STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676047	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town Hall Estates Keene, Inc.	207 S Old Betsy Rd Keene, TX 76059

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation, interview, and record review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life for 1 (Resident #100) of 8 residents reviewed for dignity. The facility failed to ensure that all residents at a table was provided meals at the same time. Resident #10 was provided a meal 26 minutes after all other residents at a table were provided meals. This failure could place residents at risk of diminished dignity and affect their quality of life. Findings included: Record review of Resident #100’s admission record dated 7/31/2025 reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included unspecified dementia (a condition used when a person exhibits symptoms of dementia (a condition for a decline in cognitive functioning), but the specific type or cause cannot be determined, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance (condition that affects a person’s emotional state), and anxiety (a condition of feeling of worry, nervousness, or unease). Record review of Resident #100’s quarterly MDS assessment dated [DATE] reflected a BIMS was not conducted due to her rarely/never being understood. Section C – Cognitive Patterns reflected Resident #100 had memory problem with short-term and long-term memory. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #100’s Care Plan undated with revised date 4/22/2025 reflected resident goal to have” nutritional status pureed thin liquids, gluten free diet. Intervention/Task: Monitor and document food intake at each meal and promptly offer resident food alternatives, including meal replacements when appropriate. Further review of Care Plan reflected she had ADL self-care deficits and was dependent on staff for eating. Resident #100 goal is to have their ADLs performed by staff. Interventions included: EATING: Resident is an assisted diner. Resident needs set-up and total assistance with meals (Assist feed). An observation on 07/20/2025 at 12:15 PM reflected Resident #100 was sitting up in a wheelchair in the dining room at a table with two other female residents requiring feeding assistance. Resident #100 remained seated and quiet at the dining table while the other two residents were served their meals and aided with eating their meals by CNA C. During an interview and observation on 07/29/2025 at 12:27 PM CNA C stated he was assisting the residents at the table with their meals. He stated Resident #100 has a special diet, no gluten and cannot have tortillas and will get a different lunch but she was waiting for it. He stated at times due to the change of diet her meal can be a bit delayed. An observation on 07/29/2025 at 12:41 PM revealed Resident #100’s lunch meal was delivered to her at the table 26 minutes after the two other residents at the table received their meal. Resident #100’s meal was pureed. She was observed feeding herself immediately after receiving her meal. During an interview on 07/31/2025 at 1:12 PM, CNA A stated residents should receive their meals together and at the same time with all other residents at the table. She stated if meals were not passed at the same time to residents sitting at the same table this can make a resident feel neglected, starved, and angry. CNA A stated the charge nurse assigned to the dining room will monitor tray passing to ensure all residents at one table receive their meals together. She stated residents waiting an unreasonable amount of time of 30 minutes would not be considered reasonable. During an interview on 07/31/2025 at 2:07 PM, CNA B stated it was better that all residents have their trays at the same table. She stated the residents should receive their meals at the same time when sitting at one table. CNA B stated if residents do not receive their meals together at a table that residents can become irritated watching others eat. She stated 5 minutes or less of a wait was reasonable, anything after this time the resident can get tired of waiting and sometimes leave the dining room without eating. She stated the charge nurse assigned to the dining room was responsible for reviewing meal tickets for each table and ensuring all residents sitting at the table have their meals. During an interview on 07/31/2025 at 2:19 PM, LVN A stated she would assign dining room monitoring periodically and there was no set schedule. She stated she would review meal tickets during the meal service, all residents at one table will be served all together, there should not have been one resident sitting and waiting. She stated she would arrange tickets based on residents sitting at a table. She stated aides helping feed residents at a table were expected to notify the charge nurse if a tray were needed at a table. Aides were expected to notify either the charge nurse or the kitchen for a missing tray and get a tray within 3 minutes or less. She stated a resident waiting more than 30 minutes for a meal when others have received theirs at the table was a ridiculous amount of time and would see this as neglect. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/31/2025 at 2:39 PM, LVN B stated she was responsible for monitoring all residents receive their meal trays at a table together. She stated all residents at one table should have been served together. LVN B stated 5 minutes or less was a reasonable amount of time a resident should wait to be served together. She stated if residents wait longer than 5 minutes after others at their table were served this can cause them to become irritated and upset. She stated 30 minutes or more of a wait for a meal was too long and unreasonable. During an interview on 07/31/2025 at 3:14 PM, the DON stated the meal passing policy was for one charge nurse to be in the dining room, rotate, set period, one leaves, another one rotates in. He stated the Aides were assigned to the dining room, 2 aids on E Hall, 2 aids on D Hall will send one each to the dining room and 2 aids from the other Halls as well. He stated aids would help with feeding residents and typically the residents at one table, when one gets their food, the others should have also gotten their food at the same time, they should not stay looking at the other residents eating. He stated if a resident was not served at the same time as other residents it could make them feel neglected. The DON stated the charge nurse were responsible for monitoring tray passing, they will check the meal tickets at the table and ensure all residents at the table are served. He stated 30 minutes for resident to wait for a meal while others eat at a table was unreasonable. He stated Resident #100 waiting 26 minutes or her meal was unreasonable, but stated he believed the delay would have been due to nervousness of surveyor on site this day. Review of the facility’s undated document titled, “Your Rights and Protections as a Nursing Home Resident” reflected the following: “Be Treated with Respect: You have the right to be treated with dignity and respect.” Record review of undated facility document titled, “Resident Rights” revealed “Dignity and respect You have the right to be treated with dignity, courtesy, consideration, and respect” and “complain about care or treatment and receive a prompt response to resolve the complaint.” Facility [NAME], [NAME] (51289) - Dining Observation No Notes

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Number of residents sampled: Number of residents cited: (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and record review, the facility failed to consider the views of the resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility or to demonstrate their response and rationale for such response for 1 of 1 Resident Council reviewed. The facility failed to follow up on concerns and requests expressed in Resident Council meetings for the months of April 2025 and June 2025. The facility failed to ensure Resident Council #1's concerns regarding the delay of call lights and resident care was being provided in a reasonable time during the evening and overnight shifts. This failure placed residents at risk of not having their preferences honored. Findings included: Review of the Resident Council minutes reflected the following with no documentation of the facility's responses to the grievances: Record review completed on 07/30/2025 of Concern and Comment Forms for February 2025 to June 2025 revealed Resident Council group concerns remained incomplete under Follow-Up sections Individual Designated to Investigate Concern, Investigation Findings, Date Findings/action Plan shared with concerned party, and Concerned party's response to Action Plan/Outcome for the following concerns: 4/16/2025, Residents do not like the time change in dining room. 4/16/2025, The evening & night shifts are slow to show up when call buttons are pushed, B Hall & C Hall. 4/16/2025, CNA's all shifts are not knocking or announcing themselves before walking into the resident's rooms, C Hall. 4/16/2025, Dining room is slower in the evening time. Getting trays to residents in dining room. 4/16/2025, No paper towels in resident restroom on D Hall. 6/26/2025 We need to get what it says on the menu, not something else. 6/26/2025, To have an older or more experienced nurse/CNA to train the new people. 6/26/2025, No mini mart, but we have shop till you drop. Record review completed on 07/30/2025 of facility Resident Council minutes for March 2025 to June 2025 revealed Resident Council group documented frequent concerns of night shift and overnight shifts regarding the delay of call lights and delay of resident care and SW and AD were made aware of the following: 6/28/2025, 3rd shift 10 - 6 no one is getting changed. 5/22/2025, leaving residents on toilet too long before coming in to help. 4/16/2025, evenings & nights are slow about showing up when button is pushed. 