STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675948	A. Building B. Wing	05/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avir at Belton	810 E 13th Ave Belton, TX 76513

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents' environment remained free from accident hazards and the residents received adequate supervision and assistance to prevent accidents for 1 of 5 residents (Resident #1) reviewed for accidents and failed to properly transfer residents 3 (Resident # 2, # 3, 4) of 6 residents reviewed for transfer status. The facility failed to prevent Resident #1 from falling when CNA A transferred resident alone without using a mechanical lift (specialized device designed to safely transfer individuals with limited mobility) resulting in Resident #1's fall and sustained a fractured right ankle on 05/01/26. Resident #1 stood and pivoted to the toilet and CNA A attempted to prevent resident from falling when resident slid to floor from toilet. The facility failed to properly transfer residents 3 (Resident # 2, # 3, 4) of 6 residents. This failure could place residents at risk for serious injury and accidents.Findings included: Record review of residents face sheet dated 05/02/26 reflected Resident #1 was a [AGE] year-old female, admitted [DATE], with diagnoses including congestive heart failure (a serious condition that occurs when the heart cannot pump enough blood to meet the body's needs), hypertensive heart disease with heart failure (when high blood pressure (hypertension) weakens the heart over time, leading to heart failure), anxiety (intense, excessive, and persistent worry and fear about everyday situations), diabetes (a group of diseases that result in too much sugar in the blood), and dementia (a general name for a decline in cognitive abilities that impacts a person's ability to perform everyday activities). Record review of Resident #1's admission MDS assessment, dated 04/06/26, reflected a BIMS score of 03 indicating severely impaired cognition. MDS reflected Resident #1 required setup or clean up assistance for eating, substantial or maximal assistance for toileting and showering, and partial to moderate assistance for personal hygiene. Record review of Resident #1's care plan, dated 04/21/26, reflected, Resident #1 had an ADL self-care performance deficit r/t terminal Dx (CHF - Congestive Heart Failure). Goal will maintain current level of function in ADLs within my [Resident #1's] functional limits through the review date. Interventions included: Toilet use: The resident requires substantial to maximal assist by one staff for toileting. Date Initiated: 04/21/2026. Revision on: 04/21/2026 - Transfer: The resident is totally dependent on two staff members for transferring using a mechanical lift. Record review of Resident #1's Care Profile Report, dated 05/02/26, reflected Resident #1 required a mechanical r lift for all transfers. Record review of Resident #2 admission face sheet dated 5/14/26 reflected a [AGE] year-old female admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #2 had diagnosis of type 2 diabetes (a chronic condition where your body either doesn't produce enough insulin or resists it), hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (complete paralysis or partial weakness on the right side of the body due to brain or spinal cord damage), seizures, muscle wasting and atrophy, vascular dementia, aphasia following cerebrovascular disease (a neurological language disorder caused by damage to the brains language centers), cerebral infarction (stroke), cognitive communication deficit (an impairment in communication caused by underlying cognitive difficulties rather than a primary language or speech issue), abnormalities of gait and mobility. Record review of Resident #2 EHR (continued on next page)

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

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Kardex report dated 5/14/26 reflected under heading Transferring Resident #2 requires total assistance of 2 staff via mechanical lift with transfer. Record review of Resident #2 Care plan dated 10/20/25 reflected an ADL self-care performance deficit in bed mobility, transfers, eating, toileting, bathing, dressing, and personal hygiene r/t frequent incontinence, aphasia, seizures, CVA, hemiplegia/hemiparesis, anxiety, pain, dysphagia, reduced mobility and malaise. Interventions of locomotion on and off unit: Resident needs assistance of 2 staff to transfer with assistance of mechanical lift. Record review of Resident #3 admission face sheet dated 5/124/26 reflected a 71-year-olf female admitted to the facility on [DATE] and re-admitted on [DATE]. Resident # 3 had diagnosis of type 2 diabetes (a chronic condition where your body either doesn't produce enough insulin or resists it), spinal stenosis of lumbar region (the narrowing of the spinal canal in the lower back which puts pressure on the nerves running to your legs), osteoarthritis (a chronic degenerative joint disease where the protective cartilage that cushions the ends of your bones wears down over time) muscle weakness, lack of coordination, muscle wasting and atrophy (muscle shrinkage), cognitive communication deficit (an impairment in communication caused by underlying cognitive difficulties rather than a primary language or speech issue), sciatica left sided pain (a symptom of an underlying problem involving the sciatic nerve), chronic pain, need for assistance with personal care, and unsteadiness on feet. Record review of Resident #3 EHR Kardex report dated 5/14/26 reflected under heading Transferring Resident #3 requires total assistance for transfers and requires mechanical sling lift for transfers. Provide 2 person for transfer. Record review of Resident #3 Care plan dated 9/2/25 reflected an ADL self-care performance deficit in bed mobility, transfers, eating, bathing, toileting, dressing, and personal hygiene r/t CVA, anxiety, vision, diabetes, and arthritis. Interventions of mechanical sling lift is a total assist for