STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675966	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Texarkana	4920 Elizabeth St Texarkana, TX 75503

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an ongoing program of activities in accordance with the comprehensive assessment to meet the interests and the physical, mental, and psychosocial well-being for 1 of 1 memory care unit consisting of 14 residents reviewed for activities. The facility failed to provide meaningful activities for dementia residents on the memory care unit. This failure could place residents at risk for not having activities to meet their interests or needs and a decline in their physical, mental, and psychosocial well-being.Findings included: Record review of the March 2026 Group Activities Calendar posted in the memory care unit dining area revealed the following activities: 03/09/2026 03/10/2026 03/11/202610 a.m.-Exercise 10 a.m.-Dancing 10 a.m.-Sit to Fit1 p.m.- Bean Bag Toss 1 p.m.- Match Up 1 p.m.- Tic Tac Toe2 p.m.- Memory Lane 2 p.m.-Name that Tune 2 p.m.-Nail Care3 p.m.-[NAME] Toss 3 p.m.- Art Shop 3 p.m.-Match Up During an observation on 03/09/2026 at 10:06 a.m., there were 6 residents sitting in the sitting/dining area of the memory care unit. The television was on with no sound. The nurse was monitoring the residents. No CNA or activity personnel were present. No exercise or other activity was taking place. During an observation on 03/09/2026 at 12:55 p.m.-1:25 p.m., the dining and sitting area nor hallways had any memory care/dementia focused activities. The television was on in dining area with no sound. No bean bag toss was taking place. No meaningful activity was offered to the residents. Five residents were in the sitting/dining area. During an observation on 03/09/2026 at 2:01 p.m.-2:30 p.m., several (6) residents were in the sitting area/dining area. No meaningful activities were offered to the residents. Television was on with no sound. Two residents sitting with head on table. Two residents were wandering up and down hallway. During an observation on 03/10/2026 at 9:49 a.m.-10:15 a.m., several (5) residents were in the sitting area/dining area with no meaningful activities offered to residents. No dancing and no music was present during this time. Television was on and nurse was sitting at table with 2 residents. The nurse was looking through a magazine and watching TV, not engaging with any residents. During an observation on 03/10/2026 at 2:48 p.m.- 3:18 p.m., several (6) residents were in the sitting area and dining area with no meaningful activities offered to residents. No arts and crafts were being performed with the residents. During an interview on 03/10/2026 at 3:20 p.m., the Memory Care Activity Assistant stated she was pulled to the floor on 200 hall to work because someone called in. She stated in her absence the nurse should be doing the scheduled activities with the residents. She stated she had not been following the activities calendar because the residents that were on memory care now were unable to participate in several of the activities. She stated she had not spoken to the activities director about making changes to the calendar to correct the calendar with more appropriate activities. She stated instead she had been letting them watch TV and do their own thing, like snack and nap when they wanted. She stated the importance of activities on the unit was to exercise the residents' bodies and minds and keep boredom down. She stated engaged residents were less likely to fall, have behaviors and become depressed. During an interview on 03/11/2026 at 10:00 a.m., the DON said staff received annual training on dementia centered care. She stated all staff should be providing person centered care to the memory care residents. She stated the facility interviewed the residents' families to get input on (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675966	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Texarkana	4920 Elizabeth St Texarkana, TX 75503

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	activities that interested their family members before admission. She stated the facility had some activities available for the residents, but she understood the activities on the calendar needed to be followed. She stated trying to find activities that all the residents would be interested in, it be safe, and not be an infection control risk could be challenging. She said not providing residents individualized, structured activities had the potential for increased behaviors and falls. She stated the AD was out on leave. During an interview on 03/11/2026 at 11:00 a.m., the Administrator said it was the IDTs responsibility to provide the residents on the secured unit dementia centered care. She stated the facility should be following the calendar and using the residents' care plans to find activities to meet their needs. She stated the activities should be at their level and staff should be assisting with activities. She stated the secured unit needed structured activities, things to keep them busy. She stated when residents were not provided with activities throughout the day, they could have increased behaviors and falls. Record review of a facility's Dementia policy dated 11/2021 indicated .direct care staff will support the resident in initiating and completing activities.therapeutic and recreational activities will be supervised and supported throughout the day as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675966	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Texarkana	4920 Elizabeth St Texarkana, TX 75503

