STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676053	A. Building B. Wing	02/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Merkel Nursing Center	1704 N 1st Merkel, TX 79536

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation for 5 of 20 (Resident #1, Resident #2, Resident #3, Resident #5, and Resident #16) residents reviewed for neglect. 1. The facility failed to ensure 34 of 84 shifts were staffed with at least two nurse aides, per the facility assessment, between the dates of 1/1/26 and 2/11/26. 2. The facility failed to ensure effective training was provided to staff based on resident care requirements and needs. Staff employees designated as Nurse Aide (NA) were aides that had not completed the Nurse Aide Training and Competency Evaluation Program and passed the required written and skills test, required to be a certified nurse aide. 3. The facility failed to ensure there was a sufficient number of qualified and trained staff, needed to meet the needs of Resident #1. Resident #1 was dropped from a mechanical lift transfer on 01/26/2026 while being transferred by one NA (NA-A), which resulted in a distal femur fracture requiring surgical intervention. NA-A who was not certified or properly trained. 4. The facility failed to ensure Resident #5 was free from neglect by not ensuring appropriate interventions and adequate staffing was in place to prevent falls which resulted in multiple rib fractures and hospitalization on 01/15/2026. 5. The facility failed to ensure Resident #3 was free from neglect by not ensuring appropriate interventions and adequate staffing were in place to prevent a fall on 01/31/2026. 6. The facility failed to ensure Resident #2 was free from neglect when Resident #2 was transferred inappropriately by NA-F on 01/29/2026. 7. The facility failed to ensure Resident #16 was free from neglect when her wet clothes were not changed for over 2 hours after asking NA-F and RN-R to help her. An Immediate Jeopardy (IJ) situation was identified on 02/13/2026. While the IJ was removed on 02/16/2026, the facility remained out of compliance at a scope of a pattern with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of their corrective systems. These failures could place residents at risk of injury, serious bodily harm, physical impairment, hospitalization or death.Findings include: During an interview on 2/12/2026 at 11:00 AM, the AIT stated the facility was short staffed and she could not hire certified nursing aides. She stated she expected the nurses to help the NAs provide care. The AIT stated her expectation was for policies and procedures to be followed, that was not always realistic. The AIT stated her expectation was for the residents to be taken care of, by whatever means necessary. The AIT stated there was no evidence of any training records or Nurse Aide checklist for NA-A. The AIT could not confirm NA-A had Abuse and Neglect training. The AIT stated all staff were to receive abuse and neglect training before working on the floor. The AIT stated according to the Nurse Aide checklist, transfers of any type and incontinent care were not allowed to be done alone by NAs. AIT stated LVN-K never notified her with concerns of NAs transferring residents with the mechanical lift alone. The AIT stated it was not safe to only have 1 NA working on the floor. During an interview on 02/12/2026 at (continued on next page)

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

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	11:30 AM, the ADON stated residents who had multiple falls, were transferred inappropriately, or not having call lights answered were all forms of neglect. ADON stated NAs could not perform any type of transfers or incontinent care alone. ADON stated the facility had difficult time due to being located in a rural area. The ADON stated she works overtime to ensure that resident care is covered but cannot work 24 hours a day. The ADON stated resident care suffers because the facility is short staffed. Resident #1 Record review of Resident #1's face sheet, accessed on 01/28/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: Dementia and Cerebral Ischemic Attack. Record review of Resident #1's Quarterly MDS assessment, dated 12/12/2025, revealed a BIMS of 03, which indicated severe cognitive impairment. Further review revealed Resident #1 used a wheelchair, had no history of falls, and required two or more people to assist for transfers. Record review of Resident #1's care plan, revised on 09/22/2024, revealed: Focus: The resident has an ADL self-care performance deficit.Interventions: The resident requires assistance by 2 staff for transfers using mechanical lift. Record review of facility's incident report, dated 01/26/2026, revealed in part: Resident came up to nurses' desk in a wheelchair pushed by an aide. Stated her left foot and hip [NAME] and stated she had fallen in her room during a transfer for Mechanical lift to wheelchair. Resident stated that she was dropped on the floor during transfer via staff member and staff member told her not to report the fall to anyone. Record review of hospital Discharge summary, dated [DATE], revealed Resident #1 was discharged back to the facility on [DATE] with diagnoses Post Distal Femur Fracture treated with surgery. During an observation and interview on 01/29/2026 at 5:00 PM, Resident #1 was lying in her bed in her room. Resident #1 stated on Monday morning, 1/26/2026, she was transferred using a mechanical lift by NA-A. She stated she was dropped to the floor, NA-A pulled her back into the wheelchair, and she was instructed not to tell anyone. She stated she was routinely transferred by only one staff member. Resident #1 did not report the incident until CNA-D was taking her for a smoke break, a few hours later on 1/26/2026. CNA-D questioned why she was dragging her leg, which prompted her disclosure of the incident. During an interview on 01/29/2026 at 12:00 PM, Resident #4, who had a BIMS of 9 (meaning moderate cognitive impairment), and was Resident #1's roommate. Resident #4 stated she observed NA-A alone in the room transferring Resident #1 using a mechanical lift the morning of 1/26/2026. She stated she heard NA-A say, oh crap and observed Resident #1 and the lift on the floor. Resident #4 stated she had never observed two staff assisting with Resident #1's mechanical lift transfers. During a telephone interview on 03/02/2026 at 4:45 PM, NA-A stated Resident #1 was not able to transfer by herself, dress herself and needed assistance to feed herself. NA -A stated she was shocked because she was accused of dropping Resident #1 while transferring her with the mechanical lift. NA -A stated she never transferred Resident #1 by herself, and NA-C assisted her with the transfer on Monday (01/26/2026) when getting the resident out of bed. NA-A stated the facility never trained her on transferring residents with a mechanical lift, but she knew you always needed two staff to transfer. During a telephone interview on 02/03/2026 at 5:45 PM, NA-C stated she worked on 1/26/2026, with NA-A. NA-C stated she had not received any training in regard to using a mechanical lift to transfer residents. NA-C stated she had never transferred a resident by herself. NA-C stated she heard there were NAs who transferred residents alone but had never witnessed staff doing transfers alone. NA-C stated she did not recall assisting NA-A with transferring Resident #1 from the bed to the wheelchair on Monday morning. NA-C stated she thought LVN-K might have assisted NA-A. NA-C stated she and NA-A were the only aides working that shift with LVN-K. During an interview on 02/04/2026 at 11:20 AM, LVN-K denied assisting NA-A with a transfer for Resident #1 on Monday morning 1/26/26. LVN-K stated she voiced her concerns in the past (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	of NAs transferring residents alone and had reported those concerns to ADON and AIT. During an interview on 02/12/2026 at 11:00 AM, the AIT denied receiving concerns from LVN-K about NAs transferring residents with mechanical lifts alone. During an interview on 02/12/2026 at 11:30 AM, the ADON denied receiving concerns from LVN-K about NAs transferring residents with mechanical lifts alone. Record review of NA-A's personnel files revealed NA-A was hired on 09/25/2025 and worked for facility full time. NA-A and was terminated on 01/28/2026, and there was no evidence of Aide Checklist for Orientation/Evaluation, abuse/neglect training or additional training regarding resident care for NA-A. 2. Record review of Resident #2's face sheet, accessed on 01/28/2026, revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included: fracture of left femur and anxiety disorder. Record review of Resident #2's Quarterly MDS assessment, dated 11/14/2025, revealed a BIMS of 00, which indicated severe cognitive impairment. Resident #2 needed the assistance of 2 or more persons to transfer. Record review of Resident #2's care plan, revised on 01/28/2026, revealed he required two-person maximum assist and two-person mechanical lift transfers. During observation on 01/29/2026 at 4:35 PM, Resident #2 was sitting in his wheelchair when NA-F entered Resident #2's room alone and exited at 4:40 PM. Resident #2 was transferred back to his bed, there was no observation of mechanical lift in the Resident's room. During an interview on 01/29/2026 at 4:45 PM, NA-F stated she was the only aide working and transferred Resident #2 by herself via stand and pivot, without the assistance of a second staff member. She stated the transfer required a mechanical lift and two staff, but she had transferred him without using the mechanical lift, because no help was available and she routinely transferred the resident this way. During an interview on 02/12/2026 at 11:00 AM, the AIT stated Resident #2 was inappropriately transferred and should not have been transferred without the mechanical lift and NA-F should not have transferred Resident #2 without the assistance of an additional aide. Record review of NA-F's personnel files revealed NA-F had a hire date of 2/28/2025, worked full time, had not been certified, and showed no evidence of mechanical lift training. 3. Record review of Resident #3's face sheet, accessed on 01/28/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included: heart failure and kidney disease. Record review of Resident #3's Quarterly MDS assessment, dated 11/19/2025, revealed a BIMS of 07, which indicated moderate cognitive impairment. Resident #3 required Partial/moderate assistance with toileting hygiene, sit to lying, sit to stand, and transfers. Record review of Resident #3's care plan, revised on 10/13/2025, revealed: Focus: The resident is at high risk for falls.Interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. During an observation on 1/29/2026 at 4:10 PM, Resident #4 was observed wheeling down the hall saying, I know you're on the floor; I will get some help. No staff were in the hall or at the nurses' station. Resident #3 was observed sitting on the floor in her room, and her call light was engaged (the light outside her door was flashing and an alarm was sounding at the nurse's station). At 4:15 PM, a hospice aide (that does not work for the facility) found Resident #3 on the floor in her room and went to find help. At 4:20 PM, the hospice aide located the RN-R and NA-F. NA-F went to the front office and got the ADON and the AIT. NA-F, the AIT, and the ADON returned to Resident #3's room at 4:25 PM. Resident #3 was assessed by ADON and was transferred to the Emergency Department by paramedics, for further assessment and returned the same day to the facility. During an interview on 1/29/2026 at 4:15 PM, Resident #3 stated she used the call light to go to the restroom but could not wait, so she stood up and attempted going to the restroom on her own. When she stood, she urinated on herself and then slipped and fell on the floor. She stated she always had to wait a (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	while for staff to answer her call light and she had fallen before. During an interview on 2/12/2026 at 11:00 AM, the AIT stated NA-F was the only aide working on 01/29/2026 during the day shift because the other NA scheduled did not show up. The AIT stated staff no shows happened often. The AIT stated she and the ADON were helping on the floor that day and did not provide a response to why she and the ADON did not assist with answering call light. Record review of the facility timecards, dated 01/29/2026, revealed NA-F was the only direct care staff on shift at the time of Resident #3's fall on 01/29/2026. 4. Record review of Resident #5's face sheet, accessed on 01/28/2026, revealed an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #5 had diagnoses which included: Colon cancer and muscle weakness. Record review of Resident #5's Quarterly MDS assessment, dated 12/12/2025, revealed a BIMS of 09, which indicated moderate cognitive impairment. Resident #5 used a walker and a wheelchair and needed assistance by one staff member for less than half of the effort for transfers. Record review of Resident #5's care plan, revised on 01/20/2026, revealed: Focus: The resident is at high risk for falls related to weakness. Further review of the care revealed no updates to fall interventions since 06/25/2025. Record review of the facility's incident log revealed Resident #5 had falls on the following dates without injury: 12/27/25, 01/06/2026, 01/08/2026, 01/14/2026, 1/15/2026 (4:45 AM) and 01/15/2026 (4:00 PM). Resident #5 had falls on 1/15/2026 at 6:00 PM and 1/24/2026 that resulted in injury. Record review of progress note, dated 1/15/2026 at 4:15 PM, by LVN-E, at 4:00 PM, documented this nurse was summoned to resident's bathroom. Resident was lying on her back near the commode, she stated she was attempting to get on the commode and lost balance and fell on floor. Resident placed on 15-minute checks and encouraged to ask for assistance from staff for transfers -Resident stable no problems. Record review of progress note, dated 1/15/2026 at 6:00 PM, by RN-N, revealed Resident was found on the floor in between the bathroom and the patient's room. She was moving all 4 extremities and wanting to get up. RN assessed Resident #5, and she was placed back in her chair. Paramedics arrived and transferred Resident from her chair to stretcher, resident complained of pain to left rib cage, it was noted that resident was weak and had difficulty standing. She was transported to hospital for evaluation. Record review of progress note, dated 1/16/2026, by LVN-B, documented the Resident was admitted the hospital on 1/15/2026 with a diagnosis of rib fractures from 4th to 8th ribs, pleural effusion, and UTI. Record review of progress note, dated 1/24/2026 at 4:00 PM, by LVN-S, revealed [Resident #5] was reaching down to the floor to pick up her phone and fell bumping left side of her forehead on floor, causing a raised circular area approximately. 2-inch purplish area on resident forehead, and denies much pain. Hospice nurse and [family member] notified, neurological and 15-minute checks initiated. During an interview on 02/08/2026 at 4:50 PM, Resident #5's family representative stated the resident had numerous falls. She stated Resident #5 was anxious and tried to get up on her own. During an interview on 02/11/2026 at 2:20 PM, the ADON stated Resident #5 had metastasized cancer and was always anxious, which was the reason for her decline in condition and multiple falls. She stated they had implemented interventions and did not know why the interventions were not updated in the care plan or medical record. The ADON stated 15-minute checks were started on 1/15/26. Record review of the facility's timecards, dated 01/15/2026, revealed NA-F was the only direct care staff on shift at the time of Resident #5's falls on 01/15/2026 at 4:00 PM and 6:00 PM. 5. Record review of Resident #16's face sheet, accessed on 01/28/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #16 had diagnoses which included: depression and anxiety disorder. Record review of Resident #16's Quarterly MDS assessment, dated 11/21/2025, revealed a BIMS of 01, which indicated severe cognitive impairment. Resident #16 required partial/moderate assistance with transfers and was (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	occasionally incontinent. Resident #16 required partial/moderate assistance with toilet transfers and toilet hygiene. Record review of Resident #16's care plan, revised on 01/23/2026, revealed she required one-person assist with transfers. Resident #16 required staff assistance of 1 for toileting. She has a mental disability and is not able to appropriately call for staff assist. Resident #16 had mixed bladder incontinence with interventions to change/check brief every 2 hours. During an observation on 2/07/2026 between 4:45 PM and 6:45 PM revealed Resident #16 waited for 2 hours for staff to change her after an incontinent episode. At 4:45 PM Resident #16 asked NA-F for assistance and NA-F responded, I can't right now, I am very busy. At 5:15 PM, Resident #16 was sitting in the hall in her wheelchair crying because she still had not been changed. At 5:35 PM, Resident #16 was sitting at the table in the dining room with wet pants and still had not been changed. At 5:45 PM, Resident #16 wheeled down the hall and asked RN-R to change her wet pants and RN-R looked at resident and failed to acknowledge resident's request. At 6:00 PM, Resident #16 was in the dining room, and was upset and attempted to take off her clothes because they were wet. The ADON reprimanded Resident #16 about her inappropriate behavior and told her to go to her room. At 6:45 PM, NA-F entered Resident #16's room and assisted her with changing her clothes. During an interview on 02/13/2026 at 11:45 AM, NA-F stated she was the only aide on shift. She stated the management was helping her. NA-F stated she had worked by herself more since other staff had quit. NA-F stated she did not remember Resident #16 asking to be changed on 2/07/2026, but it probably had occurred she was really busy due to being the only aide working during shift. NA-F stated when she worked alone, she had a hard time getting everything done. She stated being short staffed could have led to residents not getting the care they need and could have been considered neglect. During an interview on 02/12/2026 at 11:00 AM, the AIT stated the facility was short staffed and she could not hire certified nursing aides. She stated she expected the nurses to help the NAs provide care. The AIT stated her expectation was for policies and procedures to be followed, but that was not always realistic. The AIT stated her expectation was for the residents to be taken care of by whatever means necessary. The AIT stated there was no evidence of any training records or Nurse Aide checklist for NA-A. The AIT could not confirm NA-A had Abuse and Neglect training. The AIT stated all staff were to receive abuse and neglect training before working on the floor. The AIT stated according to the Nurse Aide checklist, transfers of any type and incontinent care was not allowed to be done alone by NAs. The AIT stated LVN-K never notified her with concerns of NAs transferring residents with mechanical lift alone. The AIT stated it was not safe to only have 1 NA working on the floor. The AIT stated NA-F was the only aide working on 01/29/2026 during the day shift because the other NA scheduled did not show up. The AIT stated staff no shows happened often. She stated she and the ADON were helping on the floor. When asked why they were all in the office at the time of 5 call lights going off, Resident #3 falling, and Resident #2 being inappropriately transferred, she had no response. She stated she did not know why no one answered the call lights, while she and ADON were at the nurse's station. She stated Resident #2 should not have been transferred without the mechanical lift alone. During an interview on 2/12/2026 at 11:30 AM, the ADON stated residents who had multiple falls, were transferred inappropriately, or not having call lights answered were all forms of neglect. ADON stated NAs could not perform any type of transfers or incontinent care alone. ADON denied receiving concerns from LVN-K about NAs transferring residents with mechanical lifts alone. The ADON stated the facility was short staffed, due to staff not wanting to work, staff quitting and not being able to hire staff. The ADON stated the facility had a difficult time due to being located in a rural area. The ADON stated she worked overtime to ensure resident care was covered but could not work 24 hours a day. The ADON stated resident care suffered (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	neglect as the failure of the facility, employees, or service providers to provide goods and services to a resident that are necessary avoid physical harm, pain, mental anguish, or emotional distress. This was determined to be an Immediate Jeopardy (IJ) on 02/13/2026 at 12:40 PM. The Administration was notified. The AIT and Owner were provided with the IJ template on 02/13/2026 at 12:40 PM. The following Plan of Removal submitted by the facility was accepted on 02/15/2026 at 2:15 PM: TAG F600 - Freedom from Abuse and Neglect (IJ)Direct Care Staff: A direct care staff can be any trained individual that demonstrates competency according to the facility's aid competency checklist. This may be an NA that is enrolled in a CNA training class and employed less than 120 days, a CNA, and LVN, or an RN that provides direct care to a resident, including but not limited to assistance with ADLs such as eating, bathing, toileting, transfers, hygiene care, etc. There must be two direct care staff on the floor at all times in addition to one LVN/RN charge nurse. There should be a total of one LVN/RN and two direct care staff in the building at all times if there are any mechanical lift residents. Staffing requirements will be assessed weekly based on census and resident needs. There will be two direct care staff if the facility has any residents that use a mechanical lift or are a two-person transfer.DON and ADON will ensure that all agency or temporary direct care staff have documented training prior to working a shift. Current temporary agency is giving us access to their portal so that we can check their credentials. The Sister facility will send us their CNA credentials prior to working a shift. This will be started on 02/14/2026 and will be on going.Corrective Action:Residents #5, 3, 2, and 16 were assessed by ADON for any further injury, pain, or emotional distress on 02/13/2026Resident #1's fall was immediately reported to state agency per reporting requirements on 01/26/2026. Resident #1 assessed and monitored for negative outcomes by LVN E on 01/26/2026NA-A was removed from resident care pending investigation on 01/26/2026 Investigation completed by AIT on 01/28/2026. AIT terminated NA-A as disciplinary action. NA-A does not currently hold a license to refer. AIT created and ADON reviewed an informational handout for incident reporting and mechanical lift use on 01/26/2026. Facility's COTA provided an interactional mechanical lift demonstration for all staff on 01/30/2026Identification of Other Residents at Risk:Reviewed 14/14 incidents within the last 30 days conducted by AIT on 02/13/2026No additional concerns identifiedSystemic Changes:All direct care nursing staff on shift re-educated by ADON and through an informational handout at the nurses station on abuse/neglect policy with a signature sheet after information review, including safe transfer procedures and supervision expectations on 01/26/2026 requiring review for all Direct Care Staff before start of first shift. The AIT provided the education at an in-service on 01/30/2026 with a signature page at the end. New staff are trained upon hire about abuse and neglect in the standard facility trainings. The agency and sister facility will only be sending CNAs. All CNAs have been trained by a Texas-approved training course through NATCEP that reviews abuse and neglect prior to getting their certification. The charge nurse will verbally educate any agency and sister facility staff on call lights, mechanical lift, and abuse and neglect during shift report, prior to the aid starting their shift. The charge nurse will require a verbal return instruction before the aid starts the shift to determine competencyAll residents will be re-educated by the DON on 02/14/2026 about their rights, abuse, and neglect, and reporting.All 26 residents, including residents #2, 3, 5, 8, 16, were at risk for being affected by this deficient practice.The facility will review abuse, neglect, transfers, and reporting upon hire, once a month at the mandatory in-service and provide one-on-one education annually to staff at their hire anniversary. Any violations of policy will result in termination. The charge nurse will verbally educate any agency and sister facility staff on call lights, mechanical lift, and abuse and neglect during shift report, prior to the aid starting their shift. The charge (continued on next page)

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	676053	A. Building B. Wing	02/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Merkel Nursing Center	1704 N 1st Merkel, TX 79536

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	nurse will require a verbal return instruction before the aid starts the shift to determine competency. The charge nurse will initial, date, and log the name of the agency and sister facility staff member that was educated starting 02/15/2026.Mandatory all staff in-service by AIT, COTA, and ADON completed by all staff on 01/30/2026 reviewing falls and fall prevention, reporting incidents, mechanical lift transfers, and abuse and neglect. AIT reinforced expectation that abuse/neglect, mechanical lift, and reporting policy violations by any staff member will result in disciplinary action resulting in termination on 01/26/2026. The abuse and neglect policy, the mechanical lift policy, failure to report policy- all violations of these policies will result in immediate termination. The reinforced expectation of consequence through termination was explained by the AIT in an in-service dated 01/30/2026. The DON trained all staff on falls and call light usage via phone calls with return instruction to ensure retention of information on 02/14/2026. Any staff members that do not answer the phone will not be able to return to work their shift until the staff is retrained on falls and call lights. The DON has a log of active staff members and numbers that she is systematically calling and going through. She initials next to each staff member that has been called and educated.Monitoring:DON/designee will review all incidents daily for 30 days to establish a risk of incident analysis based on patterns of staffing and incidents. Monthly abuse/neglect audit for Direct Care Staff and incidents to QAPI for 3 months.Completion Date: 02/15/2026 Monitoring of the facility's Plan of Removal revealed the following:Reviewed progress notes date 02/13/2026 that read no injuries noted and no complaints of pain for Residents #5, 3, 2, and 16.Review of incident report in TULIP received on 01/26/2026 at 7:07 PM.Review of progress notes dated 01/26/2026, revealed that Resident #1 was assessed and admitted to the hospital immediately after notifying staff of the incident.During an interview on 02/16/2026 at 9:15 am, LVN-E stated that she assessed Resident #1 immediately and notified the physician, ADON, and the family.Review of personnel file revealed NA-A was suspended on 01/26/2026 and terminated on 01/28/2026.Review of in-service regarding two-person mechanical lift protocol and policy, answering call light timely, reporting incidents abuse and neglect, and fall prevention dated 01/30/2026 signed by 16 employees. In-service stated answer call lights within 3 minutes, never ignore a call light, bathroom assistance protocol, and post fall do not move the resident after a fall, assess first, and 2 staff are required to perform a mechanical lift transfer at all times