transfers and requires mechanical sling lift for transfers. Provide 2 people for transfers. Record review of Resident #4 admission face sheet dated 5/14/26 reflected a 71-year-olf male admitted to the facility on [DATE]. Resident # 4 had diagnosis of cerebral infarction (stroke), type 2 diabetes (a chronic condition where your body either doesn't produce enough insulin or resists it), spastic hemiplegia affecting right dominant side (a common subtype of spastic cerebral palsy that causes muscle stiffness, weakness, and involuntary contractions on just the right side of the body), aphasia following cerebral infarction (a neurological language disorder caused by damage to the brains language centers), encephalopathy (a broad term for any disease, damage, or malfunction of the brain), CHF (a chronic progressive condition where the heart muscle becomes too weak or stiff to pump blood efficiently throughout the body), attention and concentration deficit following cerebral infarction. Record review of Resident #4 EHR Kardex report dated 5/14/26 reflected under heading Transferring Resident #4 is totally dependent on 1-2 staff for transferring Record review of Resident #4 Care plan dated 4/14/26 reflected ADL staff assist r/t hemiplegia affecting right dominant side, recent CVA, mood decline, encephalopathy, CHF, diabetes, A-fib, aphasias, swallowing disorder, and impaired mobility. Transfers: the resident is totally dependent on 1-2 staff for transferring. During an interview on 05/02/26 at 7:42 AM, RN A was notified of the investigation being conducted in the facility. She stated on 05/01/26, at approximately 4:40 p.m., Resident #1 arrived at the hospital emergency room for treatment via EMS. She stated EMS told her they were told Resident #1 was being transferred by a single CNA, when the resident required a two person assist and/or mechanical lift, and, as a result, Resident #1 suffered a fall in the bathroom. She stated EMS further stated they were told that Resident #1 slipped off the toilet. She stated EMS further stated that they were told that Resident #1 had an area of bleeding on her right foot that the staff had wrapped prior to their arrival. She stated during the triage nursing assessment, Resident #1's right foot was found to be discolored and cold to the touch. She stated when the dressing that was applied by the facility was removed, an obvious open fracture was identified, with a large area of bone exposed. She stated Resident #1 was only alerted to her name and location (hospital), otherwise she was only able to answer limited yes or no questions. She stated they were unable to obtain a clear history on how she was injured due to her altered mentation. She stated the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	pain. She stated she asked CNA H to get her a towel because of the area that was actively bleeding and she wrapped the towel around the area and elevated Resident #1's leg. She stated Resident #1 was a 2 person transfer and mechanical lift transfer but resident was in the bathroom floor and they could not get the lift in the bathroom to get the resident out. She stated her and CNA H rolled resident out of the bathroom in her wheelchair and she looked at the area where the wound was and there was still a little bleeding. She stated she asked CNA H to get RN D, which was also the ADON, and treatment nurse, at that time, so RN D could have assisted with and looked at the wound. She stated she then grabbed her scissors and began to cut the bandage off the wound. She stated RN D arrived and they removed the bandage completely and she noticed the wound was more than just a skin tear. She stated the ADON stepped out to get more supplies and she noticed that residents foot was kind of sagging to the side and she knew that the area could have possibly been fractured. She stated her and RN D traded spaces and she stepped out to alert the DON, hospice, family, and the doctor. She stated she also called the on-call nurse practitioner and informed her. She stated hospice was made aware that Resident #1 needed to be sent to the hospital and had given the orders to do so. She stated the family agreed and she called 911 and the resident was sent to the hospital. She stated she did not see any bone protruding through the wound and there was only coagulated (a liquid that has changed into a thickened, curdled, or solid state) blood and flesh that she saw. During an interview on 05/02/26 at 11:24 AM, CNA H stated she had worked in the facility for about a year and a half. She stated she worked 7:00 AM - 7:00 PM shift. She stated she was in-serviced on mechanical lift transfers and falls/fall prevention. She stated if a resident fell, she would have gotten help and informed the nurse immediately. She stated some fall preventions they used in the facility were gait belts, fall mats, float beds, and call lights in residents reach. She stated she knew what type of transfer assistance her residents needed by following the residents electronic record. She stated if a resident required a transfer with a mechanical lift there should have always been 2 staff present during the entire transfer. She stated a resident that required transfers with a mechanical lift should have never been transferred without the lift. She stated if a resident required to be transferred with a mechanical lift and they were transferred without the lift or transferred without 2 people, it could have caused a fall or skin tear or broken bones. She stated in the incident involving Resident #1, she went to the resident's room and the resident was on her oxygen sitting in her wheel chair. She stated she told Resident #1 she was going to take her to the bathroom and get her changed. She stated she pushed Resident #1 to the bathroom in her wheelchair and asked Resident #1 if she could stand up. She stated the resident did not have a mechanical lift sling under her. She stated the resident told her she could stand up and Resident #1 grabbed the poles and stood up. She stated