] year-old male, originally admitted to the facility on [DATE] with a readmit date of 05/30/2026. Resident #64's diagnoses included pneumonia, unspecified organism (infection of the lungs), paroxysmal atrial fibrillation (irregular heart rhythm), and essential hypertension (high blood pressure). Record review of Resident #64's MDS, dated [DATE], revealed a BIMS score of 15 which indicated that resident had intact cognitive function. Section GG revealed resident was substantial/maximal assistance for toileting, showering/bathing, upper body dressing, and putting on/taking off footwear with supervision or touch assistance with eating and oral hygiene. Resident #64 was dependent on sit to lying, lying to sitting, sit to stand, [NAME]/bed-to-chair transfer, and toilet transfers.Record review of Resident #64's care plan, dated 06/16/2026, provided an intervention that Resident #64 requires 2 people for maximum assistance for activities of daily living completion.In an interview on 06/16/2026 at 2:34 PM, Resident #64's family care giver indicated that he was assisted with showers and utilizes a lift for transfers.In an interview on 06/17/2026 at 3:09 PM, the ADM stated the facility followed the RAI policy for care planning.In an interview on 06/18/2026 at 9:03 AM, RN F stated that Resident #64 utilized a sit-to-stand mechanical lift. RN F did not know how long the resident had been using the device and was unsure if its use was documented in the care plan. RN F stated that bedside nurses could initiate the use of a lift, while the MDS coordinator oversaw the care planning process. RN F stated a negative outcome could be resident accident or injury.In an interview on 06/18/2026 at 9:06 AM, LVN E stated that Resident #64 utilized a sit-to-stand mechanical lift but was unsure how long the device had been in use. LVN F noted that the resident did not have the lift documented in his care plan, and it was the responsibility of the MDS nurse to update the care plan. LVN F stated that the lift should be included in the care plan, so staff members know how to properly care for and transfer the resident. LVN F stated a negative outcome was the risk of injury to staff or the residents. In an interview on 06/18/20256 at 9:08 AM, MDS S stated that Resident #64 used a mechanical lift and verified it was not documented in Resident #64 care plan. MDS S stated it was the MDS nurse's responsibility for the comprehensive care plan and any nurse could initiate a care plan intervention. MDS S stated a negative outcome was the risk of injury to CNA's or the residents.In an interview on 06/18/2026 at 9:15 AM, the DON stated that they were unaware of when staff began using a mechanical lift for Resident #64 but stated the lift should have been initiated in the care plan by the nurse who first determined the need for it. The DON stated that care plans were a collaborative effort between floor nurses and the MDS coordinator. The DON stated that the negative consequence of failing to document the lift in the care plan was putting both resident and staff safety at risk.In an interview on 06/18/2026 at 10:22 AM, CNA T stated that Resident #64 uses a sit-to-stand for transfers. CNA T stated that therapy said he was supposed to use it (lift). CNA T stated she was not for sure if it was in Resident #64's electronic medical record.In an interview on 06/18/2026 at 10:24 AM, RN H stated care plans were to include lifts to show the facility was allowed to use them. RN H stated that unit managers, therapy, DON, and ADM were who complete care plans. RN H stated a negative outcome could hinder recovery and it was a risk if the resident was not care planned for it (lift).Record review of the RAI Manual, dated October 2025, stated on page 2-44, under heading Care Plan Completion, The resident's care plan but (continued on next page)

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	675904	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windflower Health Center	5500 SW 9th Ave Amarillo, TX 79106

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	be reviewed after each assessment, as required by 483.20, and revised based on changing goals, preferences and needs of the resident and in response to current interventions. Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussion with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to review and revise the comprehensive care plan after each assessment, including both the comprehensive and quarterly review assessments for 2 (Resident #5, Resident #14) of 18 residents reviewed for comprehensive care plans.The facility failed to update the comprehensive person-centered care plans to address Resident # 5 and Resident #14's needs within 7 days after MDS assessment was completed.The failure could affect residents by delaying treatment, care, and services that could result in residents not attaining or maintaining their highest practicable physical, mental, and psychosocial well-being.Findings included: In a record review of Resident #5's face sheet, dated 06/16/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE] and readmitted [DATE]. Resident #5's diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance (presence of cognitive decline and memory loss), unspecified atrial fibrillation (irregular heart rhythm), and cognitive communication deficit (ability to communicate was impaired). Record review of Resident #5's MDS, dated [DATE], revealed a BIMS score of 11, indicating a moderate cognitive impairment, suggesting some memory or thinking difficulties that may require additional support. Record review of Resident #5's last 2 quarterly MDS assessments revealed completion dates of 03/05/2026 and 06/13/2026. Record review of Resident #5's last 2 completed care plans revealed completion dates of 04/27/2026 and 06/11/2026. Record review of Resident #14'd facesheet, dated 06/17/2026, revealed a [AGE] year-old female admitted to the facility on [DATE]. Resident #14's diagnoses include cerebral infarction due to embolism of unspecified cerebral artery (stroke), type 2 diabetes (insulin resistance and high blood sugar levels), hemiplegia (paralysis on one side of the body) and hemiparesis (one-sided muscle weakness). Record review of Resident #14's MDS, completed 06/13/2026, revealed a BIMS score of 14 which indicated that resident had intact cognitive function. Record review of Resident #14's last 2 quarterly MDS assessments revealed completion dates of 03/09/2026 and 06/13/2026. Record review of Resident #14's last 2 completed care plans revealed completion dates of 03/06/02026 and 06/11/2026. In an interview on 06/17/2026 at 3:09 PM, the ADM stated the facility followed the RAI policy for care planning.In an interview on 06/18/2026 at 10:52 AM, MDS S stated the MDS coordinators complete comprehensive care plans. MDS S stated care plans were due within 7 days the comprehensive assessment. MDS R stated that Resident #14's last care plan was completed on 06/11/2026. MDS R stated MDS was completed was on 06/11/2026. MDS R stated the MDS was completed when the RN signs the assessment. MDS R stated it was on 06/13/2026 that the assessment was completed. MDS R and MDS S stated the care plan was done before the completion date. MDS R stated there was no negative outcome as there would not be an alteration to the MDS versus the care and if there were any changes within those 7 days, the care plan would be updated accordingly. MDS S stated the team would still catch whatever was done between those dates when asked a negative outcome if the comprehensive care plan was completed prior to the MDS assessment completion. MDS R stated if a care plan was completed after 7 days something may have occurred that was not updated into the care plan. In an interview on 06/18/2026 at 11:05 AM, the DON stated that care plans were patient centered and there was anything specific to the resident. The care plan includes nursing care and what they were providing to the resident. The DON stated that she obtains help from MDS coordinators for assistance with due dates. The DON stated if care plans were not completed within 7 days after the MDS assessment was completed or if they were completed more than 7 days after, things could be missed involving the resident's care. Record review of the RAI Manual, dated October 2025, revealed on page 2-44, under heading Care Plan Completion, that the care plan completion date must be either later than or the same date as the CAA but no later than 7 calendar days after the CAA completion date. The RAI Manual revealed on page 4-11 facilities (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	have 7 days after completing the RAI assessment to develop or revise the resident's care plan. The RAI Manual revealed on page 4-12, line 8 that a complete care plan is required no later than 7 days after the RAI is completed.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to assess residents for risk of entrapment from bed rails prior to installation and reviewed the risks and benefits of bed rails with 2 (Residents #38 and #89) of 18 residents or their resident representatives and obtain informed consent prior to installation of bed rails. Resident #38 had (1) one-quarter bed rail, located on right side of bed with no documentation of consent or current safety assessment prior to installation.Resident #89 had (1) one-quarter bed rail, located on left side of bed with no documentation of consent or current safety assessment prior to installation. These failures could place residents at risk of injury, hinder residents from getting out of bed, and/or cause a decline in residents' ability to engage in activities of daily living.Findings included: Resident #38Record review of Resident #38's admission record dated 06/16/2026 