

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675978	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Arbor Grace Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1241 W Marshall Howard Blvd Littlefield, TX 79339	
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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interviews, and record review, the facility failed to ensure residents had the right to send and receive mail for 11 of 11 confidential residents reviewed for right to communication. The facility failed to ensure residents received their mail on the weekend. This failure could put residents in the facility who receive mail at risk for not receiving mail in a timely manner that could result in a decline in the residents' psychosocial well-being and quality of life. Findings included: During a confidential group interview at an undisclosed date and time, 11 of 11 residents said mail was not being distributed on the weekend. They indicated they were unsure why mail was not delivered by the weekend staff. They indicated they had never received mail on the weekend, nor had they ever been asked at their regular monthly meetings about receiving mail on the weekend. They stated they thought that was not a service offered by the facility. In an interview on 02/26/2026 at 09:17 a.m. AD stated she passes out the resident's mail to them Monday through Friday. She stated the post office holds mail on Saturday and delivers it on Monday. She stated she was not sure why mail was not delivered on Saturday. In an interview on 02/26/2026 at 02:15 p.m. BOM stated she received mail for the facility including mail for the residents. She stated she works Monday through Friday. She stated the post office holds the mail for Saturday and delivers it to the facility on Monday. She stated she was not sure why but that has been the way it has been since she started. She stated she delivers all mail to AD, and she passes it out to the residents. In an interview on 02/26/2026 at 09:32 a.m. ADM stated he was not aware of the mail not being delivered on Saturday. He stated he was not sure if mail was delivered to the facility on Saturday. He stated when the mail was delivered the receptionist will deliver to the right person. He stated the receptionist and BOM work Monday through Friday. He stated the potential negative outcome could be a violation of resident rights. During an interview on 2/26/26 at 4:00 p.m. the ADM stated they followed the Federal Regulations requirements for any policies not provided. Record review of Federal Resident Rights dated 02/24/2022 found in the Resident admission packet reflected in the section Privacy and Confidentiality that a resident had the right to send and promptly receive unopened mail and other letters, packages, and other materials delivered to the facility for you, including those delivered through a means other than the postal service.		

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, interview, and record review, the facility failed to provide information to residents and their representatives on their rights related to filing grievances or concerns for 11 of 11 confidential residents. The facility failed to ensure 11 confidential residents were provided with access to the grievance form and provided the procedure for how to file an anonymous grievance. This failure could place the residents at risk of unresolved grievances and decreased quality of life. Findings included: Interviews during an undisclosed date and time, 11 confidential residents stated they did not have access to the Grievance form, they did not know they could file a grievance anonymously, the grievance procedure had never been discussed in Resident Council, and they had not observed a posting of the grievance procedure in prominent locations. The confidential Residents also said they did not know where to acquire a grievance form, who to turn the form into, and what happens once a grievance was filed. Record review of the facility Grievance policy revised date 12/2023; revealed the facility's grievance information should be posted in designated locations throughout the facility. Observation of prominent postings on 02/25/2026 at 03:20 p.m., observed the front door area, area around the nurses' station, area down halls A, B, C and D, no observation of grievance information found. No observed grievance forms were available, and there was no access to submit grievances anonymously. During an interview on 02/25/2026 at 03:30 p.m. with AD, she stated the SW keeps grievance forms in her office. She stated SW was not at the facility full-time. She stated the residents would let her know if they have a grievance and they would write them for them. She stated the residents do not have access to blank grievance forms. During an interview on 02/26/2026 at 09:32 a.m. with ADM, he stated the SW was responsible for grievance forms. He stated the SW resigned on 02/23/2026. He stated he was not aware there were no forms available for residents to file a grievance anonymously. He stated his expectations were for forms to be available to residents. He stated staff have been trained in grievance forms. He stated the potential negative outcome could be violation of resident rights. Record Review Grievance Policy revised date 12/2023 revealed the following: Policy Statement:It is the policy of the facility to establish a grievance process that allows the resident(s) a way to execute their right to voice concerns or grievances to the facility or other agencies/entity without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their facility stay. The facility will make information on how to file a grievance available to the residents and make prompt efforts to resolve grievances that the resident may have.Procedure: .2. Information is made available to the resident and/or representative and posted in designated locations throughout the facility. Information includes:Resident/resident representative have the right to file grievance orally, in writing and/or anonymously.		

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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, unless the resident's clinical condition demonstrated that this was not possible or resident preferences indicated otherwise, for 1 (Resident #46) of 15 residents reviewed for nutrition. The facility failed to implement monitoring and interventions to ensure that Resident #46 did not have a significant weight loss of 30.3 pounds, a 16.5% body weight loss, between 01/02/26 and 02/03/26. This failure could place residents at risk for decreased nutritional status, malnutrition, and a decline in health. Findings Included: Record review of Resident #46's face sheet dated 02/26/26 reflected a [AGE] year-old male admitted to the facility on [DATE]. Resident #46 had diagnoses with included: end stage renal disease (the final stage of kidney failure), alcoholic cirrhosis of the liver (alcohol-associated liver disease), Type II Diabetes Mellitus (a disease resulting in inadequate control of glucose in the blood), major depressive disorder (a mental health disorder characterized by depressed mood and loss of interest in activities), and malignant neoplasm of the colon (cancerous tumor of the large intestine). Record review of Resident #46's quarterly MDS (Minimum Data Set) assessment, dated 02/05/26, reflected a BIMS (Brief Interview for Mental Status) score of 07, which indicated the resident had severe cognitive impairment. Further review of MDS, Section D - Mood, indicated the resident did not have a poor appetite. Section GG - Functional Abilities - indicated Resident #46 completed