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents for of 11 residents 20 (Resident #1, Resident #2, and Resident #3) reviewed for falls. 1. The facility failed to ensure Resident #1 was transferred with a mechanical lift by 2 staff, required when using a mechanical lift, which resulted in a distal femur fracture requiring surgical intervention 01/26/2026. 2. The facility failed to ensure Resident #5 had appropriate interventions and adequate staffing to prevent falls which resulted in multiple rib fractures and hospitalization on 01/15/2026. 3. The facility failed to ensure Resident #3 had appropriate interventions and adequate staffing to prevent a fall on 01/31/2026. An Immediate Jeopardy (IJ) situation was identified on 02/13/2026. While the IJ was removed on 02/16/2026, the facility remained out of compliance at a scope of a pattern with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of their corrective systems. This failure could place residents at risk of injury due to not being supervised and risk of serious bodily harm, physical impairment, hospitalization or death.Findings include: 1. Record review of Resident #1's electronic face sheet, accessed on 01/28/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #1 had diagnoses which included: Dementia (decline in mental ability) and Cerebral Ischemic Attack (stroke). Record review of Resident #1's Quarterly MDS assessment, dated 12/12/2025, revealed a BIMS of 03, which indicated severe cognitive impairment. Further review revealed Resident #1 used a wheelchair, had no history of falls, and required two or more people to assist for transfers. Record review of Resident #1's care plan, revised on 09/22/2024, revealed: Focus: The resident has an ADL self-care performance deficit.Interventions: The resident requires assistance by 2 staff for transfers using mechanical lift. Record review of facility's incident report, dated 01/26/2026, revealed in part: Resident came up to nurses' desk in a wheelchair pushed by an aide. Stated her left foot and hip [NAME] and stated she had fallen in her room during a transfer for Mechanical lift to wheelchair. Resident stated that she was dropped on the floor during transfer via staff member and staff member told her not to report the fall to anyone. Record review of hospital Discharge summary, dated [DATE], revealed Resident #1 was discharged back to the facility on [DATE] with diagnoses Post Distal Femur Fracture treated with surgery. During an observation and interview on 01/29/2026 at 5:00 PM, Resident #1 was lying in her bed in her room. Resident #1 stated on Monday morning 1/26/2026 she was transferred using a mechanical lift by NA-A. She stated she was dropped to the floor, NA-A pulled her back into the wheelchair, and she was instructed not to tell anyone. She stated she was routinely transferred by only one staff member. Resident #1 did not report the incident until CNA-D was taking her for a smoke break, a few hours later on 1/26/2026. CNA-D questioned why she was dragging her leg, which prompted her disclosure of the incident. During an interview on 01/29/2026 at 12:00 PM, Resident #4, who had a BIMS of 9 (meaning moderate cognitive impairment), and was Resident #1's roommate. Resident #4 stated she observed NA-A alone in the room transferring Resident #1 using a mechanical lift the morning of 1/26/2026. She stated she heard NA-A say, oh crap and observed Resident #1 and the lift on the floor. Resident #4 stated she had never observed two staff assisting with Resident #1's mechanical lift transfers. Record review of progress note, dated 01/26/26 at 3:13 PM, signed by LVN-E revealed: CNA-D brought resident up to nurses desk due to Resident wanted to report a fall she had in the mechanical lift a few nights ago to this nurse- Resident stated that night NA-A was transferring her in mechanical lift from wheelchair to bed and resident was dropped (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	on floor in mechanical Lift-Resident unable to state exact date and time of occurrence- Resident complained of left hip pain and left leg pain and left foot pain noted internal rotation at left leg /left foot with large amt of redness and swelling at left foot-Unable to move left lower leg /foot- V/S 154/74-96.5-78-20 O2 sat-97%- MD notified-Received orders Send resident to emergency room for eval and treatment. During a telephone interview on 03/02/2026 at 4:45 PM, NA-A stated Resident #1was not able to transfer by herself, dress herself and needed assistance to feed herself. NA -A stated she was shocked because she was accused of dropping Resident #1 while transferring her with the mechanical lift. NA -A stated she never transferred Resident #1 by herself that NA-C assisted her with the transfer on Monday when getting resident out of bed. NA-A stated the facility never trained her on transferring residents with a mechanical lift, but she knew you always needed two staff to transfer. During a telephone interview on 02/03/2026 at 5:45 PM, NA-C stated she worked on 1/26/2026, with NA-A. NA-C stated she had not received any training in regard to using a mechanical lift to transfer residents. NA-C stated she had never transferred a resident by herself. NA-C stated she had heard there were NAs that had transferred residents alone but had never witnessed staff doing transfers alone. NA-C stated she did not recall assisting NA-A with transferring Resident #1 from bed to wheelchair on Monday morning. NA-C stated she thinks LVN-K might have assisted NA-A. NA-C stated she and NA-A were the only aides working that shift with LVN-K. During an interview on 02/04/2026 at 11:20 am, LVN-K denied assisting NA-A transfer Resident #1 on Monday morning 1/26. LVN-K stated she had voiced her concerns in the past of NAs transferring residents alone and had reported those concerns to ADON and AIT. During an interview on 01/28/2026 at 5:15 PM, the AIT stated the checklist completed by the NAs were what NAs were allowed to do per their facility policy. She stated according to the checklist transfers were not allowed to be done alone by NAs and 2 person Mechanical lift transfers were not on the NA checklist. She stated it was her expectation for all mechanical lifts be performed with 2 staff members. She stated she could not find NA-A's NA checklist or any additional training. The AIT stated all training of NAs was the responsibility of the DON and the ADON. She stated the facility had a hard time keeping a DON and things were misplaced and probably not done correctly. The AIT stated she had never been notified of any concerns of NAs transferring residents with the mechanical lift alone. During an interview on 02/01/2026 at 12:12 PM, the ADON stated NAs could not perform any transfers without a CNA or a nurse. She stated 2 NAs together still could not perform these activities. She stated nurses were supposed to help and supervise the NAs to ensure they were not performing tasks they were not trained in. She stated when 2 NAs were on the floor the nurse was responsible for helping. The ADON denied receiving concerns from LVN-K about NAs transferring residents with mechanical lifts. Record review of NA-A's personnel files revealed NA-A was hired on 09/25/2025 worked for facility full time and was terminated on 01/28/2026, and no evidence of Aide Checklist for Orientation/Evaluation or any training regarding resident care for NA-A was documented. 2. Record review of Resident #3's electronic face sheet, accessed on 01/28/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included: heart failure (chronic condition where the heart muscle is too weak or stiff causing inability of the heart to pump sufficient blood) and kidney disease (damaged kidneys making them not filter the blood properly causing waste buildup). Record review of Resident #3's Quarterly MDS assessment, dated 11/19/2025, revealed a BIMS of 07, which indicated moderate cognitive impairment. Further review revealed Resident #3 needed partial/moderate assistance with toileting hygiene, sit to lying, sit to stand, and transfers. Record review of Resident #3's care plan, revised on 10/13/2025, revealed: Focus: The resident is at HIGH risk for falls.Interventions: Be sure the resident's call light is within reach and (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. Review of facility timecards, dated 01/29/2026, revealed NA-F was the only direct care staff on shift at the time of Resident #3's fall on 01/29/2026. During an observation on 1/29/2026 at 4:10 PM, Resident #4 was observed wheeling down the hall saying, I know you're on the floor; I will get some help. No staff were in the hall or at the nurses' station. Resident #3 was observed sitting on the floor in her room, and her call light was engaged (the light outside her door was flashing and an alarm was sounding at the nurse's station). At 4:15 PM, a hospice aide (that does not work for the facility) found Resident #3 on the floor in her room and went to find help. At 4:20 PM the hospice aide located the nurse and NA-F. NA-F went to the front office and got the ADON and the AIT. NA-F, the AIT, and ADON returned to Resident #3's room at 4:25 PM. Resident #3 was assessed by staff and was transferred to Emergency Department by paramedics, for further assessment and returned the same day to the facility. During an interview on 1/29/2026 at 4:15 PM, Resident #3 stated she used the call light to go to the restroom but could not wait, so she stood up and attempted going to the restroom on her own. When she stood, she urinated on herself and then slipped and fell on the floor. She stated that she always had to wait a while for staff to answer her call light and that she had fallen before. During an interview on 01/29/2026 at 4:45 PM, NA-F stated she was the only aide on shift. She stated management was helping her. NA-F stated she had worked by herself more since other staff had quit. She stated when she worked alone she had a hard time getting everything done. She stated being short staffed could have led to residents not getting the care they need and could have been considered neglect. 3. Record review of Resident #5's electronic face sheet, accessed on 01/28/2026, revealed an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #5 had diagnoses which included: Colon cancer (disease where cells in the large intestine or rectum grow uncontrollably) and muscle weakness. Record review of Resident #5's Quarterly MDS assessment, dated 12/12/2025, revealed a BIMS of 09, which indicated moderate cognitive impairment. Further review revealed Resident #5 used a walker and a wheelchair and needed assistance by one staff member for less than half of the effort for transfers. Record review of Resident #5's care plan, revised on 01/20/2026, revealed: Focus: The resident is at high risk for falls related to weakness. Further review of the care revealed no updates to fall interventions since 06/25/2025.The facility's incident log revealed Resident #5 had falls on the following dates without injury: 12/27/2025, 01/06/2026, 01/08/2026, 01/14/2026, 1/15/2026 (4:45 am) and 01/15/2026 (4:00 PM). Resident #5 had falls on 1/15/2026 at 6:00 PM and 1/24/2026 that resulted in injury. Record review of progress note dated 1/15/2026 at 4:15 PM, by LVN-E, revealed this nurse was summoned to resident's bathroom. Resident was lying on her back near the commode, she stated she was attempting to get on the commode and lost balance and fell on floor. Resident placed on 15-minute checks and encouraged to ask for assistance from staff for transfers -Resident stable no problems. Record review of progress note dated 1/15/2026 at 6:00 PM, by RN-N, revealed Resident was found on the floor in between the bathroom and the patient's room. She was moving all 4 extremities and wanting to get up. RN assessed [Resident #5], and she was placed back in her chair. Paramedics arrived and transferred Resident from her chair to stretcher, resident complained of pain to left rib cage, it was noted that resident was weak and had difficulty standing. She was transported to hospital for evaluation. Record review of progress note dated 1/16/2026, by LVN-B, reflected Resident was admitted hospital 1/15/26 with diagnosis of rib fractures from 4th to 8th ribs, pleural effusion, and UTI. Record review of progress note dated 1/24/2026 at 4:00 PM, by LVN-S, [Resident #5] was reaching down to the floor to pick up her phone and fell bumping left side of her forehead on floor, causing a raised circular area approx. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	2-inch purplish area on resident forehead, and denies much pain. Hospice nurse and daughter notified, neuros and 15-minute checks initiated. During an interview on 02/08/2026 at 4:50 PM, Resident #5's family representative stated Resident #5 had had numerous falls. She stated Resident #5 was anxious and tried to get up on her own. During an observation on 02/10/2026 at 11:00 AM, Resident #5 was sitting in a wheelchair in her room. Resident #5 was unable to answer questions. Room was free from clutter. She had one house shoe on and one house shoe off. During an interview on 02/11/2026 at 2:20 PM, the ADON stated Resident #5 had metastasized cancer and was always anxious, which was the reason for her decline in condition and multiple falls. She stated they had implemented interventions and does not know why the interventions were not updated in the care plan or medical record. The ADON stated 15-minute checks were started on 1/15/2026. Review of facility timecards, dated 01/15/2026, revealed NA-F was the only direct care staff on shift at the time of Resident #5's falls on 01/15/2026 at 4:00 PM and 6:00 PM. During an interview on 01/30/2026 at 11:30 AM, the AIT stated NA-F was the only aide working on 01/29/2026, day shift, because the other NA scheduled did not show up. She stated she and ADON were helping on the floor and it was not safe to only have 1 NA working on the floor. She stated she could not find any staff to hire. The AIT stated her expectation was for the residents to be taken care of by whatever means necessary. She stated she expected the nurses to help and for policies and procedures to be followed but that was not always realistic. During an interview on 02/11/2026 at 3:13 PM, the MD stated his expectation was for the facility to follow their policy regarding transferring residents. The MD stated if the policy stated mechanical lift transfers required 2 people, then there needed to be 2 persons when using the mechanical lift. The MD stated his expectation was staff who transferred residents with a mechanical lift should know how to use it. He stated being dropped during a mechanical lift transfer could cause a femur fracture, as sustained by Resident #1. The MD stated falls should have been assessed. If residents had multiple falls, the facility staff should have assessed and investigated falls to identify the underlying causes and implement interventions to prevent falls. Record review of the facility's policy titled Lifting Machine, Using a Mechanical Lift, revised July 2017, documented: At least 2 nursing assistants are needed to safely move a resident with a mechanical lift. Record review of the facility's document titled Nurse Aid checklist for Orientation/Evaluation revealed NAs cannot do the following tasks by themselves:?helping patients into chair from bed or helping patients into wheelchair. This was determined to be an Immediate Jeopardy (IJ) on 02/13/2026 at 12:40 PM. The Administration was notified. The AIT and Owner were provided with the IJ template on 02/13/2026 at 12:40 PM. The following Plan of Removal submitted by the facility was accepted on 02/15/2026 at 2:15 PM: TAG F689 - Free of Accident Hazards / Supervision (IJ) Direct Care Staff: A direct care staff can be any trained individual that demonstrates competency according to the facility's aid competency checklist. This may be an NA that is enrolled in a CNA training class and employed less than 120 days, a CNA, and LVN, or an RN that provides direct care to a resident, including but not limited to assistance with ADLs such as eating, bathing, toileting, transfers, hygiene care, etc. There must be two direct care staff on the floor at all times in addition to one LVN/RN charge nurse. There should be a total of one LVN/RN and two direct care staff in the building at all times if there are any mechanical lift residents. Staffing requirements will be assessed weekly based on census and resident needs. There will be two direct care staff if the facility has any residents that use a mechanical lift or are a two-person transfer. DON and ADON will ensure that all agency or temporary direct care staff have documented training prior to working a shift. Current temporary agency is giving us access to their portal so that we can check their credentials. The Sister facility will send us their CNA credentials prior to working a shift. This (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	will be started on 02/14/2026 and will be on going. Corrective Action for Resident Affected:Resident #1 was dropped in a single-person mechanical lift transfer by NA-A was immediately assessed by LVN-E upon findings, received treatment in hospital, and facility has followed orders upon discharge by 02/13/2026Resident #5 received immediate treatment on 01/15/2026. The resident was assessed by the nurse and sent to the hospital for further evaluation. The resident returned in stable condition. The facility put up reminder posters for the resident to use her call light and educated the resident about the importance of using the call light. The facility has worked with hospice to provide treatment to the resident and continues to follow hospice doctor orders.Resident #3 received immediate treatment on 01/29/2026. The resident was assessed by the ADON. The hospice, doctor, family, and administrator were notified upon discovery. The resident was transferred to the hospital for further evaluation. Hospital results indicate no adverse outcome for the resident. The facility continues to monitor the resident for maladaptive outcomes of the fall such as pain, emotional distress, and injury.Physician, ADON, administrator, and responsible party were notified by LVN-E on 01/26/2026.Neurological checks and monitoring were initiated by LVN-E when a CNA-D brought Resident #1 to the nurse upon resident's complaint of pain on 01/26/2026. LVN-E followed protocol to evaluate the resident after complaints of pain. The charge nurse on duty is responsible for assessing residents with neuro checks after complaints of pain. NA-A was immediately removed from resident care pending investigation on 01/26/2026 and terminated before returning to duty on 01/28/2026 pending investigation. NA-A was not immediately terminated due to pending investigation. Identification of Other Residents at Risk:100% audit of all 9 residents requiring mechanical lift transfers was completed by the ADON and a list displayed at the nurses station on 01/26/2026. The ADON notified all staff in the facility on 01/26/2026 and the list shown in the shift report between charge nurses and in the shower sheet book for the aides. All direct care received a text message about the locations of the mechanical lift on 02/14/2026. The ADON reviews the list of mechanical lift transfers weekly and the shift report.The facility will continue monitoring Residents #3 and #5 as it relates to incidents and staffing comparison. The residents have been educated by ADON on call light usage on the same day as their respective falls on 01/30/2026 and 01/16/2026. Staff in the building were educated by ADON and via informational handout at nurses' station on call light response expectations on 01/16/2026 with a signature page to confirm review before starting first shift. The AIT provided call light education at the in-service on 01/30/2026 with an in-service signature sheet. All nursing staff received education about call light usage and falls from the DON on 02/14/2026 via phone calls. The DON is tracking all staff that she has provided the education to any staff that has not received the education will not be allowed to begin their next shift until they have been educated. All direct care nursing staff will be required to take a quiz starting 02/15/2026 prior to working as a direct care staff. Quizzes will be graded prior to start of shift by the AIT or designee. Any staff that fail the quiz will be re-educated in a one-on-one educational session and retested. If they fail the subsequent quiz, staff will be removed from care. No additional incidents identified based on 9/9 mechanical lift transfer resident interviews done by the ADON.Systemic Changes:All RNs, LVNs, CNAs, and NAs on duty were re-educated by ADON and all staff were required to review an informational protocol handout on the facility's mechanical lift policy, including the requirement for two staff during Mechanical lift transfers, placed on 01/26/2026 before returning to work. The education is documented with staff signature review with the in-services. The handout educated staff on proper protocol for mechanical lift use. A follow-up in-service by AIT was conducted on 01/30/2026 with the COTA providing a return demonstration mechanical lift use. Proper mechanical lift use has been added to new hire packets and competency (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	checklists for direct care staff.Starting 02/14/2026, all agency and sister facility direct care staff will be provided an educational handout for review directed by the charge nurse prior to starting the shift on the floor. The handout will provide an in-service about abuse and neglect, call light usage, mechanical lift transfer, and falls. Verification of competency will be demonstrated with a verbal return of information and staff signature.All RNs, LVNs, CNAs, NAs on staff at the time of Resident #5's fall were re-educated by the ADON and all staff were required to review an informational fall and post-fall in-service at the nurses station with documented signatures on 01/16/2026 requiring review before the start of the first shift. The AIT reviewed falls and fall prevention at the mandatory staff in-service on 01/30/2026 with documented in-service signatures. Staff were educated via informational handout at nurses' station on call light response expectations on 01/16/2026 with a signature page to confirm review. The AIT provided call light education at the in-service on 01/30/2026 with an in-service signature sheet. Direct Care Staff will demonstrate knowledge by returning information about the call light expectations to the ADON on 02/14/2026. All staff received education about call light usage and falls from the DON on 02/14/2026 via phone calls. The DON is tracking all staff that she has provided the education to. Any staff that has not received the education will not be allowed to begin their next shift until they have been educated.New Direct Care Staff will be trained about call light expectations during their on-the-floor training before providing resident care starting 02/14/2025 to be completed the ADON/designee orientator. The orientator will ensure the new staff are competent through return verbal information before initialing the section on the orientation sheet about call lights.On 02/14/2026, the AIT will conduct an audit of in-services about mechanical lift use, incident reporting, abuse/neglect, falls, and call lights to ensure all staff have been trained. Any staff missing the in-service education will not be allowed to work until they have received the training from the AIT/designee with a verbal return instruction. An audit will be completed monthly by the AIT and reported to the IDT in the monthly QAPI meetings for three months Competency validations by COTA and ADON for mechanical lift use were completed by 100% of direct care staff (RNs, LVNs, CNAs, Nas) on 01/30/2026. All staff involved in the competency validations signed an in-service sheet on 01/30/2026. Regular, random observations by charge nurses and DON will be conducted on each shift and documents. The charge nurse will do observations three times a week. DON/designee will conduct random lift transfer observations 3x weekly for 4 weeks, then weekly for 2 months starting 02/13/2026. There will be at least one transfer monitored for each observation day and will include both aid shifts at least once a week. Any noncompliance will result in staff suspension of care until a correct return demonstration is conducted with a charge nurse. The ADON posted signage above mechanical lift resident beds to ensure staff were reminded which residents required mechanical lift use on 01/31/2026. Mechanical lift policy was reinforced with all direct care nursing staff on duty by the ADON and through information handout at the nurses station with clear disciplinary consequences for non-compliance on 01/26/2026 to be reviewed by all Direct Care Staff prior to working their first shift. Staff that have reviewed the document sign that they have reviewed the information on an in-service sheet. A follow-up return demonstration to ensure competency was conducted on 01/30/2026 by the COTA. All nursing staff were deemed competent on 01/30/2026 by the COTA and ADON with signature validation on the in-service sheet. Charge nurse/designee will monitor transfers on each shift for compliance. Checks will be tracked in a log at the nurses station and reviewed monthly by the ADON in QAPI. The charge nurse will monitor a mechanical lift transfer once per shift for four weeks and initial off completion. If there is a non-compliance noted, the staff will be immediately re-educated and removed from duty until a return demonstration is completed properly.The DON (continued on next page)