she pulled the resident's pants down and she told resident she was going to remove the brief. She stated resident had BM up her back and the wheel chair was still behind resident at this time. She stated she removed the wheelchair and got behind Resident #1 and removed the brief. She stated Resident #1 pivoted slightly and sat on the toilet. She stated she tried to clean the BM off of the resident's back and that was when Resident #1 started sliding off of the toilet. She stated she tried to help Resident #1 get back on the toilet and resident tightened up and then began to slide down again. She stated she knew she was not going to get resident back on the toilet safely, so she guided Resident #1 down to the floor. She stated at that time there was BM all over the toilet. She stated she made sure Resident #1 was in a safe place and called for RN C. CNA H stated she came back in and looked and saw Resident #1's foot was wrapped but there was some blood on the floor. She stated she ran and got RN C and informed her of the incident. She stated they went back to Resident #1's room and the resident was laying sideways on the floor and there was blood, BM, and urine on the floor. She stated Resident #1 was assessed by the nurse and her oxygen was put back on. She stated they had got the resident back into her wheelchair. She stated she was not aware that Resident #1 was a mechanical lift transfer and had a change in condition recently . She stated resident had recently been walking to the bathroom. She stated RN D came and RN D and RN C cut the bandage off of the resident's right ankle. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	She stated they could not tell what the wound was but the area was open and bleeding. She stated it looked like meat to her and there was gauze on the wound from the wound care that was previously done. She stated the wound appeared like something was sticking out but she could not tell if it was bone or the way resident was holding her foot. She stated Resident #1's foot was tilted to the side. CNA H stated Resident #1 was not reacting to the situation at all and never complained of pain. She stated the resident was sent out to the hospital. CNA H stated she was called to the office and told that resident was supposed to be a 2 person transfer and that she should have been transferred with the mechanical lift. She stated there was no sling on Resident #1 when she went in and assisted the resident to the bathroom and she told the ADM, DON, and RN D that. She stated they told her Resident #1's transfer status was in the Kardex and she was suspended pending investigation. She stated she did not know who had gotten the resident out of bed and up in the wheelchair that day. CNA H stated it was her first day back after being off. She stated she was surprised Resident #1 was up in the wheelchair to begin with because she was usually in the bed when she took care of her. She stated she usually looked at the residents Kardex's but she had not looked at it that day. In an interview on 05/02/26 at 12:01 PM, the FM stated Resident #1 was ambulatory when she admitted to the facility and walked at home with her walker. FM stated the resident was not allowed to use her walker after she was admitted to the facility. FM stated the facility staff was told that resident needed her walker back and they gave it back to her. FM stated resident had an immediate fall after getting her walker back. FM stated the hospice nurse had come out to see resident when that happened and they were not sure how the fall occurred. FM stated had not thought resident had access to the walker since then and the staff used a lift to transfer resident in and out of bed. FM stated they were not sure how resident was being transferred to the bathroom. FM stated they were notified that resident fell yesterday and initially the hospice nurse called and said resident slipped off the toilet and her foot was bleeding from the blister to her right lower leg so resident needed to be sent out to the hospital. They stated they were then told that residents foot was not stable and agreed for resident to be sent to the hospital. They stated resident was at the hospital and she had surgery last night on her ankle They stated resident was in ICU so the hospital could make sure residents toxicology report was stable and for close monitoring and she would be there for about 4-5 days. They stated resident had a compound fracture and could have possibly had to have a skin graft or amputation, but they had her in a wound vac and they would not know the extensiveness of the wound until a week from then when they removed the wound vac and got everything cleaned up. They stated the hospital said there would have likely been more than one surgical procedure that needed to be done. In an interview on 05/02/26 at 12:26 PM, the HPS stated resident was still in ICU and they had consulted plastic surgery for the wound to see if there were any recommendations for the care of the wound. She stated she had not seen the resident when she initially came to the hospital and she was not actively participating in residents care. In an interview on 05/02/26 at 12:32 PM, RN E stated she was not present when Resident #1 transferred into the hospital with EMS but she was caring for resident at that time. She stated Resident #1 had surgery overnight and the fractured area was now closed. She stated Resident #1 was in stable condition. She stated Resident #1 had a wound vac (a medical device that uses continuous or intermittent suction to accelerate healing in acute or chronic wounds) in place and she was not sure how the fracture occurred. In an interview on 05/02/26 at 12:52 PM, the MD stated she was not familiar with Resident #1, but she was the doctor on call for the weekend. She stated it was possible for a fracture to occur in a [AGE] year old resident that could have had osteoporosis in her bones. She stated Resident #1 would be a high risk for fractures. She stated it was hard to say how the actual fracture had occurred and it could have been that something happened prior to the incident. She stated it was hard to say. She stated resident could have gotten a fracture from pushing too hard on a wall or floor and it would not have taken a lot for residents brittle bones. In an interview on 05/02/26 at 12:48 PM, RN D stated she was in the process of being transitioned to ADON. She stated she had worked in the facility for about a month. She stated she was in-serviced on (continued on next page)