the task of eating independently and required set up and clean up assistance prior to and following the activity. Section K - Swallowing/Nutritional Status, indicated the resident had a weight 153 pounds. Section O - Special Treatments, Procedures, and Programs, indicated the resident received dialysis while a resident. Record review of Resident #46's Comprehensive Care Plan initiated on 02/01/26 and revised on 02/08/26, reflected: Focus: [Name] Resident #46 Has potential nutritional problem r/t risk for malnutrition and requiring a therapeutic diet to manage diabetes. Goal: Will maintain adequate nutritional status as evidenced by maintaining weight with no s/sx of malnutrition through review date. Interventions/Tasks [in part]: Diet as ordered by the physician. LCS (Low concentrated sweets), No salt on tray, regular texture with thin liquids. Monitor and report to MD as needed for any s/s of: decreased appetite, N/V, unexpected weight loss, c/o stomach pain, etc. Monitor/record/report to MD PRN s/sx of malnutrition: Emaciation [unusually thin or weak], (Cachexia) [muscle wasting], significant weight loss. Provide supplements as ordered: diabetic snack for risk of malnutrition Provide supplements as ordered: Med Pass 2.0 (nutritional supplement), Prostat (liquid protein supplement), Megace (medication for appetite stimulation). Record review of Resident #46's Physician's Orders dated 02/25/26 reflected [in part] the resident had a diet order for LCS (Low Concentrated Sweets) diet regular texture, thin liquids. Diabetic snack at bedtime for risk of malnutrition with a start date of 02/01/26. Med Pass 2.0 two times a day 90 ml BID with a start date of 12/19/25. Prostat three times a day 30 ml TID with a start date of 12/19/25. Further review reflected an order for Megace Oral Suspension 40 mg/ml - give 10 ml by mouth one time a day for weight loss with a start date of 10/24/25. Record review of Resident #46's February 2026 MAR reflected: Diabetic snack - give at bedtime for risk of malnutrition Megace Oral Suspension 40 mg/ml - give 10 ml by mouth one time per day for weight loss - start date 10/24/25 Med Pass 2.0 - give 90 ml BID - start date 12/19/25 ProStat - give 30 ml TID - start date 12/19/25 Record review of Resident #46's facility weight record reflected the resident was on weekly weights during the month of December 2025 and had one facility weight in January 2026 and one weight in February 2026. No facility weights were found in the resident's record following the significant weight loss on 02/03/26. The record reflected the following weights: 02/03/26 - 153.2 pounds [-16.5% change, -30.3 pounds] 01/02/26 - 183.5 pounds 12/16/25 - 185.0 pounds 12/17/25 - 185.7 pounds 12/03/25 - 173.6 pounds 11/28/25 - 176.8 pounds Record review of Resident #46's meal intake record for 02/02/26 - 02/25/26 reflected the resident consumed 50% or less of a meal on the following dates: 02/02/26, (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	02/07/26, 02/11/26, 02/15/26, 02/16/26, 02/17/26, 02/21/26, 02/22/26, 02/24/26, and 02/25/26. Record review for the month of January 2026 was not available. Record review of Resident #46's Annual Nutrition Evaluation, completed by the RD, dated 02/24/26 reflected [in part] a most recent weight of 153.2 pounds. Recommendations were made by the RD as follows: use dry weights [weight after dialysis] only for weight monitoring to ensure accuracy; Add house shakes (dietary supplement) daily for 30 days with a goal to maintain current weight. Record review of Resident #46's progress notes dated 02/25/26 reflected: Weight Warning: Value: 153.2-5.0% change [16.5%, 30.3]-7.5% change [17.3%, 32.1]-10.0% change [20.9%, 40.4]Resident is on a LCS regular diet. RD will review and notify DON, ADON of any new orders. During an observation and interview on 02/24/26 at 11:47 AM, Resident #46 was up in his wheelchair in his room Resident #46 was dressed and groomed. The resident stated he goes to dialysis three times per week on Monday, Wednesday, and Friday. He stated he was hard of hearing. Resident #46 stated he ate his meals in his room most of the time and he was offered snacks in between meals but stated he was not hungry some days. Resident #46 was asked if he had recently lost weight and the resident shrugged and stated, No. The resident did not respond to further questions and rolled himself out of his room. During a phone interview on 02/25/26 at 12:17 PM, the RD stated she had not been contacted by the facility regarding Resident #46's significant weight loss. She stated she was in the facility on 02/23/26 for her monthly visit and noted Resident #46's weight loss in the electronic medical record. The RD stated she did not see Resident #46 during her 02/23/26 onsite visit because he was out of the facility for dialysis. She stated she was in the facility 8 hours/month, but the facility could contact her at any time if a resident had a significant weight change or needed a virtual visit. The RD stated that when a resident had a significant weight change, she would expect to see the resident placed on weekly weights for a month, or until the weight stabilized. She stated Resident #46's weight loss was calculated as severe weight loss for a 30-day period and she made the following recommendations: Track weights using only post-dialysis weights for accuracy and consistency; Add a health shake once per day for 30 days and reevaluate resident status. The RD stated she believed Resident #46's weight loss and potential for further weight loss may have been reduced if weekly weights and implementations had been made when significant weight loss was demonstrated on 02/03/26. She stated she would follow up with Resident #46 on her next onsite visit or PRN if requested by the facility. During an interview on 02/25/26 at 3:32 PM, the Medical Director (MD) stated she had been Resident #46's physician for several years. She stated she did not recall the date the facility made her aware of Resident #46's significant weigh loss but she had seen him on a routine visit at the facility on 02/18/26. The MD stated she ordered lab work and a CT scan (a diagnostic tool that uses X-rays and computers to produce images of bones, organs and tissues) due to the resident having a previous history of colon cancer. She stated the CT scan was awaiting pre-authorization and the lab work did not show anything remarkable. The MD stated she was aware of the recommendations made by the RD and had signed the order for health shakes daily and to monitor post-dialysis weights following each dialysis session. She stated she would continue to follow Resident #46's progress on a weekly basis and PRN. During an interview on 02/26/24 at 11:44 AM, CNA F stated Resident #46 usually ate in his room. She stated the resident normally ate 50% or less at breakfast and ate more at lunch and dinner. She stated Resident #46 received a snack daily around 2 PM but he usually did not eat the snack. CNA F stated the resident had noticeably lost weight and his clothing was loose on him. She stated she recorded meal intakes in the computer and had been trained to report to the charge nurse when a resident consumed less than 25% of a meal. She stated the CNA's were responsible for obtaining resident weights at the first of the month. She stated she would weigh residents monthly as she was assigned and would turn the weights in to the charge nurse for review. During an interview on 02/26/26 at 11:50 AM, LVN C stated the CNA's were assigned to get resident weights at the first of the month. She stated the CNA's would give the completed weight list to the charge nurse and residents who