| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676154 | A. Building<br>B. Wing | 06/03/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Capstone Healthcare of Hughes Springs | 215 Fm 161 Business South<br>Hughes Springs, TX 75656 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility's only kitchen (1 of 1 kitchen) reviewed for food safety requirements. 1. The facility failed to ensure the food mixer was free of a blackish/grey dried substance on the [NAME] head on 06/01/2026. 2. The facility failed to ensure the toaster oven was free of a thick, sticky layer of brown, black and yellow crumbs on 06/01/2026. 3. The facility failed to ensure the plates and trays were appropriately dried before storing on 06/01/2026. 4. The facility failed to ensure the ice machine was free of an orange liquid substance on the interior portion of the top of the cooler on 06/01/2026. These failures could place residents at risk of foodborne illness and food contamination.Findings include: During the initial tour observation and interview on 06/01/2026 at 09:10 AM to 10:00 AM revealed:1. The food mixer had four clumps of dried blackish/grey substance around the sides of the [NAME] head. 2. The toaster oven had a layer of thick, sticky, black, brown and yellow crusty crumbs. 3. The plates and trays were stacked on a kitchen cart against a cabinet/wall with water noted in between the plates and trays.4. The ice machine had a thin line of a runny liquid orange substance with a slow drip into the fresh ice cubes. The Dietary Manager said the food mixer should be cleaned after each use which included the head portion of the [NAME] because of splashing while in use, to prevent the spread of bacteria and food contamination. The Dietary Manager said the plates and trays should remain unstacked to allow air dry to prevent the potential of bacteria growth. The Dietary Manager said the kitchen did not allow enough space for proper air drying. During an interview on 06/03/26 at 10:27 AM, the Dietary Manager said she was not sure how to clean the toaster and would have to figure out how to remove the rollers to remove all the layers of crumbs. The Dietary Manager stated she had not checked the ice machine within the last month or so because she thought that services were contracted out to the ice machine supplier. The Dietary Manager said she monitored the kitchen cleanliness by walk throughs but did not have any documentation of the check offs. The Dietary Manager said ultimately, she was responsible for ensuring the dietary staff and/or herself kept the appliances clean to prevent bacteria and cross contamination, which could make the residents unhealthy. During an interview on 06/03/2026 at 12:14 PM, the Administrator said she expected the cleanliness of the kitchen to meet the requirements. The Administrator said she expected sanitary food practices were followed to prevent food borne illness. The Administrator said she expected the Dietary Manager to monitor the kitchen for cleanliness. The Administrator said she was ultimately responsible for the Dietary Manager oversite and randomly got food out of the kitchen and spot checked while she walked through the kitchen. The Administrator said she needed to educate herself on the ice machine contracts because she had been in the facility for a year and recalled the ice machine being serviced at one time by an outside resource but somehow that was put on the side and not followed up on. The Administrator said it was important for sanitary practices to be followed with food preparation and handling to prevent the residents from getting sick or having any type of weight loss. Record review of the facility's Food Storage/Safety and Supplies policy, implemented on 03/01/2026, indicated It is the policy of this facility to procure<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | food from sources approved or considered satisfactory by federal. Food safety practices will be followed throughout the facility's entire food handling process. E. Equipment used in the handling of food including dishes, utensils, mixers, grinder, toasters . |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's drug regimen was free from unnecessary psychotropic drugs and residents who used psychotropic drugs received gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; and PRN orders for psychotropic drugs were limited to 14 days for 2 of 5 residents (Resident #8 and Resident #26) reviewed for unnecessary psychotropic drugs. 1. The facility failed to ensure Resident #8 did not have a PRN order for lorazepam 0.5 mg (a prescription medication used to treat anxiety disorders: feelings of fear, dread, and uneasiness) after 14 days without an evaluation by the physician for continued treatment with a rationale in the resident's medical record. 