revealed a [AGE] year-old female whose most recent admission occurred on 09/03/2026 with diagnoses that included but not limited to unspecified Dementia (loss of cognitive function that interferes with daily life and activities), unspecified fall, subsequent encounter and major depressive disorder, single episode (persistent feelings of sadness, loss of interest in activities).Record review of Resident #38's quarterly MDS assessment completed on 03/15/2026 revealed a BIMS score of 11 which indicated moderately impaired cognition. Section GG Functional Abilities revealed Resident #38 was independent with sit to lying and sit to stand.Record review of Resident #38's care plan completed on 06/16/2026 revealed the resident had one-quarter bed rail for mobility with an intervention to assess quarterly or with a change of condition.Record review of Resident 38's clinical record revealed physician orders dated 06/09/2026 for the use of one-quarter bed rail for positioning and mobility. Record review of Resident #38's Bed Rail Screening and Evaluation dated 02/19/2026 revealed no bed rail was in place, recommended or requested at the time of the assessment. No other bed rail assessment was in Resident #38's clinical file. Record review of Resident #38's clinical record revealed no documentation of a signed bed rail consent. During an observation and interview on 06/16/2026 at 9:18 AM, Resident #38 was observed in her room in her wheelchair dressed for the day. She was observed holding to her right side one- quarter bedrail that was up and locked in place. Resident #38 stated she had been trained on bedrail use and safety. Resident #89Record review of Resident #89's admission record dated 06/18/2026 revealed an [AGE] year-old female whose most recent admission occurred on 11/18/2025 with diagnoses that included, but were not limited to senile degeneration of brain (a progressive condition associated with cognitive decline, impaired memory, reduced judgement), major depressive disorder (a condition that affects motivation, communication of needs, participation in daily activities) and history of falling (previous fall events).Record review of Resident #89's quarterly MDS assessment completed on 05/28/2026 revealed a BIMS score of 03 which indicated severely impaired cognition. Section GG Functional Abilities revealed Resident #89 required supervision or touching assistance with sitting to standing and chair to bed transfer. Record review of Resident #89's care plan completed on 05/26/2026 revealed the resident had a one-quarter bed rail for mobility and positioning with interventions to assess quarterly or change of condition. Record review of Resident #89's clinical record revealed physician orders dated 06/01/2026 for the use of one-quarter bed rail for positioning and mobility. Record review of Resident #89's Bed Rail Screening and Evaluation dated 03/03/2026 revealed no bed rail was in place, recommended or requested at the time of the assessment. No other bed rail assessment was in Resident #89's clinical file. Record review of Resident #89's clinical record revealed no documentation of a signed bed rail consent. During an observation on 06/16/2026 at 9:23 AM, Resident #89 was observed lying in bed asleep. The resident had a one-quarter bed rail located at head of bed on left side of bed, it was up and locked in place. During an observation on 06/17/2026 at 11:50 AM, Resident #89 was observed (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	lying in bed asleep. The resident had a one-quarter bed rail located at head of bed on left side of bed, it was up and locked in place. During an interview on 06/18/2026 at 8:30 AM, The ADM stated she and the DON had recently conducted an audit of bed rail assessments and consents; however, Resident #89 and Resident #38's use of bed rails had been missed during the audit process. The ADM stated a negative outcome of failing to complete bed rail assessments and obtain informed consent included compromised resident safety. During a telephone interview on 06/18/2026 at 8:49 AM, Resident #89's family member was interviewed due to Resident #89 being unable to respond to interview questions. The family member stated he was aware Resident #89 utilized a bed rail and expressed no concerns related to the bedrail, its use or Resident #89's safety while using the device. During an interview on 6/18/2026 at 9:40 AM, RN A who worked on the hall where Resident #89 resided, stated that completion of bed rail assessments and consents was the responsibility of the charge nurse. RN A stated the assessments and consents were completed quarterly but was unable to explain why Resident #89's bed rail assessment was not located in the clinical file. RN A stated the DON was responsible for overseeing and ensuring required assessments were completed. RN A further stated a potential negative outcome of