showed weight changes were reweighed the following day. LVN C stated once all reweights were (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	obtained, the weight list was given to the DON for review and MD notification, if needed. During an interview on 02/26/26 at 1:19 PM, the DON stated Resident #46 was his own representative and attempts to contact family members for updates with the resident's care had been unsuccessful. She stated residents were weighed at the beginning of every month. She stated new admissions and residents with significant changes in weight were weighed weekly. She stated the CNA's on day shift were responsible for weighing residents and entering weights in the health record. The DON stated she was responsible for reviewing the weights and determining significant weight changes. She stated, according to policy, if a resident experienced a significant change in weight, the policy was to contact the physician and monitor weight weekly. The DON stated she did not know why Resident #46 was not placed on weekly weights when he had a significant weight loss. She stated she was aware that Resident #46 had significant weight loss on 02/11/26 and she notified the physician of the weight loss. The DON stated the physician had ordered a CT scan for the resident, which was still pending authorization. She stated the physician saw the resident on 02/18/26 and ordered lab work. She stated Resident #46 should have been placed on weekly weights to monitor further changes in weight. The DON stated a potential negative outcome for failure to monitor weights and make timely interventions for significant weight changes was malnutrition, skin integrity changes and a decreased quality of life. During an interview on 02/26/26 at 12:53 PM, the ADM stated he was not aware that Resident #46 had significant weight loss until annual survey. He stated nursing staff and nursing administration were responsible for ensuring weights are monitored and timely notifications of significant weight changes are made to physicians and the RD. The ADM stated his expectation of staff was to monitor resident weight and make timely notification of changes to physicians because it can really affect a resident. The ADM stated a potential negative outcome for failure to monitor resident weight and make timely interventions for significant changes would depend on the diagnosis, but it could cause medical issues. Record review of the facility's undated policy titled, Policy/Procedure - Nursing Clinical reflected the following: Section: Care and Treatment Subject: Nutrition: Weight Management Policy: It is the policy of this facility to ensure that all residents maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. Purpose: To provide care and services including: Assessing the resident's nutritional status and the factors that put the resident at risk of not maintaining acceptable parameters of nutritional status. Implementation of orders as written by the Doctor Clinical Evaluation: 1. Nutritional assessment may include: Weighing and weight changes 2. The Nurse will notify physician, family, and/or resident of weight loss/gain with interventions.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure that the menus were followed for 2 of 2 meals (lunch meals) and for 2 of 2 pureed food trays (on 2/24/26 and 2/25/26) reviewed for meal accuracy, in that: On 2/24/26, [NAME] E failed to serve the correct portion size of braised Swiss steak and mashed potatoes according to the prepared menu for lunch for 40 residents. 2. On 2/24/26, [NAME] E failed to follow the recipe for Braised Swiss Steak, causing dish to be served in the form of a loose meat in a liquid soup instead of a patty topped with gravy. 3. [NAME] E failed to include the wheat roll on the pureed food trays served during lunch on 2/24/26 and [NAME] D failed to include the cornbread on the pureed food trays served during lunch on 2/25/26. These failures could affect residents who received food from the kitchen by contributing to dissatisfaction, poor intake, and/or weight loss. The findings included: Record review of the menu for the lunch meal on 2/24/26 at 11:30 AM revealed, Braised Swiss Steak, Mashed Potatoes, Steamed Broccoli, Wheat Roll, Margarine, Fruit Cobbler, Beverage. During an observation and interview on 02/24/26 at 11:30 AM [NAME] E, pureed the braised Swiss steak for the lunch meal, transferred it to a tray, and placed it on the steam table. [NAME] E stated she had pureed the broccoli already and she did not have to puree the mashed potatoes. [NAME] E lifted the foil from a tray on the steam table that contained the pureed broccoli. During an observation on 2/24/26 at 12:10 PM, [NAME] E tempted the hot food before serving the lunch meal. She removed the lid from the Braised Swiss Steak, and it was noticed to be a loose meat in a soup texture liquid, the temperature was 188 F, mashed potatoes 198 F, broccoli 196 F, pureed braised Swiss steak 148 F, and pureed broccoli 172 F. During an observation on 2/24/26 at 12:15 PM, [NAME] E used the following utensils to serve the regular meal #10 spoodle (3/8 cup) to serve the liquid braised Swiss, a #4 ladle (1/2 cup) to serve the steamed broccoli, a #20 scoop (3-1/3 Tbsp) to serve the mashed potatoes, 1 roll was served, and a small cup of fruit cocktail. Record review of the facility recipe for mashed potatoes revealed the serving size was 1/2 cup. Record review of the facility recipe for braised Swiss steak for 40 servings revealed the following: salt iodized table- 1 1/8 Tsp, milk homo gallon 3 1/8 cup, eggs whole easy eggs with citric 2 1/4 cup, beef ground fine 8 1/2 lb., bread crumbs Japanese panko 1 1/8 Qt, pepper black ground 1 1/8 Tsp, Tomato diced in juice (drained) 6 lb., with brown gravy 2 7/8 cup, onion yellow jumbo (sliced) 1 cup. Serving Size: 3oz. (3/8 cup) Step #: 1 Wash hands before beginning preparation sanitize all surfaces and equipment. Combine all ingredients except gravy mix, mix on low speed only until blended, do not over mix. CCP- maintain at an internal temperature of < 41 F. Step #: 2 Portion meat using a #8 dipper (1/2 cup) onto a lightly greased or paper lined baking sheet. Flatten slightly. Refrigerate, 41 F until ready to cook. Step #: 3 Drain diced tomatoes and combine with peppered gravy, mix well Step #: 4 Layer patties slightly overlapping into 2-inch steam table pans. Place sliced onions over meat. Cover with gravy/tomato mixture. Cover with foil and bake. Serve 1 Swiss Steak with 1-2 oz of onion and gravy. CCP - cook to an internal temperature of 145 F held for 4 minutes. CCP - maintain at an internal temperature of > 140 F for only 4 hours. Record review of facility recipe for mashed potatoes for 40 servings revealed the following tap water 1 1/8 gallons, potatoes mashed real 2 lbs., margarine solids pure vegetable 1 cup. Step #: 1 Wash hands before beginning preparation sanitize all surfaces and equipment. Use water and follow for exact amount. Pour boiling water into mixer bowl. Use whip attachment to mix on low and slowly add potatoes. Mix for one minute. Scrape bowl then whip on high until fluffy (3-5 minutes). Step #: 2 Add margin. Reheat, if necessary, before serving. CCP - [NAME] to an internal temperature of one 145 F held for 15 seconds. CCP - maintain an internal temperature of >140 F for only 4 hours. CCP - cool: Product internal temperature must decrease from 140 F to 70 F within 2 hours and 70 F to 41 F within 4 hours. CCP - reheat to an internal temperature of 165 F held for 15 seconds comma within 2 hours one time only. Record review of facility recipe for wheat roll for 40 servings revealed the