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She stated if a resident required to be transferred with a mechanical lift and they were transferred without the lift, it could have caused falls, major injuries, or possible death. She stated in regard to the incident that involved Resident #1, she and the DON were notified by CNA H that Resident #1 had fallen and was on the floor and that there was blood on the floor. She stated she went to Resident #1's room and RN C was holding residents foot. She stated Resident #1 had an open blister to her right ankle and the nurse had mostly removed the dressing. She stated the area was bleeding and the wound looked like their could have been an open fracture due to the position resident was holding the foot. She stated she could not see any bone or what the actual injury was due to the bleeding. She stated she stabilized residents foot and applied abdominal pads and kerlix to try to stop the bleeding. She stated by that time EMS had come in and she stepped out while the RN C and a few other CNA's came in and assisted EMS. In an interview on 05/02/26 at 3:05 PM, LVN F stated she had worked in the facility for about 13 years. She stated she was in-serviced on mechanical lift transfers and falls/fall prevention. She stated if a resident fell, she would have assessed resident and made sure there were no injuries, sent resident to the hospital if needed, checked vital signs, checked neurological assessment, and if the resident was safe, she would have gotten them up. She stated some fall preventions they used in the facility were fall mats, residents were monitored and toileted often and they offered activities. She stated she knew what type of assistance her residents needed because she checked the Kardex. She stated if a resident required a transfer with a mechanical lift there should have always been 2 staff present during the entire transfer. She stated a resident that required transfers with a mechanical lift should have never been transferred without the lift. She stated if a resident required to be transferred with a mechanical lift and they were transferred without the lift, it could have caused a severe injury. She stated when a resident was transferred that required maximum assistance x 1 staff that meant the staff should have done more than what the resident did but that the resident could still help and could bear weight if able. In an interview on 05/02/26 at 3:11 PM, CNA I stated she had worked in the facility for 2 years plus. She stated she was in-serviced on mechanical lift transfers and falls/fall prevention. She stated if a resident fell, she would have yelled for help and asked who came to get the nurse. She stated some fall preventions they used in the facility are gait belts, check the Kardex to see how residents were transferred, residents were toileted often, and some residents were transferred with a mechanical lift. She stated she knew what type of assistance her residents needed because she looked at the Kardex as soon as a new resident arrived. She stated anytime there was an update for current residents, therapy or the nurse informed her. She stated if a resident required a transfer with a mechanical lift there should have always been 2 staff present during the entire transfer. She stated a resident that required transfers with a mechanical lift should have never been transferred without the lift. She stated if a resident required to be transferred with a mechanical lift and they were transferred without the lift, it could have caused a fall or for the resident to have gotten hurt or it could have also caused the staff member to get hurt. She stated when residents were transferred that required maximum assistance x 1 staff that meant she should have checked the Kardex first to see what kind of transfer the resident required and then followed the Kardex. In an interview on 05/02/26 at 3:22 PM, CNA J stated he had worked in the facility for about 4 days. He stated he has been in-serviced on abuse and neglect, mechanical lift transfers, and falls/fall prevention. He stated if a resident fell, he would have notified (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the charge nurse or notify whoever he saw to get the charge nurse. He stated some fall preventions they used in the facility were keeping things out of the walk ways, non-slip socks, and call lights in reach. He stated he knew what type of assistance his residents needed by checking their Kardex in POC. He stated if a resident required a transfer with a mechanical lift there should always have been 2 staff present during the entire transfer. He stated a resident that required transfers with a mechanical lift should have never been transferred without the lift. He stated if a resident required to be transferred with a mechanical lift and the resident was transferred without the lift, it could have caused a fall or broken bone. He stated when transferring residents that required maximum assistance x 1 staff that meant he should have done whatever the resident needed to keep the resident safe, so if they could bear weight he would have stayed with the resident the entire time and helped them as much as needed. In an interview on 05/02/26 at 3:31 PM, the DON stated she had in-serviced staff regularly on mechanical lift transfers and falls/fall prevention. She stated if a resident fell, the CNA should have gotten the nurse and the nurse should have assessed the resident for any injuries or open skin wounds or