failing to complete a bed rail assessment and obtain consent included resident entrapment which could result in injury. During an interview on 06/18/2026 at 9:50 AM, LVN L who worked on the hall Resident #38 resided, stated it was the responsibility of the charge nurse to ensure bed rail assessments and consents were completed. LVN L stated she was unaware Resident #38's bed rail assessment had not been completed. LVN L stated a failure to complete a bed rail assessment could place a resident a risk for adverse outcomes, including entrapment or falls while attempting to maneuver around the bed rail. During an interview on 06/18/2026 at 2:06 PM, the DON stated bed rail assessments and consents were required to be completed prior to implementation and reviewed quarterly. The DON stated the missed assessments for Residents #38 and #89 were her responsibility and stated she and the ADM were auditing the assessments and consents and those must have been missed. The DON further stated a potential negative outcome of failing to assess and obtain consent for bed rail would be resident safety.During an attempted interview and observation on 06/18/2026 at 2:36 PM, Resident #89 was awake and in her wheelchair, she did not answer any questions regarding bed rail use. Record review of facility's policy titled Proper use of Bed Rails (no date) revealed the following: .Resident Assessment-The resident evaluation must include a review of the alternatives that were attempted prior to the installation or use of the bed rail and how these alternatives failed to meet the resident's assessed needs. The resident evaluation must also assess the resident's risk for using bed rails. The resident evaluation should assess the resident's risk of entrapment between the mattress and bed rail or in the bed rail itself.Informed Consent-As informed consent from the resident or resident representative must be obtained after the appropriate alternatives have been attempted prior to installation and use of bed rails. This information should be presented in an understandable manner, and consent given voluntarily, free from coercion. Upon receiving informed consent, the facility will obtain a physician's order for the use of the specified bed rail and medical diagnosis, condition, symptom or functional reason for the use of the bed rails.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical service to include accurate dispensing and administering of drugs for 1 (Resident #43) of 12 residents reviewed to meet the needs of each resident. The facility failed to administer the prescribed anticoagulant (Coumadin) to Resident #43.The facility failed to administer the prescribed anticoagulant (Pradaxa) correctly to Resident #43. This failure could result in ineffective treatment resulting in exacerbation of residents' disease processes.Findings included: Record review of Resident #43's face sheet dated 06/16/2026 revealed she was a [AGE] year-old female admitted on [DATE] with diagnoses to include peripheral vascular disease (a slow progressive circulatory disorder characterized by the narrowing, blockage, or spasm of blood vessels outside the heart and brain), diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should), and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). Record review of Resident #43's Medicare 5-Day MDS assessment dated [DATE] listed Resident #43 with a BIMS of 15 indicating she was cognitively intact, she required partial/moderate assistance for most of her activities of daily living, and she was taking anticoagulant therapy. Record review of the baseline care plan dated 06/05/2026 with admission date of 6/01/26 for Resident #43 revealed the following: Physician orders - see current MAR orders. Record review of hospital discharge records dated 06/13/2026 revealed the following information:- [Resident #43]Date of stay: 5/15/26 - 6/01/26Instructions: Start taking:Warfarin (Coumadin) 2mg tablet - take as directed. Record review of the Prescription Delivered to Facility form dated ?? revealed 60 Dabigatran Etexilate 75mg Capsules were delivered to the facility on 6/02/26. Record review of Resident #43's Medication Administration Record (MAR) dated June 2026 revealed the following orders:- Warfarin Sodium (Coumadin - an anticoagulant used as a blood thinner) Oral Tablet 4 MG (Warfarin Sodium) Give 4 mg by mouth one time a day for afib for 3 Days -Start Date- 06/05/26 1800. - this medication was administered 6/05/26 and 6/06/26. Resident #43 was admitted to the hospital on [DATE] at 11:41 AM and treated for a deformation of the right external iliac stent (any structural, kinking, longitudinal compression, or crushing of the mesh tube placed in the pelvic artery or vein). - Dabigatran Etexilate Mesylate (Pradaxa - an anticoagulant used as a blood thinner) Oral Capsule 75 MG (Dabigatran Etexilate Mesylate) Give 1 capsule by mouth two times a day related to OTHER DISORDER OF CIRCULATORY SYSTEM (I99.8) -Start Date- 06/02/26 0800. - this medication was administered as follows:6/02/26 - AM: not administered - the nurses note documented the medication was not available. 6/02/26 - PM: administered 6/03/26 - AM: administered6/03/26 - PM: not administered - the nurses note documented the medication was not available.6/04/26 - AM: not administered - the nurses note did not provide any documentation of why the medication was not administered. 6/04/26 - PM: administered6/05/26 - AM: not administered - the nurses note did not provide any documentation of why the medication was not administered.6/05/26 - PM: administered6/06/26 - AM: not administered - the nurses note documented the medication was not available.6/06/26 - PM: administered6/07/26 - AM: Resident refused6/07/26 - PM: Resident #43 was in the hospital. During an interview on 06/17/26 at 7:58 AM LVN E the Unit Manager reported she and LVN C received the discharge orders from the hospital for Resident #43. LVN E reported there was some confusion with the Coumadin instructions, so she contacted NP D for clarification. NP D clarified the order later that evening, but she (LVN E) forgot to put the clarified order into the system (LVN E did not indicate to writer what the clarified order was). When the error of not starting the Coumadin was discovered on 6/05/26 a stat order for new lab was given and collected which revealed the lab was out of range. Coumadin was restarted. LVN E reported that as soon as she realized her mistake she reported it to her (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supervisor, NP D, management, and apologized to the family. LVN E reported she had been reprimanded, re-educated along with other staff, and a new system had been implemented to involve other staff such as the Medical Director and Administrator in notifications of issues with admitting orders to increase accountability and prevent future occurrences. LVN E reported not following orders and not giving medication such as coumadin can result in a resident developing a blood clot or not staying in a therapeutic range for treatment. During an interview on 06/17/26 at 9:41 AM NP D reported she assessed/evaluated Resident #43 on 6/03/26 and 6/05/26 and Resident #43 was stable on both occasions. NP D reported she was aware of the issues with the Coumadin for Resident #43 but the resident was covered with her other anticoagulant/antiplatelet therapy and was not at risk. NP D reported she had contacted the hospital for clarification and was instructed Resident #43 was to start her Coumadin so she could wean of her Pradaxa. NP D reported she was not made aware of the missed doses of Pradaxa. NP D reported not following medication administration correctly could be an issue, but she was not concerned due to her assessment completed for Resident #43 on 6/05/26. During an interview on 06/17/26 at 10:03 AM RN H reported she provided care for Resident #43 on 6/04/26 during the morning shift. RN H reported she looked for the medication Dabigatran Etexilate (Pradaxa) in the medication area and the surplus area and could not find it. RN H reported not giving a resident a blood thinner could result in a blood clot. RN H reported she did not report that she did not give the medication and she should have notified someone it was not available. During an interview on 06/17/26 at 10:09 AM RN F reported she remembered taking care of Resident #43 but not very well. RN F reviewed Resident #43's progress notes and reported she documented she did not give Dabigatran Etexilate (Pradaxa) and ?if she did not document a resident, it was because the medication was unavailable. LVN F reported she did not report that the medication was unavailable. LVN F reported a possible negative outcome for not giving medication to a resident such as a blood thinner would be a resident could have a stroke. During an interview on 06/17/26 at 11:59 AM the LPH verified the pharmacy did fill Resident #43's Dabigatran Etexilate (Pradaxa) but stated the facility staff may have had an issue with finding it because the medication must be delivered in a bottle instead of a blister pack so they may not have recognized it. The LPH reported if that medication was not administered per orders, then the resident would be at risk for clotting issues. On 06/17/26 several attempts to contact RN B, LVN I, RN G failed to administer Dabigatran Etexilate (Pradaxa) to Resident #43 resulted in no responses. During an interview on 06/17/26 at 2:37 PM the ADM reported she was not sure if the facility had a policy on reporting medications that were not being administered but it was the expectation that staff would notify the physician. During an interview on 06/17/26 at 3:04 PM the DON reported the expectation when staff cannot administer a medication such as this situation, they are to call the manager on call, the pharmacy which was open 24 hours, and the physician. During an interview on 06/18/26 at 10:53 AM the DON reported when staff do not administer a medication that was significant or can seriously affect a resident's safety such as an anticoagulant, or if the medication was not available they should check their emergency stock and if the medication was not there then notify the pharmacy which was available 24 hours a day. If the resident refuses, they should document the refusal. If the staff cannot give the medication, then they should notify the physician for orders and notify management to include the unit manager and the DON so they can address the issue for the residents' safety. The DON reported she had reviewed Resident #43's record and was aware of the incident with Coumadin and the situation had been addressed, the unit manager was reprimanded, and re-educated and they had changed their reporting process to include management staff so this situation would be resolved in the future. The DON had reviewed the issues with the medication Pradaxa and had noted that the prescription had been delivered to the facility, but the staff did not alert the management the medication was not being administered. The DON reported she was retraining staff on reporting medication issues. The DON reported if staff do not administer medication or report issues with medications then the resident's safety would be at risk, and the residents would not be getting the medication they need to treat their (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition. Record review of the facility provided policy titled Reconciliation of Medications on Admission revised February 2024, revealed the following: Purpose:The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, route, and dosages upon admission or readmission to the facility.Seps in the Process:4. Determine if there are discrepancies/conflicts.5. If there is a discrepancy or conflict in the medications, dose, route, or frequency. Determine the most appropriate action to resolve the discrepancy. For example:a. Contact the nurse from the referring facilityb. Contact the physician from the referring facilityd. Contact the residents' primary physician in the communityg. Contact the admitting and/or attending physician. 6. Document finding and actions. Documentation:1. Record the medication reconciliation process completed in the medication record, if discrepancy is identified also document:a. Actions that were taken.b. If the discrepancy was resolve. Record review of the facility provided policy titled Documentation of Medication Administration revised February 2024, revealed the following: 4. Documentation of medication administration includes, as a minimum:f. reason(s) why a medication was withheld, not administered, or refused (as applicable): Record review of the second facility provided policy titled Documentation of Medication Administrator revised 5/27/20, revealed the following: Incomplete medication information for each client will be obtained to the extent possible. Any incomplete medication information which cannot be determined will have documented reasons as to why this information cannot be obtained and the steps the agency has taken to obtain the information as well as what steps will be taken to continue to try to obtain a complete medication list. Medications are prepared safely, appropriately labeled, and dispensed safely.The agency develops processes for managing high-risk or high-alert medications. The agency develops processes specific anticoagulant therapy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675904	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windflower Health Center	5500 SW 9th Ave Amarillo, TX 79106

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to ensure residents were free of any significant medication errors for 1 of (Resident #43) 12 residents reviewed for anticoagulant therapy. Resident #43 did not receive her Pradaxa (anticoagulant medication) correctly or her Coumadin (anticoagulant medication) as ordered. The facility's failure could exacerbate the residents' condition resulting in complications to include increased pain, wounds, amputation, extended recovery time, and hospitalization. Findings included: Record review of Resident #43 face sheet printed 6/18/26 revealed she was a [AGE] year-old female admitted on [DATE] with diagnoses to include peripheral vascular disease (a slow progressive circulatory disorder characterized by the narrowing, blockage, or spasm of blood vessels outside the heart and brain), diabetes (a chronic condition that affects the way the body processes blood sugar (glucose), congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should), and atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow). Record review of Resident #43's Medicare 5-Day MDS assessment printed 