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen reviewed for kitchen sanitation. The facility did not ensure:1. The flour scoop was kept out of the storage container on 03/09/2026, 03/10/2026, and 03/11/2026.2. The deep fryer and stove were free of caked on grease. These failures could place residents at risk for cross contamination and food-borne illness.The findings included: During an initial tour observation in the kitchen on 03/09/2026 beginning at 9:00 a.m., it was revealed that the flour scoop was left inside the flour container. The deep fryer was located beside the stove with a small gap between them. There was solidified grease on the floor between the stove and the deep fryer, that was caked up around the legs of the deep fryer. The whole side of the stove had caked on yellowish-brown grease. The back of the deep fryer had thick layers of caked on grease that were yellowish-brown. The fryer baskets were hanging on the back of the fryer. The caked on grease was darker around the bolts of the deep fryer. During an observation in the kitchen on 03/10/2026 beginning at 10:00 a.m., it was revealed that the flour scoop was left inside the flour container. There was solidified grease on the floor between the stove and the deep fryer, that was caked up around the legs of the deep fryer. The whole side of the stove had caked on yellowish-brown grease. The back of the deep fryer had thick layers of caked on grease that were yellowish-brown. The fryer baskets were hanging on the back of the fryer. The caked on grease was darker around the bolts of the deep fryer. During an observation and interview on 03/11/2026 beginning at 10:18 a.m., [NAME] B opened the flour container to remove the scoop that had been left. The scoop was a quarter pitcher and the handle was laying on top of the flour. [NAME] B stated everyone was responsible for monitoring to ensure the scoops were not left in the storage containers. [NAME] B was unsure why the scoop was left in the flour storage container. [NAME] B stated the deep fryer had the caked on grease that would not come off. [NAME] B stated the deep fryer was cleaned twice weekly and as needed. [NAME] B stated the cooks were responsible for cleaning the deep fryer. [NAME] B stated the Dietary Manager had tried to clean the caked on grease on the stove and deep fryer, but it would not come off. [NAME] B stated it was important to ensure scoops were not left in the storage container and the deep fryer was cleaned to prevent cross-contamination and ensure the kitchen and equipment were sanitary. She stated it could have made residents sick. During an observation and interview on 03/11/2026 beginning at 10:23 a.m., the Dietary Manager stated she expected the dietary staff to ensure the scoops were not left in the storage containers. The Dietary Manager stated the cooks were responsible for monitoring to ensure the scoops were not left in the storage containers. She stated it was important to ensure the scoops were not left in the storage container to prevent cross contamination. She stated the deep fryer and stove was cleaned once per week. She stated she had tried to clean the stove and deep fryer with several cleaning products but the caked on grease would not come off. The Dietary Manager scraped the side of the stove with her fingernail and yellow debris was noted on her fingernail. The Dietary Manager stated it was important to ensure the equipment was cleaned and sanitary to prevent food-borne illness to the residents. During an interview on 03/11/2026 beginning at 1:07 p.m., the Administrator stated she expected the dietary staff to maintain sanitary conditions in the kitchen. She stated she expected scoops to be stored outside the storage container and equipment to be kept clean and sanitary. She stated the Dietary Manager was responsible for monitoring to ensure the dietary staff maintained a sanitary kitchen. She stated it was important to ensure kitchen sanitation to promote safe food handling. Record review of the Policy for Monitoring Kitchen Cleanliness and Sanitation, undated, reflected Everyone will be assigned a cleaning job in the kitchen. They will be responsible for keeping said equipment clean for the entire month. Record review of the Cleaning the Deep Fryer policy, undated, reflected The deep fryer in the kitchen is to be (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675966	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Texarkana	4920 Elizabeth St Texarkana, TX 75503

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cleaned weekly, or more often depending on the condition of the grease, at the Dietary Manager's discretion. Record review of the Food Storage policy, undated, reflected .8. Label and date all storage containers or bins. Keep free of scoops. Record review of the 2022 Food Code by the Food and Drug Administration reflected During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored. (B) In food that is not time/temperature control for safety food with their handles above the top of the food within containers or equipment that can be closed, such as bins of sugar, flour, or cinnamon. Equipment Food-contact SURFACES and UTENSILS shall be clean to sight and touch. The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. Nonfood-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675966	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Texarkana	4920 Elizabeth St Texarkana, TX 75503