2. The facility failed to ensure a GDR was attempted for Resident #26's duloxetine medication (a medication used to treat depression) in November 2025 and May 2026. The doctor did not provide an appropriate rationale for not attempting either GDR. These failures could place residents at risk of psychotropic medication side effects, adverse consequences, decreased quality of life, and dependence on unnecessary medications. Findings included: 1. Record review of Resident #8's face sheet, dated 06/01/26, reflected that she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included generalized anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry about everyday situations, even when there is little to no cause for concern). Record review of Resident #8's significant change MDS assessment, dated 03/30/26, reflected she had a BIMS score of 08, which indicated moderate cognitive impairment. She was usually able to make herself understood, and she was usually able to understand others. The assessment reflected that she took an antianxiety medication during the 7-day window. Record review of Resident #8's physician's orders, printed on 06/01/26, reflected that she had an order for lorazepam oral tablet 0.5 mg, give 1 tablet by mouth every 8 hours as needed for anxiety/restlessness for 60 days. The start date was 05/06/26, and the end date was 07/05/26. Record review of Resident #8's MAR, dated May 2026, reflected she had an order for lorazepam oral tablet 0.5 mg, give 1 tablet by mouth every 8 hours as needed for anxiety/restlessness for 60 days. The start date was 05/06/26. She received this medication two times on 05/25/26 and 05/29/26, and 1 time on 05/06/26, 05/07/26, 05/11/26, 05/12/26, 05/13/26, 05/14/26, 05/15/26, 05/16/26, 05/20/26, 05/22/26, 05/23/26, 05/26/26, 05/30/26, and 05/31/26. 2. Record review of Resident #26's face sheet, dated 06/02/26, reflected that she was an [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included major depressive disorder (a serious mood disorder characterized by persistent sadness, loss of interest in activities, and an inability to function normally) with an onset date 10/06/25. Record review of Resident #26's quarterly MDS assessment, dated 04/15/26, reflected that she had a BIMS score of 09, which indicated moderate cognitive impairment. She was able to make herself understood, and she was able to understand others. She did take an antidepressant medication during the 7-day window. Record review of Resident #26's physician's orders, printed on 06/02/26, reflected that she had this order:*duloxetine capsule delayed release 30 mg, give 1 capsule by mouth two times a day for depression. The start date was 05/21/25. Record review of a Consultant Pharmacist / Physician Communication form, dated 11/20/25, reflected: .Resident is receiving the following psychoactive medication which is due for review. Per CMS regulations please evaluate the resident for a trial dosage reduction:Medication: Duloxetine 30mg BIDSuggested Change: Duloxetine 30mg QD.If a dosage reduction is contraindicated or resident failed previous attempt, please document below.Physician/Prescriber ResponseNo [change][provider signed and dated 12/02/25] . Record review of a Consultant Pharmacist / Physician Communication form, dated May 2026, reflected: .Resident is receiving the following psychoactive medications that are due for review. Per CMS regulations, please evaluate resident for trial dose reduction.Current<br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | order: Duloxetine 30mg BIDProposed change: Duloxetine 30mg QD.If dose reduction is contraindicated for resident failed previous reduction attempt, please document below.Physician/Prescriber Response.Stable no [change][signed by provider but not dated] . During an interview on 06/03/2026 at 11:07 AM, the ADON said Resident #8's order for PRN lorazepam should have been limited to 14 days, but they had a rationale for it being 60 days. She said they attempted to change the dose to scheduled in the past, but the resident did not want it that way. She said she would search the chart to see if they had a rationale from the doctor for 60 days duration. She said she thought an appropriate rationale was provided for not attempting a GDR for Resident #26's duloxetine medication. She said she was a nurse and she was required to follow the physician's orders. She said she did not have a comment on whether the doctor should have provided a different rationale. She said the DON and ADON were responsible for ensuring that GDRs were attempted. She said the process was that they received the GDRs from the pharmacy consultant and then they sent those over to the doctor. She said they then received it back from the doctor and made changes as ordered. During an interview on 06/03/2026 at 11:21 AM, the DON said that Resident #8 could have a PRN order for longer than 14 days if the doctor had given a rationale. She said she had reached out to the doctor to see if it was in his visit note. She said that they had attempted to swap it to scheduled in the past and the resident did not like it. She said she would not go against the rationale provided for not attempting Resident #26's duloxetine GDR. She said if the resident needed anything