6/18/26 was completed 6/05/26 listed Resident #43 with a BIMS of 15 indicating she was cognitively intact, she required partial/moderate assistance for most of her activities of daily living, and she was taking anticoagulant therapy. Record review of the baseline care plan printed 6/16/26 with admission date of 6/01/26 for Resident #43 revealed the following: Physician orders – see current MAR orders. Record review of Resident #43's Medication Administration Record (MAR) printed 6/16/26 with orders scheduled for June 2026 revealed the following order: - Warfarin Sodium (Coumadin - an anticoagulant used as a blood thinner) Oral Tablet 4 MG (Warfarin Sodium) Give 4 mg by mouth one time a day for a-fib for 3 Days -Start Date- 06/05/26 1800. – this medication was administered 6/05/26 and 6/06/26. Resident #43 was admitted to the hospital on [DATE] at 11:41 AM and treated for a deformation of the right external iliac stent (any structural, kinking, longitudinal compression, or crushing of the mesh tube placed in the pelvic artery or vein). - Dabigatran Etexilate Mesylate (Pradaxa – an anticoagulant used as a blood thinner) Oral Capsule 75 MG (Dabigatran Etexilate Mesylate) Give 1 capsule by mouth two times a day related to OTHER DISORDER OF CIRCULATORY SYSTEM (I99.8) -Start Date- 06/02/26 0800. – this medication was administered as follows: 6/02/26 - AM: not administered – the nurses note documented the medication was not available. 6/02/26 - PM: administered (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/03/26 – AM: administered 6/03/26 – PM: not administered – the nurses note documented the medication was not available. 6/04/26 – AM: not administered – the nurses note did not provide any documentation of why the medication was not administered. 6/04/26 – PM: administered 6/05/26 – AM: not administered – the nurses note did not provide any documentation of why the medication was not administered. 6/05/26 – PM: administered 6/06/26 – AM: not administered – the nurses note documented the medication was not available. 6/06/26 – PM: administered 6/07/26 – AM: Resident refused 6/07/26 – PM: Resident #43 was in the hospital. Record review of the Prescription Delivered to Facility form provided by the facility on 6/17/26 revealed 60 Dabigatran Etexilate 75mg Capsules were delivered to the facility on 6/02/26. Record review of hospital discharge records received on 6/16/26 revealed the following information: - Resident #34 Date of stay: 5/15/26 – 6/01/26 Instructions: Start taking: Warfarin (Coumadin) 2mg tablet – take as directed. Record review of laboratory results with admission date of 6/01/26, collection date of 6/02/26, and results of 6/02/26 revealed the following: INR – 2.30 Final. -Suggested therapeutic ranges using INR for stable anticoagulated patients: routine oral anticoagulant therapy equals 2.0 – 3.0. -Oral anticoagulant therapy for patients with thromboembolic events on standard doses of coumadin and those with mechanical heart valves equals 2.5 – 3.5. Record review of laboratory results with admission date of 6/01/26, collection date of 6/05/26, and (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	results of 6/05/26 revealed the following: INR – 1.20 Final. -Suggested therapeutic ranges using INR for stable anticoagulated patients: routine oral anticoagulant therapy equals 2.0 – 3.0. -Oral anticoagulant therapy for patients with thromboembolic events on standard doses of coumadin and those with mechanical heart valves equals 2.5 – 3.5. During an interview on 06/17/26 at 7:58 AM LVN E the Unit Manager reported she and LVN C received the discharge orders from the hospital for Resident #43. LVN E reported there was some confusion with the Coumadin instructions, so she contacted NP D for clarification. NP D clarified the order later that evening, but she (LVN E) forgot to put the clarified order into the system (LVN E did not state what the clarified order was). When the error of not giving Resident #43 her Coumadin was discovered on 6/05/26 a stat order for new lab was given and collected which revealed the lab was out of range. Coumadin was restarted. LVN E reported that as soon as she realized her mistake she reported it to her supervisor, NP D, management, and apologized to the family. LVN E reported she had been reprimanded, re-educated along with other staff, and a new system had been implemented to involve other staff such as the Medical Director and Administrator in notifications of issues with admitting orders to increase accountability and prevent future occurrences. LVN E reported not following orders and not giving medication such as coumadin can result in a resident developing a blood clot or not staying in a therapeutic range for treatment. During an interview on 06/17/26 at 9:41 AM NP D reported she assessed/evaluated Resident #43 on 6/03/26 and 6/05/26 and Resident #43 was stable on both occasions. NP D reported she was aware of the issues with the Coumadin for Resident #43 but the resident was covered with her other anticoagulant/antiplatelet therapy and was not at risk. NP D reported she had contacted the hospital for clarification and was instructed Resident #43 was to start her Coumadin so she could wean of her Pradaxa. NP D reported she was not made aware of the missed doses of Pradaxa. NP D reported not following medication administration correctly could be an issue, but she was not concerned due to her assessment completed for Resident #43 on 6/05/26. During an interview on 06/17/26 at 10:03 AM RN H reported she provided care for Resident #43 on 6/04/26 during the morning shift. RN H reported she looked for the medication Dabigatran Etexilate (Pradaxa) in the medication area and the surplus area and could not find it. RN H reported not giving a resident a blood thinner could result in a blood clot. RN H reported she did not report that she did not give the medication and she should have notified someone it was not available. During an interview on 06/17/26 at 10:09 AM RN F reported she remember taking care of Resident #43 but not very well. RN F reviewed Resident #43 progress notes and reported she documented she did not give Dabigatran Etexilate (Pradaxa) and 'if she did not document a resident, it was because the medication was unavailable. RN F reported she did not report that the medication was unavailable. RN F reported a possible negative outcome for not giving medication to a resident such as a blood thinner would be a resident could have a stroke. During an interview on 06/17/26 at 11:59 AM the LPH verified the pharmacy did fill Resident #43's Dabigatran Etexilate (Pradaxa) but stated the facility staff may have had an issue with finding it (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because the medication must be delivered in a bottle instead of a blister pack so they may not have recognized it. The LPH reported if that medication was not administered per orders, then the resident would be at risk for clotting issues. On 06/17/26 several attempts to contact RN B, LVN I, RN G who failed to administer Dabigatran Etexilate (Pradaxa) to Resident #43 resulted in no responses. During an interview on 06/17/26 at 2:37 PM the ADM reported she was not sure if the facility had a policy on reporting medications that were not being administered but it was the expectation that staff would notify the physician. During an interview on 06/17/26 at 3:04 PM the DON reported the expectation when staff cannot administer a medication such as this situation, they are to call the manager on call, the pharmacy which was open 24 hours, and the physician. During an interview on 06/18/26 at 10:53 AM the DON reported when staff do not administer a medication that was significant or can seriously affect a residents safety such as an anticoagulant, scheduled narcotics, antibiotics, or if the medication was not available they should check]their emergency stock and if the medication was not there then notify the pharmacy which was available 24 hours a day. If the resident refuses, they should document the refusal. If the staff cannot give the medication, then they should notify the physician for orders and notify management to include the unit manager and the DON so they can address the issue for the residents' safety. The DON reported she had reviewed Resident #43 record and was aware of the incident with Coumadin and the situation had been addressed, the unit manager was reprimanded, and re-educated and they had changed their reporting process to include management staff so this situation would be resolved in the future. The DON had reviewed the issues with the medication Pradaxa and had noted that the prescription had been delivered to the facility, but the staff did not alert the management the medication was not being administered. The DON reported she was retraining staff on reporting medication issues. The DON reported if staff do not administer medication or report issues with medications then the resident's safety would be at risk, and the residents would not be getting the medication they need to treat their condition. Record review of the facility provided policy titled Medication Errors revised 5/27/20, revealed the following: Policy Statement -Significant medication errors and significant adverse drug reactions are reported in a timely manner. Policy Interpretation and Procedure: Definitions: Drug errors that cause or could cause harm to clients. -Serious physical problems, in some cases death to the client. High Risk Medications: High risk medications require special care. High risk medication are drugs that have the potential to cause serious injuries or death if not used exactly as intended. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-INR/MD/RN dose turnaround for warfarin. (Coumadin)