bruises, conducted a neurological assessment, notified her, the ADON, the RP, and the provider. She stated if there was a serious injury the staff should have sent the resident to the hospital or if they suspected resident had hit their head and were acting different or if they were on blood thinners. She stated in that case she would also have informed the ADM. She stated some fall preventions they used in the facility were low beds, fall mats, increased monitoring, call lights in reach, signage to call for help, and trying to keep residents busy with activities. She stated staff knew what type of assistance their residents needed by checking the Kardex. She stated at any time the CNA's may to have been clear they should have asked the nurse. She stated staff should have checked the Kardex every day before taking care of residents because changes occurred. She stated some of the residents transferred with the mechanical lift PRN because they could have been frequent fallers or may have their ups and downs depending on their mood and the time of day. She stated if a resident required a transfer with a mechanical lift there should have always been 2 staff present during the entire transfer. She stated a resident that required transfers with a mechanical lift should have never be transferred without the lift. She stated if a resident required to be transferred with a mechanical lift and they were transferred without the lift, it could have caused serious injury or harm to the resident and staff could have also been hurt. She stated when residents that required maximum assistance x 1 staff were transferred, that meant staff should have transferred residents with a gait belt and staff should have been doing most of the work. She stated a resident could still have been able to bear weight with maximum assistance x 1 staff. She stated in the incident that involved Resident #1 she had not witnessed the incident but RN C told her resident had fallen. She stated RN D went to Resident #1's room because she was informed there was bleeding present. She stated she informed the ADM and CNA H was suspended pending investigation. She stated they got CNA H's statement and in-serviced her abuse and neglect prior to her leaving the facility. She stated RN D and the RN C unwrapped residents dressing and she walked into Resident #1's room and assessed the area. She stated she did not see any bone poking out and she only saw the area where the wound was and it appeared the existing wound had opened up around it. She stated the area was bleeding and she told the staff to send Resident #1 to the hospital. She stated RN D informed her that she thought residents foot may have been fractured and she informed the ADM. She stated they suspected a fracture to the area due to how the residents foot was moving. She stated resident never showed any sign of pain at all during the entire incident. She stated EMS transferred resident to the hospital. She stated she called the hospital and was informed that resident had a fractured right foot. She stated she and the ADM received statements from all staff who was had worked and found that none of the staff at the facility or

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	675948	A. Building B. Wing	05/15/2026

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Avir at Belton	810 E 13th Ave Belton, TX 76513

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident maintained acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrated this was not possible or the resident's clinical condition demonstrated that this was not possible or resident preferences indicated otherwise for 6 of 6 Residents (Residents #4, Resident # 5, Resident # 6, Resident # 7, Resident # 8 and Resident # 9) reviewed for nutrition status maintenance. The facility failed to ensure Resident #4 weights were obtained and monitored and interventions were addressed or implemented for his weight lossThe facility failed to obtain and monitor new residents (Resident #5, Resident #6, Resident #7, Resident #8, and Resident #9) weights according to the facility policy to ensure weight loss and nutritional status were not compromised. These failures could place residents at risk of losing weight and result in unplanned weight loss and a decline in the residents' overall health.Findings include: Observation on 5/14/26 at 5:20 PM revealed Resident # 4 being weighed with a mechanical lift by MA M and AD/CNA L with Resident #4 weight of 136.6 lbs. displayed on the scale reading. 1. Record review of Resident #4 admission face sheet, dated 5/14/26, reflected a 71-year-olf male who was admitted to the facility on [DATE]. Resident #4 had diagnoses which included cerebral infarction (stroke), type 2 diabetes (a chronic condition where your body either doesn't produce enough insulin or resists it), spastic hemiplegia affecting right dominant side (a common subtype of spastic cerebral palsy that causes muscle stiffness, weakness, and involuntary contractions on just the right side of the body), aphasia following cerebral infarction (a neurological language disorder caused by damage to the brains language centers), encephalopathy (a broad term for any disease, damage, or malfunction of the brain), CHF (a chronic progressive condition where the heart muscle becomes too weak or stiff to pump blood efficiently throughout the body), and attention and concentration deficit following cerebral infarction. Record review of Resident #4's admission Comprehensive MDS, dated [DATE], section GG reflected under heading Eating, resident was dependent on staff for eating. Record review of Resident # 4 Baseline Care plan, dated 3/27/26, reflected Resident # 4 required substantial/maximal assistance for eating. Resident # 4 was cognitively impaired. Under dietary/nutritional status reflected the residents' dietary goal was to maintain current weight and prevent weight loss. Risks of weight loss, swallowing problems, and chewing problems Record review of Resident #4's Comprehensive Care