following: Dough roll honey wheat (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unbaked 40 each. Step #: 1 Wash hands before beginning preparation sanitize all surfaces and equipment. Per manufacturer instructions - for the wheat roll: pan 48 (6X8) for clusters or 24 (4X6) for singles on lined sheet pan. Thaw: retarder thaw time (35- 38 F) for 12-18 hours. Room temperature 60 minutes. Proof at 95 F / 85 % relative humidity for 40-50 minutes. Baking standard oven 375 F for 12-14 minutes with five second's steam. Deck oven 375 F for 12-14 minutes. Convection oven 325 F for 10-12 minutes and turn the tray 180 F after 5 to 6 minutes of baking mist water generously on rolls with a spray bottle just before rolls go in the oven. Step #: 2 For the whole grain roll: On lined greased pan, pan 24 (4x6) for singles or 48 (6x8) for clusters. Thaw: Retard at 38 F for 18 hours on a covered rack. Floor thaw to template #21 (2 3/4 x 1 3/4) for 60-90 minutes at ambient conditions to template #22. Baking: before placing in oven, spray product with water and sprinkle with seed if desired, Standard oven 375 F for 10-12 minutes (14-18 minutes if clustered baked) then steam for 20 seconds. Convection oven 325 for 10-12 minutes, rotate tray at 6-7 minutes. Optional: in place of wheat roll, serve a whole grain roll. During an interview on 2/24/26 at 12:20 PM, the DS stated it was important for staff to follow the menu, and they must follow the menu when serving meals to residents because it could cause someone to get sick, be served the wrong diet, or choke. He also stated it was important to serve correct portions as it could affect residents' diet or weight. The DS stated they did not have all the ingredients to make the fruit cobbler, so it was substituted with a cup of mixed fruit. During an observation on 2/24/26 at 12:41 PM, two trays of pureed food included braised Swiss steak, broccoli, mashed potatoes, and fruit. The wheat roll was not observed on the tray. Record review of the menu for the lunch meal on 2/25/26 at 11:30 AM revealed baked ham, sweet potato, seasoned greens, cornbread, margarine, bread pudding, beverage. During an observation on 2/25/26 at 12:42 PM, two trays of pureed food included sweet potatoes, green beans, ham with gravy, and lime-green colored ice cream. The cornbread was not observed on the tray. Record review of [name of certification] Certification certificate, dated 2/11/24, revealed [NAME] D had successfully completed the Texas Food Handler Training. During an interview on 2/26/26 at 11:30 AM, [NAME] D stated she prepared the lunch puree meal yesterday (2/25/26) and only prepared the starch and meat items on the menu. She stated she was trained to puree the starch, vegetables, meat, and bread items listed on the menu. She stated cornbread was on the menu yesterday, but she did not puree it yesterday for lunch because she was running behind but she normally purees the bread items listed on the menu. She stated she did not substitute the cornbread with anything else for that meal. She stated she was aware menu items count for certain proteins and carbohydrates and so those meals were short of those items. She stated it was important for residents who eat puree meals to be served all items listed on the meals so they could get the correct calorie count for their body, for their bones, and to have energy. She stated she was not trained to skip menu items when running late and that she was supposed to still puree the cornbread. She stated she was responsible for ensuring all items on the menu for puree meals were prepared. [NAME] D stated she must follow all recipes to ensure they cooked the right amount of food. [NAME] D stated the recipe book indicated the portion size or scoop they must use when serving the food. She stated it was better to give more food than not enough. She stated residents could lose weight if they did not use correct scoop size and didn't serve enough food on their plates. She stated she told her boss when she needed to substitute items for items they could not make. She stated she compared labels on the containers of the food items to ensure they were substituting something adequate, but they usually used food they had in the kitchen for the substitution. She stated residents could lose weight and lose protein and not have electrolytes they needed to function properly. During an interview on 2/26/26 at 12:29 PM, the RD stated staff should've followed recipes when preparing meals. She stated substituted food items should've been something of equal nutrient value and documented in a log or staff should've sent a text message or called herself or the DS for approval for substituted food items. She stated the Swiss steak dish should've been a patty steak with a sauce on top and should not have been served as loose meat in a liquid soup. She stated puree meals should've been served the same menu items as the regular and (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675978	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Arbor Grace Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1241 W Marshall Howard Blvd Littlefield, TX 79339	
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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mechanical meals aside from things that could not be pureed such as rolls, bread, cornbread, etc., however those items should have been substituted for another food item that was of equal nutrient value. She stated staff should've followed all portion sizes according to the recipe when serving meals. She stated they were in the process of ordering new utensils since they did not have all the utensils listed on the recipes however in the meantime, staff should've still served the correct amount of food listed on the recipe. Record review of [name of training program] Texas Food Handler Training Program certificate, dated effective 8/14/25, revealed [NAME] E had successfully completed the [name of training program] Texas Food Handler Education or Training Program. During an interview on 02/26/2026 at 12:50 PM, [NAME] E she stated when she prepared the braised Swiss steak she did not have the correct meat, she needed a cubed steak, and she used a thin shaved like steak. She stated the braised Swiss steak didn't thicken, that it had a lot of tomato sauce. She stated that she had used 1 large can of tomato sauce (approximately 102 to 106 ounces). She didn't add enough flour, and it didn't thicken correctly because there was too much tomato sauce, so it was a soup consistency. She stated she followed the recipe to the best of her ability. She stated on the portion sizes / scoop sizes for the meal on the braised Swiss steak, she did as much as she could but might have had too much sauce and not enough meat, so she put more meat in the bowl, and there was too much liquid, she had made an error. She stated that she had not tried to puree bread before and it was an error on her part. She did not puree the roll for the two puree trays. She stated it was important to follow the recipe and correct portions size because of allergies, safety, weight loss, and lack of nutritional value. She stated if residents did not receive the correct portion sizes, they could not get the correct nutritional values they needed. She stated she received in-services and training; however, it was usually about abuse, neglect, and other topics like that, and not topics specific to her department. Record review of a National Restaurant Association license certificate, undated, revealed the DS had successfully completed the program set forth for Food Protection Manager Certification Examination with an