3/13/2025, night shift bad at coming when button is pressed. During a Resident Council meeting on 07/30/2025 at 1:00 PM, 7 anonymous residents stated the AD or SW helps to document the minutes for each monthly meeting. They all stated when there is a concern, they address it in the Resident Council meeting monthly and a grievance was documented, but these grievances were not being addressed. They all stated they were not aware of any method by which the facility management provided resolutions to the concerns that came up in the Resident Council minutes. They all stated they have filed a grievance each time as these were a priority of the residents. They all stated that they discuss their resident rights during meetings, but feel they were not being taken seriously. They stated they had never seen any kind of written paper or grievance form that reflected their concerns and requests during Resident Council or explained any resolution.During an interview on 07/31/2025 at 1:12 PM, CNA A stated grievances were submitted to SW. She stated she verbally provided grievance information to the SW who will complete a grievance form. CNA A stated she was unsure of the resolution and who specifically handles this. During an interview on 07/31/2025 at 2:07 PM, CNA B stated she reported grievances to the Grievance Counselor, the SW. She stated grievances were provided verbally to the SW, but he was not sure what was done after to ensure follow-up with resident. She stated this was the responsibility of the SW. During an interview on 07/31/2025 at 2:19 PM, LVN A stated she at times she will receive verbal grievances from aides and in turn she will notify the SW either verbally or fill out a grievance form. She stated it was the responsibility of the SW to work on the grievances provided, work on resident's concern, and provide follow-up to the resident. During an interview on 07/31/2025 at 2:39 PM, LVN B stated she will at times fill out the grievance form for a resident, this form was then given to the SW to follow-up with the resident. She stated at times the ADON will also follow-up on grievances as well. During an interview on 07/31/2025 at 2:49 PM, the SW stated she and the ADM were responsible for handling facility grievances from residents and from the Resident Council group. She stated she keeps the grievance forms directly outside of her office on a hanging file for quick access. She stated staff will take information verbally from a resident and fill out the grievance form for them. She stated she has been invited to the Resident Council meetings and she helps record the minutes and write the grievances mentioned in the meeting. The process was for the staff to submit the grievance form directly to her, as she was the Grievance Officer of the facility, she will then assign it to the department head the grievance has concern with. She stated there was a

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on interview and record review, the facility failed to provide accurate PASRR screenings for individuals with a mental disorder for 6 (Resident #3, Resident # 11, Resident #14, Resident #76, Resident #78, Resident #94) of 6 residents reviewed for PASRR. The facility failed to complete an accurate PASRR level one screening after Resident’s #3, #78, and #94 was admitted with a negative PASRR Level 1 screening but had a mental illness. The facility failed to ensure Resident # 11, Resident #14, Resident #76’s PASARR Level One screenings accurately reflected his diagnoses of mental illness and submit a corrected PASARR level one screening This failure could place residents at risk of not receiving or benefiting from specialized therapy and equipment services they may require. This failure could place residents at risk of not being evaluated and receive needed PASARR services that would enhance his quality of life. Findings included: Record review of Resident #3’s admission record dated 07/31/2025 reflected an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included unspecified dementia (is characterized by a significant loss of cognitive function, including memory and reasoning skills), unspecified severity, without behavioral disturbance (no notable behavioral disturbances present), psychotic disturbance (conditions that affect the mind, causing a loss of contact with reality, where thoughts and perceptions are disturbed), mood disturbance (refers to changes in mood that are clinically significant, often associated with mental health conditions), and anxiety (refers to feelings of worry, nervousness, apprehension, or fear). Record review of Resident #3’s quarterly MDS assessment dated [DATE] reflected BIMS score of 03 indicating severely impaired. Further review of MDS Assessment reflected active diagnoses of Non-Alzheimer’s Dementia and Resident #3 is taking antipsychotic and antidepressant medications. Record review of Resident #3’s Care Plan dated with revised date of 06/27/2025 reflected resident focus: “Psychosocial well-being: Dementia. Goal: Resident will reach their highest practicable level of psychosocial well-being by quarterly review. Interventions included: Monitor for anxiety, agitation, aggression, social withdraw, reduced social contact, and sleeplessness.” (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #11’s admission record dated 07/31/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included unspecified dementia (is characterized by a significant loss of cognitive function, including memory and reasoning skills), unspecified severity, without behavioral disturbance (no notable behavioral disturbances present), psychotic disturbance (conditions that affect the mind, causing a loss of contact with reality, where thoughts and perceptions are disturbed), mood disturbance (refers to changes in mood that are clinically significant, often associated