or if she did not agree with it then she would have a conversation with the provider. She said if she received a piece of paper that said stable no changes then that was what they were going to go with. She said she felt like the GDR rationale was proper. She said she felt that the physician writing stable no changes meant it was clinically contraindicated to do the GDR. During an interview on 06/03/2026 at 12:20 PM, the DON said she did not have a rationale documented for Resident #8's PRN lorazepam. She said she was waiting to hear back from the doctor to see if he had documented it in a doctor's note. A rationale was not provided. During an interview on 06/03/2026 at 12:31 PM, the Administrator said they should have a documented rationale for why Resident #8 had an order for PRN lorazepam extended past 14 days. She said she was not clinical, so she was unsure what the risk was. She said she was unsure on the process for GDRs and was unable to comment on Resident #26's GDRs. Record review of the facility's policy, Use of Psychotropic Medication(s), dated 03/01/26, reflected: .16. Psychotropic medications used on a PRN basis must have a diagnosed specific condition and indication for the PRN use documented in the resident's medical record and is subject to the limitations as noted:a. PRN orders for psychotropic medications, excluding antipsychotics, shall be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond 14 days. The medical record should include documentation from the physician or prescriber for the rationale for the extended time period and indicate a specific duration. Record review of the facility's policy, Gradual Dose Reduction of Psychotropic Drugs, dated 03/01/26, reflected: .1. Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner has initiated a psychotropic medications, the facility will attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated.2. After the first year, a GDR will be attempted annually, unless clinically contraindicated.6. Rationale for clinical contraindications may be documented on the Clinically Contraindicated Dosage Reduction form or other facility designated form or format. |

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| F 0644<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to refer all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment for 1 of 4 residents (Resident #26) reviewed for PASRR. The facility failed to complete an HHSC 1012 form and submit a new PASRR Level 1 form to the local health authority, when Resident #26 received a new diagnosis of major depressive disorder (a serious mood disorder characterized by persistent sadness, loss of interest in activities, and an inability to function normally) on 10/06/25. This failure could place residents at risk for their specialized services not being provided in a timely manner. Findings included:Record review of Resident #26's face sheet, dated 06/02/26, reflected that she was an [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included major depressive disorder (a serious mood disorder characterized by persistent sadness, loss of interest in activities, and an inability to function normally) with an onset date of 10/06/25. Record review of Resident #26's quarterly MDS assessment, dated 04/15/26, reflected that she had a BIMS score of 09, which indicated moderate cognitive impairment. She was able to make herself understood, and she was able to understand others. Record review of Resident #26's PASRR Level 1 Screening, dated 05/21/25, indicated that in Section C, Mental Illness was marked as no, which indicated Resident #26 did not have a mental illness. During an interview on 06/03/2026 at 10:28 AM, the MDS coordinator said she was responsible for reviewing PASRR forms. She said they did not do an HHSC form 1012 or anything to ensure that Resident #26 received a PASRR Evaluation when she received her major depressive disorder diagnosis in October 2025. She said she was not sure if they should have referred Resident #26 for a PASRR Evaluation. She said she did not know they should have referred Resident #26 to the local health authority for a PASRR Evaluation when she received the major depressive disorder diagnosis. She said it was possible Resident #26 may have received PASRR services since she received the diagnosis in October 2025. During an interview on 06/03/2026 at 11:07 AM, the ADON said she did not review PASRR forms. She said the MDS coordinator was responsible for PASRR. During an interview on 06/03/2026 at 11:21 AM, the DON said she did not deal with or review PASRR forms. During an interview on 06/03/2026 at 12:31 PM, the Administrator said she did not know about PASRR forms and did not deal with them. She said she expected the MDS coordinator to fill out the PASRR forms accurately, and ensure that when they received them, they were accurate. Record review of the Facility's policy, Resident Assessment - Coordination with the PASARR Program, dated 03/01/26, reflected: .9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Pre-admission Screening and Resident Review (PASRR) Level I assessment accurately reflected the resident's status for 2 of 4 residents (Resident #12 and Resident #36) reviewed for PASRR Level I screenings. 1. The facility failed to ensure the accuracy of the PASRR Level 1 screening for Resident #12. The PASRR Level 1 screening did not indicate a diagnosis of mental illness, although the diagnosis (schizoaffective disorder, bipolar type) was present upon Resident #12's admission date on 09/22/25. 2. The facility failed to ensure the accuracy of the PASRR Level 1 screening for Resident #36. The PASRR Level 1 screening did not indicate a diagnosis of mental illness, although the diagnosis (major depressive disorder) was present upon Resident #36's admission date on 09/01/24. These failures could place residents at risk of not receiving a needed assessment (PASRR Evaluation), individualized care, or specialized services to meet their needs. Findings included:1. Record review of Resident #12's face sheet, dated 06/01/26, reflected that she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included schizoaffective disorder, bipolar type (a chronic mental health condition characterized by a combination of schizophrenia symptoms [such as hallucinations or delusions] and severe mood swings) with an onset date of 09/22/25. Record review of Resident #12's quarterly MDS assessment, dated 04/14/26, reflected that she had a BIMS score of 10, which indicated moderate cognitive impairment. She was able to understand others, and she was able to make herself understood. Record review of Resident #12's PASRR Level 1 Screening, dated 09/22/25, indicated that in Section C, Mental Illness was marked as no, which indicated Resident #12 did not have a mental illness. 2. Record review of Resident #36's face sheet, dated 06/01/26, reflected that she was an [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included major depressive disorder (a serious mood disorder characterized by persistent sadness, loss of interest in activities, and an inability to function normally) with an onset date of 09/01/24, and vascular dementia, mild (a decline in thinking and reasoning skills caused by restricted or blocked blood flow to the brain) with an onset date of 09/27/24. Dementia was not marked as her primary diagnosis. Record review of Resident #36's medical diagnosis sheet, printed on 06/02/26, reflected that dementia was not her primary diagnosis during her entire stay at the facility. Record review of Resident #36's annual MDS assessment, dated 04/24/26, reflected that she had a BIMS score of 03, which indicated severe cognitive impairment. She was able to make herself understood, and she was usually able to understand others. Record review of Resident #36's PASRR Level 1 Screening, dated 02/21/25, indicated that in Section C, Mental Illness was marked as no, which indicated Resident #36 did not have a mental illness. Further, in Section C, Primary Diagnosis of Dementia was marked yes, which indicated her primary diagnosis was dementia. This section further reflected .This must be listed in the medical record as the primary diagnosis by the physician. During an interview on 06/03/2026 at 10:28 AM, the MDS coordinator said she was responsible for reviewing PASRR forms. She said she did not correct the PASRR Level 1 form for Resident #12, but she did call the local health authority to get them to conduct a PASRR Evaluation. She said she would look into Resident #12's records and provide a copy of the Evaluation. She said for Resident #36 she did not know major depressive disorder PASRR diagnosis. She said she did not get a PASRR Evaluation completed for Resident #36. She said Resident #36 may have received PASRR services since September 2025 if she was evaluated and considered to be PASRR positive. She said she was responsible for ensuring the PASRR forms were done correctly. She said her corporate consultant checked these behind her. She said the DON and ADON did not check the PASRR forms. She said she was not aware that Resident #36 did not have a primary diagnosis of dementia. She said she would check the PASRR forms on admit more thoroughly from now on. During an interview on 06/03/2026 at 11:07 AM, the ADON said she did not review PASRR forms. She said the MDS coordinator was responsible for PASRR. During<br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | an interview on 06/03/2026 at 11:21 AM, the DON said she did not deal with or review PASRR forms. During an interview on 06/03/2026 at 12:13 PM, the MDS coordinator said that she was unable to find a PASRR Evaluation for Resident #12. She said she called the local health authority, and they were also unable to find any evaluation for Resident #12. She said she was going to fill out an HHSC form 1012 and send it to the local health authority for each of these PASRR residents identified in the citation. During an interview on 06/03/2026 at 12:31 PM, the Administrator said she did not know about PASRR forms and did not deal with them. She said she expected the MDS coordinator to fill out the PASRR forms accurately, and ensure that when they received them, they were accurate. Record review of the facility's policy, Resident Assessment - Coordination with the PASARR Program, dated 03/01/26, reflected: .9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. |