plan, dated 4/14/26, reflected ADL staff assist r/t hemiplegia affecting right dominant side, recent CVA, mood decline, encephalopathy, CHF, diabetes, A-fib (rapid irregular heart rate), aphasias, swallowing disorder, and impaired mobility. Eating: The resident is dependent on 1 staff for eating. Further review reflected the resident has diabetes mellitus. Dietary consultation for nutritional regimen and ongoing monitoring. Record review of Nutrition Risk Assessment, dated 4/7/26, reflected the most recent weight documented was 154 lbs. Hospital records documented weight of 160 lbs. Resident has dysphagia (swallowing disorder) diagnosis on mechanical soft texture diet. Resident requiring assistance/supervision while eating per documentation. No significant weight changes currently. Record review of Resident #4's weights and vitals documentation reflected weight 154 lbs. dated 3/27/26. and weight of 154 lbs. dated 5/7/26. No other weights documented. Record review of Resident #4's Clinical physician orders, dated 5/14/26, reflected no orders for scheduled weights to be obtained or monitored. During an interview on 5/15/25 at 2:10 PM with the ADON revealed she was aware of Resident # 4's weight loss it had been brought up and the resolution was for the CNAs and therapy staff to sit and feed him. The ADON stated Resident #4 had been going to the dining room but had behaviors or exposing himself while in the dining room so he was now being fed in his room. ADON stated she did not think Resident #4's weight loss was expected. The ADON stated the facility had probably not been getting resident weights because of low staffing. The ADON stated it was her expectation that the nurse would obtain (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident weights and would designate 1-2 people to complete all weights for consistency and accuracy. The ADON stated resident weights were supposed to be obtained and entered before the 7th day of the month. The ADON stated she would expect staff to track resident weights and make sure they were accurate. The ADON stated she would expect training to be completed to make sure staff knew what they were doing when it came to obtaining resident weights, so the results were consistent and there weren't any gaps. The ADON stated hospice services were discussed with the family previously, but the family had declined them at that time. The ADON stated hospice services would likely be discussed in the future due to disease process contributing to weight loss and refusal of food. The ADON stated resident documentation should be consistent and accurate because it triggered tasks and follow up actions. The ADON stated staff should stay on top of documentation and interventions by adding a house shake or additional supplement. The ADON stated she could not say for sure as to what documentation or tasks triggered Resident #4 currently had. The ADON stated if weight loss was noticed the next steps were to notify the dietician and get recommendations, notify the physician, notify the family to obtain preferences and cultural accommodations, request health shakes and preferred snacks from dietary, assistance with feeding consistently using the same staff, if possible, to maintain baseline knowledge of condition. The ADON stated she was not immediately familiar with the facility policy and procedures for obtaining/maintaining weights. The ADON stated she was told any orders would automatically populate to the EMAR when it was time for weights to be obtained. ADON stated she did not feel Resident # 4 weight loss has negatively impacted the resident's health status. The ADON stated Resident #4 was still up and with it, not in distress, appeared comfortable, with a little anxiety but nothing so alarming that she felt he needed to be sent out to the emergency room for evaluation. The ADON stated it could negatively impact a resident if weights were not obtained or monitored, because it could lead to serious injury or death. The ADON stated weights were consistently needed to correctly ascertain a resident's status and condition. During an interview on 5/15/26 at 3:37 PM with the MD revealed he was made aware of Resident #4's weight loss earlier this week while in the facility and had relayed to the NP to follow up. The MD stated he was unaware of Resident #4 weight loss prior to this week. The MD stated it was his expectation that resident weights be obtained once a week for new admissions and at regular intervals. During an interview on 5/15/26 at 3:41 PM with Resident # 4's RP revealed she was not aware of Resident # 4 significant weight loss The RP stated when she asked if Resident # 4 had eaten, she was always told yes. During an interview on 5/15/26 at 4:00 PM with NP revealed she had recently had discussion with Resident # 4's FM and the facility staff about the resident's decline. The NP stated Resident #4's weight loss was expected due to disease process. c During an interview on 5/15/26 at 5:45 PM with RNC revealed she was not aware of Resident #4's weight loss until yesterday (5/14/26) because both weights that were entered into the electronic health record were the same. The RNC stated she had already been made aware the weight system was broken and implemented action in April of 2026. The RNC stated Resident #4's weight loss was not expected but he did have dysphasia and had a stroke previously so it could have been possibly expected. The RNC stated she was not as familiar with this resident so after thinking about it with his diagnosis, the RNC stated she was changing her previous answer to reflect Resident #4's weight loss was probably expected. The RNC stated every resident should have weights obtained monthly unless there were special conditions or prior weight loss that indicated weights needed to be obtained more often but at a minimum, they should be obtained monthly. The RNC stated interventions should have been in place for Resident #4 if the facility was aware of the weight loss. The RNC stated the care plan was updated today and the RD had also seen the resident and ordered supplements. The RNC stated the only time there were physician orders for weights was if the weights were out of the ordinary scheduled monthly weights. The RNC stated if a resident had weight loss, the MD, RD, and DON should be notified to address the weight loss. The RNC stated monthly weights were completed by the 7th of the month and the DON should run a report and see who triggered for significant weight loss (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and the IDT team should be notified to address the weight loss. The RNC stated the staff were trained on facility systems and policy and procedures upon hire and the DON and ADON completed the training. The RNC stated it could negatively affect a resident if weights were not obtained timely and accurately because it was hard to look at someone and be able to tell if they lost weight. The RNC stated the negative impact could be malnutrition and overall systems effect. During an interview on 5/15/26 at 6:02 PM with the ADM revealed she was aware of Resident #4's weight loss. The ADM stated she was informed the resident was not eating. The ADM stated she had spoken with the ADON to ensure Resident #4 was being brought to the dining room for all meals after therapy brought the weight loss to her attention on Monday 5/11/26. The ADM stated it was her expectation the resident weights were obtained monthly and more if the RD or MD requested more often and the staff followed the facility policy regarding weights. The ADM stated she was not a clinical person, but she expected Resident #4 to have some weight loss because of his overall condition. The ADM stated there should be interventions for weight loss if the weight loss was known. The ADM stated the RD, MD, and DON should be notified of weight loss. The ADM stated obtaining weights was primarily delegated to the CNAs to obtain. The ADM stated she was unsure if the weight loss would negatively impact Resident #4 since she was not a clinical person but stated anytime someone was not eating there could be a negative impact. The ADM stated Resident #4's weight loss may have been expected due to diagnosis. The ADM stated not obtaining resident weights could negatively impact because residents could become ill and not get the nutrients needed for the body to be healthy. 2. Record review of Resident # 5 admission face sheet, dated 5/15/26, reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Resident #5 had diagnoses which included cerebral infarction (stroke), epilepsy (chronic neurological disorder characterized by recurrent unprovoked seizures), hypertension (elevated blood pressure), aphasia following cerebral infarction (a language disorder caused by damage to the brains language centers following a stroke), dysarthria (speech disorder), dysphagia (swallowing disorder), ataxia (lack of voluntary muscle coordination and control), cognitive communication deficit (an impairment in communication caused by a disrupted thinking process rather than a direct physical issue), emphysema (a progressive lung disease that damages the tiny air sacs in your lungs), atherosclerotic heart disease (a condition in which the arteries that supply blood to your heart become narrowed or blocked by plaque), and displaced fracture of right femur (right hip fracture). Record review of Resident #5's admission Comprehensive MDS, dated [DATE], reflected a BIMS score of 3, which indicated severe cognitive impairment. Resident # 5 required set up or clean up assistance for eating. Record review of Resident #5's Clinical physician orders, dated 5/15/26, reflected no orders for scheduled weights to be obtained or monitored. Record review of Resident #5's weights and vitals documentation reflected a weight of 102.4 lbs., dated 4/30/26 and weight of 105 lbs. dated 5/12/26. No other weights documented. 3. Record review of Resident # 6's admission face sheet, dated 5/15/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #6 had diagnoses which included cerebral infarction (stroke), unspecified dementia (when a patient has clear cognitive decline and memory loss but the exact underlying cause cannot be determined), sepsis (the body's extreme life-threatening response to an infection), thyrotoxicosis (a condition caused by excess thyroid hormones in the bloodstream), hyperlipidemia (fat particles in the blood), type 2 diabetes (a chronic metabolic condition where the body either resists the effects of insulin or doesn't produce enough insulin causing sugar to buildup in the bloodstream), depression (a serious mental health condition that causes a persistent feeling of sadness, loss of interest, and a wide range of emotional and physical symptoms), CHF (a chronic progressive condition where the heart muscle becomes to weak or stiff to pump blood efficiently), hypertension (elevated blood pressure), COPD (a progressive lung disease that causes obstructed airflow and makes breathing difficult), atrial fibrillation (a heart rhythm disorder), peripheral vascular disease (circulation disorder), and GERD (acid reflux). Record review of Resident #6's admission Comprehensive MDS, dated [DATE], reflected a BIMS score of 8, which indicated moderate cognitive (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	impairment. Resident # 6 was independent for eating. Record review of Resident #6's Clinical physician orders, dated 5/15/26, reflected no orders for scheduled weights to be obtained or monitored. Record review of Resident #6's weights and vitals documentation reflected weight of 216 lbs., dated 4/29/26, and a weight of 179 lbs., dated 5/13/26. No other weights documented. 4. Record review of Resident #7's admission face sheet, dated 5/15/26, reflected a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #7 had diagnoses which included traumatic subdural hemorrhage with loss of consciousness (a life-threating brain injury where blood leaks and pols between the surface of the brain and the brains tough outer covering following a head impact), anemia (low blood iron), protein-calorie malnutrition, hyperlipidemia (fat particles in the blood), fluid overload, unspecified dementia (when a patient has clear cognitive decline and memory loss but the exact underlying cause cannot be determined), hypertension (elevated blood pressure), heart failure, COPD (a progressive lung disease that causes obstructed airflow and makes breathing difficult), chronic kidney disease stage 4, BPH (enlarged prostate), atrial fibrillation (a heart rhythm disorder), thrombocytosis (a condition where the blood produces to many platelets and is too thick), right hip pain, hypoxemia (low blood oxygen levels), abdominal aortic aneurysm without rupture (a [NAME] like bulge in the lower part of the aorta the body's main artery), and syncope with collapse (fainting with collapse). Record review of Resident #7's admission Comprehensive MDS, dated [DATE], reflected a BIMS score of 8, which indicated moderate cognitive impairment. Resident # 7 required setup or clean up assistance for eating. Record review of Resident #7's Clinical physician orders, dated 5/15/26, reflected no orders for scheduled weights to be obtained or monitored. Record review of Resident #7 weights and vitals documentation reflected weight of 145.2 lbs., dated 4/24/26, and weight of 143.6 lbs., dated 5/3/26. No other weights documented. 5. Record review of Resident #8's admission face sheet, dated 5/15/26, reflected an 84 -year-old female who was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident #8 had diagnoses which included moderate protein calorie malnutrition, type 2 diabetes (a chronic metabolic condition where the body either resists the effects of insulin or doesn't produce enough insulin causing sugar to buildup in the bloodstream), hyperlipidemia (fat particles in the blood), dementia (a decline in mental ability severe enough to interfere with daily life), Alzheimer's disease (a progressive irreversible brain disorder that slowly destroys memory, thinking skills, and the ability to carry out simple daily tasks), hypertension (elevated blood pressure), GERD (acid reflux), history of falling, and neuromuscular bladder dysfunction (nerve damage that impairs bladder storage and emptying). Record review of Resident #8's Comprehensive care plan, dated 4/2/24, reflected the resident required assistance with ADLs. Record review of Resident #8's Clinical physician orders, dated 5/15/26, reflected no orders for scheduled weights to be obtained or monitored. Record review of Resident #8's weights and vitals documentation reflected weight of 126.2 lbs., dated 3/5/26, and weight of 130 lbs., dated 5/12/26. No other weights documented. 6. Record review of Resident #9's admission face sheet, dated 5/15/26, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #9 had diagnoses which included CHF (a chronic progressive condition where the heart muscle becomes too weak or stiff to pump blood efficiently), malignant neoplasm of brain (brain cancer), anemia (low blood iron), hypothyroidism (underactive thyroid), hyperlipidemia (elevated fat particles in the blood), depression (a serious mental health condition that causes a persistent feeling of sadness, loss of interest, and a wide range of emotional and physical symptoms), Alzheimer's disease (a progressive irreversible brain disorder that slowly destroys memory, thinking skills, and the ability to carry out simple daily tasks), meningitis (inflammation of the meninges which are protective membranes surrounding the brain and spinal column), hypertension (elevated blood pressure), GERD (acid reflux), chronic kidney disease stage 2, osteoarthritis (arthritis that occurs when the cartilage that cushions the ends of your bones gradually breaks downs causing movement to become painful), anxiety disorder, osteoporosis (brittle bones), and non- [NAME] lymphoma (lymphatic cancer). Record review of Resident #9's Comprehensive care plan, dated 3/29/26, reflected the resident required assist in all (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ADLs with eating requiring assistance by 1 staff. Resident #9 had impaired cognition r/t Alzheimer's with a BIMS score of 2, which indicated severe cognitive impairment. Record review of Resident #9's Clinical physician orders, dated 5/15/26, reflected no orders for scheduled weights to be obtained or monitored. Record review of Resident #9's weights and vitals documentation reflected weight of 147.6 lbs., dated 4/5/26 and weight of 150 lbs., dated 5/12/26. No other weights documented. Record review of Weight Assessment and Intervention policy, dated 3/2022 with a revision date of 5/12/25, reflected under heading policy statement: Resident weights are monitored for undesirable or unintended weight loss or gain.Under heading policy Interpretation and Implementation:Residents are weighed upon admission or readmission and weekly for four weeks, as determined by the Interdisciplinary Team (IDT) and monthly thereafter.Weights are recorded in the resident's electronic health record.Any weight change of 5 pounds or more since the last weight assessment will be reweighed for confirmation.Monthly weights will be obtained by the 7th of each month, reweighs within 48 hours. The dietitian will review monthly weights and will intervene as needed.The threshold for significant unplanned and undesired weight loss will be based on the following criteria [where percentage of body weight loss = (usual weight - actual weight)/(usual weight) x 100]:1 month - 5% weight loss is significant; greater than 5% is severe.3 months - 7.5% weight loss is significant; greater than 7.5% is severe.6 months - 10% weight loss is significant; greater than 10% is severe.If the weight change is desirable, this is documented, and no change in the care plan will be necessary.If a resident has significant unplanned weight change, all pertinent members of the interdisciplinary team (IDT) are made aware with the month.Heights will be obtained on admission and annually.