expiration date of 12/1/26. During an interview on 2/26/26 at 1:39 PM, the DS stated he would make a list of approved substitutions for staff to follow in the future. He stated he expected staff to follow recipes because they could include ingredients that should not be in the recipe and then residents would be served those ingredients and could get sick. He stated staff should've served the portions listed on the recipe because this could cause residents to gain weight or cause malnutrition. He stated residents that ate pureed meals were vulnerable and not getting items listed on the menu would cause them to have a shortage of nutrition and prevent their ability to heal. He stated he expected staff to ask for help when running late. During an interview on 2/26/26 at 2:28 PM, the ADM stated he was recently hired and had not had a chance to go into the kitchen and inspect it for any concerns. He stated he was not aware staff were not following menus and he was not aware of any other issues going on in the kitchen. He stated he would provide resources for staff and monitor issues in the kitchen more closely. He stated the kitchen staff had not been in-serviced on kitchen related topics the kitchen since he started employment. He stated the DS would be responsible to ensure kitchen staff were trained. He stated he would meet with the DS and staff to see where they are and provide them with proper training because he was not aware if they were trained properly. He stated residents that ate a pureed diet should've been served all items on the menu or they would not receive the proper nutritional value. During an interview on 2/26/26 at 4:00 PM, the ADM stated they followed the Federal Regulations requirements for any policies not provided. Record review of the facility's policy titled Dietary, undated, revealed in part: Policy Statement: The facility shall ensure that all food service operations comply with applicable state and federal regulations, including those set forth by Texas Health and Human Services Commission (HHSC) and Centers for Medicare & Medicaid Services (CMS), to protect residents from foodborne illness and ensure nutritional adequacy. 3. Following Approved Recipes Policy: All meals shall be prepared according to approved, standardized recipes to ensure consistency, food safety, and nutritional compliance. Procedure: Use only recipes approved by: -Registered Dietitian (RD)-Dietary (continued on next page)		

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

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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 service safety in 1 of 1 kitchen (Kitchen A) reviewed for dietary services. The facility failed to ensure no expired food items were in the kitchen. 2. Toxic items were not stored in a manner to prevent contamination of foods and food contact equipment (hand sanitizer). 3. Time Temperature Controlled for Safety cold foods were not maintained at 41 F or below (milk/supplements) due to refrigerators not functioning properly. 4. Foods were held for use beyond the manufacturers recommended Best if used by/ Best by dates (kitchen storage). 5. Clean plates and bowls were stored facing upward. These failures could place residents at risk for food contamination and foodborne illness. The findings included: On 2/24/26 at 9:44 AM an initial kitchen observation tour began. The tour ended at 10:30 AM and revealed the following: The external thermometer of Refrigerator B indicated an internal temperature of 45 F. The contents observed inside the refrigerator was a case of tomatoes, a case of butter, 2 large bags of unopened shredded cheddar cheese, a gallon sized sandwich bag filled with diced chicken, three heads of purple cabbage, an unopened bag of shredded cabbage, nine gallon sized containers of various condiments that were previously opened, four gallon size unopened bags of chopped iceberg lettuce, six cartons of pasteurized eggs, one gallon size unopened bag of shredded parmesan cheese, an opened gallon of whole milk 3/4 empty, a container filled with pureed sausage, a container of mechanically altered sausage, 6 unopened containers of chicken base, a container filled with puree egg, two packages of unopened chicken thighs, and a container of chicken noodle soup labeled use by 2/24/26. The external thermometer of the Refrigerator named Victory, indicated an internal temperature of 45 F. The internal thermometer on the left side of the refrigerator indicated an internal temperature of 38 F. The internal thermometer on the right side of the refrigerator indicated an internal temperature of 46 F. The DS stated he received a shipment of food this morning and was in the process of labeling the food before putting it in the refrigerators, which affected the temperatures of the refrigerators. The Dietary Supervisor stated refrigerator temperatures should be at or below 35 F. He stated the facility was currently working on getting everything up to code. He stated the facility had purchased new refrigerators and was waiting for them to be delivered. A personal beverage and a bottle of Premium Hand Sanitizer with Aloe was observed sitting on the bottom shelf of the preparation table next to a loaf of bread, a tub of peanut butter dated 2/16, and an opened bottle of Grape jelly dated 8/5. Additionally, the outside of the Grape Jelly was labeled, refrigerate after opening. The tour of the dried food pantry revealed five bags of corn tortilla chips dated 12/16, a tray of whole white onions dated 2/16 use by 2/29 had 3 white onions with large black spots and 5 onions that sprouted green stocks, and an opened 37 lb. tub of multi-use lemon filling over 1/2 empty dated 8/19 were all stored on shelves in the pantry. The DS stated the chips were probably expired and the lemon filling were expired and should both have been thrown away. During an observation and interview on 2/24/26 at 2:35 PM the external thermometer of Refrigerator B indicated 46 F and the internal thermometer indicated 44 F. Temperatures were taken of food items in Refrigerator B by the DS. A raw pasteurized egg had a temperature of 50.2 F. A tub of chick noodle soup had a temperature of 46 F. A tray of raw bacon had a temperature of 28 F. The dietary supervisor stated the bacon was still partially frozen. A bag of mechanical soft chicken had a temperature of 49 F. A bag of chopped lettuce had a temperature of 48.7 F. The Dietary supervisor stated refrigerator temperature should've been between 40 F and 30 F and the current temperature was not safe. The external thermometer of Refrigerator named Victory indicated 42 F. The left side internal thermometer indicated a temperature of 36 F and the right-side thermometer indicated a temperature of 42 F. Temperatures were taken of food items in Refrigerator named Victory by the DS. A pack of deli ham had a temperature of 43.3 F. A single carton of whole milk had a temperature of 41.5 F. A single-use carton of Mighty Shake had a (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	temperature of 43.7 F. A 1/2 cup of whole milk poured from a gallon of whole milk had a temperature of 45.1 F. During an interview on 2/24/26 at 2:50 PM, the DS stated the temperatures of the food in the refrigerators were above safe temperatures and that he would contact his boss and notify him of the refrigerators and food temperatures. During an interview on 2/24/26 at 3:07 PM, the Clinical Practitioner stated all the food in the refrigerators was thrown away and a refrigerated truck was ordered to be brought to the facility by [food distribution company] to hold an emergency order of refrigerated food they purchased. During an interview on 2/24/26 at 3:59 PM, the DS supervisor stated he was in the process of placing an emergency order to the [food distribution company] who would deliver the refrigerated food truck by 5:00 AM on 2/25/26. He stated the refrigerated food truck would remain on the premises to hold refrigerated food. He stated he purchased the chicken being served this afternoon at the local grocery store. On 2/25/26 from 10:21 AM to 10:28 AM, a kitchen observation tour revealed the following: The dried food panty revealed five bags of corn tortilla chips dated 12/16 and an opened 37 lb. tub of multi-use lemon filling dated 8/19 were stored on shelves in the pantry. A personal beverage and a bottle of Advanced Gel Hand Sanitizer was observed sitting on the bottom shelf of the preparation table next to a loaf of bread, a tub of peanut butter dated 2/16, and an opened bottle of Grape jelly dated 8/5. Additionally, the outside of the Grape Jelly was labeled, refrigerate after opening. Two stacks of clean plates and two bowls were observed faced upwards on a shelf. During an interview on 2/26/26 at 11:30 AM, [NAME] D stated she was supposed to store clean dishes face down to dry because stuff would sit in them such as sanitizer if they were stored right side up. She stated she would leave them like that until they dried completely. She stated opened food was dated for the date it was opened and had to be thrown away after 3 days. She stated all staff were responsible for ensuring open food was thrown away within 3 days. She stated cold food was to be kept between 20 to 35 . She stated frozen food was to be kept at 20 or in the negative temperatures; hot food meat must be between 160 -170 ; veggies were to be between 145 - 150 . She stated she usually kept hand sanitizer by the sink, and the sanitation buckets were kept underneath the area they were working in, personal drinks for all staff were kept in the office. She stated she was certified in food handling and was due this month for renewal. She stated staff checked the dry food storage area every Tuesday to rotate and throw away expired food since this was when the truck brought in new food orders. She stated staff should've included the year when writing the date on the food. She stated the lemon pie filling should've been thrown away. She stated she had not had any new in-services since new company took over earlier this month. During an interview on 2/26/26 at 12:29 PM, the RD stated cold food should be kept at 41 or they run risk of possible infection as the food was in the danger zone of possible contamination. She stated she was contacted on Wednesday (2/24/26) about refrigerators not holding temperatures of 41 by the DS. She stated the DS threw food away all the food in the refrigerators and bought new food at the grocery store. She stated the DS placed an emergency food order to replace the discarded food and received a shipment for the supplement shakes today. She stated she sent a recipe for supplement shakes to the DON and approved for them to buy other premade supplement shakes to give residents that needed them on 2/25/26. During an interview on 02/26/26 at 12:50 PM, [NAME] E stated cold food items needed to be kept at a safe temperature of 30 F and 40 F. She stated if the refrigerator temperatures go over 40 F, she was to monitor and see if the temperature would go back down. That the seal on refrigerator marked B could be weird and staff would have to push on the door all the way, hold it and make sure it would seal. She stated if cold food was above 40 F, it could develop foodborne pathogens. She stated she reported to the DS if the temperature was above 40 F. [NAME] E stated the lunch she prepared on 2/24/26 was meat from the freezer, a package of peppered gravy, canned tomato sauce, frozen broccoli, and a can of fruit cocktail, instant mashed potatoes, wheat rolls. During an interview on 2/26/26 at 1:39 PM, the DS stated he expected staff to report temperatures on refrigerators to him immediately. The DS stated clean bowls and plates were to be placed in a dry rack and then put up once dried. He stated clean dishes were to be stored face down because any standing water would (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not drain and could grow bacteria. He stated unopened dry food was good until the expiration date, however opened dry food should've been discarded 3 to 5 days after being opened. The DS stated new refrigerators were scheduled to be delivered sometimes today. He stated 5 cases of supplement health shakes were received today and were stored in the refrigerated truck until the new refrigerators were set up. The DS stated he preferred staff to keep personal drinks in the office. He stated hand sanitizer should've been kept on the bottom shelf near the preparation station however, it should not have been stored next to the bread or any food items. He stated in-services that addressed food temperatures and notifications were completed with staff that were yesterday and today. He stated [NAME] E had not been in-serviced yet since she was not working. He stated he was a new employee and was still working on getting everything up to code in the kitchen. He stated they would use [food distribution company] as their provider in the future which was a different company than was used before the new company took over earlier this month. He stated he had ordered utensils and all supplies from [food distribution company] and this company should be able to provide everything else they need for the kitchen. He stated he was responsible for ensuring all guidelines in the kitchen were being followed. During an interview on 2/26/26 at 2:28 PM, the ADM stated he was not aware the refrigerators were not cooling to the appropriate temperature as he was recently hired and had not had a chance to go into the kitchen and inspect it for any concerns. He stated the DS also just started working at the facility last week. He stated he was not aware of any issues going on in the kitchen. He stated he would provide resources for staff and monitor issues in the kitchen more closely. He stated the kitchen staff had not been in-serviced on kitchen related topics the kitchen since he started employment. He stated the DS would be responsible to ensure kitchen staff were trained. He stated he would meet with the DS and staff to see where they are and provide them with proper training because he was not aware if they were trained properly. He stated cold food temperature issues could have caused sickness. He stated clean dishes should have been stored face down because they could have standing water that could grow bacteria. During an interview on 2/26/26 at 4:00 PM, the ADM stated they followed the Federal Regulations requirements for any policies not provided. Record review of the facility's policy titled Dietary Services, Subject: Food Sanitary Conditions for, undated, revealed in part: Policy: It is the policy of this facility to procure food from sources approved or considered satisfactory by Federal, State, and/or local authorities. Procedures:1. The facility will store, prepare, distribute, and serve food under sanitary conditions.2. Hot foods will leave the kitchen (or steam table) above 135 F and cold foods at or below 41 F.5. Refrigerator temperatures should be at 41 F or below.7. Toxic items (i.e., insecticides, detergent, and polishes) will be properly stored, labeled, and used separately from the food. Record review of the facility's policy titled Dietary, undated, revealed in part: Policy Statement: The facility shall ensure that all food service operations comply with applicable state and federal regulations, including those set forth by Texas Health and Human Services Commission (HHSC) and Centers for Medicare & Medicaid Services (CMS), to protect residents from foodborne illness and ensure nutritional adequacy. Scope: This policy applies to all dietary, nursing, and supervisory staff involved in food handling, preparation, service, and storage. Procedures1. Dish and Utensil StoragePolicy: All clean dishes, utensils, and food-contact equipment shall be stored in a sanitary manner to prevent contamination.Procedure:-Store clean dishes and utensils covered or inverted in designated clean storage areas.