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	676053	A. Building B. Wing	02/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Merkel Nursing Center	1704 N 1st Merkel, TX 79536

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	trained all Direct nursing Care Staff on falls and call light usage via phone calls with return instruction to ensure retention of information on 02/14/2026. Any Direct Care Staff members that do not answer the phone will not be able to return to work their shift until the staff is retrained on falls and call lights. Monitoring:DON/designee will conduct random lift transfer observations 3x weekly for 4 weeks, then weekly for 2 months starting 02/13/2026. There will be at least one transfer monitored for each observation day and will include both aid shifts at least once a week. The observer will initial a log kept at the nurses station. If non-compliance is noted, staff conducted a mechanical lift improperly will be terminated immediately and the resident will be assessed for pain or injury.Results will be reported at the monthly QAPI for 3 months.Completion Date: 02/14/2026 Monitoring of the facility's Plan of Removal revealed the following:Review of progress notes dated 01/26/2026, revealed that Resident #1 was assessed and admitted to the hospital immediately after notifying staff of the incident.Review of Hospital Discharge Orders and Instructions dated 01/29/2026, revealed that physicians orders and review of physicians' orders revealed they were entered into the system.During an interview on 02/16/2026 at 9:15 AM LVN-E stated that she assessed Resident #1 immediately and notified the physician, ADON, and the family.Review of progress notes dated 01/15/2026, revealed that Resident #5 was assessed and sent to hospital after having multiple falls and complaints of pain on 01/15/2026.During an interview on 02/15/2026 at 6:20 PM, RN-N stated that Resident #5 was assessed and sent to hospital after having multiple falls and complaints of pain on 01/15/2026.Observation on 02/15/2026 at 2:20 PM revealed posters in residents room reminding her to use th3e call light. Resident was unable to answer questions regarding her education.During a phone interview on 02/15/2026 2:35 PM, LVN-B stated that she has educated Resident #5 regarding falls and using her call light. She stated that she had documented the education many times in the progress notes. Review of progress notes revealed multiple entries regarding education on call light.During an interview on 02/16/2026 at 9:15 AM, LVN-E stated that she assessed Resident #1 immediately and notified the physician, ADON, and the family. Review of progress notes dated 01/26/2026, revealed physician and family were notified regarding Resident #1.Review of Neurological checks and monitoring sheet dated 01/26/2026, revealed monitoring was initiated, and that LVN-E followed protocol on 01/26/2026Review of personnel file revealed NA-A was suspended on 01/26/2026 and terminated on 01/28/2026.Observation on 02/15/2026 at 2:20 PM the Mechanical Lift resident list, was displayed at the nurses' station in the shift report book, and in the shower book. The Mechanical Lift resident list identified 9 residents who required transfers by a mechanical lift.During interviews on 02/15/2026 from 2:20 PM- 02/16/2026 9:25 AM, LVN-E and LVN-K stated they work the day shift from 6am-2PM. They stated that they were notified of the Mechanical lift transfer sheet and where it was located on 01/26/2026. They stated that they received a text message on 02/14/2026 with all of the locations of the Mechanical lift list. They verbalized understanding.During interviews on 02/15/2026 from 2:20 PM- 02/16/2026 9:25 AM, CNA-D, NA-H, and NA-F stated they work the day shift from 6am-6PM. They stated that they were notified of the Mechanical lift transfer sheet and where it was located on 01/26/2026. They stated that they received a text message on 02/14/2026 with all of the locations of the Mechanical lift list. They verbalized understanding.During interviews on 02/15/2026 from 2:20 PM- 02/16/2026 9:25 AM, RN-R and RN-T stated they work the evening shift from 2PM-10PM. They stated that they were notified of the Mechanical lift transfer sheet and where it was located on 01/26/2026. They stated that they received a text message on 02/14/2026 with all of the locations of the Mechanical lift list. They verbalized understanding.During interviews on 02/15/2026 from 2:20 PM- 02/16/2026 9:25 AM, LVN-B stated she worked the night shift from 10PM-6am. She stated that she was notified of the Mechanical lift transfer sheet and (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	where it was located on 01/26/2026. She stated that she received a text message on 02/14/2026 with all of the locations of the Mechanical lift list. She verbalized understanding.During an interview on 02/15/2026 at 3:00 PM, the ADON stated that she performed a mechanical lift audit on 01/26/2026 and she displayed the list. She stated that she had reviewed the list weekly for updates.Record review of Weekly Mechanical lift Review List was completed on 02/14/2026 by ADON that stated 9 residents were using Mechanical lifts some or all of the time and that nurse's station Mechanical lift list accurately list all Mechanical lift use. Record review of in-service titled Falls, Post-Fall, Bathroom, dated 01/16/2026 revealed 16 staff signatures. In-service stated answer call lights within 3 minutes, never ignore a call light, bathroom assistance protocol, and post fall protocol. In-service stated, do not move the resident after a fall, assess first.Record review of in-service regarding two-person mechanical lift protocol and policy, answering call light timely, reporting incidents abuse and neglect, and fall prevention dated 01/30/2026 signed by 16 employees. In-service stated answer call lights within 3 minutes, never ignore a call light, bathroom assistance protocol, and post fall do not move the resident after a fall, assess first, and 2 staff are required to perform a mechanical lift transfer at all times.Record review of in-service titled Mechanical lift with return demonstration, dated 01/28/2026 with 9 staff signatures and one dated 01/30/2026 revealed 16 signatures. In-service stated 2 staff are required to perform a mechanical lift transfer at all times.During interviews on 02/15/2026 from 2:20 PM- 02/16/2026 9:25 AM, LVN-E and LVN-K stated they work the day shift from 6am-2PM. They stated that they were in-serviced on 01/16/2026 by ADON regarding falls and call light response and again on 01/30/2026 by the AIT on call light response. They stated on 02/16/2026 prior to working her shift she was educated by the DON regarding falls