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a comprehensive resident-centered assessment of each resident's cognitive, medical, and functional capacity in a timely manner for 1 of 22 residents (Resident #47) reviewed for comprehensive MDS assessment timing. The facility failed to complete Resident #47's annual comprehensive MDS assessment within 366 days of the previous comprehensive MDS assessment. This failure could place residents at risk of not having their needs met. The findings included: Record review the face sheet, dated 03/10/2026, revealed Resident #47 was a [AGE] year-old male who admitted to the facility on [DATE] with a diagnosis of dementia (memory loss). Record review of Resident #47's annual MDS assessment reflected an ARD date of 01/28/2025. The next comprehensive MDS assessment should have been scheduled on or before 01/28/2026. Record review of Resident #47's annual MDS assessment reflected an ARD date of 02/27/2026, which indicated the comprehensive MDS assessment was completed 30 days late. Record review of the MDS final validation report, dated 03/04/2026, reflected Resident #47's annual MDS assessment was completed late. During an interview on 03/11/2026 at 9:00 a.m., the MDS Coordinator stated it was her responsibility to ensure all MDS assessments were completed and transmitted timely. She stated Resident #47 was due for an annual assessment and she failed to transmit it timely. She stated she was unsure how she overlooked it because she had a paper backup system in place to ensure scheduling stayed on time for MDS assessments, and the system they used to input the data tracked the due date. The MDS Coordinator stated annual assessments were due every 366 days, except when a significant change was completed. She stated the significant change assessment took the place of the annual assessment. The MDS Coordinator stated the only thing being late with an MDS could affect was billing. She stated there was no negative impact on the residents from a late MDS. During an interview on 03/11/2026 beginning at 1:07 p.m., the Administrator stated she expected MDS assessments to have been completed within the required timeframes. She stated the regional MDS nurse was responsible for monitoring to ensure MDS assessments were completed timely. She stated it was important to ensure MDS assessments were completed timely to ensure residents received the care and services they required. Record review of a Comprehensive Assessments facility policy last updated 02/2025 indicated, .Comprehensive assessments are conducted to assist in developing person-centered care plans.Comprehensive assessments are conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual. Record review of the RAI Manual, dated October 2025, reflected Annual (comprehensive) assessments should have been completed no later than ARD of previous comprehensive assessment + 366 calendar days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675966	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Texarkana	4920 Elizabeth St Texarkana, TX 75503

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to complete the quarterly MDS assessment not less frequently than every 3 months for 1 of 16 (Resident #62) residents reviewed for MDS completion. The facility failed to complete the quarterly MDS assessment for Resident #62, within 92 calendar days of the previous annual assessment dated [DATE]. These failures could place residents at risk of not receiving services to provide quality care.The findings included: 1. Record review of a face sheet dated 03/09/2026 indicated Resident #62 was a [AGE] year-old male that admitted on [DATE] with diagnoses of dementia (a progressive decline in mental ability-including memory, thinking, and behavior-that interferes with daily life and is not a normal part of aging), benign prostatic hypertrophy (a common, noncancerous condition in men over 50 where the prostate gland enlarges, pressing on the urethra and causing urinary issues like weak stream, frequency, and urgency), and hypertension (high blood pressure). Record review on 03/09/2026 of MDS data for Resident #62 revealed the following:08/06/2025- Quarterly MDS Completed11/06/2025- Annual MDS Completed Record review of the 11/06/2025 Annual MDS assessment revealed Resident #62 had a BIMS score of 01, which indicated severe cognitive impairment. He required supervision with ADL assistance for safety. During an interview on 03/11/2026 at 9:00 a.m., the MDS Coordinator stated it was her responsibility to ensure all MDS assessments were completed and transmitted timely. She stated Resident #62 was due for a quarterly MDS on 02/06/2026 and she overlooked transmitting it. She stated she was unsure how she overlooked it because she had a paper backup system in place to ensure scheduling stayed on time for MDS assessments, and the system they used to input the data tracked the due date. The MDS Coordinator stated quarterly assessments were due every 92 days, except when an annual was completed. She stated the annual assessment took the place of the quarterly assessment. The MDS Coordinator stated the only thing being late with a MDS could affect was billing. She stated there was no negative impact on the residents from a late MDS. During an interview on 03/11/2026 at 9:21 a.m., the DON said the MDS Coordinator was responsible for completing and transmitting the all MDSs in a timely manner. She said she expected the MDS assessments to be completed and transmitted in the appropriate timeframe. She said MDSs not being completed and transmitted in the appropriate timeframe would not negatively affect resident's care. During an interview on 03/11/2026 at 11:01 a.m., the Administrator said the MDS Coordinator was responsible for completing MDS assessments and transmitting them in a timely manner. She said she did not feel like there could be a negative outcome for the assessments not being completed timely or being transmitted timely. Record review of a Quarterly Assessments facility policy last updated 02/2025 indicated, .Quarterly assessments are conducted to assist in updating person-centered care plans.Quarterly MDS assessments are conducted in accordance with criteria and timeframes established in the Resident Assessment Instrument (RAI) User Manual.The quarterly MDS assessment is a quarterly assessment due every 92 days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675966	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Texarkana	4920 Elizabeth St Texarkana, TX 75503