-Keep storage shelves at least 6 inches off the floor.-Separate clean items from soiled items at all times.-Air-dry dishes; do not towel-dry.-Inspect storage areas daily for cleanliness, dust, pests, or moisture.-Remove chipped, cracked, or damaged dishes from service immediately.2. Expired Food ControlPolicy: The facility shall not store, prepare, or serve expired, spoiled, or unsafe food.Procedure:All food items must be clearly labeled with:-Date received or prepared-Use-by or expiration dateImmediately discard:-Expired food-Food with signs of spoilage (odor, mold, discoloration)-Food from compromised packaging (swollen cans, broken seals).		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure all drugs and biologicals were stored in accordance with currently accepted professional principles for 1 of 2 medication cart (Hall D medication cart) reviewed for storage of drugs. The Facility failed to provide change direction labels for Resident #15's medication package of hydroxyzine (hydroxyzine is an antihistamine that reduces symptoms caused by allergies) which had medication order change from as needed every 6 hours to 10 mg twice a day. This failure could place residents at risk of medication misuse and diversion. The findings were: Record review of Resident #15's physician orders, dated 02/26/2026, revealed an order for hydroxyzine 10 mg give 1 tab by mouth twice a day with a start date of 01/29/2026 and no end date. Observation on 02/25/2026 at 08:32 a.m. revealed a package in the Hall D medication cart contained medication for Resident #15 with a label for 10 mg of hydroxyzine, and instructions to give 1 tab by mouth every 6 hours as needed. MA administered 10 mg of hydroxyzine to Resident #15. During an interview on 02/26/2026 at 09:08 a.m. the MA B stated she was aware Resident #15 hydroxyzine medication was changed from as needed to twice a day. She stated the process when medication order change was to place a label change sticker on the top of the medication blister pack until the new medication blister pack was received from pharmacy. She stated she was not sure why the sticker was not put on the blister pack. She stated she had been trained in medication changes. She stated the potential negative outcome could be resident not getting the medication as ordered. During an interview on 02/26/2026 at 09:10 a.m. LVN A stated when medication orders were changed, they notify the MA and remind them to place a medication change sticker on the medication blister pack. She stated she had been trained in medication order changes. She stated the potential negative outcome could be the resident getting the wrong medication dose. During an interview on 02/26/2026 at 09:23 a.m. the DON stated the process for medication order changes was there should be a sticker on blister pack and notifying the pharmacy. She stated all staff have been trained in medication order changes. She stated all nurses and MA were responsible for making sure a sticker was placed on the medication blister pack when the medication order has changed. She stated her expectations would be that once they have a new medication order, they address it with MA so the sticker can be placed on blister pack at that time. She stated the potential negative outcome could be over dosage or under dosage. During an interview on 02/26/2026 at 09:32 a.m. the ADM stated he was not aware Resident #15 medication label was wrong. He stated he was not sure what the process was and would have to talk with his DON. He stated his expectation was for the nurses to be following the facility policy and keeping the residents safe. He stated the DON, ADON and pharmacy consultant were responsible for monitoring medication order changes. He stated the potential negative outcome were lots of variables. On 02/26/2026 at 11:44 a.m. surveyor requested policy related to medication order changes and medication label changes from ADM. During an interview on 2/26/26 at 4:00 p.m. the ADM stated they followed the Federal Regulations requirements for any policies not provided.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 1 resident (Resident #52) reviewed for infection control. LVN C did not wash her hands after removing PPE and exiting Resident #52's room. These failures could place residents at risk for cross contamination and infection. Findings included: Record review of the admission record for Resident #52 undated, revealed a [AGE] year-old male who was admitted on [DATE] and readmitted on [DATE] with the following diagnoses: sepsis (infection which can result in widespread inflammation and damage to vital organs), epilepsy (seizure disorder), diabetes (high blood sugar) and quadriplegia (partial or complete loss of function in all four limbs and torso). During an observation on 0/24/2026 at 04:46p.m., LVN C was preparing G-Tube medications for Resident #52 at the medication cart located in the hallway outside of the resident's door. Observation of the PPE cart located beside Resident #52's door revealed an EBP sign above the cart. LVN C put on PPE (gown and gloves), gathered supplies off top of cart and entered Resident #52's room. LVN C put supplies and medications on the bedside table. LVNC determined she was missing a medication and she picked up medications off bedside table, removed PPE and exited Resident #52's room. LVN C did not wash her hands after removing PPE. During an interview on 02/24/2026 at 05:18 p.m., LVN C stated she was aware she did not wash her hand or use ABHR after removing PPE. She stated she should have washed her hands after removing PPE but she forgot. She stated she had been trained on proper hand hygiene and to wash hands after removing PPE. She stated the potential negative outcome could be spreading infection. During an interview on 02/26/2026 at 09:23 a.m., the DON stated staff should wash their hands after removing PPE. She stated all staff were responsible for following proper hand hygiene. She stated all staff have been trained in proper hand hygiene and PPE. She stated she expects all staff to wash hands or use ABHR after removing gloves. She stated the potential negative outcome could be spread of infection and cross contamination. During an interview on 02/26/2026 at 09:32 a.m., the ADM stated he was not aware staff were not washing hands or using ABHR after removing gloves. He stated all staff had been trained on proper hand hygiene. He stated staff should be washing hands or using ABHR after removing gloves. He stated the potential negative outcome could be possible cross contamination and infection control. Record review of the facility policy titled, Handwashing/Hand Hygiene, with a revised date of 10/2022 reflected the following: Policy Statement: It is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene based on accepted standards. Purpose:Hand hygiene is one of the most effective measures to prevent the spread of infection.Procedure: .2. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: .m. After removing gloves; .		

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow their own established smoking policy for 1 of 2 residents reviewed for smoking. (Resident #29) The facility failed to ensure Resident #29 followed the smoking policy and did not have smoking supplies (cigarettes and lighter) in their room. This failure could place residents at risk of injury or harm. The findings included: Review of Resident #29's face sheet, dated 2/25/26, revealed a [AGE] year-old male with an initial admission date of 1/28/20 with the following diagnoses: Acute Respiratory Failure with Hypoxia (inability for the lungs to adequately transfer oxygen to the blood), Unspecified Dementia, Unspecified Severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (memory loss, inability to think/plan), Epilepsy, unspecified, intractable, without status epilepticus (neurological disorder characterized by unprovoked seizures), personal history of Transient Ischemic Attack, and cerebral infarction without residual deficits (temporary blockage of blood flow to the brain, resulting in stroke-like symptoms causing brain damage), major depressive disorder, recurrent severe without psychotic features (mental illness), and tobacco use. Record review of Resident #29's annual MDS dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 1, indicating the resident had moderate problems with thinking and memory. Section J & Health Conditions, Other Health Conditions revealed Resident #29 used tobacco. Record review of Resident #29's comprehensive care plan, dated 2/2/26, revealed focus: resident #29 used tobacco, date initiated 2/2/26. Goal: Resident would adhere to the tobacco/smoking policies of the facility, dated initiated 2/2/26. Intervention: Educate Resident / Family on risks & health effects of tobacco use; Resident smoking materials will be kept at the nurse's station, dated 2/2/26. Record review of Resident #29's Smoking Evaluation, dated 2/2/26, revealed Resident #29 was alert and oriented and able to light his own cigarette and able to hold properly. Record review of facility policy titled: Smoking and Safety Measures, original date 3/2008, revealed in part: Safety Measures: 4. All smoking materials, charging devices and charging of electronic cigarettes will be secured at the nurse's station when not in use during designated smoking times. Additionally, the document was signed by Resident #29 on 2/2/26. During an interview on 2/25/26 at 10:39 AM, the Driver stated Resident #29 went outside on his own to smoke because he could smoke independently. During an interview on 2/25/26 at 10:43 AM, Resident #29 stated he kept smoking materials in his pocket. Resident #29 stated he had something else he needed to do and he ended the interview. During an observation on 2/25/26 at 10:45 AM, Resident #29 was observed outside in the smoking area. Resident pulled a container out of his sweater pocket. Resident #29 took a cigarette and lighter out of the container. Resident #29 put the cigarette in his mouth and lit it without staff assistance. The Driver observed Resident #29 light his cigarette as well. During an interview and observation on 2/26/26 at 9:44 AM, Resident #29 stated he kept his (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675978	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Arbor Grace Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1241 W Marshall Howard Blvd Littlefield, TX 79339	
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 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cigarettes and lighter in his sweater pocket. Resident #29 stated he had never been told he had to keep his cigarettes and lighter at the nurse station. Resident #29 pulled a container out of his sweater pocket and opened it in which cigarettes and a lighter were observed. During an interview on 2/26/26 at 10:13 AM, the ADM stated there was no one to his knowledge that kept smoking materials in their room. The ADM stated there was no variance given to any residents regarding the new smoking policy that was implemented when the new company took over the facility. During an interview on 2/26/26 at 12:45 PM, the Driver stated she supervised the 2:00 PM smoking breaks for residents. The Driver stated Resident #29 kept his smoking materials including cigarettes and lighters in his room. She stated Resident #29 kept his cigarettes and lighter in an empty deodorant container on his person when he brought them outside to smoke. She stated Resident #29 was able to light his own cigarette and smoke independently. She stated she previously was told by a nurse that no one was supposed to have smoking materials in their room. She stated she had gotten another resident to voluntarily hand over their lighter recently. She stated she had not asked Resident #29 for his smoking materials because he had always smoked on his own. The Driver stated she told some nurses that Resident #29 had smoking materials in their room after the new policy was implemented when the new company took over the facility. The Driver stated she could not recall what nurses she told. She stated she was not given any additional instructions after reporting the information to the nurses. She stated Resident #29 could be difficult at times. The Driver stated she had not received training on the new smoking policy since the switch over to the new company. The Driver stated Resident #29's family buys his smoking materials. She stated other residents' smoking materials were locked in the medication room. The Driver stated a potential negative outcome was that someone could accidentally set a fire, burn the facility down, an oxygen tank could explode, or a resident could get burned. The Driver stated someone else could get ahold of the smoking materials and have an accident. During an interview on 2/26/26 at 2:47 PM, the ADM stated residents were not allowed to keep smoking materials including lighters in their rooms and that all smoking materials must be kept at the nurse's station. The ADM stated the current smoking policy was implemented on 2/1/26 when the new company took over the facility. The ADM stated all residents that smoked reviewed the new policy and signed the agreement. The ADM stated he was not aware there were residents who kept smoking materials in their rooms. The ADM stated he would continue to educate residents about how smoking materials were safety hazards and fire hazards however he could not confiscate the smoking materials against their will due to resident rights. The ADM stated all staff had been in-serviced on the new smoking policy during morning meetings. The ADM stated he expected staff to tell him or the DON if they were to become aware of any residents that kept smoking materials in their rooms so they could educate the residents. The ADM stated potential negative outcome was that it was a fire hazard. Record review of the facility' policy titled Smoking and Safety Measures, original date March 2008 reflected the following in part: Safety Measures: . 4. All smoking materials, charging devices and charging of electronic cigarettes will be secured at the nurse's station when not in use during designated smoking times.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675978	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Arbor Grace Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1241 W Marshall Howard Blvd Littlefield, TX 79339	
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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review, the facility failed to ensure residents were aware of where to locate the State Agency (SA) survey inspection results such as surveys, certifications, and complaint/incident investigations, and post in a place readily accessible to residents, family members, and legal representatives of residents for 1 of 1 facility in that: The facility failed on 02/25/2026 to make a survey binder that was readily available and easily identified to all residents or the public that included survey results for viewing. This failure placed residents at risk of not being able to fully exercise their rights and at risk of not being aware of the facility's past deficiencies. Findings included: During a confidential group interview at an undisclosed date and time, 11 of 11 residents stated they did not know where or how to access survey results in the facility. They all stated they had never seen a binder labeled with that information near the front door or receptionist desk. In an observation on 02/25/2026 at 10:45 a.m. of the facility's front door area, the receptionist desk, the area around the nurses' station, and the area near the administrative offices revealed there was no evidence of a survey results binder or notice of where to locate the binder. In an observation and interview on 02/26/2026 at 09:32 a.m. with the ADM who when asked where the state survey results binder was located, the ADM stated it was posted at the front door area, and the binder was in the receptionist office. During observation with the ADM there was no sign posted at the front door area and no survey binder available in the receptionist office. He stated his expectations were for proper signage to be always posted and survey binder available. He stated the potential negative outcome would be violation of resident rights. On 02/26/2026 at 11:44 a.m. surveyor requested policy related to posting and availability of State Agency (SA) survey inspection results such as (surveys, certifications, and complaint/incident investigations). During an interview on 2/26/26 at 4:00 p.m. the ADM stated they followed the Federal Regulations requirements for any policies not provided.		