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing sufficient numbers of licensed nurses and nurse aides for 34 of 84 shifts reviewed for nurse staffing and 4 of 28 (Resident #2, Resident #3, Resident # 5 and Resident #16) residents reviewed for sufficient staffing. The facility failed to ensure 34 of 84 shifts were staffed with at least two direct care staff, per the facility assessment, between the dates of 1/1/26 and 2/11/2026 (1/02/26 6:00PM -6:00AM; 1/06/26 6:00PM -6:00 AM; 1/08/26 6:00PM -6:00 AM; 1/10/26 6:00AM -6:00PM; 1/11/26 6:00AM -6:00 PM; 1/15/26 6:00AM -6:00 PM; 1/16/26 6:00PM -6:00 AM; 1/17/26 6:00PM -6:00AM; 1/18/26 6:00PM -6:00AM; 1/19/26 6:00AM -6:00 PM; 1/21/26 6:00PM -6:00 AM; 1/22/26 6:00PM -6:00 AM; 1/26/26 6:00AM -6:00 PM;1/26/26 6:00PM -6:00 AM; 1/27/26 6:00AM -6:00 PM; 1/27/26 6:00PM -6:00 AM; 1/28/26 6:00PM -6:00 AM; 1/29/26 6:00AM -6:00 PM; 1/29/26 6:00PM -6:00 AM; 1/30/26 6:00PM -6:00 AM; 1/31/26 6:00PM -6:00 AM; 2/01/26 6:00AM -6:00 PM; 2/01/26 6:00PM -6:00 AM; 2/02/26 6:00PM -6:00 AM; 2/03/26 6:00AM -6:00 PM; 2/03/26 6:00PM -6:00 AM; 2/04/26 6:00AM -6:00 PM;2/04/26 6:00PM -6:00 AM; 2/05/26 6:00AM -6:00 PM; 2/05/26 6:00PM -6:00 AM; 2/06/26 6:00AM -6:00 PM; 2/06/26 6:00PM -6:00 AM; 2/07/26 6:00AM -6:00 PM; and 2/08/26 6:00AM -6:00 PM). The facility failed to ensure sufficient staffing were in place to prevent Resident #2 from being inappropriately transferred by NA-F on 01/29/2026. The facility failed to ensure sufficient staffing were in place to prevent Resident #3's fall on 01/31/2026. The facility failed to ensure sufficient staffing were in place to prevent Resident #5 from failing which resulted in multiple rib fractures and hospitalization on 01/15/2026. The facility failed to ensure sufficient staffing were in place to prevent Resident #16 not being changed for over 2 hours after asking NA-F and RN-R to help her. An Immediate Jeopardy (IJ) situation was identified on 02/13/2026. While the IJ was removed on 02/16/2026, the facility remained out of compliance at a scope of a pattern with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of their corrective systems. This failure could place residents at risk of not getting needed care and services, a decrease in quality of care and quality of life and/or injury.Findings include:Record review of document titled, Facility Assessment dated 01/07/2026 revealed the staffing requirement to be 2 direct care staff and 1 nurse were needed per shift. Record review of facility time sheets dated between 01/01/2026 and 02/11/2026 revealed: 1/02/26 6:00PM -6:00AM there was only 1 direct care staff.1/06/26 6:00PM -6:00 AM there was only 1 direct care staff.1/08/26 6:00PM -6:00 AM there was only 1 direct care staff.1/10/26 6:00AM -6:00PM there was only 1 direct care staff.1/11/26 6:00AM -6:00 PM there was only 1 direct care staff.1/15/26 6:00AM -6:00 PM there was only 1 direct care staff.1/16/26 6:00PM -6:00 AM there was only 1 direct care staff.1/17/26 6:00PM -6:00AM there was only 1 direct care staff.1/18/26 6:00PM -6:00AM there was only 1 direct care staff.1/19/26 6:00AM -6:00 PM there was only 1 direct care staff.1/21/26 6:00PM -6:00 AM there was only 1 direct care staff.1/22/26 6:00PM -6:00 AM there was only 1 direct care staff.1/26/26 6:00AM -6:00 PM there was only 1 direct care staff.1/26/26 6:00PM -6:00 AM there was only 1 direct care staff.1/27/26 6:00AM -6:00 PM there was only 1 direct care staff.1/27/26 6:00PM -6:00 AM there was only 1 direct care staff.1/28/26 6:00PM -6:00 AM there was only 1 direct care staff.1/29/26 6:00AM -6:00 PM there was only 1 direct care staff.1/29/26 6:00PM -6:00 AM there was only 1 direct care staff.1/30/26 6:00PM -6:00 AM there was only 1 direct care staff.1/31/26 6:00PM -6:00 AM there was only 1 direct care staff.2/01/26 6:00AM -6:00 PM there was only 1 direct care staff.2/01/26 6:00PM -6:00 AM there was (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	only 1 direct care staff.2/02/26 6:00PM -6:00 AM there was only 1 direct care staff.2/03/26 6:00AM -6:00 PM there was only 1 direct care staff.2/03/26 6:00PM -6:00 AM there was only 1 direct care staff.2/04/26 6:00AM -6:00 PM there was only 1 direct care staff.2/04/26 6:00PM -6:00 AM there was only 1 direct care staff.2/05/26 6:00AM -6:00 PM there was only 1 direct care staff.2/05/26 6:00PM -6:00 AM there was only 1 direct care staff.2/06/26 6:00AM -6:00 PM there was only 1 direct care staff.2/06/26 6:00PM -6:00 AM there was only 1 direct care staff.2/07/26 6:00AM -6:00 PM there was only 1 direct care staff.2/08/26 6:00AM -6:00 PM there was only 1 direct care staff. Resident #2Record review of Resident #2's electronic face sheet, dated 01/28/2026, revealed an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #2 had diagnoses which included: fracture of left femur (left hip broken bone) and anxiety disorder. Record review of Resident #2's Quarterly MDS assessment, dated 11/14/2025, revealed a BIMS score of 00, which indicated severe cognitive impairment. Further review revealed Resident needed the assistance of 2 or more persons to transfer. Record review of Resident #2's care plan, revised on 01/28/2026, revealed he required two-person maximum assistance and two-person mechanical lift transfers. During observation on 01/29/26 at 4:35 PM, NA-F entered Resident #2's room alone and exited at 4:40 PM. Resident #2 had been transferred back to his bed, there was no observation of mechanical lift in the Resident's room. During an interview on 01/29/2026 at 4:45 PM NA-F stated she was the only aide working and transferred Resident #2 by herself, without the assistance of a second staff member. She acknowledged the transfer required a mechanical lift and two staff, but she had transferred him without using the mechanical lift, because no help was available and that she routinely transferred the resident this way. NA-F stated transferring residents inappropriately could have led to an injury.Resident #3Record review of Resident #3's electronic face sheet, dated 01/28/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #3 had diagnoses which included: heart failure (chronic condition where the heart muscle is too weak or stiff causing inability of the heart to pump sufficient blood) and kidney disease (damaged kidneys making them not filter the blood properly causing waste buildup).Record review of Resident #3's Quarterly MDS assessment, dated 11/19/2025, revealed a BIMS score of 07, which indicated severe cognitive impairment. Further review revealed Resident #3 Partial/moderate assistance with toileting hygiene, sit to lying, sit to stand, and transfers.Record review of Resident #3's care plan, revised on 10/13/2025, revealed: Focus: The resident is at HIGH risk for falls.Interventions: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.During an observation on 1/29/2026 at 4:10 PM, Resident #4 was observed wheeling down the hall saying, I know you're on the floor; I will get some help. No staff were in the hall or at the nurses' station. Resident #3 was observed sitting on the floor in her room, and her call light was engaged (the light outside her door was flashing and an alarm was sounding at the nurse's station). At 4:15 PM, a hospice aide (that does not work for the facility) found Resident #3 on the floor in her room and went to find help. At 4:20 PM the hospice aide located the nurse and NA-F. NA-F went to the front office and got the ADON and the AIT. NA-F, the AIT, and ADON returned to Resident #3's room at 4:25 PM. Resident #3 was assessed by staff and was transferred to the Emergency Department by paramedics, for further assessment and returned the same day to the facility.During an interview on 1/29/2026 at 4:15 PM, Resident #3 stated she used the call light to go to the restroom but could not wait, so she stood up and attempted going to the restroom on her own. When she stood, she urinated on herself and then slipped and fell on the floor. She stated that she always had to wait a while for staff to answer her call light and that she had fallen before. Review of facility timecards, dated 01/29/2026, revealed NA-F was the (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	only direct care staff on shift at the time of Resident #3's fall on 01/29/2026.Resident #5Record review of Resident #5's electronic face sheet, dated 01/28/2026, revealed an [AGE] year-old female who was admitted to the facility on [DATE] and readmitted on [DATE]. Resident #5 had diagnoses which included: Colon cancer (disease where cells in the large intestine or rectum grow uncontrollably), and muscle weakness.Record review of Resident #5's Quarterly MDS assessment, dated 12/12/2025, revealed a BIMS score of 09, which indicated moderate cognitive impairment. Further review revealed Resident #5 used a walker and a wheelchair and needed assistance by one staff member for less than half of the effort for transfers.Record review of Resident #5's care plan, revised on 01/20/2026, revealed: Focus: The resident is at high risk for falls related to weakness. Further review of the care revealed no updates to fall interventions since 06/25/2025.The facility's incident log revealed Resident #5 had falls on the following dates without injury: 12/27/25, 01/06/2026, 01/08/2026, 01/14/2026, 1/15/2026 (4:45 AM) and 01/15/2026 (4:00 PM). Resident #5 had falls on 1/15/2026 at 6:00 PM and 1/24/2026 that resulted in injury.Record review of progress note dated 1/15/2026 at 4:15 PM, by LVN-E, revealed this nurse was summoned to resident's bathroom. Resident was lying on her back near the commode, she stated she was attempting to get on the commode and lost balance and fell on floor. Resident placed on 15-minute checks and encouraged to ask for assistance from staff for transfers -Resident stable no problems.Record review of progress note dated 1/15/2026 at 6:00 PM, by RN-N, revealed Resident was found on the floor in between the bathroom and the patient's room. She was moving all 4 extremities and wanting to get up. RN assessed [Resident #5], and she was placed back in her chair. Paramedics arrived and transferred Resident from her chair to stretcher, resident complained of pain to left rib cage, it was noted that resident was weak and had difficulty standing. She was transported to hospital for evaluation.Record review of progress note dated 1/16/2026, by LVN-B, Resident was admitted hospital 1/15/26 with diagnosis of rib fractures from 4th to 8th ribs, pleural effusion, and UTI.Record review of progress note dated 1/24/2026 at 4:00 PM, by LVN-S, [Resident #5] was reaching down to the floor to pick up her phone and fell bumping left side of her forehead on floor, causing a raised circular area approx. 2-inch purplish area on resident forehead, and denies much pain. Hospice nurse and daughter notified, neuros and 15-minute checks initiated.During an interview on 02/08/2026 at 4:50 PM, Resident #5's family representative stated Resident #5 had numerous falls. She stated Resident #5 was anxious and tried to get up on her own.During an observation on 02/10/2026 at 11:00 am, Resident #5 was sitting in a wheelchair in her room. Resident#5 was unable to answer questions. Her room was free from clutter. She had one house shoe on and one house shoe was off.During an interview on 02/11/2026 2:20 PM, the ADON stated Resident #5 had metastasized cancer and was always anxious, which was the reason for her decline in condition and multiple falls. She stated they had implemented interventions and does not know why the interventions were not updated in the care plan or medical record. The ADON stated 15-minute checks were started on 1/15/2026.Review of facility timecards, dated 01/15/2026, revealed NA-F was the only direct care staff on shift at the time of Resident #5's falls on 01/15/2026 at 4:00 PM and 6:00 PM.Resident #16Record review of Resident #16's electronic face sheet, dated 01/28/2026, revealed a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #16 had diagnoses which included: depression and anxiety disorder.Record review of Resident #16's Quarterly MDS assessment, dated 11/21/2025, revealed a BIMS score of 01, which indicated severe cognitive impairment. Further review revealed Resident required partial/moderate assistance with transfers and was occasionally incontinent.Record review of Resident #16's care plan, revised on 01/23/2026, revealed she required one-person assist with transfers.During an observation on 2/07/2026 at 4:45 PM, Resident #16 waited for 2 hours for staff to change her after an (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	incontinent episode. NA-F told Resident #16 I can't right now, I am very busy. At 5:15 PM, Resident #16 was sitting in the hall in her wheelchair crying because she still had not been changed. At 5:35 PM, Resident #16 was sitting at the table in the dining room and still had not been changed. At 5:45 PM, Resident #16 wheeled down the hall and asked RN-R to change her wet pants and RN-R looked at resident and failed to acknowledge resident's request. At 6:00 PM, Resident #16 was in the dining room, she appeared upset and attempted to take off her clothes because they were wet. The ADON reprimanded Resident #16 about her inappropriate behavior and told her to go to her room. At 6:45 PM, NA-F entered Resident #16's room and assisted her with changing her clothes. During an interview on 2/13/2026 at 11:45 AM NA-F stated that she was the only aide on shift. She stated that the management was helping her. NA-F stated that she had worked by herself more since other staff had quit. She stated when she worked alone, she had a hard time getting everything done. She stated being short staffed could have led to residents not getting the care they need and could have been considered neglect. During an interview on 01/30/2026 at 11:30 am, the AIT stated that NA-F was the only aide working on 01/29/2026 day shift because the other NA scheduled did not show up. She stated that she and the ADON were helping on the floor. When asked why they were all in the office at the time of 5 call lights going off, Resident #3 falling, and Resident #2 being inappropriately transferred, she had no response. She stated Resident #2 should not have been transferred without the mechanical lift, and that it was not safe to only have 1 NA working on the floor. She stated that she could not find any staff to hire. AIT stated that her expectation was for the residents to be taken care of whatever means necessary. She stated that she expected the nurses to help and for policies and procedures to be followed but that was not always realistic. During an interview on 2/12/2026 at 12:30 PM, the ADON stated the facility has been short staffed, due to staff not wanting to work, staff quitting and not being able to hire staff due to being in a rural area. The ADON stated she worked overtime to ensure that resident care was covered but cannot work 24 hours a day. The ADON stated resident care suffers because of being short staffed. During an interview on 2/11/2026 at 3:13 PM, the MD stated he was not aware the facility had been using so many uncertified aides. The MD stated the facility should have been using agency staff to ensure residents were receiving care by staff who were qualified. The MD stated the facility had a hard time hiring certified aides because the facility could not compete with the bigger facilities and/or the hospitals.This was determined to be an Immediate Jeopardy (IJ) on 02/13/2026 at 12:40 PM. The Administration was notified. The AIT and Owner were provided with the IJ template on 02/13/2026 at 12:40 PM and a Plan of Removal was requested.The following Plan of Removal was accepted on 02/15/2026 at 2:15 PM: TAG F725 - Sufficient Nursing Staff (IJ)Direct Care Staff: A direct care staff can be any trained individual that demonstrates competency according to the facility's aid competency checklist. This may be an NA that is enrolled in a CNA training class and employed less than 120 days, a CNA, and LVN, or an RN that provides direct care to a resident, including but not limited to assistance with ADLs such as eating, bathing, toileting, transfers, hygiene care, etc. There must be two direct care staff on the floor at all times in addition to one LVN/RN charge nurse. There should be a total of one LVN/RN and two direct care staff in the building at all times if there are any mechanical lift residents. Staffing requirements will be assessed weekly based on census and resident needs. There will be two direct care staff if the facility has any residents that use a mechanical lift or are a two-person transfer.DON and ADON will ensure that all agency or temporary direct care staff have documented training prior to working a shift. Current temporary agency is giving us access to their portal so that we can check their credentials. The Sister facility will send us their CNA credentials prior to working a shift. This will be started on 02/14/2026 (continued on next page)

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	676053	A. Building B. Wing	02/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Merkel Nursing Center	1704 N 1st Merkel, TX 79536

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	and will be on going.Corrective Action:The facility will require two direct care nursing staff on each rotation starting 02/13/2026. The facility will utilize staffing agency and aides from the sister facility if the facility does not have enough qualified staff. Direct care nursing staff are staff who provide direct care to residents including but not limited to assistance with ADLs. The facility assessment will be completed weekly to assess acuity and needs for direct care nursing staffing requirements. The IDT will review the facility assessment policy for guidance on acuity levels and staffing needs on 02/15/2026. The facility will follow the facility assessment to determine staffing needs. Residents #5, 3, 2, and 16 were assessed by ADON for any further injury, emotional distress, or pain on 02/13/2026. Immediate review of staffing patterns was conducted by the AIT to evaluate gaps in coverage and needs for staffing on 02/09/2026. Multiple gaps in direct care nursing staff were identified. The AIT began contacting temporary staffing agencies on 02/10/2026 to meet staffing requirements. The AIT utilized aides from sister facility to cover gaps until the staffing agency was able to fill assignments. Facility implemented temporary agency staffing to ensure a two direct care staffing coverage on 02/13/2026. The facility will request a copy of the aides certification from the staffing agency. Certification checks will be conducted on all aides arriving from our sister facility. The charge nurse will verbally educate any agency and sister facility staff on call lights, mechanical lift, and abuse and neglect during shift report, prior to the aid starting their shift. The charge nurse will require a verbal return instruction before the aid starts the shift to determine competency. Schedule adjusted by AIT to prevent only one direct care staff at all times on 02/13/2026. Adjustments were made through temp agencies and [sister facility] CNAs. Systemic Changes:The facility assessment was reviewed by the DON and ADON on 02/14/2026 to ensure accurate information Direct Care Staff requirements revised on the facility assessment by AIT and ADON to ensure two direct care staffing requirements are met at all times on 02/13/2026. Direct care nursing staff are staff who provide direct care to residents including but not limited to assistance with ADLsAdministrator and DON will review daily Direct Care Staff sheets immediately on 02/13/2026 and daily for all shifts thereafterFacility has initiated active recruitment efforts by the AIT including agency utilization starting 02/13/2026. If there is noncompliance, the facility will utilize staffing agencies and aides from [sister facility] to cover any gaps in coverage.The DON trained all staff on falls and call light usage via phone calls with return instruction to ensure retention of information on 02/14/2026. Any Direct Care Staff members that do not answer the phone will not be able to return to work their shift until the staff is retrained on falls and call lights.The IDT will create a flow sheet on 02/15/2026 for a response protocol to be enacted when a scheduled direct care nursing staff does not show up for their shift to ensure there are two direct care nursing staff will be on the floor at all times. Monitoring:Daily staffing audits by the AIT will be completed for 30 days starting 02/13/2026. This will be monitored through punch tracking on a spreadsheet. If there is noncompliance, the facility will initiate a PIP to resolve the issue. Weekly review in IDT meeting on 02/13/2026Ongoing review in QAPI for 3 monthsCompletion Date: 02/15/2026Monitoring of the facility's Plan of Removal revealed the following:During an interview on 02/16/2026 at 6:00 PM, the AIT stated the facility assessment was reviewed and updated.Review of Facility assessment, dated 02/16/2026 signed by ADON and Owner revealed: Staffing and Plans- Nurse Aides 2; Staff Direct Care staff 2.Review of schedules and timecards revealed: 02/14/2026 6a-6p CNA-D and Agency CNA worked as direct care staff.Observation on 02/14/2026 at 12:30 PM observed CNA-D and Agency CNA in the facility providing direct patient care.Review of schedules and timecards revealed: 02/14/2026 6p-6a LVN-V worked as direct care staff from 6PM-10PM and ADON worked until 10PM. Review revealed sister facility CNA-U worked from (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	10PM-6am.Observation on 02/14/2026 at 6:15 PM observed ADON and LVN-V in the facility providing direct patient care.Review of schedules and timecards revealed: 02/15/2026 6a-6p CNA-D and DON worked as direct care staff.Observation on 02/15/2026 at 11:30 am observed CNA-D and DON in the facility providing direct patient care.Review of schedules and timecards revealed: 02/15/2026 6p-6a Agency CNA and NA- Worked as direct care staff.Observation on 02/15/2026 at 6:15 PM observed in the facility Agency CNA and NA-O providing direct patient care.Observation on 02/16/2026 at 3:00 PM observed DON and LVN-K providing direct patient care.Record review of progress notes dated 02/13/2026 revealed no injuries noted and no complaints of pain for Residents #5, 3, 2, and 16.During an interview on 02/16/2026 AIT stated she re-did the schedule and had monitored and updated it daily to ensure the facility was staffed with 2 direct care staff at all times. During an interview on 02/16/2026 the AIT stated she was utilizing a staffing agency for staffing and staff from the sister facility. She stated she had educated charge nurses on location of training materials to be completed by agency and sister staff prior to them working on the floor.Reviewed education hand out for agency and temporary staff covered abuse and neglect, call light usage, mechanical lift transfer, and falls. signed by CNA-U and dated 02/14/2026.During a phone interview on O2/05/2026 at 4:45 PM, CNA-U stated she was given the handout prior to working her shift on 02/14/2026 by RN-R.During an interview on 02/05/2026 at 4:50, RN-R verified CNA-U received the handout and verbalized understanding prior to working her shift on 02/14/2026.02/15/2026 at 6:15 PM observed DON review educational handout for agency CNA coming on-shift. Agency CNA acknowledged the information and signed the form. During an interview on 02/16/2026 at 6:00 PM, the AIT stated she was reviewing staffing daily and on-going.During interviews on 02/15/2026 from 2:20 PM- 02/16/2026 9:25 am, CNA-D, NA-H, and NA-F stated they work the day shift from 6am-6PM. They stated that they were in-serviced on 01/30/2026 by the AIT regarding falls and call light response. They stated on 02/14/2026 they were educated by the DON regarding falls and call lights and took a Quiz. Verified their signature on all in-services and completed Quiz. They stated the expectation was for call lights to me answered within 3 minutes.During interviews on 02/15/2026 from 2:20 PM- 02/16/2026 9:25 am, RN-R and RN-T stated they work the evening shift from 2PM-10PM. They stated that they were in-serviced on 01/30/2026 by the AIT regarding falls and call light response. They stated on 02/14/2026 they were educated by the DON regarding falls and call lights and took a Quiz. Verified their signature on all in-services and completed Quiz. They stated the expectation was for call lights to me answered within 3 minutes.During interviews on 02/15/2026 from 2:20 PM- 02/16/2026 9:25 am, LVN-B stated she worked the night shift from 10PM-6am. She stated that she was in-serviced on 01/30/2026 by the AIT regarding falls and call light response. She stated on 02/14/2026 she was educated by the DON regarding falls and call lights and took a Quiz. Verified her signature on all in-services and completed Quiz. She stated the expectation was for call lights to be answered within 3 minutes.During an interview on 02/15/2026 at 3:25 PM, the DON stated she provided education via phone to all employees regarding falls and call lights on 02/14/2026.Review of Employee roster and in-service signature sheets revealed all staff currently employees for the facility were trained by the DON on 02/14/2026 and 02/16/2026 all prior to working their shift. Reviewed document titled, Flowchart for Direct Care Staff. It included: CNA Staff Member> Temp Agency> Sister Facility Staff> Nurse or RN> DON/ADON.During an interview on 02/16/2026 at 6:00 PM, AIT, ADON, and Owner stated an IDT meeting was held on 02/13/2026. Review of document titled, IDT Meeting, dated 02/13/2026 revealed: Topic: Staffing contingency plan, IJ corrections, staff trainings, mechanical lifts, facility assessment/direct care staff. Attendees: AIT, ADON, Owner, and DONDuring an interview on 02/16/2026 at 6:00 PM the AIT stated an informal QAPI was done on 02/11/2026 with the MD and he stated this would (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	count as QAPI. She stated the MD was notified by the owner when the IJs were called. She stated she was getting all of the information together to have an official QAPI meeting.During an interview on 02/16/2026 at 4:00 PM, the MD stated he did perform a QAPI at the facility on 02/11/2026 and he was a part of the plan of removal. He stated he was notified immediately after the IJs were called. He stated the facility is doing the best they can to fix the immediate concerns.The AIT and Owner were informed that Immediate Jeopardy was removed on 02/16/2026 at 8:20 PM. The facility remained out of compliance at a severity level of no actual harm with the potential for minimum harm that was not immediate jeopardy and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that nurse aides were able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care for 9 (NA-A, NA-C, NA-F, NA-G, NA-H, NA-J, NA-L, NA-M, and NA- P) of 9 NA's reviewed for competency and training and 1 of 8 (Resident #1) residents reviewed for mechanical lift.The facility failed to ensure NA-A did not transfer Resident #1 with a mechanical lift without the assistance of a CNA or nurse, which resulted in Resident #1 receiving a distal femur fracture.The facility failed to ensure nurse aides were trained on how to use a mechanical lift for NA-A, NA-C, NA-F, NA-G, NA-H, NA-J, NA-L, NA-M, and NA- P. An Immediate Jeopardy (IJ) situation was identified on 02/13/2026. While the IJ was removed on 02/16/2026, the facility remained out of compliance at a scope of a pattern with the potential for more than minimal harm, due to the facility's need to evaluate the effectiveness of their corrective systems.This failure could place residents at risk of injury due to not being supervised and placed them at risk of serious bodily harm, physical impairment, hospitalization or death.Findings include:Record review of the facility provided Nurse Aid checklist for Orientation/Evaluation not dated, revealed NAs cannot do the following tasks by themselves:?helping patients into chair from bed or helping patients into wheelchair.Record review of personnel files revealed:NA-A hired on 09/25/2025 worked for facility full time and was terminated on 01/28/2026, and no evidence of Aide Checklist for Orientation/Evaluation or any training regarding resident care for NA-A.NA-C had a hire date of 11/19/2024, worked full time, had not been certified, and showed no evidence of mechanical lift training.NA-F had a hire date of 2/28/2025, worked full time, had not been certified, and showed no evidence of mechanical lift training.NA-G had a hire date of 3/29/2024, worked full time, had not been certified, and showed no evidence of mechanical lift training.NA-H had a hire date of 3/12/2025, worked full time, had not been certified, and showed no evidence of mechanical lift training.NA-J had a hire date of 9/2/2025, worked full time, had not been certified, and showed no evidence of mechanical lift training.NA-L had a hire date of 1/15/2025, worked full time, had not been certified, and showed no evidence of mechanical lift training.NA-P had a hire date of 6/6/2025, worked full time, had not been certified, and showed no evidence of mechanical lift training. During an interview on 01/28/2026 at 3:10 PM, NA-F stated she was not certified. She stated that she had not been trained regarding 2-person mechanical lift transfers. She stated she had performed a skills checklist when she was hired but could not remember if mechanical lifts were on it. She stated she never transferred with a mechanical lift without there being 2 staff. She stated she had no restrictions, and she provided full resident care. During an interview on 01/28/2026 at 3:15 PM, NA-G stated she was not certified. She stated that she had not been trained regarding 2-person mechanical lift transfers. She stated she had performed a skills checklist when she was hired but could not remember if mechanical lifts were on it. She stated she never transferred with a mechanical lift without there being 2 staff. She stated she had no restrictions, and she provided full resident care.During an interview on 01/28/2026 at 5:15 PM, the AIT stated the checklist completed by the NAs was what NAs were allowed to do per the facility policy. She stated that according to the checklist transfers were not allowed to be done alone by NAs and verified that 2-person mechanical lift transfers were not on the NA checklist. She stated that it was her expectation for all mechanical lifts to be performed with 2 staff members. She stated she could not find NA-A's checklist or any training. AIT stated that all training of NAs was the responsibility of the DON and the ADON. She stated that the facility has had a (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	hard time keeping a DON and that things have been misplaced and probably not done correctly. AIT stated she had never been notified of any concerns of NAs transferring residents with the mechanical lift alone.During an interview on 02/01/2026 at 12:12 PM, the ADON stated NAs cannot perform any transfers without a CNA or a nurse. She stated that 2 NAs together still cannot perform these activities. She stated that nurses are supposed to help and supervise the NAs to ensure that they are not performing tasks that they are not trained in. She stated that when 2 NAs are on the floor the nurse is responsible for helping. ADON denied receiving concerns from LVN-K about NAs transferring residents with mechanical lifts.During an interview on 02/11/2026 at 3:13 PM, the MD stated he was not aware the facility had been using so many uncertified aides. The MD stated the facility should have been using agency staff to ensure residents were receiving care by staff were qualified. The MD stated the facility did have a hard time hiring certified aides because the facility could not compete with the bigger facilities and/or the hospitals. The MD stated facility should ensure staff receive the appropriate training and certifications. The MD stated his expectation was that the facility follow their policy regarding training of staff and ensuring staff work within their scope of practice. The MD stated his expectation was if the policy stated mechanical lift transfers required 2 people, then there needed to be 2 persons when using the mechanical lift. The MD stated his expectation was that staff who transfer residents with mechanical lift should know how to use it. The MD stated his expectation was that staff who were not certified follow the facility policy/procedures when providing care to residents. Facility policy titled Lifting Machine, Using a Mechanical Lift, revised July 2017, states: At least 2 nursing assistants are needed to safely move a resident with a mechanical lift.The facility's job description for nurse aide revealed Qualifications: . 2. Must be enrolled in a competency training program approved by the State and performs only services of a type for which he/she has demonstrated competence.4. Demonstrates competency in skills and technical necessary to care for residents' needs as identified through Resident Assessment and described in the Plan of Care.This was determined to be an Immediate Jeopardy (IJ) on 02/13/2026 at 12:40 PM. The AIT and Owner were notified. The AIT and Owner were provided with the IJ template on 02/13/2026 at 12:40 PM. A Plan of Removal was requested.The following Plan of Removal was accepted on 02/15/2026 at 2:15 PM: TAG F726 - Competent Nursing Staff (IJ)Direct Care Staff: A direct care staff can be any trained individual that demonstrates competency according to the facility's aid competency checklist. This may be an NA that is enrolled in a CNA training class and employed less than 120 days, a CNA, and LVN, or an RN that provides direct care to a resident, including but not limited to assistance with ADLs such as eating, bathing, toileting, transfers, hygiene care, etc. There must be two direct care staff on the floor at all times in addition to one LVN/RN charge nurse. There should be a total of one LVN/RN and two direct care staff in the building at all times if there are any mechanical lift residents. Staffing requirements will be assessed weekly based on census and resident needs. There will be two direct care staff if the facility has any residents that use mechanical lift or are a two-person transfer. DON and ADON will ensure that all agency or temporary direct care staff have documented training prior to working a shift. Current temporary agency is giving us access to their portal so that we can check their credentials. The Sister facility will send us their CNA credentials prior to working a shift. This will be started on 02/14/2026 and will be on going.Corrective Action:Resident #1 was dropped in a single-person mechanical lift transfer by NA-A and was immediately assessed by LVN-E upon findings, received treatment in hospital, and facility has followed orders upon discharge by 02/13/2026.All residents residing in the facility have the potential to be affected by not having certified aides. Immediate review of staffing credentials was conducted on 02/02/2026 by AIT. Five of the (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	NA's did not have certification. All uncertified staff will be moved to hospitality aide positions on 02/14/2026 and the facility will utilize temporary staffing agency to meet certified aide requirements.Any Direct Care Staff not meeting CNA requirements were removed from assignment requiring certification on 02/13/2026. If the aides are not certified, they will be moved to a hospitality aid position or relieved from duty and will not count towards the two direct care staff count. The IDT did not have a clear understanding of CNA requirements in relation to NAs that have completed part or the entire NATCEP training and waiting for approval to test until 02/13/2026. The IDT redefined aide requirements on 02/14/2026 with clear definitions and assigned titles accordingly to all aides. Systemic Changes:Facility will ensure only certified nurse aides are assigned to CNA-required roles starting 02/13/2026. The AIT will be responsible for scheduling CNAs for each shift. The facility will utilize temporary staffing agencies and aides from the sister facility, [sister facility], to meet certified aide requirementsVerification by the AIT of active CNA certification will be completed prior to scheduling on 02/13/2026. CNAs have been trained by their NATCEP program instructor through the Texas approved training course on call lights, peri care, mechanical lifts, and resident care as part of their CNA classroom and clinical training per NATCEP requirements. All staff have been educated by AIT on call light usage on 01/30/2026 and have been trained upon hire since. The DON is providing an in-service on call light usage on 02/14/2026 to all nursing staff including RN, LVN, and all aides. The in-service must be completed prior to the beginning of the first shift. Office Manager/designee will perform license verification checks on 02/13/2026 for all direct care staff upon hire, and weekly thereafter for 12 weeks. The AIT will review the list for accuracy and completionThe DON trained all Direct Care Staff on falls and call light usage via phone calls with return instruction to ensure retention of information on 02/14/2026. Any staff members that do not answer the phone will not be able to return to work their shift until the staff is retrained on falls and call lights. Monitoring:Administrator/DON will review staffing roster weekly for 12 weeks to ensure compliance. If non-compliance is discovered, then the facility will utilize staffing agencies and aides from the sister facility in [sister facility town] to ensure there are adequate staffing levels for CNAs. Starting 02/14/2026, all agency and sister facility direct care staff will be provided an educational handout for review directed by the charge nurse prior to starting the shift on the floor on their first shift. Agency and sister facility staff will sign a check-in sheet that they have reviewed the educational material in a binder at the nurses station for every shift worked thereafter starting 02/15/2026. The handout will provide an in-service about abuse and neglect, call light usage, mechanical lift transfer, and falls. Verification of competency will be demonstrated with a verbal return of information and staff signature. Findings will be reviewed in monthly QAPI for 3 months.Completion Date: 02/15/2026Monitoring of the facility's Plan of Removal revealed the following:Review of progress notes dated 01/26/2026, revealed that Resident #1 was assessed and admitted to the hospital immediately after notifying staff of the incident.Review of Hospital Discharge Orders and Instructions dated 01/29/2026, revealed that physicians orders and review of physicians' orders revealed they were entered into the system.During an interview on 02/16/2026 at 9:15 am, LVN-E stated that she assessed Resident #1 immediately and notified the physician, ADON, and the family.During an interview on 02/16/2026 at 3:45 PM, AIT stated that her review of staffing credentials revealed that 5 NA's that did not have certification: NA-F, NA-H, NA-G, and NA-C and NA-J who are no longer employed here. She stated NA-G was the activity director and was no longer working the floor and NA-F and NA-H were changed to HAs.During an interview on 02/15/2026 at 2:55 PM, NA-H stated that she was an HA and that she could not provide direct care. She stated that she could not perform any transfers or any incontinent (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	care.During an interview on 02/16/2026 at 12:00 PM, NA-F stated that she was an HA and that she could not provide any direct resident care. Stated that she can only pass out trays, answer call lights, and push residents wheelchairs. Stated that she could not transfer or perform any direct patient care. During an interview on 02/16/2026 at 12:25 PM, DON stated she received clarification on the difference between an HA and an NA and that the facility was going to ensure that all staff knew their titles and their job qualifications and restrictions.Review of schedules and timecards revealed: 02/14/2026 6a-6p CNA-D and Agency CNA worked as direct care staff.During an observation on 02/14/2026 at 12:30 PM observed CNA-D and Agency CNA in the facility providing direct patient care.Review of schedules and timecards revealed: 02/14/2026 6p-6a LVN-V worked as direct care staff from 6PM-10PM and ADON worked until 10PM. Review revealed sister facility CNA-U worked from 10PM-6am along with NA-W.During an observation on 02/14/2026 at 6:15 PM observed ADON and LVN-V in the facility providing direct patient care.Review of schedules and timecards revealed: 02/15/2026 6a-6p CNA-D and DON worked as direct care staff.During an observation on 02/15/2026 at 11:30 am observed CNA-D and DON in the facility providing direct patient care.Review of schedules and timecards revealed: 02/15/2026 6p-6a Agency CNA and NA-O worked as direct care staff.During an observation on 02/15/2026 at 6:15 PM observed in the facility Agency CNA and NA-O providing direct patient care.During and observation on 02/16/2026 at 3:00 PM observed DON and LVN-K providing direct patient care. Review of in-service regarding two-person mechanical protocol and policy, answering call light timely, reporting incidents abuse and neglect, and fall prevention dated 01/30/2026 signed by 16 employees. In-service stated answer call lights within 3 minutes, never ignore a call light, bathroom assistance protocol, and post fall do not move the resident after a fall, assess first, and 2 staff are required to perform a mechanical lift transfer at all times.During interviews on 02/15/2026 from 2:20 PM- 02/16/2026 9:25 am, LVN-E and LVN-K stated they work the day shift from 6am-2PM. They stated that they were in-serviced on 01/30/2026 by the AIT regarding falls and call light response. They stated on 02/16/2026 prior to working her shift she was educated by the DON regarding falls and call lights and took a Quiz. Verified their signature on all in-services and completed Quiz. They stated the expectation was for call lights to me answered within 3 minutes.During interviews on 02/15/2026 from 2:20 PM- 02/16/2026 9:25 am, CNA-D, NA-H, and NA-F stated they work the day shift from 6am-6PM. They stated that they were in-serviced on 01/30/2026 by the AIT regarding falls and call light response. They stated on 02/14/2026 they were educated by the DON regarding falls and call lights and took a Quiz. Verified their signature on all in-services and completed Quiz. They stated the expectation was for call lights to me answered within 3 minutes.During interviews on 02/15/2026 from 2:20 PM- 02/16/2026 9:25 am, RN-R and RN-T stated they work the evening shift from 2PM-10PM. They stated that they were in-serviced on 01/30/2026 by the AIT regarding falls and call light response. They stated on 02/14/2026 they were educated by the DON regarding falls and call lights and took a Quiz. Verified their signature on all in-services and completed Quiz. They stated the expectation was for call lights to me answered within 3 minutes.During interviews on 02/15/2026 from 2:20 PM- 02/16/2026 9:25 am, LVN-B stated she worked the night shift from 10PM-6am. She stated that she was in-serviced on 01/30/2026 by the AIT regarding falls and call light response. She stated on 02/14/2026 she was educated by the DON regarding falls and call lights and took a Quiz. Verified her signature on all in-services and completed Quiz. She stated the expectation was for call lights to be answered within 3 minutes.During an interview on 02/15/2026 at 3:00 PM, the ADON stated she provided an in-service on 01/16/2026 regarding falls and call-light response.During an interview on 02/15/2026 at 3:05 PM, the AIT stated she provided an in-service regarding call light response on 01/30/2026. During an interview on 02/15/2026 at 3:25 PM, the (continued on next page)

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	676053	A. Building B. Wing	02/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Merkel Nursing Center	1704 N 1st Merkel, TX 79536

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	DON stated she provided education via phone to all employees regarding falls and call lights on 02/14/2026.Reviewed document titled, Weekly License Verification Checks, last completed 02/16/2026 by BOM revealed: NA-W enrolled in college, NA-O enrolled in college, NA-F not licensed, NA-H not licensed, N-G not licensed, and CNA-D licensed. During an interview on 02/16/2026 at 2:50 PM, the AIT who stated that weekly verification checks would be performed by BOM and that she would ensure that this would be completed.During an interview on 02/16/2026 at 2:55 PM, the BOM stated she performed a license verification check on 02/13/2026 and will continue to do that weekly.During an interview on 02/15/2026 at 3:25 PM, the DON stated she provided education via phone to all employees regarding falls and call lights on 02/14/2026.Reviewed in-service training provided by DON on 02/14/2026 revealed 6 signatures. Over the phone training was conducted with 4 employees.Review of Employee roster and in-service signature sheets all staff currently employees for the facility were trained by the DON on 02/14/2026 and 02/16/2026 all prior to working their shift. During an observation on 02/16/2026 9:30 am call light for room [ROOM NUMBER] go off at 9:30 am. LVN-E answered and assisted the resident off of the toilet at 9:33 am.During an observation on 02/16/2026 2:30 PM call light for room [ROOM NUMBER] go off at 2:30 PM and answered at 2:32 PM by DON.Reviewed education hand out for agency and temporary staff that covered abuse and neglect, call light usage, mechanical lift transfer, and falls. signed by CNA- U and dated 02/14/2026.During a phone interview on 02/05/2026 at 4:45 PM, CNA-U stated that she was given the handout prior to working her shift on 02/14/2026 by RN-R.During an interview on 02/05/2026 at 4:50 PM, RN-R verified that CNA-U received the handout and verbalized understanding prior to working on 02/14/2026.Observation on 02/15/2026 at 6:15 PM, DON reviewed educational handout for agency CNA coming on-shift. Agency CNA acknowledged the information and signed the form. During an interview AIT stated that an informal QAPI was done on 02/11/2026 with the MD and he stated that this would count as QAPI. She stated that the MD was notified by the owner when the IJs were called. She stated that she was getting all of the information together to have an official QAPI meeting.During an interview on 02/16/2026 at 4:00 PM, the MD stated that he did perform a QAPI at the facility on 02/11/2026 and that he was a part of the plan of removal. He stated that he was notified immediately after the IJs were called. He stated that the facility was doing the best that they can to fix the immediate concerns.The AIT and Owner were informed that Immediate Jeopardy was removed on 02/16/2026 at 8:20 PM. The facility remained out of compliance at a severity level of no actual harm with the potential for minimum harm that was not immediate jeopardy and a scope of pattern due to the facility's need to evaluate the effectiveness of the corrective systems that were put into place.

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Merkel Nursing Center	1704 N 1st Merkel, TX 79536

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interviews and record reviews, the facility failed to designate a registered nurse to serve as the director of nursing on a full-time basis for 1 of 1 facility reviewed for full-time DON.The facility failed to ensure there was a full-time (worked 40 or more hours a week) DON in 9 of 11 (week 12/14/2025 - 12/20/2025, week 12/21/2025 - 12/27/2025, week 12/28/2025 - 01/03/2026, week 01/04/2026 - 01/10/2026, week 01/11/2026 - 01/17/2026, week 01/18/2026 - 01/24/2026, week 01/25/2026 - 01/31/2026, week 02/01/2026 - 02/07/2026, and week 02/08/2026 - 02/14/2026) weeks reviewed. This failure could affect all residents in the facility by leaving residents and staff without supervisory coverage for nursing care and services.Findings included:Record review of the DON clock-in / clock-out reports for December 2025 to February, 14th 2026, revealed no evidence of 40 hours of DON coverage for: week 12/14/2025 - 12/20/2025, week 12/21/2025 - 12/27/2025, week 12/28/2025 - 01/03/2026, week 01/04/2026 - 01/10/2026, week 01/11/2026 - 01/17/2026, week 01/18/2026 - 01/24/2026, week 01/25/2026 - 01/31/2026, week 02/01/2026 - 02/07/2026, and week 02/08/2026 - 02/14/2026. The DON clock-in/clock-out reports revealed the DON worked 4 hours on 1/13/2026, 7 hours on 1/14/2026, 8 hours on 1/20/2026, 3 hours on 1/30/2026, and 8 hours on 2/5/2026.During an interview on 1/28/2026 at 12:30 p.m., the AIT stated there was no DON present in the building at the time of entrance.During an interview on 1/28/2026 at 12:30 p.m., the owner stated there was no DON present in the building at the time of entrance.During an interview on 1/28/2026 at 12:30 p.m., the ADON stated there was no DON present in the building at the time of entrance.During an interview on 02/05/2026 at 8:55 a.m., the DON stated that 02/05/2026 was her first day working on the floor in the facility and that she was in training. She stated she had done online training prior to 02/05/2026.During an interview on 02/09/2026 at 5:45 p.m., the ADON stated the facility had not had a DON in the building 40 hours per week since mid-December 2025. The ADON stated a DON had been hired but had not been in the building full-time. The ADON stated resident care had been affected because the facility did not have an Infection Preventionist, no one had conducted antibiotic stewardship, and the care plans had not been updated. She stated the previous DON's last day was sometime in December of 2025. She stated the facility had RNs that worked in the facility, but they were not fulfilling the DON duties. She stated both RNs working in the facility did not want to serve in the DON role. The ADON did not specify how resident care was not affected by not having a DON.During an interview on 02/09/2026 at 6:20 p.m., the AIT stated the facility did not have a full-time DON. She stated the facility had hired a DON. She stated the DON had completed online training but had not started full-time in the facility.During a telephone interview on 02/11/2026 at 3:42 p.m., the MD stated it was his expectation for the facility to have a full-time DON. He stated the interim DON was set to start full-time February 23rd, 2026. The MD would not state if there had been any effect on the residents at the facility from there not being a full-time DON. He stated he expected the facility to follow their policies on DON coverage.Record review of the facility policy titled Director of Nursing Services, revised on August 2006, reflected The Director is employed full-time (40-hours per week) and is responsible for, but is not necessarily limited to: a. Developing and periodically updating the nursing service objectives and statements of philosophy; b. Developing standards of nursing practice; c. Developing and maintaining nursing policy and procedure manuals; d. Developing and maintaining written job descriptions for each level of nursing personnel; e. Scheduling of daily rounds to visit residents; f. Developing methods for coordination of nursing services with other resident services; g. Recruiting and retaining the number and levels of nursing personnel necessary to meet the nursing care needs of each resident; h. Developing staff training programs for nursing service personnel; i. Participating (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	in the planning and budgeting for Nursing Services; j. Ensuring that all health services notes are informative and descriptive of the supervision and care rendered including the resident's response to his or her care; k. Assessing the nursing requirements for each resident admitted and assisting the Attending Physician in planning for the resident's care; l. Participating in the development and implementation of the resident assessment (MDS) and comprehensive care plan; m. Establishing resident selection criteria for determining which residents may be fed by paid feeding assistants; and n. Assuring that nursing care personnel are administering care and services in accordance with the resident's assessment care plan.

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. Based on interview and record review the facility failed to not use any individual working in the facility as a nurse aide for more than 4 months on a full-time basis unless that individual is competent to provide nursing and nursing related services and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the state or had been deemed or determined competent as provided in S483.150(a) and (b) for 8 of 11 (NA-A, NA-C, NA-F, NA-G, NA-H, NA-J, NA-L, and NA-P) Nurse Aides. The facility failed to ensure NA-A, NA-C, NA-F, NA-G, NA-H, NA-J, and NA-L were certified within the required time frame.This failure could place residents at risk for receiving care from an individual whose skill level was not known. Findings include:Review of the facility's employee files revealed: NA-A had a hire date of 9/25/2025 and worked full time until she was termed on 1/28/2026. NA-C had a hire date of 11/19/2024 and worked full time. NA-F had a hire date of 2/28/2025 and worked full time. NA-G had a hire date of 3/29/2024 and worked full time. NA-H had a hire date of 3/12/2025 and worked full time. NA-J had a hire date of 9/2/2025 and worked full time until she was termed on 2/4/2026. NA-L had a hire date of 1/15/2025 and worked full time until he was termed on 1/28/2026.During a telephone interview on 02/03/2026 at 4:45 p.m., NA-A stated she had worked at the facility since September. NA-A stated she had taken the CNA classes and passed the written test two years ago, but failed the skills test. NA-A stated she had been rescheduled to retake the skills test but never took the retest and now she had to take the classes again.During a telephone interview on 2/3/2026 at 5:45 p.m., NA-C stated she had worked for the facility for over a year. NA-C stated she had completed 40 hours of online CNA training and completed two in person classes provided by the facility. NA-C stated the facility just stopped the CNA classes and she had not completed the certification for that reason.During an interview on 02/03/2026 at 6:35 p.m., NA-F stated she had been working for the facility for over a year. She stated she had taken a written exam in the past and passed the exam but could not pass the clinical exam and was not certified. She stated she was waiting on the next 20 hours of training so that she could complete her certification process.During an interview on 02/09/2026 at 3:50 p.m., NA-H stated she had worked at the facility since March of 2025. NA-H stated she had finished the 60 hours of computer training to become a CNA but still had to do her clinical hours. She stated there was nowhere to take the clinical hours part of certification and that was why she had not tested.During an interview on 02/07/2026 at 5:45 p.m., the AIT stated none of the NAs were certified because they had not tested. She stated the facility was going to have the NAs complete the classes in February at their sister facility, but the NATCEP program had been cancelled. Record review of the Nurse Aide job description, not dated, reflected QUALIFICATIONS: 1. Has completed a training and competency evaluation program or a competency evaluation approved by the State and holds a current certificate from the State. 2. Must be enrolled in a competency training program approved by the State and performs only services of a type for which he/she has demonstrated competence. 3. Personality a tuned to the requirements of meeting needs of the infirm and aged. 4. Demonstrates competency in skills and technical necessary to care for residents' needs as identified through Resident Assessment and described in the Plan of Care.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and record reviews, the facility failed to establish an infection prevention and control program that included an antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use for 3 of 3 months reviewed for antibiotic stewardship.The facility failed to maintain a system to monitor antibiotic use during the months of December 2025, January 2026 and February 2026.These failures placed residents at risk of adverse outcomes associated with the inappropriate use of antibiotics.Findings included:Record review of the facility infection tracking log revealed no evidence of an infection tracking log for antibiotic stewardship program for the months of December 2025, January 2026 and February 2026. During an interview on 02/09/2026 at 5:45 p.m., the ADON said she had performed IP tasks such as tracking infection prior to the previous DON being hired into the facility. The ADON stated she was not currently responsible for the tracking/trending of infections, but she had previously had a binder with all the residents who received antibiotics. She stated the previous DON's last day was sometime in mid-December of 2025 and she could not provide any evidence of antibiotic stewardship since when she had tracked infections and antibiotic use prior to the previous DON taking over. The ADON did not say how residents were affected or could be affected by not maintaining a system to monitor antibiotic use. During an interview on 02/10/2026 at 10:38 a.m. the AIT stated the previous DON, and the new DON had completed the infection preventionist program and were the IPs of the facility. She could not provide any evidence of the infection tracking/trending in the months of December 2025, January 2026 and present. She stated the facility had hired a DON, but she had not started full-time. During an interview on 02/05/2026 at 8:55 a.m., the DON stated 02/05/2026was her first day working on the floor in the facility and that she was still training. She stated she had completed online training prior to 02/05/2026.Record review of facility policy titled Surveillance for Infections, revised on date September 2017, reflected 1. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and Healthcare-Associated Infections, to guide appropriate interventions, and to prevent future infections. 2. The criteria for such infections are based on the current standard definitions of infections. 3. Infection that will be included in routine surveillance include those with: a. Evidence of transmissibility in a healthcare environment; b. Available processes and procedures that prevent or reduce the spread of infection; c. Clinically significant morbidity or mortality associated with infection (e.g., pneumonia, UTIs, C. difficile); and d. Pathogens associated with serious outbreaks. (e.g., invasive streptococcus Group A, acute viral hepatitis, norovirus, scabies, influenza (Flu).

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interviews and record reviews, the facility failed to have a designated Infection Preventionist who worked at least part-time at the facility and had completed specialized training in infection prevention and control for 1 of 1 facility reviewed for infection control.The facility failed to have a designated Infection Preventionist (IP) who worked at least part-time in the months of December 2025, January 2026 and February 2026.This failure could affect residents by placing them at risk of infection spread by the facility not appropriately recognizing and responding to communicable diseases and infections. Findings included:Record review of IP certificate dated 01/14/2026 reflected the DON had completed the course for Nursing Home Infection Preventionist Training. During an interview on 02/09/2026 at 5:45 p.m., the ADON said she had performed IP tasks such as tracking infection prior to the previous DON being hired into the facility. She stated the previous DON's last day was December 12, 2025. She stated she made sure that the new DON had completed training on infection preventionist, but she had not started full-time in the facility and was not keeping track of the infections in the facility at this time. She could not provide any records of where the facility had recently tracked the infections in the facility. The ADON stated there was no IP appointed when the DON position was vacant.During an interview on 02/10/2026 at 10:38 a.m. the AIT stated the previous DON, and the new DON had completed the infection preventionist program. She provided the new DON's Infection Preventionist certificate dated 1/14/2026. She stated the facility had been working with another staff member with infection control and provided a certificate titled Infectious Diseases and Infection Control dated 10/25/2017 for that staff member but it was not a nursing?facility-specific Infection Preventionist (IP) training.During an interview on 02/05/2026 at 8:55 a.m., the DON stated 02/05/2026 was her first day working on the floor in the facility and that she was in training. She stated she had completed online training prior to 02/05/2026.Record review of facility policy titled Surveillance for Infections, revised on September 2017, reflected The Infection Preventionist will conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions.At the time of exit, no further policies were provided.