with mental health conditions), anxiety (refers to feelings of worry, nervousness, apprehension, or fear), and depression (term used in healthcare settings to describe a state of sadness or loss of interest). Record review of Resident #11’s quarterly MDS assessment dated [DATE], reflected Resident #11 had a BIMS score of 11, indicating moderately impaired. Further review of MDS reflected active diagnoses of psychiatric/mood disorder, Depression and Resident #11 is taking antianxiety and opioids medication. Record review of Resident #11’s Care Plan dated last revised 02/07/2025 reflected resident focus “Psychosocial well-being: Depression. Goal: Resident will reach their highest practicable level of psychosocial well-being by quarterly review. Interventions/Task: Monitor for anxiety, agitation, aggression, social withdraw, reduced social contact, and sleeplessness.” Record review of Resident #14’s admission record, dated 07/31/2025, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Alzheimer’s disease, unspecified (a general term for memory loss and other cognitive abilities serious enough to interfere with daily living), schizoaffective disorder (mental health condition marked by a mix of symptoms, such as hallucinations and delusions), unspecified, unspecified psychosis not due to a substance or known psychological condition. Record review of Resident #14’s quarterly MDS assessment dated [DATE] reflected a BIMS was not conducted due to her rarely/never being understood. Section C – Cognitive Patterns reflected Resident #14 had memory problem with short-term and long-term memory. Further review reflected Resident #14 had active diagnoses of Alzheimer’s Disease, psychotic disorder, and schizophrenia. Record review of Resident #14’s Care Plan dated with revision date of 02/01/2024 reflected resident focus “Psychosocial well-being: Alzheimer's disease, known psychosocial condition. Goal Resident will reach their highest practicable level of psychosocial well-being by quarterly review. Interventions/Task: Monitor for anxiety, agitation, aggression, social withdraw, reduced social contact, and sleeplessness. ” (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #76's quarterly MDS Assessment, dated 06/25/25, reflected the Resident #76 was a [AGE] year-old male who was admitted to the facility on [DATE]. Resident #76 had an active diagnosis of schizoaffective disorder, unspecified (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania), alcoholic cirrhosis of liver without ascites (a severe form of liver damage caused by chronic alcohol consumption, characterized by scarring of liver tissue, and it can occur without the presence of ascites (fluid accumulation in the abdomen), [NAME] encephalopathy (an acute neurologic emergency resulting from thiamine (vitamin B1) deficiency with varied neurologic manifestations, typically involving mental status changes and gait and oculomotor dysfunction), polyneuropathy, unspecified (type of neuropathy, or nerve disease, that affects many nerves. In general, polyneuropathy is caused by a systemic disease process (affecting the whole body) that damages many nerves, like diabetes or chronic alcohol overuse). The resident had a moderately impaired BIMS score of 12. Record review of Resident #76’s Care plan dated 3/18/2025 reflected Record review of Resident #76's Care plan dated 3/18/2025 reflected Focus: “Resident on psychotropic drug evidenced by Seroquel 25 mg tablet (quetiapine fumarate) 1 tablet by mouth daily in the morning and Mirtazapine 30 mg tablet by mouth at bedtime. Goal: Resident will reach their highest practicable level of psychosocial well-being by quarterly review. Interventions/Task: Monitor signs and symptoms for anxiety, agitation, aggression, social withdraw, reduced social contact, and sleeplessness. Record review of Resident #76's PASRR Level 1 Screening, dated 07/10/24, reflected he did not have a mental illness. PASRR Level 1 screening did not indicate Resident #76 had primary diagnosis of schizoaffective disorder, unspecified. Record review of Resident #78's quarterly MDS assessment, dated 6/6/2025, reflected a [AGE] year-old female admitted to the facility on [DATE]. He had diagnoses of depression, unspecified (diagnostic term used when a person was experiencing significant distress or impairment, but there’s limited information to establish a more precise diagnosis within the depressive disorder category), unspecified psychosis not due to a substance or known physiological condition (a mental state characterized by a loss of touch with reality without identifiable causes), major depressive disorder, single episode, mild (a prevalent mental health issue that affects millions of people worldwide. It can manifest as either a single episode or a recurrent condition), major depressive disorder, single episode, severe without psychotic features (major depressive disorder that does not include psychotic symptoms. Symptoms typically include Persistent sadness or loss of interest in activities, Significant changes in appetite or sleep patterns, Difficulty concentrating or indecisiveness, Recurrent thoughts of death or suicidal ideation), generalized anxiety disorder (a mental health condition that causes fear, a constant feeling of being overwhelmed and excessive worry about everyday things), major depressive disorder, recurrent severe without psychotic features (recurrent severe without psychotic features, is characterized by multiple episodes of severe depression that significantly impair daily functioning, without the presence of hallucinations or delusions). His BIMS score was a 07 which indicated moderate cognitive impairment. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #78's care plan dated last revised 10/14/2024 reflected resident Focus: “Resident on psychotropic drug evidenced by Escitalopram Oxalate Oral Tablet 20 MG 1 tablet by mouth daily for depression and Zyprexa Oral Tablet 2.5 MG at bedtime. Goal: Resident will reach their highest practicable level of psychosocial well-being by quarterly review. Interventions/Task: Monitor signs and symptoms for anxiety, agitation, aggression, social withdraw, reduced social contact, and sleeplessness. Record review of Resident #78's electronic health record revealed a PASRR 1 evaluation for Resident #78 was not completed. Record review of Resident #94’s admission record dated 07/31/2025 reflected an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Her diagnoses included: unspecified dementia (is characterized by a significant loss of cognitive function, including memory and reasoning skills), unspecified severity, without behavioral disturbance (no notable behavioral disturbances present), psychotic disturbance (conditions that affect the mind, causing a loss of contact with reality, where thoughts and perceptions are disturbed), mood disturbance (refers to changes in mood that are clinically significant, often associated with mental health conditions), anxiety (refers to feelings of worry, nervousness, apprehension, or fear), bipolar disorder (mental health condition characterized by extreme mood swings that include emotional highs and lows) and major depressive disorder (a mental disorder characterized by persistent low mood and decreased interest in activities), single episode, mild. Record review of Resident #94’s quarterly MDS assessment dated [DATE] reflected a BIMS score of 04 indicating severely impaired. Further review of MDS Assessment reflected active diagnoses of depression and bipolar disorder and Resident #94 is taking antipsychotics, antidepressants, and opioids. Record review of Resident #94’s Care plan dated with revised date of 07/21/2025 reflected resident Focus: “Psychosocial well-being: Insomnia, related to diagnosis of Depression and Dementia with impaired cognition. Goal: Resident will reach their highest practicable level of psychosocial well-being by quarterly review. Interventions included: Monitor for anxiety, agitation, aggression, social withdraw, reduced social contact, and sleeplessness.” Further review of Resident #94’s Care Plan reflected resident Focus: has a behavior problem yell at night/resistive/anxiety /defiant at times/physical and verbal aggression/purposely sets self on floor. Goal: The resident will have fewer episodes of acting out/anxiety/resistance with care by review date. Interventions included: On 1/31/2025 Add Zyprexa 2.5mg and on 12/9/2024 physical and verbal aggression to staff, redirected. PRN anxiety med renewed.” In an interview with MDS A Coordinator/LVN on 7/31/2025 at 3:51 pm revealed they received the PASARR before they were admitted . If the resident was positive, they contact the state to have them come out to interview the resident and gather their information. Then they will determine if they qualify for services. The MDS Coordinator works along with social services and the admission coordinator to make sure the PASARR gets entered the system. The MDS Coordinator stated if the resident does not have a PASARR I, they do not get the services they need, and the facility does not get paid. She did not provide reasoning for not have completed the PASARR’s. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with Social Worker on 7/31/2025 at 3:34 pm revealed the process when a resident was admitted into the facility and they are PASARR positive, the MDS Coordinator will input the PASARR into the electronic system (SIMPLE) and that allows HHS, the case manager will contact them to schedule to have them come out and evaluate the resident for services. If the PASARR was documented wrong, they will reach back out to the hospital and have them amended. The MDS Coordinator will cross reference the PASARR from SIMPLE and it triggers to HHS to set up initial visit. The SW stated residents are not allow into the facility without a PASARR. If they came from somewhere else than the hospital, they would then have to reach out to the family to have it filled out. SW stated without a PASARR it would cause the resident to have a lapse in services they may qualify for. Review of the facility's PASRR policy undated policy revealed, The purpose of this policy is to ensure compliance with the Texas PASRR requirements as outlined by Texas Health and Human Services (HHS), the policy establishes procedures for the appropriate identification, screening, admission, and care planning for individuals with serious mental illness (SMI), intellectual disabilities (ID), or development disabilities (DD) being admitted to or residing in our long-term care facility.”

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	676047	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town Hall Estates Keene, Inc.	207 S Old Betsy Rd Keene, TX 76059

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide care and services needed for residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 2 (Resident #19 and Resident #23) of 3 residents and 1 of 1 Resident Council reviewed. The facility failed to ensure Resident #19 was offered/provided timely incontinent care for urine as identified on the resident's Care Plan. The facility failed to ensure Resident #23 remained clean and dry throughout the day and night as identified on the resident's Care Plan. This failure could have a potential to cause a negative outcome to a resident's physical, mental, or psychosocial health or well-being. Findings included: Record review of Resident #19's admission record dated 7/31/2025 reflected an [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included Parkinson's disease (a progressive disease of the nervous system that affects movement) with dyskinesia (strange, jerky movements you can't control), with fluctuations, mild cognitive impairment of uncertain or unknown etiology (is the in-between stage between typical thinking skills and dementia. The condition causes memory loss and trouble with language and judgment) major depressive disorder (condition characterized by persistent low mood and decreased interest in activities), recurrent, moderate, difficulty in walking, not elsewhere classified, other lack of coordination, carpal tunnel syndrome (is a condition caused by pressure on the median nerve in the write, leading to symptoms such as numbness, tingling, and weakness in the hand), left upper limb, muscle wasting and atrophy (refers to the decrease in size of a body part), muscle weakness, and mobility, unsteadiness on feet. Record review of Resident #19's quarterly MDS assessment dated [DATE] reflected BIMS score of 11, indicating moderately impaired. Further review of MDS Assessment reflected Resident #19's functional abilities with Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement was Substantial/maximal assistance -Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. Record review of Resident #19's Care Plan dated with revised date of 2/25/2025 reflected she had ADL self-care deficits and was dependent on staff for toileting. Resident #19's goal is to be able to perform ADLs r/t mentally and physically alert by target date 9/18/2025. Interventions included: TOILETING: Resident requires supervision assistance of 1 staff. Further review of Care Plan reflected Resident #19 is frequently incontinent of bladder and is at risk for skin complications. Interventions included: Give peri-care when resident is incontinent and Offer/provide timely incontinent care for urine. Record review of Resident #23's admission record dated 07/31/2025 reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Her diagnoses included unspecified dementia (is characterized by a significant loss of cognitive function, including memory and reasoning skills), unspecified severity, without behavioral disturbance (no notable behavioral disturbances present), psychotic disturbance (conditions that affect the mind, causing a loss of contact with reality, where thoughts and perceptions are disturbed), mood disturbance (refers to changes in mood that are clinically significant, often associated with mental health conditions), anxiety (refers to feelings of worry, nervousness, apprehension, or fear), and depression (term used in healthcare settings to describe a state of sadness or loss of interest). Record review of Resident #23's quarterly MDS assessment dated [DATE] reflected a BIMS score of 12 indicating moderately impaired. Further review of MDS Assessment reflected Resident #23's functional abilities: Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement was Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. Record review of Resident #23's Care Plan dated with revised date of 07/21/2025 reflected she had ADL self-care deficits and was dependent on staff for toileting. Resident #23's goal is to be able to perform ADLs r/t mentally and physically alert by target date 9/18/2025. Interventions included: TOILETING: Resident requires limited-total assistance of 1 staff. Further review of Care Plan reflected Resident #23 is Mostly Bowel Incontinence. Goal: Resident will remain clean and dry throughout the day and night. Interventions included: Give peri-care when resident is incontinent. Give good peri-care each incontinent episode. Offer/provide timely incontinent care for bowel. During an interview on 07/30/2025 at 4:47 PM Resident #23 stated she urinates in the middle of the night in her brief, the staff come into the room and do not change her and the next morning she was soaking wet. She stated starting after 12:00 AM she cannot get out of the bed by herself and by the morning her entire bed was soaked. She stated before she would be changed every 3-4 hours, but this doesn't occur now. She

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** Number of residents sampled: Number of residents cited: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interviews, and record review, the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range unless the resident clinical condition demonstrated that this was not possible or resident preferences indicated otherwise for one (Resident #12) of one resident reviewed for nutrition status maintenance.The facility failed to ensure a weight variance was addressed and documented to ensure management of weight loss for Resident #12. The facility failed to keep accurate record of Resident #12's food intake per record review of the resident electronic health record. These failures could place residents at risk of further weight loss, malnutrition, and decreased quality of life. Findings included:Record review of Resident #12's dated 07/30/2025 reflected an [AGE] year-old male who was admitted to the facility on [DATE]. His diagnoses included Other Transient cerebral ischemic attacks and related syndromes (a short period of symptoms like those of a stroke), other specified disorder of bone density and structure unspecified site (a condition involving abnormalities in bone density and structure that are not specified to a particular location in the body), essential tremor (a nervous system condition, also known as a neurological condition. It causes rhythmic shaking that you can't control), age-related cognitive decline (the gradual loss of cognitive abilities such as memory, reasoning, and attention, which can vary significantly among individuals), polyneuropathy is (a disorder that involves damage to the peripheral nerves, which are the nerves outside the brain and spinal cord). Record review of Resident #12's quarterly MDS dated [DATE] reflected a BIMS score of 9, indicating moderately impaired. Resident requires staff assistance times one for ADL's. Record review of Resident #12's Care Plan dated 7/31/25 reflected he had ADL self-care deficits and was dependent on staff for eating. Resident #12 goal is to consume at least 50% of each meal served for the next 90 days. Lab's values indicative of nutritional status will be within normal range; not develop complications from weight gain; weight to return to baseline range of 149 lbs. by target date 10/16/2025. Interventions included: Resident #12 diet is a regular ground texture diet, Nectar thick liquids through a straw only; he is to be weighed weekly as of 5/20/2025. Review of Resident #12's physician orders reflected an order with a start date of 05/27/2025 for weekly weights every Tuesday.Review of Resident #12's weights reflected:5/1/2025 159.2lbs. Mechanical Lift System warning reflected, -7.5% change [Comparison Weight 4/1/2025, 168.4 lbs., - 7.8%, -13.2 lbs.]6/3/2025 158.4lbs. Mechanical Lift6/18/2025 155. 7lbs. Mechanical Lift System warning reflected, -7.5% change [Comparison Weight 4/1/2025, 168.4 lbs., - 7. 8%, -12.7 lbs.]6/23/2025 156.0lbs. Mechanical Lift6/23/2025 156.0lbs. Standing 7/1/2025 155.2lbs. Mechanical Lift7/3/2025 155.2lbs. Mechanical LiftIn an interview with MA A on 7/31/2025 at 3:45 pm revealed she was responsible for taking residents weights and she receives the weekly weight list. She stated June 2025, Resident #12 was on her weekly weight list. MA A stated he was on the weekly list all June and July and he just went back to the monthly weight list on the week of July 31, 2025. MA A stated she spoke with the dietician, and she tells her who was on the weekly weights list. MA A stated she was advised to place him back on the list because he started losing weight. She stated when a resident has a significant change in weight, she was to report it to the charge nurse or the ADON. MA A stated the nursing aides should be monitoring how much the residents eat. The nurses go through the dining area, and the aide charts it. If Resident #12 ate under 25-50% it should be charted, and he should be offered another meal or a shake to replace it. MA A stated when the doctor puts in orders, the nurse was supposed to tell her the residents that were on weekly weights. She denied knowing how to locate the doctors' orders for weights, but she can see the orders for transfers. In an interview with ADON A on 7/31/2025 at 4:15 pm revealed MA A was responsible for taking residents weights. She stated once month or twice a month the dietician will check residents' weights for a loss or gain. If anybody has 5% or more weight loss in a month, their family members and the doctors were notified. The bases were if a resident lose 5% in 1 month, 7.5% in 3 months, and 10%b in 6 months. The dietician will make recommendations if they gain or lost. ADON A stated if the doctor makes the recommendation, it was because they want to see if there was a trend and they want to control and narrow down the trend. She stated it can be determined faster if the residents are weighed weekly opposed to monthly. ADON A stated monitoring of how much resident eats depends on if the resident eats in the dining room. The 4-charge nurses will take 30 minutes increments. The charge nurses will pick up the ticket and see how much the resident have eaten and document it and the CNA's will record it. If they eat in their rooms, the CNA's when they pick up their trays they will record it. They record every resident. The tickets of the resident that eat less than 50% will be documented and the resident was offered a supplement

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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. Number of residents sampled: Number of residents cited: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interviews, and record reviews, the facility failed to store food by professional standards for food service safety in the reviewed 1 of 1 kitchen. - Food items were not labeled and/or dated. - Food items were out of date. - Tortillas that were 3 years old were being used.These failures can potentially cause foodborne illness. Findings include:Observation on 7/29/2025 at 9:15 AM of the walk-in cooler reflected the following:Jalapenos that were not in the original container and were in a sealed container labeled 7/12/2025 when it was put in the container with an expiration date of 7/18/2025. The ham was in a sealed package, and did not have any dates at all on the package. Ham in a Ziplock bag with a date of 7/28, did not have a use-by date on the bag. Lemons in an open plastic container, there was one lemon that was rotten on top of the lemons. Bag of tortillas did not have an open or use-by date on the package. Observation on 7/29/2025 at 9:25 AM of the walk-in cooler reflected the following:Various boxes of frozen items in the freezer were not organized. Was not able to see what was in the boxes and the dates on the boxes. boxes were just thrown in the freezer. Observation on 7/29/2025 at 9:30 AM of the one stand-up cooler reflected the following:White Cheese in a Ziplock bag had a date when it was put in the bag on 7-24 with an expiration date of 7-24.Yellow sliced cheese in a Ziplock bag that had no date at all on the bag. 1 milk carton containing 30 whole milks (chocolate) with an expiration date of 7-28-2025. Container of cottage cheese with a date of 7-28 with no end date on the container. Red onion that has been cut in a bag, which had no date on the bag. 4 premade sandwiches that were labeled with a date of 7/28, and no use-by date. 1 premade salad labeled with a date on 7/28. There was a red drink in a container that had no label on it. Orange drinks and tea in a single-serving glass that was dated 7/28 on the tray. Observation on 7/29/2025 at 9:40 AM of the kitchen reflected the following:Container of sugar had a prep date of 5/9/2025 with no use by date. Container of flour had a shelf-life date of 4/1/2025 with no use by date. Container of corn starch had a shelf-life date of 4/1/2025 with no use by date. One clear plastic container that kitchen serving utensils were in it had food and a bread tie in the container. The lower shelf of the counter that had serving bowls was dirty with food crumbs. Observation on 7/29/2025 at 11:50 AM of the kitchen during puree observation:While watching the puree of tortillas, the frozen tortillas on the counter thawing out, had a date of 2/6/2022. The DM has a mustache and was not wearing a beard guard during lunch service. An interview on 7/30/2025 at 2:22 PM DA 10 stated Dietary Aide stated that when they get new stock in she will put those items in the back and the old items in the front. DA 10 stated she will let the DM know about the out-of-date items and throw the items in the trash. All foods should be labeled with a use-by date and expiration date. Shen will then put the item in a proper container and date the item. The kitchen was cleaned and sanitized daily. There was a check-off list with tasks, and the schedule was sanitized after each use. She said training was done periodically. An interview on 7/30/2025 at 2:33 PM DA 11 stated that they have been there for 5 months. DA 11 stated that she checks for out-of-date items daily. DA 11 stated that prepared items have a shelf life of three days. DA 11 stated that she will tell the about the out-of-date item and she will throw the item away. DA 11 said that all food should be labeled and dated. DA 11 stated that items should be labeled with the day it is opened and then the day it expires. DM 11 stated that the kitchen is cleaned daily, and everyone had their task to clean. She said that she has not been trained in food storage since she started. An interview on 7/30/2025 at 2:40 PM CK 1. CK stated that new food items are put in the back and the old in the front. CK1 tells the DM, then throws outdated items away. CK 1 stated that all foods were labeled with the use and expiration date. CK 1 stated that she cleans the kitchen as she works during the day. CK 1 stated surfaces and equipment are cleaned after they are used. CK 1 stated when she is in the kitchen, she uses a hair net. CK 1 said that it is everyone's responsibility to stock the freezer. An interview on 7/30/2025 at 2:49 PM CK 2. CK 2 stated when the truck comes, they move old items to the front and the new items to the back. Expired food was thrown away immediately. All food was labeled and dated. CK2 stated that she puts the date the item is opened, then date it expires. CK2 said that the item is thrown away after 6 days. CK 2 said that the kitchen is cleaned multiple times daily. CK 2 stated there is a checklist, and you check off what you did. She said they had someone doing the freezer, but now everyone does it. An interview on 7/30/2025 at 2:57 PM DM. DM stated all food items are to be rotated by first in first out. DM stated that food items should be labeled and dated correct date it was opened and the day it expires. DM stated that all expired food is to be thrown in the trash. DM stated that all ready-to-eat food should be labeled and dated. DM stated that cooked food has a three-day shelf life from when it is prepared. DM said that food that come out of a package, has a 6-day shelf