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|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment for 1 of 17 residents (Resident #16) reviewed for comprehensive care plans. The facility failed to ensure Resident #16's refusal to wear her splint for contracture management was included in the comprehensive care plan. This failure could place residents at risk of not having individual needs met and a decreased quality of life. The findings included: Record review of the face sheet, dated 06/03/26, reflected Resident #16 was an [AGE] year-old female who admitted to the facility on [DATE] with a diagnosis of hemiplegia (weakness) and hemiparesis (paralysis) following a stroke affecting the right dominant side. Record review of the annual MDS assessment, dated 05/19/26, reflected Resident #16 had clear speech, was understood by others, and was able to understand others. Resident #16 had a BIMS score of 7, which indicated severe cognitive impairment. The MDS reflected Resident #16 had no behaviors or refusal of care. Record review of the comprehensive care plan, dated 03/04/26, reflected Resident #16 had a resting hand splint to be applied to the right upper extremity due to late effects of stroke. The care plan did not address Resident #16's refusal to wear the resting hand splint. Record review of the TAR, dated May 2026, reflected Resident #16 refused her resting hand splint 31 out of 31 days. Record review of the TAR, dated June 2026, reflected Resident #16 refused her resting hand splint 3 out of 3 days. During an observation on 06/01/26 at 10:35 a.m., Resident #16 was lying in the bed with the head of the bed elevated slightly. She did not have a resting hand splint to her right hand. During an observation on 06/01/26 at 3:15 p.m., Resident #16 was lying in the bed on her left side. The head of the bed was elevated slightly. She did not have a resting hand splint to her right hand. During an observation and attempted interview on 06/02/26 at 9:44 a.m., Resident #16 was lying in bed with the head of bed elevated slightly. She had no resting hand splint to her right hand. She was unable to answer questions appropriately related to cognition. During an observation on 06/03/26 at 11:13 a.m., Resident #16 was lying in bed. She had no resting hand splint to her right hand. During an interview on 06/03/26 at 11:33 a.m., RN B stated Resident #16 did not like wearing her resting hand splint to her right hand. She said Resident #16 refused to wear the splint a lot and stated it was uncomfortable. RN B stated the MDS Coordinator, ADON, or DON were responsible for care planning. She said refusal of care should have been included in the care plan. RN B stated she had access to the care plan on the electronic charting system. She stated it was important to ensure refusal of care was included in the care plan so the staff would know. During an interview on 06/03/26 at 1:25 p.m., the MDS Coordinator stated she was responsible for care planning. The MDS Coordinator stated she was aware Resident #16 refused to wear her resting hand splint for contracture management. She said she added Resident #16's refusal of care to the care plan earlier this morning (06/03/26). She stated refusal of care should have been included in the care plan. She said that she was on vacation and was getting things caught up. She stated it was important to ensure a resident's refusal of care was included in the care plan for continuity of care and making sure the staff were aware of the refusal. During an interview on 06/03/26 at 1:46 p.m., the DON stated the MDS Coordinator was responsible for care planning. The DON stated she expected refusal of care to have been included in the care plan. She stated it was important to ensure refusal of care was included in the care plan to ensure residents were getting the proper care and to ensure communication among staff. During an interview on 06/03/26 at 1:49 p.m., the Administrator stated she expected refusal of care to be included in the care plan. She stated nursing management was responsible for monitoring to ensure refusal of care was included in the care plan. She stated it was important to ensure refusal of care was included in the care plan to show<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 676154 | A. Building<br>B. Wing | 06/03/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Capstone Healthcare of Hughes Springs | 215 Fm 161 Business South<br>Hughes Springs, TX 75656 |

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

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|---|---|
| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the residents needs and honor their rights. Record review of the Comprehensive Care Plans policy, dated 03/01/26, reflected The comprehensive care plan will describe, at a minimum, the following: .b. Any service that would otherwise be furnished but are not provided due to the resident's exercise of his or her right to refuse treatment. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure in accordance with State and Federal laws, that all drugs and biologicals were stored in locked compartments under proper temperature controls, and permitted only authorized personnel to have access to the keys for 2 of 18 residents (Resident #12 and Resident #36) reviewed for storage of medication. 1. The facility failed to securely store Resident #12's dermal wound cleanser on 06/01/26. 2. The facility failed to securely store Resident #36's stomach relief medication (bismuth subsalicylate 525 mg) on 06/01/26, 06/02/26, and 06/03/26. These failures could place residents at risk for adverse reactions to medications or overdose. Findings included:1. Record review of Resident #12's face sheet, dated 06/01/26, reflected that she was a [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included schizoaffective disorder, bipolar type (a chronic mental health condition characterized by a combination of schizophrenia symptoms [such as hallucinations or delusions] and severe mood swings) with an onset date of 09/22/25. Record review of Resident #12's quarterly MDS assessment, dated 04/14/26, reflected that she had a BIMS score of 10, which indicated moderate cognitive impairment. She was able to understand others, and she was able to make herself understood. During an observation on 06/01/2026 at 9:45 AM, Resident #12 was lying in bed resting. There was a bottle of wound cleanser on the dresser at the end of Resident #12's bed. 2. Record review of Resident #36's face sheet, dated 06/01/26, reflected that she was an [AGE] year-old female, admitted to the facility on [DATE]. Her diagnoses included major depressive disorder (a serious mood disorder characterized by persistent sadness, loss of interest in activities, and an inability to function normally) with an onset date of 09/01/24, and vascular dementia, mild (a decline in thinking and reasoning skills caused by restricted or blocked blood flow to the brain) with an onset date of 09/27/24. Record review of Resident #36's annual MDS assessment, dated 04/24/26, reflected that she had a BIMS score of 03, which indicated severe cognitive impairment. She was able to make herself understood, and she was usually able to understand others. Record review of Resident #36's physician's orders, printed 06/01/26, did not contain an order for the stomach relief medication (an over-the-counter medication used to treat diarrhea, upset stomach, heartburn, nausea, and indigestion). During an observation on 06/01/2026 at 9:33 AM, Resident #36 was sitting in a wheelchair watching TV in her room. The refrigerator on her side of the room had a bottle of stomach relief medication inside it. During an observation on 06/01/2026 at 11:11 AM, Resident #36 was sitting in her wheelchair in the room. There was a bottle of stomach relief medication in the refrigerator. During an observation on 06/02/26 at 03:19 PM, Resident #36 was sitting in a wheelchair in her room watching TV. There was a bottle of stomach relief medication in her refrigerator. During an observation on 06/03/2026 at 9:53 AM, Resident #36 was not in the room at this time. The refrigerator had a bottle of stomach relief medication inside. During an interview on 06/03/2026 at 11:07 AM, the ADON said the wound cleanser should not have been on Resident #12's dresser and should have been secured in the wound care cart. She said a resident could potentially get a hold of it and use it for unintended purposes. She said the medication should not be in Resident #36's refrigerator. She said everybody was responsible for ensuring that medications were not left in the resident's room or fridge. She said anyone had access to the refrigerator and could use it for unintended purposes. During an interview on 06/03/2026 at 11:21 AM, the DON said the wound cleanser should not have been in Resident #12's room, and it should have been on the wound care cart. She said the stomach relief medication should not have been in Resident #36's refrigerator. She said someone could get ahold of it. She said everyone was responsible for checking the fridge. She said housekeeping was responsible for checking the refrigerator daily. During an interview on<br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 06/03/2026 at 11:53 AM, Housekeeper A said she checked the resident refrigerators when she cleaned the rooms. She said she worked on Resident #36's hall on 06/01, 06/02, and 06/03. She said she did not see the stomach medicine in the refrigerator any of those three days. She said it was housekeeping's responsibility to ensure that the refrigerators were checked. She said she checked it this morning sometime between 08:00 AM and 08:30 AM and there was no medication in the refrigerator. She said the risk of the medication being in the refrigerator was that someone could drink it. During an interview on 06/03/2026 at 12:31 PM, the Administrator said the wound cleanser should not have been at Resident #12's bedside. She said it could have a negative impact on her. She said every staff member should be checking for medications at the bedside. She said the stomach relief medication should not have been in Resident #36's refrigerator. She said the risk was that Resident #36 could drink it or use it as lotion. She said everyone should have been checking the fridges and housekeeping was also responsible. Record review of the facility's policy, Medication Storage, dated 03/01/26, reflected: .It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.All drugs and biologicals will be stored in locked compartments.under proper temperature controls. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>Based on observation, interview and record review the facility failed to ensure menus met the nutritional needs of residents in accordance with established national guidelines for 1 of 2 meal (the lunch meal) reviewed for food and nutrition services. The facility failed to ensure [NAME] F followed the recipe for pureeing the rice pilaf on 06/02/26 for the lunch meal. This failure could place residents at risk for weight loss, not having their nutritional needs met, and a decreased quality of life.Findings include: During an observation and interview on 06/02/26 at 12:26 PM, [NAME] F was observed on the procedure of pureeing the rice pilaf. [NAME] F appropriately scooped the rice from a pot and placed it into a canister to puree and added water, no were measurements used. [NAME] F said he did not have a recipe for the pureed rice pilaf to follow. He said he used to have one, but he did not know what the Dietary Manager did with it. [NAME] F said he had been doing this (cooking) for a while, so he knew how to puree the food with no recipe or measurements of the additive. [NAME] F said he knew he was supposed to follow the recipe when he pureed food. [NAME] C said he had to use water because the rice pilaf was too dry to puree and would not thin out if water was not used. [NAME] F was unsure why water should not be used as a diluent for pureed food. During an interview on 06/02/26 at 01:13 PM, the Dietary Manager said she was unable to locate the puree rice pilaf recipe. During an interview on 06/02/26 at 2:42 PM, the Dietician said there was a recipe for pureed rice pilaf. The Dietician said water should not be used for pureed rice pilaf or any other pureed food. The Dietician said not following the recipe and by using water, it could diminish the nutritive value of the food and cause weight loss. The Dietician said the dietary manager was responsible to oversee the cooks were using the proper recipe as well as ingredients to maintain the recommended daily caloric intake. During an interview with the Dietician on 06/02/26 at 2:42 PM, the recipe for pureeing the rice pilaf was requested and was not received by the time of exit. During an interview on 06/03/26 at 10:27 AM, the Dietary Manager said [NAME] F was supposed to be following the recipe when pureeing food because water was not ever used to provide a consistency because it had no nutritional value or if not following the recipe adding too much thickener could affect the consistency of the pureed food. The Dietary Manager said she trained all the cooks on how to puree food and tried to observe them making pureed food. The Dietary Manager said if the cooks added too much beef base or water when pureeing, it altered the flavor of the food and it also altered the nutritional value. The Dietary Manager said it was important to follow the menu when pureeing food because if the food did not taste good the residents would not eat it and altering the nutritional value of the food could result in the residents losing weight. The Dietary Manager said [NAME] F not following the recipe to make the pureed rice pilaf was the Dietary Manager's fault for not providing [NAME] F with the recipe. The Dietary Manager said [NAME] F not following the recipe could cause the residents to have weight loss During an interview on 06/03/2026 at 12:14 PM, the Administrator said the Dietary manager was responsible for ensuring the cooks followed the recipes and served the correct food according to the menu. The Administrator said she expected the cooks to follow all the recipes correctly. The Administrator said not following the recipe when pureeing food could make it too thin and could take nutrients away. The Administrator said water should not be used for pureeing due to there being no caloric value. Record review of the Puree Food Preparation policy, implemented on 03/01/26 indicated, .Fundamental Information: A preplanned menu is provided to the facility, which has been planned or reviewed by a Registered Dietitian and includes meals that are adequate to meet the average resident's nutritional needs. 5. Do not use water as an additive to prepare puree food. |