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure an accurate MDS assessment was completed for 1 of 16 residents reviewed for MDS accuracy. (Resident #8) The facility failed to accurately code Resident #8's psychotropic medication use. This failure could place residents at risk of receiving unneeded care and services.Findings included: Record review of an undated face sheet revealed Resident #8 was an [AGE] year-old female, admitted on [DATE] with the diagnoses of Alzheimer's disease (a progressive, incurable neurodegenerative disorder and the most common cause of dementia, characterized by memory loss, cognitive decline, and behavioral changes), fibromyalgia (a chronic disorder characterized by widespread musculoskeletal pain, fatigue, sleep disturbances, and cognitive difficulties), and diabetes type II (a chronic condition where the body resists insulin or fails to produce enough, causing high blood sugar). Record review of a quarterly MDS assessment dated [DATE] for Resident #8 revealed a BIMS score of 03, which indicated severe cognitive impairment. The MDS also revealed Resident #8 required partial assistance (helper does less than half the work) with bed mobility, transfer, and toileting. The MDS revealed Resident #8 took antipsychotic medications daily. Record review of the consolidated physician orders for December 2025 revealed no orders for antipsychotic medications for Resident #8. Record review of the MAR dated December 2025 revealed no antipsychotic medications were administered for Resident #8. During an interview on 03/11/2026 at 10:00 a.m., the MDS Coordinator revealed Resident #8 should not have been coded as receiving daily antipsychotic medications. The MDS Coordinator stated Resident #8 had no order for antipsychotic medications in December 2025 and this must have been a miscoding. The MDS Coordinator stated miscoding the MDS can lead to wrong information reported on the Quality Measures and potentially wrong information being care planned for the resident which could confuse the staff caring for the residents. During an interview on 03/11/2026 at 11:15 a.m., the DON stated it was the responsibility of the MDS Coordinator to ensure accurate MDSs were produced and transmitted to CMS. The DON stated there was currently no system check in place to audit the MDS accuracy but ultimately the DON or Regional Nurse signed the MDS for completion and the MDS nurses signed it for accuracy. During an interview on 03/11/2026 at 12:00 p.m., the Administrator stated it was the responsibility of the MDS Coordinator to produce accurate MDSs and care plans. The Administrator stated accuracy is important for revenue as well as to ensure the facility was reporting the correct information to CMS on the quality measures. During a record review of the facility's undated Minimum Data Set Policy for MDS assessment Data Accuracy, revealed the purpose of the MDS policy was to ensure each resident received an accurate assessment by qualified staff to address the needs of the resident who are familiar with his/her physical, mental, and psychosocial well-being. The assessment should accurately reflect the resident's status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675966	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Texarkana	4920 Elizabeth St Texarkana, TX 75503

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the resident environment remained free from accident hazards for 1 of 20 residents (Resident #84) reviewed for accident hazards.The facility failed to keep prohibited items, chemical insecticide (targeting roaches), out of Resident #84's room.This failure could place residents at risk for injury, harm, and impairment or death.Findings included: Record review of Resident #84's face sheet, dated 11/21/25, indicated he was a [AGE] year-old male, re-admitted to the facility on [DATE] and originally admitted on [DATE]. His diagnoses included Major Depressive Disorder (a common, serious mental health condition characterized by persistent sadness, loss of interest, and fatigue lasting at least two weeks, significantly impairing daily life), Cerebral Infarction (a type of ischemic stroke caused by a blockage in a blood vessel, leading to brain tissue death due to lack of oxygen and nutrient), and Pneumonia (an infection causing inflammation in one or both lungs' air sacs, resulting in cough, fever, chills, and breathing difficulties). Record review of Resident #84's Annual MDS assessment, dated 12/16/25, indicated he had a BIMS score of 15, which indicated intact cognition. Record review of Resident #84's care plan indicated that a problem initiated on 2/21/2019 showed that Resident #84 had a problem with depression and anxiety related to decreased cognition that required monitoring by staff. During an interview and observation on 3/9/26 at 9:27 a.m. it was observed that Resident # 84 had a spray bottle of chemical insect killer in his room. He said that if he saw a bug he would spray and kill them. He said that he got bug spray from his family. He said that he had had it for a while and no staff told him he couldn't have it. During an interview on 3/11/26 at 10:27 a.m. with CMA A she said that residents should not have bottles of chemical bug spray in their rooms. She said that residents could misuse the spray or a resident who was confused could enter the room and poison themselves. During an interview on 3/11/26 at 10:38 a.m. the Director of Nursing said that residents should not have chemical bug spray in their rooms. She said that residents could potentially poison themselves if they misused a chemical, especially poison. She said that there are a number of items that residents cannot have in their room and chemical poisons was one of them. During an interview on 3/11/26 at 10:50 a.m. with the Administrator she said that residents should not have chemical bug spray in their room. She said that Resident #84's family brought the chemicals into the room. She said they contract pest control and residents should not have pest control products in their room. She said that residents could poison themselves if they misused chemical bug spray. Record review of a facility policy titled, Safety and Supervision of Residents dated July 2017 indicated that the purpose of this policy was to, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.Our facility-oriented approach to safety addresses risks for groups of residents.Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; reviews of safety and incident/ accident data; and a facility-wide commitment to safety at all levels of the organization.Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards, and try to prevent avoidable accidents.Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents.